Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

The Health, Social Care and Sport Committee

27/09/2017

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Others in attendance

Bob Chadwick	Cyfarwyddwr Cyllid, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Director of Finance, Cardiff and Vale University Local Health Board
Gary Doherty	Prif Swyddog Gweithredol, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Chief Executive Officer, Betsi Cadwaladr University Local Health Board
Russ Favager	Cyfarwyddwr Cyllid, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr

	Director of Finance, Betsi Cadwaladr University Local Health Board
Stephen Forster	Cyfarwyddwr Cyllid, Bwrdd Iechyd Lleol Hywel Dda Director of Finance, Hywel Dda Local Health Board
Steve Moore	Prif Swyddog Gweithredol, Bwrdd Iechyd Lleol Hywel Dda Chief Executive Officer, Hywel Dda Local Health Board
Len Richards	Prif Swyddog Gweithredol, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Chief Executive Officer, Cardiff and Vale University Local Health Board
Mark Thomas	Cyfarwyddwr Cyllid, Bwrdd Iechyd Lleol Cwm Taf Director of Finance, Cwm Taf Local Health Board
Allison Williams	Prif Swyddog Gweithredol, Bwrdd Iechyd Lleol Cwm Taf Chief Executive Officer, Cwm Taf Local Health Board
Vanessa Young	Cyfarwyddwr, Cydffederasiwn GIG Cymru Director, Welsh NHS Confederation

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

Sarah Sargent	Dirprwy Glerc Deputy Clerk
Sian Thomas	Clerc Clerk
Dr Paul Worthington	Ymchwilydd Researcher

Dechreuodd y cyfarfod am 09:30.
The meeting began at 09:30.

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

[1] **Dai Lloyd:** Bore da i chi gyd a chroeso i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol

Dai Lloyd: Good morning to you all and welcome to the latest meeting of the Health, Social Care and Sport

a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. O dan eitem 1, a allaf i gyhoeddi bod Angela Burns wedi cyflwyno ei hymddiheuriadau ac mae Suzy Davies yma fel dirprwy? Bore da, Suzy. A allaf i bellach egluro bod y cyfarfod yn naturiol ddwyieithog? Gellir defnyddio clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1, neu i glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2. A allaf i atgoffa pobl hefyd i naill ai ddiffodd eu ffonau symudol ac unrhyw gyfarpar trydanol arall, neu eu rhoi nhw ar y dewis tawel? Hefyd, a allaf bellach eich hysbysu chi y dylid dilyn cyfarwyddiadau'r tywyswyr os bydd larwm tân yn canu?

Committee here at the National Assembly for Wales. Under item 1, may I announce that Angela Burns has apologised and Suzy Davies is here as a substitute? Good morning, Suzy. May I further explain that the meeting is naturally bilingual? You can use headphones to hear the simultaneous translation from Welsh to English on channel 1, or for amplification on channel 2. May I remind people to either turn off their mobile phones and any other electronic equipment or switch them to silent? Also, may I let you know that we should follow the directions from the ushers should there be a fire alarm?

09:31

Paratoi ar gyfer Craffu ar Gyllideb Ddrafft Llywodraeth Cymru ar gyfer 2018-19—Sesiwn Dystiolaeth 1—Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr a Bwrdd Iechyd Lleol Cwm Taf
Preparation for Scrutiny of the Welsh Government Draft Budget 2018-19—Evidence Session 1—Betsi Cadwaladr University Local Health Board and Cwm Taf Local Health Board

[2] **Dai Lloyd:** Felly, symudwn ymlaen, gyda chymaint â hynny o ragymadrodd, i eitem 2: paratoi ar gyfer craffu ar gyllideb ddrafft Llywodraeth Cymru 2018-19. Hon ydy'r sesiwn gyntaf, sesiwn 1, ac o'n blaenau mae Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr a Bwrdd Iechyd Lleol Cwm Taf, a hefyd Conffederasiwn Gwasanaeth Iechyd Gwladol Cymru. Felly, mae'n bleser

Dai Lloyd: So, we then move on, with those few words of introduction, to item 2: preparation for scrutiny of the Welsh Government's draft budget 2018-19. This is the first session, and before us we have Betsi Cadwaladr University Local Health Board and Cwm Taf Local Health Board, and also the Welsh NHS Confederation. It's a pleasure to welcome to the meeting Gary

croesawu i'r bwrdd Gary Doherty, prif weithredwr Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr; a hefyd Russ Favager, cyfarwyddwr cyllid Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr. Symudaf ymlaen i groesawu Allison Williams, prif weithredwr Bwrdd Iechyd Lleol Cwm Taf; a hefyd Mark Thomas, cyfarwyddwr cyllid Bwrdd Iechyd Lleol Cwm Taf; yn ogystal â Vanessa Young, cyfarwyddwr Conffederasiwn Gwasanaeth Iechyd Gwladol Cymru. Croeso ichi i gyd. Diolch am yr holl dystiolaeth ysgrifenedig ymlaen llaw. Mae'r Aelodau wedi'i darllen mewn cryn fanylder, ac wedyn mae yna res o gwestiynau yn seiliedig ar y dystiolaeth honno. Yn ôl yr arfer, symudwn yn syth i mewn i gwestiynau, felly, a'r adran gyntaf o dan iechyd meddwl. Mae Rhun yn mynd i arwain.

Doherty, chief executive officer of Betsi Cadwaladr University Local Health Board; and also Russ Favager, director of finance at Betsi Cadwaladr University Local Health Board. I move on to welcome Allison Williams, chief executive officer at Cwm Taf Local Health Board; and also Mark Thomas, director of finance, Cwm Taf Local Health Board; as well as Vanessa Young, director of the Welsh NHS Confederation. Welcome to you all. Thank you for all the written evidence beforehand. Members have read that evidence in great detail, and there is a series of questions based on that evidence. As usual, we will go straight into questions, and the first section under mental health. Rhun is going to lead on this section.

[3] **Rhun ap Iorwerth:** Bore da ichi gyd. Mi wnawn ni ddechrau efo ychydig o gwestiynau ynglŷn ag iechyd meddwl, a chwestiwn cyffredinol i ddechrau ynglŷn â'r *ring fence* a pha mor ddefnyddiol ydy hwnnw. Tybed a allwn ni gael sylwadau gennych chi i gyd, gan gychwyn o bosibl efo'r conffederasiwn, ynglŷn â phriodoldeb y *ring fence*, yr hyn sy'n cael ei gynnwys o'i fewn o, a pha un a oes yna werth i gael y *ring fence* yma fel mesur o'r hyn sy'n cael ei wario a'r hyn sydd angen ei wario ar iechyd meddwl.

Rhun ap Iorwerth: Good morning to you all. Can I begin, then, with some questions on mental health, and a general question to start with regarding ring-fencing and how useful that is? Can you perhaps give us your comments, maybe starting with the confederation, regarding how appropriate the ring fence is, what is included within the ring fence, and also whether there is any real value in having that ring fence as a useful measure of spending and what needs to be spent on mental health?

[4] **Dai Lloyd:** Bydd o'n digwydd yn awtomatig. Siaradwch ymlaen, Vanessa.

Dai Lloyd: It will happen automatically. Just carry on talking, Vanessa.

[5] **Ms Young:** Thank you, yes. In terms of ring-fenced funding in general, obviously, it is put in place to ensure that the health boards do spend the funding on the purpose for which it was intended. But, actually, that can create, in some instances, a lack of flexibility within the health board about how they allocate that funding to support specific services. Also, as you'll hear from colleagues, the funding that they use from their own budgets often exceeds the element of the ring fence in any event. So, for us, ring-fenced funding sometimes has a purpose, particularly when we are setting up a new initiative. But, actually, discretionary funding is more useful in the longer term, to give health boards that flexibility.

[6] The other point to make is that ring-fenced funding can sometimes be tied too much to outputs rather than to outcomes. So, it needs to be considered in the context of a wider discussion around performance management and outcome accountability, rather than output accountability, so that we can focus on allowing health boards the discretion to determine how to spend the money effectively to get the best patient outcome and the best value for money. Sometimes, the terms and conditions associated with ring-fenced funding can make that more difficult.

[7] **Rhun ap Iorwerth:** And some initial comments—yes, from Betsi first.

[8] **Mr Doherty:** Bore da. Just to add, one point I would make is that certainly, as a matter of principle, I think, protecting mental health expenditure is a very good thing for all of the reasons that you'll be very familiar with—there is a major challenge in mental health services and a major challenge for our communities that we serve. So, something that protects and focuses on that expenditure, I think, is invariably good. There you do get into some of the complexities: what gets included, what doesn't get included. There are many services and resources that I would see as making a massive contribution to improving people's mental health and well-being that wouldn't be included inside that ring fence. But I think, for us, leaving to one side those complexities—and that does make it difficult to compare across organisations sometimes, because people do things in different ways, which comes back to that achieving the outcome is what you want, not necessarily how you achieve it.

[9] But, as a principle, I support it and, certainly, for an organisation like Betsi, where we're clear on what we're counting and what we're not counting, it's a useful measure over time, because you can see are you spending more, are you both at the ring fence and are you spending more each year on mental health services, and the answer, within Betsi, to both those questions is 'yes'. So, I think, as a matter for principle, it's helpful. I think there are some technicalities in the details and do you need to have a—you know, the debate needs to be a sophisticated one and, in that regard, I think it's a useful part of that picture, but only a part.

[10] **Ms Williams:** If I could add, and I endorse everything that's already been said, I think what we also have to recognise, though, is that mental health and physical health are not necessarily always very discretely attributed, both in terms of the service delivery and the individual's care needs. So, whilst it's important that we have the ability to track that expenditure and to ensure that the proportional attention of the health board's business is on the mental health as well as the physical health of the individual, increasingly we're finding that we're having to design care around the complexities of physical and mental health, which requires us to be more flexible with the use of the resources.

[11] **Rhun ap Iorwerth:** The purpose of a ring fence, you would have thought, would be to drive positive change. But, given that you're spending above the ring-fence allocation, that would suggest to me that you're actually being driven by just responding to need rather than being edged towards, say, what a Government would be seeking you to do. Would that be a fair assessment?

[12] **Ms Williams:** Perhaps, if I could start, I think that, if we go back in time to when the ring fence was originally established, I think the position was really quite different. I think we, as a system, a health and care system, were very different. Working in an integrated healthcare system, with all of the recognition of the impact of mental health, not just in the traditional psychiatric services, but actually mental health throughout the whole of our system, has meant that our investment in integrated care has been much greater. So, I think that's a real positive—that we can see how that expenditure, but also the attention and the manpower and the skills of the workforce around mental health, have increased.

[13] So, the ring fence, where perhaps it was seen as a floor and not a ceiling, is very much seen as a safety net now, but I think that, if you look

across all of the health boards, you will see that our expenditure is exceeding that, which I would see as a positive.

[14] **Rhun ap Iorwerth:** Just looking at figures for Betsi Cadwaladr, I think the budget for mental health and learning disability in 2015-16 was £103.9 million and actual spend was £112.3 million. How do you account for going 10 per cent, almost, over what you had predicted and planned for, knowing that, when you were setting the 2016-17 budget, you were aware of the pressures of mental health and the need to respond to that?

[15] **Mr Doherty:** I think, if you look across all our budget-setting and our planning processes every year, we set off with an intention to deliver a set of services within a given level of resource, whether that's manpower, whether that's non-pay, whether that's services we provide ourselves, whether that's services that other people provide for us, and, obviously, within mental health services, that ranges from less intensive to high secure, very, very complex services. So, I think, for us, each year we set off with that intention. Our planning then has to respond to what happens in-year, has to respond to the levels of medical manpower, particularly, that we can secure, has to respond to people who might leave, who might join, and has to respond to peaks and demands.

[16] So, for us, obviously, for all our budgets across our whole £1.4 billion at any one point in time, clearly, it's the sign of a good planning system that you set a budget and you stick to it. As Allison has already said, mental health services, as a standalone element of our service—. We have an awful lot of other services that also come into that equation, so I think picking one out is always a challenge. As we set our budget this year, we tried to learn from what had happened last year, particularly in areas like out-of-area beds, where, if you look, that was one of our more volatile expenditure items within mental health last year, but a number of others were also volatile. So, for us, it's about them responding to it, learning for this year's budget setting, but making sure that, obviously, as you would expect us to do, the services that we give to our patients and our communities is at the centre of what we do, and, clearly, where that gives us monetary issues, that's a very important point, but, in-year, we have to respond to service need.

[17] **Rhun ap Iorwerth:** It's interesting that you mention out-of-area spend, and that's because of a lack of capacity, or, in some cases, a need for specialisms elsewhere. We know that, in child and adolescent mental health services, we have severe problems, not just in north Wales, but right across

Wales, yet we see an underspend there in 2016-17, compared with what you had proposed. Is that a highlight of a capacity issue, or better budgeting, or—

[18] **Mr Doherty:** I think some of the key issues there are around our ability to recruit, and also the additional funding that we put in at the start of the year, and our intention is then to go out and get specialised staff to get into those roles. Now, obviously, we did reduce waiting times successfully last year in child and adolescent mental health services. This year, it is a pressure to us. This year, we have had more out-of-area costs there. So, from that perspective, I think, if we did those same numbers at the end of this year, you'd see a slightly different position there. But, obviously, as I did emphasise, I think both, particularly when you're looking at out-of-area, high-cost patients—and, as you say, some of those are for services that we don't provide in north Wales, they're very, very expensive, and very specialised—these are very volatile budgets that can move, and, obviously, the work we've done—. We've done quite a lot of work this year on child and adolescent mental health services, and, as we sit here now, compared to a couple of months ago, that number of out of areas has come down, and that budget pressure has reduced.

[19] **Rhun ap Iorwerth:** And, just finally, I think we'd all accept that there is a volatility in the provision of health and care services. In Cwm Taf, how confident are you, considering the range of services that you have to provide in mental health, that you have the correct balance of budget and capacity to able to deliver for your patients' needs?

[20] **Ms Williams:** We've been undertaking a significant piece of transformation work, moving towards a recovery model for mental health since 2010. And that has resulted in us significantly redesigning and reconfiguring services, a very significant reduction in bed-based care, because most mental health care doesn't get delivered in a bed, very large investment into community alternatives, models of repatriation and de-escalation from specialist out-of-area placements, and we're on the fourth phase of that journey now for older people with mental health. So, I'm very confident that the model, which we have co-produced with the community, and particularly with some of the third sector mental health charities, is the right model. We've put significant investment in, and it's a journey we will continue to progress over the next few years.

[21] **Rhun ap Iorwerth:** Okay. Thank you.

[22] **Dai Lloyd:** Okay. Julie Morgan on this issue as well.

[23] **Julie Morgan:** I wanted to ask about the services you provide in the prisons, because I think both boards provide some service to the prisons. I wondered if—. I think, Betsi, it's £0.9 million on mental health services in prison. Is that what you actually spend, or is that what you—? Is that enough, because, obviously, the demand must be enormous?

[24] **Mr Doherty:** It's a relatively new—. I'm trying to remember the exact date it opened, but it's not been going that long. So, we do need to keep the situation under review, and, obviously, the prison is stepping up its capacity in terms of the number of men that it has there. And I would just like to take the opportunity just to pay tribute, I think, to the team that have worked, together with the prison service, to put in what I think is a really good model of care. So, we make as much as we can of things like telehealth, so we can minimise security risk and minimise moving people around. We've got a very good team on site, very, very good facilities. So, for us, I think that, certainly right here, right now, there was a visit by our board to the prison last week. I've been on several occasions and met the staff there. So, I would certainly say at the moment I think that model is working well. It was a tough timetable to get things ready for the opening but people delivered that and, obviously, as we step up the number of people within the prison, we will review it. But, certainly, right here, right now, that's meeting the need that we've got.

09:45

[25] **Julie Morgan:** And how does that funding work when you have a new prison coming to an area and you've got all these additional demands, because I think we all know that many prisoners do have mental health issues?

[26] **Mr Favager:** We receive funding from the National Offender Management Service, which fully funds the health implications for prisons. As Gary said, it's a kind of step up as more and more prisoners—. It's not to full capacity at the moment, so we expect that spend to increase. But, yes, we get fully reimbursed for the costs incurred.

[27] **Julie Morgan:** So, the actual spend, you get reimbursed, but, obviously, whether you're able to cover all the needs as you—.

[28] **Mr Doherty:** Well, we've been given a budget for the new service that we've put in. That's, as I said, I think quite an innovative service model that we've put in place. We will have to keep it under review, and, obviously, what is not clear to us, but will become clear over time, is, when prisoners leave prison, where they choose to live afterwards. Clearly, that would then be something that we'd have to keep an eye on in terms of where people are choosing to take up residency afterwards and the impact on services there. But, right here, right now, our main focus is obviously on inmates within that prison.

[29] **Julie Morgan:** Yes, and many of them may not be from Wales. Thank you. And could I ask, because I think you provide some services to HM Prison Parc, don't you?

[30] **Ms Williams:** A very small service that we provide into Parc: the majority of the services are provided by Abertawe Bro Morgannwg University Local Health Board. We do, through our child and adolescent mental health service, have a service-level agreement for a very small sum of money to provide some forensic specialist CAMHS services for the young men who are in transition between children and adulthood. But it's a £50,000 a year service-level agreement, and a very small demand.

[31] **Julie Morgan:** So, that doesn't cause any financial problems.

[32] **Ms Williams:** No.

[33] **Dai Lloyd:** Rhun, cwestiwn atodol.

Dai Lloyd: Rhun, a supplementary question.

[34] **Rhun ap Iorwerth:** A very, very quick question for Betsi Cadwaladr: you receive money from offender management for running mental health services at Berwyn. Does that have any capacity impact on the rest of Betsi at all—i.e., are staff taken, using that budget, to deliver services in the prison?

[35] **Mr Doherty:** Recruitment to those posts, full stop, and then where those people—. Being able to fill the posts at all, and then where that person might come from, was one of our major concerns. What we find is that, in the vast majority of instances—I couldn't off the top of my head give you the exact numbers, but the impact on pulling from staff within our existing service has been very small. A number of prisons around the country have

closed and we have had a number of staff move in who work—. NHS staff who worked within that service have relocated, so the impact in terms of reducing other staffing numbers has been very, very small, if anything.

[36] **Mr Favager**: And I think it's also worth just mentioning that one of the things that we're looking to do there, or we've started doing, is around telehealth. So, it's not necessarily about our staff going to the prisons. They're still actually dealing with prisoners. They sit in the prison, our staff sit in the health resource.

[37] **Dai Lloyd**: Reit, symud ymlaen nawr i berfformiad ariannol. Cwestiynau byr ac atebion byr, os gallwn ni, neu fyddwn ni yma drwy'r dydd ac nid ydym ni'n mynd i fod yma drwy'r dydd. Cwestiynau cyntaf gan Caroline ac wedyn Suzy.

Dai Lloyd: Moving on, therefore, to financial performance. Short answers and questions, if you please, or we'll be here all day and we don't want to be here all day. First questions are from Caroline and then Suzy.

[38] **Caroline Jones**: Diolch, Chair. I'd like to ask you a couple of questions regarding financial performance. Obviously, we know that four health boards were in deficit and we also see that one health board has a recurring overspend, and the other has a stable financial position, but, obviously, has challenges to meet in the forthcoming financial period. We see that the cost of agency nursing has risen from 2.4 per cent to 5.7 per cent from 2013-14 to 2016-17. So, that's a large chunk of money. What I'd like to ask you is: what do you see as the challenges ahead for your health boards, and how are you going to meet these challenges for the future? How are we going to deal with the financial constraints that are facing us then for health to become sustainable?

[39] **Dai Lloyd**: Who wants to kick off?

[40] **Mr Doherty**: I don't mind starting. Well, taking my cue from the Chairman, I'll try to give a short answer to that one, but that one is quite a big question. So, I think, in terms of particularly looking at the financial challenges and how we meet them, there is a very, very large number of opportunities to do things differently, but each of them are difficult to achieve. If we take one of the things that Allison referred to as the work that they've done around mental health services, we know that our mental health services are not as recovery-focused as we would like, and that there are more patients being admitted into expensive and intensive acute beds than

there would be in other more effective services. So, we have been out, particularly over this last year, spending a great deal of time working with partners to come up with a strategy that would see us change that service model. The proof, obviously, will be in the pudding in doing so, but I believe that we could have a mental health service with lower cost per patient and higher outcomes. So that's a big kind of strategic piece of work. Perhaps, at the other end of the spectrum, there is the fact that, this year, we are looking at—. We've got a number of patients on very complex medications. You can get the same clinical outcome with a cheaper, what's called a biosimilar. So, in substituting, so that people get the same service but it's a different brand, if you like, that substitution effect for us just this year to date is £0.5 million of savings, and I'll be expecting that to increase when we get to year end, because not everybody has moved across as we liaise with patients and clinicians.

[41] So, to try to keep it short, I think there is a change in service models in a transformational—that word that we use a lot—sense, then I think there is, for want of a better term, the good housekeeping sense. Then one final point within that, as you very rightly identified, is workforce. Workforce is essential, both for the transformational thing—you might need new ways of working, you might need new roles, you might need physician associates, you might need a whole range of training for staff to work in a different way—and then you've got the basics of, 'Can I fill my shift next week?' We spend something like £2.5 million a month on agencies. So, again, within that, it is about recruitment and retention, it's about trying to use roles in different ways. It's making sure that, with the staff that you've got, you use their time to be the most effective that they possibly can—so, whether that's getting rid of the paperwork, replacing it with handheld computers, which is one of the things we're doing for our nursing staff. That does seem to suggest that we can save something like 20 per cent of the time they take in admitting patients. All these things, I think, are that we're aware that we try to meet that challenge. I genuinely could go on for quite a long time.

[42] **Dai Lloyd**: Excellent succinctness, actually. That should inspire Members to be similarly succinct. I don't know, is there a view from Vanessa?

[43] **Ms Young**: I was just going to refer back to the Health Foundation report, which looked at the long-term projections for health and social care, and identified that we needed at least a 2 per cent increase in funding, but within that, assuming that we were going to do all the things that Gary has already talked about as well, and that that report assumed that there would

be no improvement in performance on the basis of that increase in funding year on year, it took no account of changes in technology or in medicines, which can increase the costs further beyond 2 per cent. So, I think it's just as important to put in context that, when you look at the public finance outlook, the gap is still going to be significant, even though we're going to continue on technical efficiency, driving greater value transformation. There's a more fundamental question about how we fund health and care in the long term in the future.

[44] **Ms Williams:** There were just three very quick things I'd like to add. We have been investing, over the last three years, in training additional staff, and we're going to start to see the reaping of the benefits of that over the next 18 months, which will help us to close the gap around, particularly, agency nursing significantly. Redesigning the workforce and looking at alternative workers in the multidisciplinary team: Wales has been in the forefront of doing some of this—the use of clinical pharmacists in primary care, physician associates, healthcare support workers at advanced level, community paramedics—really looking at the efficiencies that we can deliver through that. I think the other final bit for me is that we're having to focus on prevention so that we've got a positive deal with the community about how we support them to manage their own healthcare as well as investing in the efficiencies in the delivery of care. If you don't do both together, then we're just increasing the burden on the NHS and social care for the future.

[45] **Caroline Jones:** Thank you. Secondly, from me, the Cabinet Secretary has said that there is still scope for improved efficiency within the NHS in Wales. Having read the evidence, I've noted that a lot of comments have come back saying that the efficiencies have already been exhausted, practically, in the past. So, can you please tell me whether you think this comment is feasible, practical and what your comments are?

[46] **Ms Williams:** Perhaps if I could start. I think what you will have seen from the evidence is that what we're saying is that the delivery of efficiencies gets harder every year—

[47] **Caroline Jones:** Yes, of course.

[48] **Ms Williams:** —rather than that we've exhausted the opportunities because the low-hanging fruit has gone many years ago. I think what we're now into is efficiencies that are much more transformational than transactional. It is about different ways of delivering care. I mentioned earlier

reducing bed-based care in mental health, looking at ways of supporting people to care for themselves, looking at different drug therapies, looking at the use of technology, and productivity is something that we're driving constantly with the NHS. So, it's how we can do more for the money that we've got or how we can do the same amount of activity for less. So, I wouldn't want you to think that that isn't a key component of all of our financial plans, but I think what we're saying is that, you know, the days where you could take 3, 4, 5 per cent out a year through efficiencies are gone.

[49] **Caroline Jones**: Yes, obviously.

[50] **Dai Lloyd**: Okay. Timing is tight, as I alluded to, so there is no need to feel an obligation for everyone to answer every question, so I'll leave you off that particular hook as well. Thanks very much. Suzy.

[51] **Suzy Davies**: Can I address separate questions to separate boards? Are you happy with that?

[52] **Dai Lloyd**: I'm deliriously happy, Suzy.

[53] **Suzy Davies**: I'll keep it short. My questions are primarily on capital, but I want to start with Betsi Cadwaladr to do with savings. The board has signed off your financial recovery plan. I'm assuming that the three-year planning process has been a help in putting that plan together, yet you've just said that £2.5 million a month goes on agency staff. How can you make £1 million-worth of savings if even things like nursing staff are costing so much?

[54] **Mr Doherty**: Well, last year, we delivered £30 million of savings. This year, our plan is to deliver £35 million. We have signed off our recovery plan. Fundamentally, in terms of how we can—. Spending £2.5 million a month on agency is a high cost where you're providing a service. But, obviously, in terms of our overall spend, what we have done is manage to reduce that amount that we're spending. So, if you look at the amount we're spending on medical agency in particular this year, that's reduced so far. And that's been about replacing some of those posts with permanent staff, which obviously, on NHS rates, are cheaper. What we're also doing is a lot of work this year on how we can use the electronic nursing rostering system a lot more effectively, give staff more notice in advance in terms of rotas and what they're going to be working, which I think is good for staff, but also then we

can be much clearer, especially using some of the case-mix monitoring that we've got on wards, where we can more effectively deploy staff and how we can then avoid going out to agency, how we can maximise the use of our own bank. But if you look at our saving plan this year, it has got everything in it from reducing agency spend, reducing some of the things that drive our needs to get extra—

[55] **Suzy Davies**: Can I ask—sorry to interrupt, because I'll get a row otherwise—very specifically, how are you going to use tech to reduce your revenue costs, because tech is a capital cost?

[56] **Mr Doherty**: Well, I've already mentioned one example. So, replacing paper-driven processes with electronic processes saves time. That allows us to reduce the staff resource that we would need. Two examples we've mentioned so far: telehealth allows us to reduce anything from travelling cost, it can be a more effective way of providing services and can require less time, so that can reduce your revenue costs. Where you've got equipment—so point-of-care testing, a range of diagnostic areas where you can potentially get decisions made quicker; if you can reduce your lengths of stay, you can reduce the number of extra escalation beds you might need to open. That is a big driver of our extra costs.

[57] **Suzy Davies**: And can you afford the tech? That's why I'm asking these questions.

[58] **Mr Doherty**: Well, you know, fundamentally, as I say, if you look at the pilot, what we are doing is piloting work to make sure it works, and that is a very important point, I would say, on tech. Then, in terms of scale and roll-out, we would do that very—. If we had unlimited capital resource, we'd do that roll-out quicker, but I am very, very conscious that, as much as I would like to see some roll-out of tech, I've got some substantial issues around buildings and some of the investment needed there, and I appreciate that the capital budget from a Welsh Government perspective will have all sorts of constraints and challenges on it. So, I will make the best of what I've got. If there was more available for tech innovation, I would not say 'no', but, equally, I think there's a lot that we can get out of the budget that we've got.

[59] **Mr Favager**: We will also be applying for Welsh Government invest-to-save moneys.

[60] **Suzy Davies**: All right, thank you. Then, a different challenge in Cwm

Taf, of course: much better balanced budgets but great big spending plans for capital. How are you going to finance those plans?

10:00

[61] **Ms Williams:** A number of—. The primary care and the secondary care spend routes are different.

[62] **Suzy Davies:** The capital spend—

[63] **Ms Williams:** So, the capital that's required in primary care has an alternative route to resolution, but the capital spend within the secondary care sector, if you look at our plans, some is on health and safety, fire code compliance and building regulation issues. Those are the subject of business cases, which are all in the approval process in Welsh Government. The revenue consequences of those, tied up within the business case process, is actually how we use that capital to best effect to reduce the demand for revenue. Where possible, we have done that and have a good track record of doing that. The big spend for us is on Prince Charles Hospital over the next five years, because we've already done a huge amount with the rest of our estate over the last 10 years in Cwm Taf.

[64] **Suzy Davies:** The supplementary on that is: does all your funding come from a Welsh Government source—one source or another—or are there external cost supplies?

[65] **Ms Williams:** Capital is generally Welsh Government sourced. We do have some—for example, with palliative care—support from Macmillan and other sources, but not a private finance initiative and any other source of funding like that.

[66] **Suzy Davies:** That's good. And then, just to finish that off, you mentioned the Prince Charles is going to need a lot of money on it. We talked about three-year financial planning cycles. There's a possibility that the Princess of Wales will be coming into your estate. Are you already, albeit potentially, scoping the additional cost that you might be needing to incur if it comes into your estate?

[67] **Ms Williams:** What we have had are some initial conversations with ABMU. Obviously, there's a consultation that needs to be undertaken first, but in terms of the scoping, we are sharing information between the two

health boards, both in terms of the estate, and also in terms of service configuration and service models, particularly in light of the fact that we're keen that nobody does anything between now and the outcome of consultation that we might have to subsequently undo. We are working very closely to scope that together.

[68] **Suzy Davies**: Okay, thank you.

[69] **Dai Lloyd**: Diolch yn fawr, Suzy. Starring questions. Dawn has got a starring supplementary.

[70] **Dawn Bowden**: It was something that Betsi was talking about in terms of locum and agency costs, and I think you've all highlighted the rising cost of that. What I wanted to know was whether—. There are lots of issues around why that has risen, and that's given in your evidence, but in terms of bringing those costs down, do you consider that there are perverse incentives at the moment, i.e. that if somebody goes to work for an agency they get paid a damn sight more than if they're on a nurse bank or if they're working overtime? And that's something that we really have to give some serious consideration to. I know in Cwm Taf you stopped using agencies for a while, but your agency costs are still very high. It does seem like a perverse incentive where our own staff will go and work for an agency because it's more cost-beneficial to them, but we won't pay them overtime, or we pay them the minimum rates on the bank if we want them to do extra hours.

[71] **Mr Doherty**: I think there are, I'm sure, many reasons why people choose different ways of working. I think the view of, perhaps, younger people is—. I think there was a time where what you wanted, whether you were a medic or a nurse, was to get your first substantive job, get your name down, get in the NHS, and then you stayed there for a long time. I think people—younger people—for whatever reason, maybe don't view that in quite the same way. I think there are lots of reasons why people would choose it, but the fact is, you can earn a level of working for some of these agencies. Clearly, you then need to be very flexible. You might not get some of the team working and staff satisfaction, but in terms of what's important to you at any point in time, then financially there is a gap there, so we do have to work, I think, to try and bring down that gap.

[72] Clearly, whatever levels of pay the NHS set is a very big debate for, perhaps, another day, but in terms of some of the work that we're doing at the moment across Wales, which they've done in England, it's to have a

national agreement on the rates that you pay, to then stick together and stick to them so there is more negotiating power for you as an employer than there is for the employee, in that regard, if you like, in terms of the rates you're willing to pay to people. In that way, hopefully, we can bring down, across the whole of Wales—as they've seen some success in England—the amount that we're paying for agency shifts. In that way, then obviously that gap gets smaller and I would then hope—. We have seen some changes already. Some of you might be familiar—I am no expert in some of the changes around IR35 and some of the tax and how self-employment tax works. Well, we did see some changes where some people, the ones I know of on the medical side, were effectively being self-employed through agencies because of that change, yet decided it would be actually better to work for the NHS, and then they took up substantive posts. So, I think that does show that there is a financial calculus when people make that decision, and hopefully we can influence that.

[73] **Dawn Bowden**: But is there a difference between medical locums and nursing staff—agencies—in terms of the patterns and the choices that are made, or not?

[74] **Ms Williams**: Perhaps I could answer that. Generally speaking, we have more doctors that elect to work solely as locum agency doctors. We have nurses that generally tend to supplement their core contract by working agency shifts. We have done work within our health board where we've looked at paid overtime as opposed to working agency shifts. We've had some success with that. I think, as an NHS, we have to think differently about the way that we pay people, because people working overtime in the NHS don't get the money in their pay packet until the following month, whereas if I work an agency shift I can get my money by the end of the week. So, I think we are looking at mechanisms also through payroll where we can do that without getting into difficulty in terms of tax implications, because that's also complicated. Because, to be honest, staff would rather work in areas where they're familiar if they're doing those extra shifts, if they can. But we have to have an increased and a different sort of flexibility to make that work for them and for us.

[75] **Dai Lloyd**: Mae'r cwestiynau nesaf o dan ofal Lynne Neagle.

Dai Lloyd: The next questions are from Lynne Neagle.

[76] **Lynne Neagle**: Thanks, Chair. In 2016-17, it was the third year in a row that Betsi's budget didn't balance. Is this something that we can expect

to see every year?

[77] **Mr Doherty:** Well, currently, we are spending this year putting together our three-year-and-beyond strategy. And I mentioned mental health earlier on as a good example where I do think that that strategy that we've agreed now with all partners—whether that's local authorities, patients and other groups—that the implementation of that strategy will see us run a more cost-effective service in mental health. If you look at all the benchmarking statistics, that is one of our biggest high-cost areas, if I may use that phrase. So, I think that we are developing plans that would see us have a high quality, sustainable service that would be within budget. Our challenge will be in implementing those plans. Allison made the point that that's the direction of travel that they're going down.

[78] Across all our number of services, we've got to make some changes—mental health is probably the biggest one. But if you look at the direction of travel, if you look at some of the savings that we've delivered over previous years, I think that we can get into a position of a sustainable budget. But equally, we start from a position where our track record isn't one of delivering that. So the challenge should definitely not be underestimated, and as people have made the point, some of the more straightforward ways to bring costs down have been taken over the years. So, in a sense, it gets harder, but for us that's the direction that we need to get into because it is not a sustainable position for us to spend more money than the taxpayer's giving us.

[79] **Lynne Neagle:** Okay, well that's a very long way of saying that you're not really confident that's going to happen any time soon, isn't it? When can we expect Betsi to balance the books?

[80] **Mr Doherty:** Well, it would be wrong of me to speculate before we've got an agreed integrated medium-term plan in front of the committee today as to exactly what year and exactly what level it's going to get to. Am I confident we can improve our position? Yes. Am I able to give you today a date exactly when that break-even position will be achieved? No, because like I say, that would be putting us into a position where we shouldn't be today, and it wouldn't be right for me to get into that position. From my perspective, it may not be as clear as the answer that I might've liked to have given, but for an organisation with Betsi's history, with Betsi's complexity and size, I think it's probably the most realistic answer that I can give you today.

[81] **Lynne Neagle:** Okay. Can I just ask a question to Allison then? Cwm Taf serves one of the areas with the highest concentrations of deprivation in the whole of Wales, really. Some of the extra money that's gone out to the NHS over the years has gone out on a Townsend share, but it's a fairly limited resource allocation based on deprivation. Are you satisfied that Welsh Government is doing enough to reflect the high levels of deprivation and the health inequalities in your area?

[82] **Ms Williams:** If we look at the funding formula that's used at the moment, if you had any chief executive sitting in front of you and you asked them how they would wish the funding formula to change—

[83] **Lynne Neagle:** But I'm asking you.

[84] **Ms Williams:** I would say that deprivation needed to be reflected greater within the formula. I suspect, if I was sitting in Hywel Dda, I'd be saying I would expect rurality to be reflected differently in the formula. The fact of the matter is the formula that we have is the one that we have at the moment, and I think the real challenge for us is how, as a public sector, together with, particularly, our local authority partners, we use the totality of the money that we've got available to us, through our public service board machinery, to ensure that we are pooling resources and wrapping the right type of interventions around our deprived communities. And they are very different. We know our deprived communities are often the areas that have greatest poverty and therefore have greatest need for social care and intervention, but they're the same people that often have greatest healthcare need, and that by pooling that resource, we can genuinely make a greater difference. So, I think the challenge on this—. I would always want more money to be given to the deprived communities, but while we've got what we've got, we've got to use those resources, generally, better, in a more holistic way around those people.

[85] **Lynne Neagle:** Okay. Can I ask the NHS Confederation, then, do you think enough is being done across Wales to ensure that lessons are learnt between health boards in terms of balancing their budgets, and is the Welsh Government doing enough to spread that good practice?

[86] **Ms Young:** There's a lot of work that has been going on in the last 12 months in particular around collective understanding of chairs, chief execs and directors within the NHS about the relative performance in individual

organisations and things that can be learnt from that. There are director peer groups that meet regularly to review that evidence. Chairs and chief execs also are doing that, and there are arrangements in place to—. Key individuals are working to support other health boards to look at lessons that can be learnt. So, I think there is a lot of work in place.

[87] In terms of board development, we have two sessions, now, in the next couple of weeks, in terms of improving financial scrutiny and board members' understanding of financial governance. And also, we're working with Welsh Government, through the efficiency board, which is chaired by Andrew Goodall, around identifying opportunities for learning from organisations what efficiency measures have been put in place and delivered, and what other organisations can take from that, and also looking at opportunities for whole-system efficiency, too, through that process. So, I think there's been a shift in concentration and emphasis on that learning in the last 12 months, I would say.

[88] **Lynne Neagle**: Thank you.

[89] **Dawn Bowden**: Dawn, you had a supplementary, here.

[90] **Dawn Bowden**: Yes. It's on the same point, but in the auditor general's report that we had with these papers, it talks about the 2014 Act and the three-year financial plans—and I'll quote from that. It says that the idea behind that was that it was

[91] 'expected to result in better decision making and optimal solutions'.

[92] But the evidence that we've got is that health boards don't seem to be using the three-year accounting provision in quite the way—not all health boards—in quite the way that we'd expected, and some of them are still doing it on an annual basis. So, my question, really, to you is: do you have a view on why the three-year period is not being used to greatest effect in the majority of the health boards?

[93] **Ms Young**: I think that, overall, the intention of the Act has delivered an improved focus on medium-term financial planning, and that has been welcomed within health boards. I think one of the challenges is that, because of the nature of the settlement that Welsh Government has received, it's been delivering more annual budgets over recent years to the health boards, which has, perhaps, increased the focus on a short-term view of financial planning,

which is more difficult. There's also an issue with the way in which the provisions in the Act work, which means that you have to look at the three-year period but also the individual years, because it's almost like a rolling annualised plan. That also makes it more difficult, perhaps, to be thinking more of the medium term. I'm sure that my colleagues in individual health boards can give their perspective.

10:15

[94] **Mr Favager:** I think it's a welcome policy, and from a finance point of view it is good, because it leads to that medium to long-term planning. I think it depends on where you start off as an organisation. As an organisation that hadn't got an approved three-year plan, you get into that cycle of annual planning. So, I think it's where you start off. But, I think it's a welcome policy, and I think, certainly, from a finance point of view, I welcome that three years to horizon scan.

[95] **Dawn Bowden:** And Cwm Taf—it seems to work for you.

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

[97] **Dai Lloyd:** Diolch am hynny, Dawn. Symudwn ymlaen nawr i Jayne Bryant.

Dai Lloyd: Thank you for that, Dawn. We move on to Jayne Bryant.

[98] **Jayne Bryant:** We've heard from a variety of bodies, including the Cabinet Secretary, about the need for change in health and social care, and Professor Marcus Longley of the University of South Wales recently said of health and social care:

[99] 'Effective integration of effort and budget between these services is one vital building block to ensure maximum value from the Welsh £, but progress has been slow.'

[100] What are your views on the pace of change in health and social care?

[101] **Ms Williams:** Perhaps I could start. I think that in the last three years particularly—and I have worked in Wales a long time—I have seen a very significant change in attitudes and appetite for greater integration of health and social care, not at a structural level but at a practical level, on the ground, in terms of the delivery of services. The allocation of the integrated

care fund jointly to health and social care has been a really significant step forward, because it has brought a joint accountability between staff in local government and health, to agree—supported by the public service board structures—on the key priorities and then how that investment is used. If we take the last three years, I think in year one we saw a few disparate initiatives being funded through that route. By the time we got to the current year in my own organisation, we actually put the entirety of the money invested against a single business case that was supported by the cabinets of the two local authorities and by my own board, which was about anticipatory care, early intervention, and services at the front door of hospitals to turn people around. We've now got social workers, seven days a week, working in our two major DGHs. We've got the ability of a team that's working 10 hours a day, seven days a week, so that if somebody hits the front door of a hospital, to deploy health and social care resources for a period of up to 72 hours, so that we are able to get people back out into the community for decisions to be made, as opposed to them being admitted into a hospital bed for decisions to be made. We've now got teams where, actually, who employs them becomes irrelevant because they are one team. So, I think the integrated care fund has been a really positive development. Now, the duty around pooled budgets from next April is going to take us further on that journey. So, I think we've got a long way to go, but what I've seen over the last three years is a huge step forward.

[102] **Mr Doherty:** In the interests of brevity, I won't repeat but I'd echo those points. The only bit I would add is just that I would hope that, as we move forward, there are some enabling things that we are doing that will help us up that pace even more. So, co-locating people in the same building—we've got a number of plans in north Wales to do that. That should not get in the way, but that is a big enabler, I think, to this kind of joint working. Also, some of the IT systems—moving on to using the same IT systems. We've got a plan to roll that out across north Wales. Just moving some of those blockages, so that people can work together more effectively, will help take that pace and step it up.

[103] **Dai Lloyd:** Okay. Suzy has got a supplementary.

[104] **Suzy Davies:** I think Vanessa wants to come in.

[105] **Dai Lloyd:** Oh, Vanessa and then Suzy.

[106] **Ms Young:** I just wanted to refer to a report that the King's Fund

produced around health and social care transformation, which identified two key success factors. One is about having sufficient capacity in terms of staff resource to focus on the programmes that you are trying to put in place. The other is about this need for transformation and transition funding. The ICF has been a really good example of that—having that discrete pot of money has really helped to inject pace into that, so if we want to see more pace and scale in terms of progressing this agenda, then it's about having staff resource time and also funding to be able to do more.

[107] **Dai Lloyd**: Okay. Suzy.

[108] **Suzy Davies**: Yes, I was very interested to hear what you said, but you did say that it's at the hospital door that this turnaround takes place. My question is about GP clusters. How much effort is going in to changing culture at that point, because we've had evidence in this committee that clusters are still very variable, both in the way they plan and their culture?

[109] **Ms Williams**: I can only speak from my own health board experience, but I think that our clusters are very advanced in terms of their developments. For example, they've taken the lead in early cancer diagnostics. We've got the first roll-out in the Cynon valley and we're going into the Merthyr valley—

[110] **Suzy Davies**: But, the social care element.

[111] **Ms Williams**: All of that, together with how they access services through the integrated care team. We've got Stay Well at Home services that they can access directly, and community paramedics working within the clusters and working alongside the GPs who can deploy those resources. So, as I say, it's a good start, but we've still got a long way to go, but they're very, very engaged in this agenda.

[112] **Suzy Davies**: That's good to hear. Is that replicated?

[113] **Mr Doherty**: I think that it's probably only really in the last year or so that the clusters in north Wales have really got going. That would be my view. I think that we're perhaps a little behind and probably, therefore, have got a bit of variation, but in terms of working with social care, certainly they're at the heart of trying to drive some plans we've got going forward. So, I think we're perhaps not in quite such a good place, but we are getting there.

[114] **Suzy Davies**: Lovely, thank you very much. Thank you, Chair.

[115] **Dai Lloyd**: Diolch, Suzy. Mae'r cwestiwn olaf gan Dawn Bowden.

Dai Lloyd: Thank you, Suzy. The final question is from Dawn Bowden.

[116] **Dawn Bowden**: Thank you. My question is about Brexit. You didn't think you were going to get away with not having a question on Brexit. [*Laughter.*] Because there is evidence from you in terms of the potential impact of that, I just wanted your views on how you feel that that is going to impact on you. Is it impacting already? Is it going to continue to impact and what kind of preparations are you undertaking to deal with that?

[117] **Ms Young**: The Welsh NHS Confederation is a member of two groups that are looking across the UK at the impact of Brexit on the NHS. The first is the Cavendish Coalition, which is focusing on the workforce implications, and then also the Brexit Health Alliance, which is looking at issues associated with things like research, innovation, trials and the other non-workforce implications.

[118] On workforce, we have around 1,300 people within the service currently from European countries. We are monitoring to see whether or not there is change in terms of the number of people applying as a consequence. It's early days and actually the figures suggest that there isn't a clear pattern yet, certainly across all of the organisations. But it is a concern that we will see fewer people applying for roles and, obviously, the key priority for us is to ensure that health workers are able to continue to work here and also that our workforce can continue to work in the European Union, if they want to do that too. So, that's the first aspect of the workforce concerns.

[119] There are also concerns around cross-border and how our residents will be able to receive services in Europe after Brexit and vice versa, and also concerns around research and innovation and our ability to continue to participate in European trials and research, because we know that technological and drug developments here are very much dependent on and involved in the work that we do across the European Union. So, those are probably the key aspects of our concerns.

[120] **Suzy Davies**: Sorry, can I just check, you said 1,300—[*Inaudible.*]

[121] **Ms Young**: Sorry, I'll double check that figure. It is in our evidence.

[122] **Suzy Davies**: If it's in the evidence, that's fine. I apologise.

[123] **Dawn Bowden**: You've got quite a high proportion in Betsi—37 per cent in the entire workforce.

[124] **Mr Favager**: Who are not British.

[125] **Dawn Bowden**: Non-British.

[126] **Mr Favager**: So, they might be European or they might not be.

[127] **Dawn Bowden**: Sure, okay.

[128] **Mr Doherty**: If I can keep the answer short, I think that greater risk and uncertainty makes it more difficult to plan, and whether that's the drugs that we buy from Europe, or the staff, or any of those elements, clearly, from our perspective, as I'm sure for many people, the sooner that certainty will be there, the better, and the lowest possible impact on those things, the better.

[129] **Dawn Bowden**: Sure.

[130] **Dai Lloyd**: Excellent answer. Rhun has got a final, final question.

[131] **Rhun ap Iorwerth**: Just a final, final question, unless I think of something else afterwards, about the overall budget allocation. Aimed most at Betsi Cadwaladr, but I'll ask the same question of Hywel Dda. Are you being asked to do the impossible with your overall allocation, considering the demographic pressures, the geographic area pressures? It's no coincidence, perhaps, that it's Hywel Dda and Betsi Cadwaladr, serving perhaps similar areas, that are struggling most and have been for longest? Or does there, in your view, need to be a significant change in formulas? You're all welcome to comment on it as well.

[132] **Mr Doherty**: Well, I hope it's not impossible because that wouldn't be good for my mental health and well-being. But to give a less glib answer, I think I've used words, I'm sure today, like 'challenging' and 'very difficult' because it is. The track record shows that in terms of balancing our books. Whilst our deficit is, I think, about 2 per cent of our spend, we have real challenges, particularly in terms of workforce and vacancies and other things. Our service models, as I've suggested, are, in some areas, needing to

change. It's about the fact that we do provide services over such a large geography. In terms of economies of scale, and large big units can have substantial economies of scale, that will not be available to us as we are. The patch that we serve will not lend itself to that. Maybe I would say this—it's a bit like Allison said earlier on in terms of the formula—but I would say that those are very distinctive challenges that make the job of those within Betsi Cadwaladr of trying to square that circle incredibly difficult. I don't think it's impossible, genuinely, or I wouldn't have applied for the job. But, I, in no way, shape or form underestimate how difficult it will be, and in particular, the kind of stability, the leadership, the hard work that will be needed to get to the point where we're able to provide the right quality of services within the budget we've been given, and make the experience of the staff who work for us the one that I want it to be. If you summarise it to those three deliverables, that keeps me up at night, but I don't think it's impossible.

[133] **Rhun ap Iorwerth**: And at risk of pitching one board against the other. [*Laughter.*]

[134] **Ms Williams**: The fact of the matter is that every health board has its own different challenges, and one is not more difficult than another. I think the challenge for us as a system though is to have more honest conversations about the reality of what we can deliver within the resources that are available, because, to be honest, the NHS could consume more and more and more resources, and we could make an argument for the good that we could do with that. But where the money is the money, the challenge really is about the honest conversations about the shape of services for the future, so that we can deliver for the citizens of Wales in the best way that we possibly can.

[135] **Rhun ap Iorwerth**: Okay. Thank you.

[136] **Dai Lloyd**: Diolch yn fawr, ac mae hwnnw yn ateb da iawn i gloi'r sesiwn yma y bore yma. Felly, diolch yn fawr iawn i chi unwaith eto am yr holl dystiolaeth ysgrifenedig gwnaethoch chi ei danfon ymlaen llaw, ac hefyd am eich presenoldeb y bore yma, ac hefyd am ateb y cwestiynau mewn ffordd mor raenus ac aeddfed. Diolch yn fawr iawn i chi.

Dai Lloyd: Thank you very much, and that's a great answer to bring this session to a close this morning. Thank you very much once again for all the written evidence you supplied to us in advance, and also for being here today, and for answering our questions so fully and maturely. Thank you very much.

[137] **Ms Williams:** Diolch yn fawr iawn.

Ms Williams: Thank you very much.

[138] **Dai Lloyd:** A allaf gyhoeddi i fy nghyd-Aelodau y cawn ni egwyl nawr o bum munud cyn y sesiwn nesaf? Felly, pawb yn ôl yma erbyn 10:35. Diolch yn fawr.

Dai Lloyd: Can I just tell my fellow Members that we're going to have a five-minute break now before the next session? So, everyone back by 10:35 please. Thank you.

Gohiriwyd y cyfarfod rhwng 10:28 a 10:37.
The meeting adjourned between 10:28 and 10:37.

Paratoi ar gyfer Craffu ar Gyllideb Ddrafft Llywodraeth Cymru ar gyfer 2018-19—Sesiwn Dystiolaeth 2—Bwrdd Iechyd Lleol Hywel Dda a Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro
Preparation for Scrutiny of the Welsh Government Draft Budget 2018-19—Evidence Session 2—Hywel Dda Local Health Board and Cardiff and Vale University Local Health Board

[139] **Dai Lloyd:** Croeso nôl i sesiwn ddiweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Cyn yr egwyl roeddem ni yn craffu ar gyllideb ddrafft Llywodraeth Cymru. Dyna'r sesiwn gyntaf. Croeso ichi i gyd i'r ail sesiwn, ac o'n blaenau ni rŵan, sesiwn dystiolaeth 2 ar graffu ar gyllideb ddrafft Llywodraeth Cymru 2018-19, mae cynrychiolwyr o Fwrdd Iechyd Lleol Hywel Dda a Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro. Croeso i chi. Rydym yn diolch i chi ymlaen llaw am eich tystiolaeth ysgrifenedig. A gaf i yn benodol groesawu i'r bwrdd Steve Moore, prif weithredwr Bwrdd Iechyd Lleol Hywel Dda—croeso—ac hefyd Stephen Forster, cyfarwyddwr cyllid

Dai Lloyd: Welcome back to this latest session of the Health, Social Care and Sport Committee here in the National Assembly for Wales. Before the break we were scrutinising the Welsh Government draft budget. That was the first session. So, welcome now to the second session, and before us now we have evidence session 2, scrutiny of the Welsh Government draft budget 2018-19. We have representatives of Hywel Dda Local Health Board and Cardiff and Vale University Local Health Board. Welcome to you. We're very grateful to you for your written evidence. Can I welcome Steve Moore, chief executive officer of Hywel Dda Local Health Board, and also Stephen Forster, director of

Bwrdd Iechyd Lleol Hywel Dda, yn ogystal â Len Richards, prif weithredwr Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro ac hefyd Bob Chadwick, cyfarwyddwr cyllid Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro. Croeso a bore da ichi gyd. Fel rwy'n dweud, rydym wedi derbyn eich tystiolaeth chi, mae pawb wedi ei darllen, ac wedyn rydym yn syth i mewn i gwestiynau, gyda'ch caniatâd. Mae yna amryw o gwestiynau, rhai mewn manylder, felly fe fuaswn i'n erfyn ar fy nghyd-Aelodau i ofyn cwestiynau cryno ac hefyd, wrth gwrs, atebion cryno. A gawn ni ddechrau efo iechyd meddwl? Rhun ap Iorwerth.

finance, Hywel Dda Local Health Board, also Len Richards, chief executive officer, Cardiff and Vale University Local Health Board, and also Bob Chadwick, director of finance, Cardiff and Vale University Local Health Board? Good morning to you all and welcome. As I say, we have received your written evidence, everyone has read that, so we'll go straight into questions, if we may. We have several questions for you, some in more detail than others, so can I ask my fellow Members please to ask succinct questions and maybe succinct answers as well, if we may. Can we begin with mental health? Rhun ap Iorwerth.

[140] **Rhun ap Iorwerth**: Diolch yn fawr iawn, Gadeirydd, a bore da ichi i gyd. Mi hoffwn i ddechrau efo ychydig o gwestiynau ynglŷn ag iechyd meddwl, a gofyn eich barn chi'n gyntaf ynglŷn â'r egwyddor o neilltuo arian ar gyfer iechyd meddwl—*ring fence*, felly. A ydych chi'n cytuno efo'r egwyddor ac ydy o yn gwneud yr hyn y byddai rhywun yn tybio ddylai fo fod yn ei wneud, sef gyrru newid a gwelliant gwirioneddol ym maes darpariaeth iechyd meddwl?

Rhun ap Iorwerth: Thank you very much, Chair, and good morning to you all. I'd like to start with a few questions on mental health, and ask you for your views on the principle of ring-fencing funding for mental health. Do you agree with the principle and is it doing what someone would assume it would do, which would be to drive change and improvement in the mental health provision?

[141] **Dai Lloyd**: Nid oes yn rhaid i bawb ateb bob cwestiwn, gyda llaw.

Dai Lloyd: You don't all have to answer every question, by the way.

[142] **Mr Moore**: Thank you. Thanks for the question. I'll start off, if that's okay. I've come from England and, actually, we didn't use to have ring fences in England for things like mental health when I was there and, actually, I think it is a particular characteristic of Wales that I would really support. I would probably characterise the ring fence itself as much more of a floor of

spending than maybe a ceiling of spending, and you'll see—probably it's true of all health boards, but certainly for ours—we tend to spend above the ring fence allocation. So, I think it's helpful in that regard, in that it ensures that there is a minimum level, but I think, generally, the view across probably all of the health services, I would say, across England is of the growing importance of mental health issues, actually, and how they impact on physical health issues. So, we see it as one of our key priorities, going forward. We've got 10 strategic priorities, and one of them is very deliberately around mental health. So, we see where we are at the moment as a starting point for how we can invest more in mental health services. As a factor itself, I don't think it pushes things particularly, because, as I say, it is that floor level, but, as a priority for us, I think mental health has never been a bigger priority than it is now.

[143] You may be aware, certainly in the Hywel Dda area, we're doing a very large piece of transforming mental health strategy at the moment. We've been talking to the public, to service users, to carers and the voluntary sector for the last two years, and we're looking in our board meeting in November to be committing to a very innovative model for mental health that is much more about prevention than, maybe, the higher end care, to try and get the money and the investment and the people at the point where people could really do with support. I think that's going to be a really innovative model for us. It's based a lot on work in Trieste, and we've done a lot of work with them. So, I think mental health is a growing priority for us generally—

[144] **Rhun ap Iorwerth**: We'll come back to more detail about Hywel Dda, but on that point of principle, first of all, and considering that you are spending above the notional ring fence, if you like, doesn't that really show that you're just being driven by demand, rather than being driven by what the ring fence suggests you should be throwing at this?

[145] **Mr Richards**: I would agree with what Steve said: the ring fence is more of a floor than a ceiling, in a sense. I think it's a useful principle, because it's a principle that signals priority. So, I think it's good from that perspective. Mental health, as Steve has already highlighted, is a significant priority for health services. There's no doubt about that. It's growing in its priority and, therefore, that signal is a useful thing.

[146] In terms of whether we're being driven by demand, my sense of the system is that mental health has its true place, but it is subject to a lot of reform. We are looking at how we provide mental health services to make

sure that they're more responsive to patients, to make sure that patients are seen more in the community and that mental health issues are dealt with earlier in the pathway. So, I don't think we're being driven by demand for hospital-type services; I think we are recognising the burden of disease that is there within the community and we're looking for ways to respond to that.

[147] **Rhun ap Iorwerth:** I note you've told us now and I note in Hywel Dda's written evidence to us that mental health provision certainly is a priority of yours, but whilst ring fencing has increased over the past five years or so, spending on mental health in Hywel Dda, actually, as a percentage of your total spend, has fallen, albeit very, very slightly. How do you square that?

[148] **Mr Forster:** I think that's a reflection, really, of where our other services are. We've had a particular deficit situation within our acute services, and the demand there has been driving those costs continually up. So, although mental health expenditure has risen, it hasn't risen at the same rate as the other services. It's more of a relative thing, rather than actually an absolute reduction in mental health spending.

[149] **Rhun ap Iorwerth:** But you also say in your evidence that you expect, on the basis of

[150] 'Evidence and local data…demand will continue to rise for Community Mental Health teams and LPMHSS by circa 8% each annually.'

[151] I would guess that would be greater than the overall increase in demand for health services, so how are you going to be able to—by, say, maintaining the percentage of your overall funds going into mental health, if that's your intention—address that increase?

10:45

[152] **Mr Moore:** It is a challenge for us. That's not the overall growth in mental health as an entirety. It is certainly at the level of, you know, our communities and maybe the lower level support that we're seeing significant growth, particularly for children and young people and the growing mental health issues in schools that I think we all read about. We're seeing that demand coming through our local primary care mental health teams in particular. The thing I refer to around our transforming mental health strategy is actually trying to address that by ensuring that we can reallocate the totality of our spend to be much more about prevention and very early

intervention.

[153] **Rhun ap Iorwerth:** Sorry to interrupt—is that something that can happen quickly enough though, or is that something that is a two, three or five-year programme?

[154] **Mr Moore:** We think it can happen pretty quickly. As I say, we've been working on this model now for two years, using the best in the world, and I mentioned Trieste. They are a World Health Organization exemplar site for mental health, and particularly community-based mental health, and their clinicians have been working with our clinicians and the public and our service users. So, what will be coming to board in November, following the consultation that we've just closed actually over the summer, will be the implementation plan for this new model, which will essentially take that whole budget. It won't spend any more, but we'll be putting in place much more local support—24/7 local support with no waiting lists, one of the principles being that people can walk in when they need to. And the idea of that, again based on the experience of Trieste, is that if we do that quickly and we do that early enough for people, people don't get into the higher levels of care where we are spending quite a lot of money. So, it becomes a much more preventative and support sort of service. So, we're quite optimistic about where that will go, and the implementation timelines are relatively fast around that.

[155] **Rhun ap Iorwerth:** Chair, I think it'd be interesting to look at Trieste and what happens there.

[156] **Dai Lloyd:** Yes.

[157] **Rhun ap Iorwerth:** From your experience and looking ahead to the pressures, because you will have your projections as well about the pressures that will come your way because of mental health demands, are you confident that you're going to be able to meet those demands—and increasing demands—in the coming years?

[158] **Mr Richards:** I think there are real pressures within the mental health system. But where we are trying to address that—and it is, again, very similar to what you've just heard—is we're looking at boosting services in the community, and that goes as far as to GP practices as well, within the clusters. I know that, within the clusters, some of those clusters have invested in primary care clinicians who will work in the GP practice to identify

mental health problems as they emerge, and then to really have a fast response to the treatment of those people so that we can try and avoid the higher cost bedded-type services that the system has got.

[159] So, one of the things we've seen in our system is a reduction in the number of beds through investment in community services, and bedded services are much more expensive than community services. So, we're seeing a benefit from that for reinvestment then further in community services, going forward.

[160] **Rhun ap Iorwerth**: What should happen to the ring fence? Considering that you are putting service changes in place, would it be useful if that ring fence continues to grow in order to keep you on your toes or make sure that you're putting in the right investment? What should happen to that ring fence?

[161] **Mr Moore**: I think there are different views around that. As I said earlier, I think the ring fence is significant because of the signal that it sends, and the signal is more about treating those particular services as a priority. We invest more than the ring fence, because we recognise that there's a priority there. So, in a sense, I don't think it drives behaviour; it sends a signal to us within the service that this must be a priority, but that's a signal that we've heard loud and clear and we hear that from our clinicians every day.

[162] **Rhun ap Iorwerth**: Okay, thank you.

[163] **Dai Lloyd**: Julie.

[164] **Julie Morgan**: Carrying on with Cardiff and the Vale, I know that you say that there's been Welsh Government investment in patient psychological therapies and dementia link nurses—a whole list of Welsh Government investment. Does that continue year upon year, that investment? What's the actual plan for it?

[165] **Mr Chadwick**: The investment is of a recurrent nature, so that will continue to be invested year on year.

[166] **Julie Morgan**: So, it's indefinite.

[167] **Mr Chadwick**: Yes, subject to the service, or the clinicians who work in

that service reviewing the pathways and the design of that service to see if the benefits can actually be improved. So, we don't tie our clinicians down if they can show to us that there are benefits for patients in changing that. The ring-fence money remains intact, the investment remains intact, but the opportunity to do more differently and get better benefits and outcomes for patients always remains on the table.

[168] **Julie Morgan**: Right. So, it's within the ring fence, this additional Welsh Government money.

[169] **Mr Chadwick**: Yes.

[170] **Julie Morgan**: Right. And do you have anything similar?

[171] **Mr Moore**: We don't. We're in a very similar situation and we would look, similarly, to invest in those things, which we do get specific allocations for from the Welsh Government, and do it in a way that ensures that our clinicians are designing how that gets implemented.

[172] **Julie Morgan**: Right. And the other question I just wanted to ask briefly, because I asked the other witnesses earlier on: in terms of providing the mental health services for the prison service, obviously that is something that—. How do you actually fund that?

[173] **Mr Chadwick**: It's funded out of the—[*Inaudible.*]—allocation that we get, and that's been an existing budget that we've maintained over a number of years.

[174] **Julie Morgan**: Do you get money from the National Offender Management Service to fund it, which one of the other health boards does?

[175] **Mr Chadwick**: Yes.

[176] **Julie Morgan**: You do.

[177] **Mr Chadwick**: Yes.

[178] **Julie Morgan**: So, that is all totally covered, what you spend on the prison service.

[179] **Mr Chadwick**: Yes.

[180] **Julie Morgan:** Right. Thank you very much.

[181] **Dai Lloyd:** Ocê. Diolch, Julie. Symud ymlaen nawr at faterion yn ymwneud â pherfformiad ariannol, yn benodol, ac mae Caroline yn mynd i ddechrau'r cwestiynu, a wedyn Lynne. Caroline.

[182] **Dai Lloyd:** Thank you, Julie. Moving on now to financial performance, specifically, and Caroline has the first questions, followed by Lynne. Caroline.

[183] **Caroline Jones:** Diolch, Chair. Good morning to you. First of all, neither health board has balanced its budget. I'd like to ask: is this going to be a repeated pattern year on year? Can we expect much of the same? Do you think something more fundamental needs to be done to bring this in line? I note, with Hywel Dda, that the biggest overspend was on acute services. You both acknowledge the excessive use of agency staff. Cardiff and the Vale, you highlight the high level of staff vacancies that's causing you a problem and therefore agency staff are needed to bridge this gap. So, could you answer these questions as to how we can rectify this overspend and meet the £32 million—in Hywel Dda's case—savings requirement, along with everyone else?

[184] **Mr Moore:** Shall I go first?

[185] **Dai Lloyd:** Yes.

[186] **Caroline Jones:** Thank you.

[187] **Mr Moore:** I acknowledge we've got a very challenging financial system, actually. I'm two and a half years in Wales now, so I don't think I can describe myself as the new boy, but I still feel slightly new. Some of these issues are actually very long-standing issues for Hywel Dda, and part of the—

[188] **Caroline Jones:** Yes, I appreciate that.

[189] **Mr Moore:**—job of the board is to really grapple with those. So, I do think that squaring the circle for us is possible. Very hard, I would say, but not impossible to do. We've got a couple of challenges. I was watching the previous evidence and heard what the chief executive of Cwm Taf said. Of course, we do have a rurality issue in Hywel Dda. We've got a very dispersed

population, and possibly one of the most dispersed in Wales, but also we do, similarly, have a demographic challenge. When you compare us to the all-Wales average, we have about 18 per cent more people over the age of 85, and we know that over-85-year-olds drive a significant amount of cost in the health system. They use something like, I think, about seven times the resource of someone in the 25 to 40-year-old age bracket. So, we have some particular challenges. We're not shying away from those. There is a lot we can do and we are doing. You mentioned our £32 million-worth of savings. A very large part of that is around our variable pay bill. We have, for many years, seen significant increases in the costs of locum and agency, both medical and nursing. Last year, we managed to stabilise that, so it stopped rising. This year it started to fall, and that's been really down to a lot of hard work around ensuring that we're working very closely with the schools of nursing, particularly in Swansea. We've had 100 newly qualified nurses start with us this month.

[190] **Caroline Jones**: That's encouraging.

[191] **Mr Moore**: We've also been doing some overseas recruitment. I'd never thought of overseas as being a long-term solution for us, but it certainly helps in the short term. We see our future very much in growing our own and ensuring that local children think about the health service—and all sorts of careers, actually, not just clinical careers—and that they are supported. We're doing work, for example, in south Pembrokeshire, where we've got a Destination: NHS process for 16 to 18-year-olds, starting to talk to them now about what careers they might like, whether that's in catering, engineering or indeed in the clinical professions, and helping them to come through. So, we've got that. Our savings schemes are in place.

[192] There was some discussion, I think, at the earlier session, around medicines as well. We've got a lot of work going on around medicines management and generic prescribing, use of biosimilars and so on. We think that will get us to a level of efficiency, but it does leave, however, still some quite difficult challenges around how our services are organised, and we've set in our transforming clinical services strategy that we've been putting together—. We've been talking over the summer to the public, engaging on what their issues are, and we're trying to square a circle, actually, which is ensuring that we can continue to provide safe services that are sustainable—and there are still some challenges and some fragile services that we have out there—but also that whatever we put in place has to be accessible for our local population so that, if you're in Fishguard, you know that, in a moment

of crisis, you can get into the bit of the service you need and, indeed, mid Wales for Aberystwyth and so on. So, we're in the process of talking to the public about that.

[193] Part of the honest discussion with the public is how much it costs to run all of these various systems, whether that's in pay terms more generally, or in the fact that it's quite challenging to employ clinicians in quite small hospitals, which is an added challenge for us. So, we're at the very early stages of that. We looking to develop that and bring that forward in the next year for consideration through our—hopefully our first ever integrated medium-term plan next year, and that will start to address some of these underlying issues that are driving the deficit position that we have.

[194] And we're working very closely with Welsh Government. We said when we went into escalated intervention last year that we saw that very much as a supportive move. And I do believe that. I think that's Welsh Government being alongside us to help us deal with, as I say, some very long-standing issues for Hywel Dda. And I'm hopeful that, when we come out the other side of it, we'll have sustainable services that are fully accessible and we can balance the budget.

[195] **Caroline Jones**: Thank you.

[196] **Mr Chadwick**: Thank you. I think it's fair to say that Cardiff and Vale has had a history of cumulative deficits that it's struggled to manage over the years. Certainly now that is something the board is facing into and something we're clearly calling out amongst our own organisation. We've made some good progress in putting some good systems in there and challenging some of the choices being made and encouraging staff to live and deliver sustainable services within the resources they've got, to manage risk in a different way but support sustainable services that are safe, accessible, a good patient experience, and affordable.

[197] We suffer from the same pressures as any other health board. We have vacancies. We have 76 vacancies in nurses that we have to cover to keep patients safe. We have 25 vacancies in hard-to-fill consultant posts, which require us to cover with locum and agency staff. We've made lots of savings this year, more than we've made over the last three years, and they are recurrent, but it's still not enough to get us where we would like to be. The challenges remain: the rising costs of delivering healthcare; we know that Cardiff is a growing city with a rising population that brings demand on us.

And, as a tertiary provider and a teaching hospital, we do receive a case mix of patients flowing to Cardiff from other areas that is very expensive to maintain. So, they're the pressures that we are trying to do. Our plan is to look at every opportunity that's available to us through every possible efficiency, but, clearly, providing safe services that are sustainable is our clear underlying objective.

[198] **Caroline Jones:** Yes. Thank you very much. The level of vacancies does seem to be a lot higher compared with other areas. Could you go into detail as to why you think this applies to you more maybe than other areas?

[199] **Mr Chadwick:** Well, we've looked deeply into why this is a problem. We've tried recruiting overseas nurses. That's offered some relief. We encourage people to come and work in Cardiff, but there are some areas in Cardiff that are very hard places to work. It's a very, very busy A&E, the medical wards are very, very busy, and people choose to work elsewhere. The cost of living in the city could also play into this factor, but we do pursue this. We've got a project called Project 95, which is led by our director of nursing, which has been very successful in recruiting people in, and we've seen lots of unqualified nurses wanting to work for us. So, we've a constant address of this on a weekly basis to look at every opportunity to recruit nurses, qualified nurses, into Cardiff and Vale.

[200] **Caroline Jones:** Okay, thank you. And my next question, which Steve has partially answered, is: what are the barriers to securing an approved integrated medium-term plan?

[201] **Mr Chadwick:** Well, first and foremost, we need to address and plan for the cumulative deficits that we've got historically. I think there are lots of barriers. All those barriers can be overcome, but there are internal challenges for the board and for clinicians alike. There's the challenge of collaboration and working with external stakeholders, which will bring down some of those barriers, but we don't think those barriers are insurmountable. But they are hard yards and time will be required to do that, and the support of our external stakeholders, working in collaboration.

11:00

[202] **Caroline Jones:** Okay, thank you. Diolch, Chair. I think everyone's—.

[203] **Dai Lloyd:** Diolch yn fawr. **Dai Lloyd:** Thank you very much. We

Symudwn ni ymlaen nawr i Lynne, efo'r ddau gwestiwn nesaf.

move on to Lynne with the next questions.

[204] **Lynne Neagle:** Thanks, Chair. Obviously, you have touched on some of the pressures, but can you tell us what you think the main pressure areas are and the challenges for both health boards, this year and going forward?

[205] **Mr Moore:** Sure. Again, Len—. Is that okay? Sorry. I'm getting into a pattern here.

[206] **Mr Richards:** That's fine. I'm happy with that.

[207] **Mr Moore:** Our fundamental challenge, I think, as I've already mentioned, is one around demographics, that what we see is an increasingly elderly, frail population, and that drives all sorts of costs. I would say that our challenge in that is how do we reconfigure our health services so that we can do better for those people, quite often outside of the hospital setting. Because I think there is at least anecdotal evidence that when an elderly, quite often frail, person comes into the acute centre, they don't come out the other end of that, maybe, with the independence that they had at the beginning. So, there's a need for us, I think, to think very differently about that, but, fundamentally, that's one of our bigger pressures.

[208] Alongside that, and, as I've already mentioned, workforce is a challenge for us and that comes through in a number of ways, not least the financial challenge that we face with that, and we are seeing, again, some improvements in that. Some of that is down to us being increasingly innovative about the way that we attract staff, so working with all sorts of social media platforms, being on the right systems, using our own clinical networks, our own doctors and nurses, to put Hywel Dda on the map, given where we are in the world is both a beautiful place, but a long way from some of the big population centres. That is starting to show some fruit—bearing some fruit for us. In 2015-16, for example, we employed about 25 new consultants, and these were replacing locums, quite often. Last year, that rose to 45, and this year we're at 50 already. So, we're starting to see that happening.

[209] I think the other thing for us that helps is putting our performance back where it should be, so being an organisation that can deliver on targets, and for many years we've struggled with that, but, actually, we've now seen, particularly in areas like cancer, it is quite often between us and Cardiff and

Vale about who's best in Wales for cancer targets. I think one month we're ahead, and the next month Cardiff are, but there's significantly improved performance there, as well as things like stroke. Even our referral-to-treatment targets are now better than they were. So, I think there's a lot we can do, but certainly our pressures—you won't be surprised—fundamentally relate to either the workforce or the population that we're trying to serve.

[210] **Lynne Neagle**: Okay, thank you.

[211] **Mr Richards**: I think, in a very similar way, the pressures that I foresee for Cardiff and Vale specifically—. We've got workforce pressures, and we've touched on that in answer to a previous question, particularly around registered nursing in our medical areas—in our medicine areas. But, in addition to that, I think we've got some specific challenges around the buildings that we have, and the estate, and whether, because of the way that's built up over time, that is the most efficient sort of set-up for the hospital services. The Heath is a very overcrowded facility. It's piecemeal in development, and that doesn't encourage efficient working, in a sense. So, I think there are some issues that are particular to Cardiff and Vale, around some of the facilities that we have.

[212] And then the third pressure, I would say, and it's emerging within Cardiff and Vale, is around the sustainability of some of our primary care services, having posts that are attractive to GPs, having a sustainable primary care to build on. Because the emphasis that we have, which, I would suggest, is the same for most health boards in Wales, is about how we invest in primary care services to identify need at the earliest, and then how we provide, and support patients in the community, rather than in the hospital. So, I think we're all chasing that particular aim, but you need a very solid primary care foundation on which to do that.

[213] And then, just the last thing, and Steve, I think, touched on this, around—. Or, sorry, Bob touched on this earlier. We provide a lot of specialist services. We and Swansea provide specialist services for Wales, and therefore there is a growing demand in some of those areas. New technologies are coming about. New treatments are coming about, and we have to respond, because it's either us or Swansea, and I think some of that brings pressures in terms of development.

[214] **Lynne Neagle**: Okay, thank you. The Cabinet Secretary has said that he thinks there's scope for further efficiencies within the health service. Do you

agree with that view and, if so, where are you going to be finding those efficiencies within your health boards?

[215] **Mr Richards:** I'll pick this up. I think there is. I think there is scope for further efficiencies. I think, when we walk through our hospitals—certainly when I walk through Cardiff hospitals—you see patients in the hospital that shouldn't really be there. But it's being able to move them into a place of safety, either in the community, residential care, or in the home. And sometimes we don't have the alternatives to be able to provide. So, I think that's—. Again, it sort of pursues that philosophy that I talked about earlier on, around building services or alternatives outside of the hospital setup. The model that I talked about in terms of mental health is a good model. We've been able to reduce the number of beds that we've had within our mental health service, and that's enabled us to invest in community services, which means we can address health need earlier in the pathway. That, in simple terms, is a principle that we would like to apply to many of our services.

[216] We're looking at the Canterbury health system, which is a very similar health system to our own, and Canterbury is a health system in New Zealand. And they've seen, through investment in primary and community services, a significant reduction in demand on hospital services, and they've been able to demonstrate that over a number of years. And where, on a lot of our trajectories, more and more people are being admitted to hospital, across their health system they can see reduced requirement for beds because of reduced admissions, and many more alternatives directed by GPs from within primary care. So, it's being done in a system. We can see evidence of that occurring, and that's the sort of strategy that we're pursuing in Cardiff and the Vale.

[217] **Lynne Neagle:** Okay, thank you.

[218] **Mr Moore:** Just on that for a moment, I think the other point I would just add is the ability for us to make what might be described as technical efficiency—the easier, low-hanging fruit things, doing things better—is becoming more tight, this many years in, to create savings. There are still certainly things in there that we can do, certainly around things like drugs and devices and those sorts of areas, as well as, of course, our variable pay bill. But, increasingly, I think, as Len's alluded to, it's about how we ensure that we allocate the money in the most efficient way to what we're trying to achieve, and particularly trying to move funding upstream into prevention

and ensuring that we are helping people to stay well, I think, is the next frontier for us in terms of efficiency. And we do have some really interesting examples of what can be done differently with relatively small amounts of money, and then we need to systemise.

[219] For example, in north Ceredigion, we've had, through the cluster work, a piece of work around people who are in the pre-diabetic stage, so these people haven't yet got active disease and therefore have all the costs and outcomes associated with that. And, through much stronger working with that population of people through identifying who they are and then working with them, that cluster has seen a 39 per cent improvement in the number of people who are then moved out of that into a much lower-risk category. I think that has to be much more about what we do in the future and how we ensure that that works across the whole system.

[220] **Lynne Neagle**: Thank you.

[221] **Dai Lloyd**: Okay. Those answers have inspired a list of supplementaries, so supplementary first, Suze, then two other supplementaries, and I'll come back to you—[*Inaudible*.]

[222] **Suzy Davies**: Well, okay. You'll be glad to hear all my questions invite short answers, so there you go. I just—

[223] **Dai Lloyd**: Suzy, you're wonderful.

[224] **Suzy Davies**: I just wanted to look at two of the cost pressures very briefly. The first is for you both. I notice that medicines and drugs pressures are high as well. I would imagine you've got different reasons for why your drugs bills are so high. I wanted to particularly find out what relationship there is between people who are being kept on holding drugs, if you like, until they have a shorter referral to treatment time. Do you see what I mean? Do you spend a lot on drugging people up until the consultant can see them?

[225] **Mr Chadwick**: Drug costs do rise year on year as new drugs come onto the market. Certainly, we've seen an increase in drug spend this year and in previous years, as we do more complex, specialist procedures that require more expensive drugs.

[226] **Suzy Davies**: So, it's the unit cost that's most expensive in your case.

[227] **Mr Chadwick**: Unit cost increases, but also use of new, more expensive drugs for more specialist work that we undertake at Cardiff and Vale, which is unavoidable.

[228] **Suzy Davies**: Okay, so it's not necessarily the length of time people are on them.

[229] **Mr Chadwick**: No.

[230] **Suzy Davies**: Okay, that's—. Is that the same for you?

[231] **Mr Moore**: Yes.

[232] **Suzy Davies**: That's a short answer. Fantastic. Right. My next question was particularly for Hywel Dda—again, it invites a short answer. Obviously, you have a strong relationship with ABMU for the provision of certain specialist items, and I notice one of the pressures relating to you specifically is £3.5 million on specialist services and LTA cost pressures. My understanding was that this relationship was obviously supposed to provide better outcomes for an individual, but also to save money. It doesn't look like it's saving money. Is there a short answer to that?

[233] **Mr Moore**: I think the short answer is we're seeing more people needing specialist care, particularly in things like cardiac and cancer. So, there's just a growing number of people needing that level of support through the specialist centres. So, it's more of a volume issue for us.

[234] **Suzy Davies**: You don't have an equivalent. Okay, thank you. So, my main question is: how can capital expenditure help with revenue expenditure—help with your savings—and how much capital have you got to spend?

[235] **Mr Moore**: Well, we have our discretionary capital pot, which is about £8 million for Hywel Dda. A lot of that does get taken off on the normal maintenance arrangements that we need—replacing scanners and so on—across the health board. However, I think, on the general question about how capital can help, I think it can have a significant impact on the revenue spend, if you get it right. I would highlight things like telehealth, that we can get people to access services, reduce waiting times, reduce travel times, but also improve the outcome for patients through use of that sort of technology. So, things like mental health: we're doing many more

consultations using telemedicine, which means that we're able to help people—more people, probably—who would then, potentially, if we hadn't done that, get into more costly services. So, there's certainly something around that. There is also something around how we ensure that the sort of designs of our hospitals work very well. So, I would highlight, for example, the Prince Philip Hospital front of house scheme. It was a relatively small capital scheme, but it actually reconfigured the front door of the hospital such that the patients could be directly streamed into the beds they needed to go to, without going through the bottleneck of the emergency department. That's meant that Prince Philip, whilst I understand it doesn't have a surgical take, so it isn't comparing fairly, maybe, with every other hospital in Wales—however, it is the only hospital in Wales that has delivered the 95 per cent accident and emergency four-hour target since last October for a whole year, every month, right through the winter.

[236] **Suzy Davies:** Well, congratulations on that.

[237] **Mr Moore:** And I think that demonstrates how you can use money to—.

[238] **Suzy Davies:** Does GP clustering help avoid the need for primary care on-site capital spend?

[239] **Mr Moore:** Again, for us, it certainly does. I've mentioned the pre-diabetic thing—that was a cluster development in north Ceredigion, which has helped with demand into the diabetes service. But, in Carmarthenshire, for example, they're working on 'stay well' plans for, particularly, elderly, frail individuals, and they've been able to demonstrate a significant reduction, for those people who have those plans, of their usage of secondary care, of hospital-based services. We want to see that roll out over time, across the whole health board, because it seemed like such a strong evidence base.

[240] **Suzy Davies:** That's good to hear. Difference setup with Cardiff, but—.

[241] **Mr Chadwick:** Yes. We get up to £16 million capital to spend each year. Most of that is taken up in maintaining all sites, maintaining the Heath, which has got tremendous amounts of need—backlog work that needs to be done to keep it functioning and operational. We do try to use some of it to improve our revenue position by replacing old, outdated theatres, or old, outdated areas for the delivery of clinical care that allow modern layouts to make care easier and less reliant on old infrastructure. So, unfortunately, it's

taken up with most of that, so the opportunity to use it to reduce revenue is quite limited, I'm afraid.

[242] **Suzy Davies**: All right. So, you don't have the spare to look at the use of tech, basically.

[243] **Mr Chadwick**: No, we do invest in information technology. We do invest in digital technology.

[244] **Suzy Davies**: But it's not much, is it?

[245] **Mr Chadwick**: We do carve some of that out. I think there was a brief mention of it. We do carve some of that out. It's not as much as we would like, though. It's only very limited, I'm afraid.

[246] **Suzy Davies**: Okay. Well, that's what I wanted you to tell me. Okay, thank you very much.

[247] **Dai Lloyd**: Okay. Rhun.

[248] **Rhun ap Iorwerth**: Inspired by your reference to the work you're undertaking with Canterbury in New Zealand—the committee has taken plenty of evidence over the years on the advantages of investing in primary care in order to release or relieve the pressure on other parts of the NHS. We've already established, in this session, that ring fencing can be useful in making sure that you spend on mental health services. There is strong evidence that we are suffering in Wales because of the slippage in the proportion of NHS funds going to primary care from—forgive me if the numbers are wrong—around the 11 per cent mark to well below 10 per cent. Should we be moving, incrementally, perhaps, towards restoring that balance and making sure that investment goes into primary care as well? And what would you like to see the Welsh Government doing in its budget to, perhaps, move towards that, if you agree?

11:15

[249] **Mr Richards**: So, I would say 'yes' to that question around a focus on primary care. As I've described earlier, I think the future of health services requires a really strong platform in primary care. We need to look at how we bring services together, how we co-ordinate services within the community, and how we also, I guess, raise awareness around what people themselves

can do to look after themselves within the community through public health messages as well. So, it's not just about GP practices. It would involve public health. It would involve community resource teams, which is a mechanism that we have within Cardiff and the Vale. So, my sense is that, over time, we need to significantly invest in primary care services to build that platform to keep people healthier for longer.

[250] **Rhun ap Iorwerth**: Yes, including investment, Hywel Dda, and edging up again towards a higher proportion of your actual money—not just ideas and programmes but actual money going towards primary care.

[251] **Mr Moore**: Yes, I would agree. As Len has already said, this is the bedrock, and we need to have a very stable bedrock for primary care. Some of our challenges are not to do with money; they are to do with recruitment and ensuring that we have enough primary care clinicians, but also challenges in discussing with the public what primary can do these days. Because, actually, it's not just about the GP, it's about the community paramedic, the pharmacist. We've put together all sorts of different models in Hywel Dda to support that, and actually talking to the public about what that means. You may not necessarily see a GP for some of your care. That's an ongoing discussion. For some people, that's a bit of a worry, and I think we need to help them with that.

[252] I would agree with Len: it's much more than just primary care for us. I mentioned our transforming community services strategy that we are at the point of developing. Yes, part of it is absolutely about the secondary care element, but, actually, the much bigger and more important and more exciting part of it is the whole out-of-hospital community primary care provision. We want to see, and the sort of messages that we're getting back from our clinicians, is a much more scheduled approach to how primary care works in the longer term, so that we know we've proper risk stratification in place, for example, so that we know where our high-risk populations are—those people who may be coping at the moment, but a bit more support would prevent them from getting into higher cost services. So, we are at the very early stages, but we're working with the clusters and some of the experiences that they have had with their money to really build a much more systematic approach to primary care going forward. So, I would say that if we get our strategy right, what we should see is a correction in that sort of investment difference that you've highlighted.

[253] **Rhun ap Iorwerth**: Okay, thanks.

[254] **Dai Lloyd**: Dawn, you've got a supplementary.

[255] **Dawn Bowden**: Thank you, Chair. I suppose, to be fair, this may be a question more properly addressed to the health Minister, but I'd welcome your views on this. We've had evidence now from a number of health boards, which have been talking to us about their cost pressures and what they're doing to try to address that. But I'm just wondering whether we're getting to a point where we need to have some kind of debate with the people of Wales about making hard choices about what the NHS in Wales actually delivers. We can spend a lot of time focusing our energy on looking at things like financial management regimes, managing overspends and so on, but I'm just wondering whether you think that there may be a bigger debate required about what our NHS actually delivers going forward.

[256] **Mr Moore**: If I can just come in, I think there is certainly something in that. The NHS has been challenged across the UK, actually, for the last seven or eight years, in particular. We've seen increasing new stories of organisations with financial problems, one of them being mine. I think, in the end, the wider point for me is, firstly, that the NHS needs to ensure that it has got its house in order. We talked a bit about the efficiency stuff that we can do, because I don't think the public would be up for that sort of discussion unless we can demonstrate that, actually, we're doing everything we can to be technically efficient and to do things better, but also to put our money in the right places to help support people.

[257] I think, beyond that, we'd need to look at things like the Health Foundation report that recently came out on the sustainability of the NHS in Wales, which sets out a number of criteria, actually, that would need to be hit. Some of those are really quite challenging. My personal view, and I've been in the NHS now for 27 years, I think, is that it's such a well-supported institution that people need to know that, in a moment of crisis, they can get access where they need it. It doesn't necessarily mean that, once they get past the front door, they have to be in that hospital. It may be that they have to go elsewhere, but they know they can get fast access to the start of their treatment when they really need it. I think that's a real challenge in rural parts of the country, as you can imagine. But I would like to think that we can square that circle so that people can continue to feel supported, because I think, for us, the wrong answer would be a full centralisation of services somewhere where it may be very safe and sustainable for those patients who can get there, but for many it wouldn't work at all.

[258] So, I think we've got to continue to work at that and we've got to continue to debate that. Some of what we're talking to the public about around primary care is a part of that debate, about what you can expect these days, and it isn't always time with your GP, but we'll make sure you see the right professional for your needs. So, that's where I would probably go with the debate—what you can expect, how things are changing, but that we will be there when you need us, because I think that's what the NHS is all about.

[259] **Dawn Bowden**: That's, kind of, the discussion we had in the primary care inquiry—it was that sort of public education of where the right place to go is for whatever the particular condition is. I don't know if you've got any—

[260] **Mr Richards**: I don't have much to add to that, because I think the debate with the public is around what we can deliver for them, but also their responsibilities as well in avoiding risk-taking behaviours, in looking after themselves for as long as possible with our support. The issue is challenging some of those older traditions—if I'm ill I need to be in a hospital. Often, you don't. So, getting into a debate with the public around all of those sorts of things, long before we get into the debate about can we do something or not, that's where I would be.

[261] **Dawn Bowden**: Sure. Okay, thank you.

[262] **Mr Moore**: I'll just add to that, if I may. That's just struck a thought in my mind—one of the other expectations around patients going into hospital is that they go into a bed. We're doing a lot of work at the moment on ending pyjama paralysis, because we know that when someone spends a long time in bed, they don't get out again—it's a real challenge. Again, it's about what you expect when you come into the hospital—that needs to change, I think. So, I think there is a debate, certainly, to have around that.

[263] **Dawn Bowden**: Okay, that's helpful. Thank you.

[264] **Dai Lloyd**: Diolch. Jayne.

[265] **Jayne Bryant**: Thank you, Chair. We've heard from a variety of bodies, including the Cabinet Secretary, about the need to change, in health and social care, the new models of care to ensure maximum value for money. What are your views on the pace of change that's happening at the moment?

[266] **Mr Moore**: Is this particularly around health or health and social care integration?

[267] **Jayne Bryant**: Health and social care, yes.

[268] **Mr Moore**: Well, I think we've seen a huge acceleration, actually, over the last couple of years, particularly at the operational level, around joint working between health and social care. When I first arrived, I travelled around the whole patch, and it is quite a big patch—I think 25 per cent of Wales—to see our services. I saw many, many examples of where our staff were not just co-located with social care but you couldn't tell the difference between who worked for health and who worked for social care. We've got growing examples of that probably across the whole of Wales, I would say. I don't think we're particularly ahead of the game on that, but the practical advantages of doing that, I think, are just well made.

[269] The next step will be the pooled budget arrangements and I think that will give us another step forward and I'm quite ambitious about actually how much further we can take that so that we can really think quite innovatively about pooling quite a large amount of money and maybe doing something completely different with it. I think relationships with local authorities are strong. We both have our challenges around finances and service delivery, but I think in Wales in particular there are very strong joint-working relationships. I'm hopeful that we've seen some real momentum grow and actually we're going to see it grow even faster in the future.

[270] **Mr Richards**: My sense of it is there's room for real optimism around this. I was at a regional partnership board just a couple of weeks ago, with the local authorities, with the third sector and ourselves, just looking at what services have been put in place, and what reform has been put in place. I was really quite impressed by the level of integrated working and the knowledge that there was throughout the room—that we needed to work together to deliver on these services, that it wasn't what the local authority could do and us in health doing something quite different.

[271] I can't comment on the pace of change because I haven't been in Wales for that long, to be honest, but I was really buoyed up by the conversations and the discussions that we had at that meeting, which I think plays into what Steve said. I think there's a real appetite. Pooled budgets is a challenge but, again, there's again a real appetite to achieve that. I think it

will go from strength to strength. I think it's our job to make it go from strength to strength and I think that's also recognised within the local authorities as well.

[272] **Dai Lloyd**: Ocê. Mae'r cwestiwn olaf i Dawn Bowden.

Dai Lloyd: Okay. Dawn Bowden has the final question.

[273] **Dawn Bowden**: Thank you, Chair. In previous evidence we've had from health boards, there's been some indication of potential workforce risks around Brexit. I'm kind of making assumptions here that this could be potentially a bigger issue for Cardiff than it is for Hywel Dda, but I could be completely wrong. I was just wondering whether you have concerns in that area and, if you have, whether you're thinking about your contingency planning for that or whether you're talking across health boards about that—whether it's a particular problem for you or not.

[274] **Mr Richards**: I'll take that, from Cardiff. I think that there are concerns and risks around Brexit. We do have a number of—. I think, across Wales, there are 1,300 staff who are European and I think there's a proportion of those within the medical staffing. I think it's variable. So, in some specialties, we can recruit from within quite easily, and in others we recruit from the EU. Then it depends on what happens as a result of Brexit in terms of that movement of people. I think that's the unanswered question. If there's a restriction put on that, then that will have an impact in pockets within our services. If that's at a medical staff level, then that will have an impact on capacity in those particular areas. So, I think it's a concern; I think it's a risk. I don't think we know enough at this point around what the impact of Brexit will be and over what timescale that will take place, but it's something, certainly, that we are watching.

[275] **Mr Moore**: I will say that I think at the moment we haven't seen a particular impact that I'm aware of from staff in relation to this, but we have a fabulous workforce from the EU, and actually, I would also say, particularly in terms of our nursing establishment, from around the world—we have many staff from around the world. So, I think it's something we're keeping a wary eye on. We are very much supporting our EU and other overseas staff through this, and as Len said, quite often, they are key to some very specific services within the health board, so we'll want to ensure that we look to care for them through what might be a difficult process. We haven't particularly seen yet any drop-off in people looking with interest in the health board, as a result, but that may be partly a reflection of what I was talking about earlier

around using social media and being better in UK recruitment than we've been previously. So, that may be offsetting any effect, but I've not seen anything specifically.

[276] **Dawn Bowden**: Okay. Thank you.

[277] **Dai Lloyd**: Mae gan Suzy gwestiwn atodol. **Dai Lloyd**: Suzy has a supplementary question.

[278] **Suzy Davies**: Just to refer back to those two last questions, actually, while the impact on direct staff within the health service may not be that great, judging by what you're saying, we were just talking about working with social care, and the impact on social care and the number of care workers might be considerable. I was wondering if you've got any views at this stage on what kind of pressures that might place then on the integration agenda, where the NHS side of things may end up picking up some work that's not able to be done.

[279] **Mr Moore**: Again, I haven't seen any specific issues at the moment. I think there is a risk, going forward, as the clarity comes around what Brexit looks like. I'd also highlight that I wouldn't just limit it to social care. There are issues within the care home market as well—

[280] **Suzy Davies**: I meant generally.

[281] **Mr Moore**: —outside of NHS direct employees. We are working with our care home providers—some of our bigger care home providers—to ensure that we, for example, do joint recruitment and that if we do get nurses, in particular, that we're helping to support them, because they're part of the system, even if they're not part of the health board. So, we haven't seen anything specific yet around either social care or more widely around the care home community. But, again, we are keeping a close eye on them.

[282] **Suzy Davies**: Yes, if you can keep an eye on it—that's what I was flagging it up for. Is it the same with you?

[283] **Mr Richards**: Yes, I would go along with that. The only reflection I would bring to that—and again, just coming back to the Canterbury experience, where they've got 10 years of experience of investment in primary care, they actually reduced the load in social care as a result of that,

as well as reducing the burden on hospital services. So, my sense of it is that it's about trying to keep people well in their homes—

[284] **Suzy Davies**: Yes, but we've got to get to that stage first.

[285] **Mr Richards**: We have to get to that and we have to have a stable position on which to build that, but I would say that that would be the aim that we'll be pursuing.

[286] **Suzy Davies**: Thank you. Diolch, Gadeirydd.

[287] **Dai Lloyd**: Dyna ni. Diolch yn fawr iawn i chi. Dyna ddiwedd y sesiwn. Diolch yn fawr iawn i chi unwaith eto am y dystiolaeth ysgrifenedig a wnaethoch chi ei gyflwyno ymlaen llaw a hefyd am eich presenoldeb y bore yma, a hefyd am ateb y cwestiynau mewn modd mor aeddfed a graenus. Diolch yn fawr iawn i chi.

Dai Lloyd: There we are. Thank you very much. That's the end of the session. Thank you very much to you once again for the written evidence that you submitted and for attending this morning, and also for answering the questions in such a mature and eloquent way.

[288] Fe wnewch chi dderbyn trawsgrifiad o'r cyfarfod yma i'w wirio i wneud yn siŵr ei fod yn ffeithiol gywir. Ni allwch chi newid eich meddwl am unrhyw beth, ond fedrwch chi wneud yn siŵr ei fod o'n ffeithiol gywir. A gyda hynna o eiriau, diolch yn fawr iawn i chi i gyd am eich presenoldeb.

You will receive a transcript of this meeting to check for factual accuracy. You cannot change your mind about anything, but you can make sure that it is factually accurate. So, with those few words, I thank you for attending here today.

11:29

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

Cynnig: *Motion:*

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog 17.42(vi).

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

Cynigiwyd y cynnig.
Motion moved.

[289] **Dai Lloyd:** Gallaf symud ymlaen i eitem 4 nawr, gyd-Aelodau, a chynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod a symud mewn i drafodaethau preifat. A ydy pawb yn gytûn? Yn amlwg. Diolch yn fawr.

Dai Lloyd: We move on to item 4, and a motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting and move into private discussion. Are we all in agreement? Yes. Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:30.
The public part of the meeting ended at 11:30.