



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

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

**Dydd Iau, 16 Hydref 2014
Thursday, 16 October 2014**

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of the Meeting

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

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

**Aelodau'r pwyllgor yn bresennol
Committee members in attendance**

Alun Davies

Llafur
Labour

Janet Finch-Saunders	Ceidwadwyr Cymreig Welsh Conservatives
John Griffiths	Llafur Labour
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Mark Drakeford	Aelod Cynulliad, Llafur (y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (Minister for Health and Social Services)
Vaughan Gething	Aelod Cynulliad, Llafur (y Dirprwy Weinidog Iechyd) Assembly Member, Labour (Deputy Minister for Health)
Dr Andrew Goodall	Cyfarwyddwr Cyffredinol, Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cymru Director General, Health and Social Services, Welsh Government
Albert Heaney	Cyfarwyddwr Gwasanaethau Cymdeithasol ac Integreiddio, Llywodraeth Cymru Directive of Social Services and Integration, Welsh Government
Martin Sollis	Cyfarwyddwr Cyllid, Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cymru Director of Finance, Health and Social Services, Welsh Government

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

Sian Giddins	Dirprwy Glerc Deputy Clerk
Martin Jennings	Y Gwasanaeth Ymchwil Research Service
Llinos Madeley	Clerc Clerk

Dechreuodd y cyfarfod am 11:04.
The meeting began at 11:04.

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. I welcome Members and the public to this morning's session of the Health and Social Care Committee, where we will be scrutinising the Minister for Health and Social Services and the Deputy Minister for Health in relation to the budget proposals from the Welsh Government. The meeting is bilingual and you can use the headphones for simultaneous translation from Welsh to English, which is on channel 1, or for amplification, if you wish, which is on channel 0. There are no scheduled fire drills, so if any alarms do go off, please follow the directions of the ushers. I ask everyone to turn off any pieces of equipment that may interfere with the broadcasting, or to put them on silent mode, at least. I am glad to see that the Deputy Minister is doing just that. We have not received any apologies this morning, so we will move next to item 3 on the agenda.

11:04

Papurau i'w Nodi Papers to Note

[2] **David Rees:** We have received papers to note, namely the minutes of the previous meeting; the correspondence from the First Minister regarding the ministerial duties in relation to the Deputy Minister in particular; the additional information from the Minister for Health and Social Services regarding the Welsh Ambulance Services NHS Trust's recruitment plan; and the correspondence between the Chair of the Constitutional and Legislative Affairs Committee and the Minister for Health and Social Services regarding the Social Services and Well-being (Wales) Act 2014. Are we happy to note those?

[3] **Darren Millar:** I am happy to note them, Chair, but can I just suggest that we write again to the Minister—I know he is in the room—[*Inaudible.*] I welcome the note on the ambulance service's recruitment, but it does not actually say how many people have departed the ambulance service in the same period. I would be interested to know what the net difference is.

[4] **David Rees:** I am happy to write to the Minister to ask for that information, particularly as we have seen in the press that large numbers have departed in the English NHS, and in London in particular. So, yes, we will write to the Minister to ask that question.

11:05

Cyllideb Ddrafft Llywodraeth Cymru ar gyfer 2015-16: Sesiwn i Graffu ar Waith y Gweinidog Welsh Government Draft Budget 2015-16: Ministerial Scrutiny Session

[5] **David Rees:** We now move on to the main emphasis of this morning's session, that is, the scrutiny of the draft budget. May I welcome the Minister Mark Drakeford and the Deputy Minister Vaughan Gething? Minister, would you like to introduce your officials, please?

[6] Y Gweinidog Iechyd a Gofal Cymdeithasol (Mark Drakeford): Diolch yn fawr, Gadeirydd. Gyda fi y bore yma mae Dr Andrew Goodall, pennaeth yr adran iechyd a gwasanaethau cymdeithasol; Albert Heaney, sy'n arwain ar wasanaethau	The Minister for Health and Social Services (Mark Drakeford): Thank you very much, Chair. With me this morning are Dr Andrew Goodall, director general of health and social services; Albert Heaney, who leads on social services; and Martin
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cymdeithasol; a Martin Sollis, sy'n arwain ar Sollis, who leads for us on finance. bethau cyllidol i ni.

[7] **David Rees:** Thank you for that, Minister. We have some questions for you and we will go straight into them. We will start with Gwyn Price.

[8] **Gwyn R. Price:** Good morning to you all. It seems that there are more of you than us this morning, but there you are. Can you comment on how successful the implementation of the National Health Service Finance (Wales) Act 2014 has been in terms of achieving the expected benefits from a three-year planning horizon? Also, can you comment on the robustness of the planning system itself?

[9] **Mark Drakeford:** Thanks, Chair, and thank you, Gwyn, for those questions. As Members will know, we have had the first cycle of the new three-year planning regime. I noticed that the auditor general, in his report on NHS finances published on Tuesday, commented on the fact that it was inevitable that, with a completely new system, it would take a while to bed in. However, I think he referred to it as a successful and necessary measure. As you will know, when this committee was scrutinising the legislation, Members here and Members in other committees as well pursued a line of questioning to ensure that we had a sufficiently robust way of testing plans that were produced by local health boards and trusts and that they really did what we require them to do, which is to bring together, in an integrated plan, service planning, financial planning and workforce planning in an integrated way. At the end of the process, four health bodies in Wales had three-year plans approved and, again, the auditor general says that he takes that as a sign that, as a Government, we set the bar high and that we were only willing to approve those plans that were genuinely of the quality and calibre that merited approval.

[10] Having gone around the track once, we have been revising the guidance, checking that the system is as fit for purpose as we can make it. We are optimistic that a larger number of health boards and trusts will submit plans, as they now have to in January, that will allow them to have three-year approved plans as from 1 April next year.

[11] **Gwyn R. Price:** You say that you are optimistic. Are you very optimistic or just optimistic?

[12] **Mark Drakeford:** Well, I start from the same exact place as I did last year, Gwyn. No plan will be approved that we do not believe is worth approving. So, I am very keen to get that message out to the health service. There is no open door here where we will approve plans simply to be able to say that we have a large number of plans approved. The other health organisations, which were very close to having three-year plans approved last year, but were just below the bar that we had set, have learned, they tell me, from that experience and are confident that the plans that they will submit for next year will be of the right quality. If they are, they will be approved, but they will not be approved if they are not.

[13] **David Rees:** Darren is next.

[14] **Darren Millar:** Thank you, Chair, and thank you, Minister, for the paper that you forwarded to the committee. Obviously, this year's budget allocations are going to have an impact on the baseline, I suppose, for future years' budgets, and, of course, you announced a £200 million bail-out for the NHS in the current financial year on the same day that the budget announcements were made for next year. Have you determined how that is going to be allocated to the national health service yet?

[15] **Mark Drakeford:** I will answer the substantive question. We can do the ritual stuff, if you like. It is not a bail-out; it is a response to the Nuffield review of NHS finances that

identified a sum of money that needed to be invested in the health service. So, there is £200 million of extra investment in this year and £225 million of additional investment next year. But the substantive question is the important one: how is the money to be allocated? It is to be allocated in two different ways, so, I will try to be as clear as I can about this. The money in this year will be used, first of all, to make sure that those four organisations that submitted successful three-year plans will have those plans fully underwritten. So, any health organisation that produced a plan that required extra investment upfront in year 1 of the three-year programme in order to drive up efficiencies and savings in years 2 and 3 now knows that the extra investment that it needs from us as part of a three-year plan will be provided in full to it this year.

[16] We will have to retain a portion of the £200 million centrally, because my overriding responsibility is to ensure that the health and social services main expenditure group, in the round, lives within the overall ambit that we have for everything that the department does. As we have some health boards that may not be in balance at the end of this financial year, I have to retain some of that £200 million to make sure that services in those areas are not compromised. Now, for next year, what we are doing is distributing the whole of the £200 million on a Townsend-share population basis. So, all health boards next year will get the share of the £200 million that they would have got had we redistributed it all this year on that basis. Now, we are going to do that as late in the cycle as we can, because we want to make sure that we have the most up-to-date information in terms of population estimates and projections—the age-sex curve, as it is called, because it is a weighted population basis—and we want to make sure that we have the most up-to-date information so that we allocate the £200 million to help organisations for next year with the best Townsend-driven population-based formula that we can have.

[17] **Darren Millar:** Can you just help me here? So, this year's additional in-year resource is going to be spent in the two ways that you have suggested. What proportion are you holding back for the end of the financial year? You are clearly anticipating that some health boards will not be able to break even.

[18] **Mark Drakeford:** Martin will probably be able to remind me how much we have committed.

[19] **Mr Sollis:** It is £60 million available in the MEG at the moment. The rest will cover the plans have been submitted, but it is holding onto that £60 million centrally to see improvement in the performance of some of those plans.

[20] **Darren Millar:** It begs the question, Minister, in that, given that you are anticipating that some health boards are not going to be able to break even, and that plans were signed off without the resources being properly available, it suggests that you were planning to make additional resources available in any case, before the review over the summer. Is that not a fair assumption to make? If they were asking for extra cash in the current financial year, and it was not there, and you have now made it available, does that not suggest that the three-year planning processes that you as a Government have signed off have been very poor?

[21] **Mark Drakeford:** If I can quote the auditor general's report, he says that there is not unlimited flexibility in the system to allow all NHS bodies to invest upfront at the same time. I remember, quite specifically, being in front of this committee and explaining that, had all health bodies in Wales last year produced three-year plans that were sufficiently robust to be above the line, we would not have been in a position to have been able to offer all of them the extra investment that they needed. Now, we retained a central reserve at the start of the year to allow us to give the go-ahead to three-year plans among those organisations that had plans above the line. We are now able to give them complete confidence that everything in those plans will be underwritten by the Welsh Government.

11:15

[22] So, it is not a matter of poor planning; it is a matter, inevitably, of cutting your coat according to your cloth and having to prioritise investment where the case for that investment is strongest. The extra £200 million allows us to go further than that for those organisations that have the best plans. We have to retain the £60 million centrally against the day when some other health boards that do not have three-year plans may need some extra assistance in the round to allow the whole of the NHS and social services MEG to live within our means.

[23] **Darren Millar:** However, what you are suggesting, with respect, Minister, is that you were not able to give confidence to those health boards that had submitted three-year plans and had them signed off that you were properly able to resource those plans. Is that not a fundamental flaw in the three-year planning process? I fully accept that not everybody can have an extra dollop of cash in any financial year, because you have to live within your means—I completely understand that point, and it is well made and well understood—but is there not a fundamental flaw in your three-year planning processes if health boards submit plans that you sign off and you are not able to guarantee them the resources that they need to be able to deliver against those plans?

[24] **Mark Drakeford:** It clearly is not a fundamental flaw, because of the first proposition that you agreed with, that if there simply is not enough resource to be able to allow every single plan to go ahead, then you end up, as a responsible Government, prioritising from within those plans, and the very best plans get the go-ahead. There is not unlimited flexibility in the system; that is what the auditor general says, and he is right. The job of Government, then, is to identify those plans that are the best of all and resource them with whatever we are able to provide. If more money can be found, then you are able to add on top of that other things that you can do to allow three-year plans to move forward.

[25] **Darren Millar:** However, there is an additional £140 million that has been given in order to help to finance those plans that have been submitted before the start of the new financial year, which was not available at the start of the financial year to help to finance them. I just find that surprising.

[26] I would like to pick up the issue on Townsend, if I may. Obviously, there are winners and losers under the Townsend formula in terms of the way in which health boards receive their current allocations. It seems to me that that will mean that some of those parts of Wales that are facing the greatest pressures in NHS spending, particularly in north and west Wales in terms of activity and waiting-time pressures, may well not get the resources that they need if Townsend is the basis of distribution for additional resources in future. Can there not be a more targeted approach so that resources are allocated where there are greatest pressures, rather than simply an arbitrary—well, not an arbitrary formula, but a formula that has its merits, but also has its drawbacks in terms of the pressures it may create and add in the system?

[27] **Mark Drakeford:** I think that if I had made that proposition, the opposition spokesperson would have said that my strategy was to reward failure—to look where the biggest holes are in the system and always to be filling those holes first. That is not my approach. We have the Townsend formula. The spend per head in both those areas that Darren identified is between £200 and £300 higher for every single person than it is in Cardiff and Vale University Local Health Board.

[28] **Darren Millar:** Of course.

[29] **Mark Drakeford:** There is no ‘of course’ about it. If you talk to Cardiff and Vale

LHB, it will point out to you that it has to absorb hundreds of asylum seekers every week because of the Home Office's dispersal policy; that it provides tertiary services, which draw people into the capital city through the halo effect; and, that it has densities of deprivation that are not faced in any other part of Wales. Every health board that comes to see me tells me that it has unique challenges that make it different to everywhere else. I say to each one of them that everyone has challenges of their own. There are challenges in north Wales and west Wales of rurality and dispersed populations, and they are properly recognised in the Townsend formula. If we moved away from a fair funding basis, in which we allocate money according to a transparent formula based on evidence, and started going down the road of saying, 'Well, we will look to see who has the biggest problems, and we will give them the largest amounts of cash', I really do not think that that would be a sustainable way ahead.

[30] **David Rees:** I want to move on a little bit, Darren. Kirsty has a question and then Elin wants come in.

[31] **Kirsty Williams:** Minister, with regard to the £60 million that you are holding back, you said that you are doing so to ensure that your department is not compromised. What is the basis on which you will allocate that £60 million? When you say that you do not want to be compromised, is that compromised in terms of budget or in terms of performance within those LHBs?

[32] **Mark Drakeford:** I have not had to make these decisions as yet for this year, Chair, but if I just reflect for a moment on the decisions that were taken last year, we reached a point in the final period of last year when a number of LHBs were unable to live within their means. What had happened in the past was that, at the end point of the year, extra resource was passed to those LHBs by the Welsh Government to allow them to rebalance their balance sheets. We did not do that last year, so there are three organisations in Wales whose accounts were qualified as a result. I did not do it in the way that we have done it before exactly in order not to give a message out there to LHBs that, if you overspent, the Welsh Government would ride in at the last minute and rescue you from that. We cannot have that culture in the NHS. However, neither will I allow services in those areas to those local populations to be compromised in a quality sense. I will not say to people in the areas of Powys, Betsi Cadwaladr or Hywel Dda that, if their health board is not able to deliver within its means, the impact of that will fall on those populations. So, we ensured, from the Welsh Government, that all of the bills were paid, staff remained in work and that services continued to be provided, but we did it in a way that shone a spotlight, in a way that had not been done before, on the performance of those LHBs that were unable to deliver a service according to their statutory obligation, which is to live within the means with which they have been provided.

[33] **Kirsty Williams:** So, my question again is: having taken a different approach last year to the approaches that had previously been taken, what will your approach be this year in the allocation of the £60 million?

[34] **Mark Drakeford:** As I said, Chair, I have not had to face that decision yet and I cannot anticipate it in full in front of the committee. However, I believe that the underlying way that we did it last year was the right way and I go into the rest of this year with that in mind.

[35] **David Rees:** John, on this particular point, because I want to move on now to the actual budget, and not the in-year increase in the supplementary budget. I will come back to you in a minute, Kirsty.

[36] **John Griffiths:** It is in terms of process, Chair, and how we can ensure that the requirements of the Act, the plans that are being produced and the plans that will come on stream are effective and that we get the outcomes that we expect. Obviously, there is a

ministerial role here, there is a role for officials and there is a role for others to make sure that the extra resource produces the goods, as it were. I know that Vaughan, as Deputy Minister, will perhaps be holding feet to the fire to some extent, or however we might describe it, in terms of ensuring that delivery is effective and that we get the progress that we require. I wonder if you might say a little bit, Mark, about how that will work so that we can be confident that necessary progress will be achieved.

[37] **Mark Drakeford:** Thank you, John, for that question, because just as we have done our best to put in place a challenging system for the approval of plans, we equally have to have a system in place that monitors the implementation of those plans and makes sure that organisations that have committed to deliver certain standards and volume of services do exactly that. Maybe, Chair, I could ask Vaughan to say something about the work that he is doing, and then I might ask Andrew whether he could describe for you briefly the system that we have put in place to monitor the plans that we have approved.

[38] **The Deputy Minister for Health (Vaughan Gething):** Thank you, Mark. The main focus that I have been given—you have had the remit letter—is on delivery and performance as to the effective use of the resource that has gone in. So, it is about trying to look at the financial performance, but, at the same time, looking at whether that is delivering the outcomes that we would expect with regard to our targets. Where that is not happening, it is certainly my role in dealing with chairs—and we are going through this already—to go through the pressure points that they have individually, how those pressure points exist across a range of health boards and then what is happening at the end of it. I have made it very clear that it will not be acceptable to come back at the end of the year and say, ‘We did not manage to do this’, or, ‘We thought that everything would be alright and it is not’, because that is exactly the culture that we are trying to get away from, so that in the planning part of it, and where things are not happening in terms of performance against outcomes and performance against financial management, that happens through the year and that challenge takes place.

[39] It is important that organisations feel supported to achieve what they are supposed to, but they also have to be challenged where they do not. I have had a range of interesting conversations already with chairs that will continue throughout the year. Unless we have that focus on achieving performance, then there are going to be some difficult questions asked. I think that the response of the Welsh NHS Confederation on the day that the in-year funding was announced, and the money for next year as well, was very helpful. There is recognition within the health service that this resource is being pulled in and that even more difficult choices are being made across other parts of the public service. So, that sense of responsibility within the NHS, to use finance responsibly and effectively, is something that I am definitely keen to reinforce. It might be helpful if Andrew talks about the formal processes that we already have in place to deal with that financial management in-year and ahead to next year as well.

[40] **Dr Goodall:** In response to the change in planning, environment and the framework, we just needed to make sure that we were able to draw them into our performance management perspectives outwith the service. We still have a requirement that individual boards, as independent individual organisations, have to take that local responsibility to make sure that they are overseeing their performance, that they are making sure that boards are signing off both the approved three-year plans and the annual plans as they see fit, and are making progress and actually doing that in a very open and transparent manner. So, all of the boards across Wales will have their performance reports; they will have committees in place and they will scrutinise and oversee those. However, the availability of the plans has meant that we have been able to have different discussions and some targeted debates with individual boards, not least where there are concerns. It is about making sure that these plans do not just describe what the future looks like, but actually make it happen at the same time.

[41] Officials have a number of different mechanisms. We are able to draw in the information that is around us—that which is submitted—to highlight some areas of concern, but we actually have a lot of contact points with the service in Wales to make sure that we can oversee this. So, that will be through mechanisms like the monthly chief executive meetings that I oversee; we have integrated board meetings; and we have the ability to draw on an escalation framework. One of the differences for this year was that we took a different look and have now produced a recognised escalation framework, which is not just about Welsh Government and officials making their own decisions; we actually align the views there with our regulators, particularly with the Wales Audit Office and Healthcare Inspectorate Wales, all of which is about saying, ‘Do we have the confidence?’, ‘Are we seeing progress?’ and ‘Are we getting the improvement that we are expecting on these different areas?’ So, there are a lot of mechanisms that we have in place, but we have particularly tried to make sure that everything comes back to the three-year plans and our expectations on those.

[42] **David Rees:** Elin, do you want to ask your question?

[43] **Elin Jones:** Yes. On the financial aspects of this year’s budget and next year’s budget, the Wales Audit Office report this week on NHS finances outlined the issue of budgets within this financial year. You have, apparently, already allocated £23 million to two NHS LHBs, but the other LHBs are projecting a deficit in-year of £192 million. That is a figure that is quite close to the £200 million that has been found additionally this year. Am I right, then, in thinking that the way that you are addressing this is to provide an additional £200 million, bail-out or no bail-out, at this point, and that you have a reserve of £60 million should they not be in a position again to meet their end-of-year point of break-even, so that the whole package of additional funding could be up to £260 million this year? I wanted to ask you then, in terms of the next financial year, about providing an extra £225 million at that point. It seems to me that what you are doing is providing this underfunding upfront, which is probably a good idea, rather than addressing these issues midyear, as has happened historically. So, for the next financial year, with the additional £225 million for the NHS, what level of contingency would you have in that budget for the next financial year? Are you secure enough in your financial projections and your three-year planning with the LHBs to be able to reduce the contingency fund from the £60 million that you said was in this year’s budget?

11:30

[44] **Mark Drakeford:** I will go back one step to answer that question, Chair. You will remember that the extra investment that the Welsh Government is making this year and next year comes as a result of the Nuffield Trust review of NHS finances in Wales. It showed that, when everything had been done—and it identified four major ways in which the NHS in Wales has taken steps to become more efficient—there was a likely need for £200 million extra in this financial year and £221 million extra next year for the NHS to go on providing the services that we wish to see it providing. I worked with the Minister for finance all the way through the summer and with Cabinet colleagues on some very difficult decisions to secure that extra resource for the NHS, and the fact that we were able to do it is the strongest sign that you can imagine of this Government’s determination to go on providing for the NHS in the way that it needs to be provided for.

[45] There is £200 million in this year—not £260 million. We were talking earlier about the way that we are deploying that £200 million. I have committed to distributing £200 million of the £225 million next year according to Townsend population share, so that organisations know now what the uplift in their baseline will be for next year. We are still scrutinising the remainder of the money against the demands that we know are there and against some key strategic objectives that we have, in particular the need to try to make a reality of the shared commitment—. People right around the Chamber, I think, speak up on

behalf of this principle that we want to see services moving out of secondary care and into community and primary care. So, that is a key strategic objective. We are looking at the resource that we have above the £200 million to see whether there is anything that we can do to align that funding, both against the other demands that are there and against that key strategic ambition.

[46] **Elin Jones:** So, I am right in thinking that the projected deficit that the WAO talks of as £192 million, plus possibly the £23 million, is the same kind of—. It is obviously the same figure as the Nuffield Trust one, but it is identifying the underfunding that was generally in the system anyway. That is basically it, is it not?

[47] **Mark Drakeford:** The figures are very similar and there are other analyses as well that come out very much in the same ballpark. The NHS in Wales this year, when everything else had been done, still needed £200 million to do the things that we want it to do, and we talked earlier about how we prioritise within that to allow that to happen.

[48] **David Rees:** That is clear. We will move on now. Just to inform you, the Children, Young People and Education Committee has also asked us to look at some aspects of children's services on its behalf, and Lynne has a question on that.

[49] **Lynne Neagle:** I had a broader question on the ring-fenced budget for mental health—you have brought forward the consideration of that, and I was wondering whether we could have an update on that. As you know, the Children, Young People and Education Committee has been looking at child and adolescent mental health services. It is a work in progress, but we have a lot of concerns about the service. A lot of witnesses told us that, while there is a ring fence in place for mental health, they do not feel that that is being translated into protection for children's services. So, what are your comments on that, please?

[50] **Mark Drakeford:** Thank you. Lynne is exactly right. We committed earlier to moving the examination of ring-fenced budgets—not just for mental health, but ring-fenced budgets in the round within the health MEG—to a year earlier as part of the Townsend formula work that we are doing. You will know that spending on mental health has moved within the ring fence from about £387 million to over £550 million in recent years. So, the money within the ring fence, certainly, has substantially increased.

[51] Organisations with an interest in the field are always worried that bits of money escape the fence and are not spent on mental health purposes. We will examine that as part of the work we are doing. Do we want ring fences within ring fences? I just do not think that we can aim to manage budgets in that sort of way. People who provide the services have a different account of it, which I have offered to the children's committee. However, on the spending on CAMHS, which is a specialist service for young people with real mental health concerns, obviously, once you become 18, you no longer use the CAMHS service, whereas adult mental health services can be working with people from the age of 18 to the age of 88. It is inevitable, therefore, that spend per head and the weight of spending in mental health falls into the adult side of the equation rather than CAMHS. So, I am not intending to add an additional ring fence within the ring fence for CAMHS services, but everybody out there knows that the focus on CAMHS services is unremitting and they have to be able to account for the way they spend the money that they get for these services in a way that stands up to scrutiny.

[52] **Darren Millar:** May I just ask a very brief follow-up question? So, within the mental health line, not all of it is ring-fenced.

[53] **Mark Drakeford:** It is all ring-fenced.

[54] **Darren Millar:** It is all ring-fenced.

[55] **Mark Drakeford:** It is all ring-fenced within mental health. The children's committee was, I think, exploring whether, within the ring fence, you might want to further ring fence.

[56] **Darren Millar:** I accept that. It is a question I have raised with the First Minister in the past. The figure you gave, however, was £500-something million—

[57] **Mark Drakeford:** It is £550 million or something; I do not have it in my head, sorry.

[58] **Darren Millar:** Okay, but the line in the budget is significantly greater than that. It appears to be greater than that.

[59] **David Rees:** We will come back. If you could write to us and clarify that point, it would be helpful.

[60] **Mark Drakeford:** I will make sure that we clarify that.

[61] **David Rees:** Lynne, did you have a question?

[62] **Lynne Neagle:** Yes. I just have two follow-up questions to that, and I want to raise some other issues later on. In terms of the CAMHS money, I accept what you are saying about having a ring fence within a ring fence. Is it your intention to put any other measures in place then to monitor expenditure on CAMHS? As part of the review that you are doing into the general ring fence, is there any danger, do you think, that the ring fence will be removed so that the money goes into the general pot?

[63] **Mark Drakeford:** Well, we have to be open-minded about a review of the ring fence. I have this conversation quite regularly with people in the sector who come to me and complain about the ring fence: 'Oh, the ring fence, it doesn't work, it's leaky, money goes elsewhere', and so I say, 'Fine, we'll take it away then; if it's a useless ring fence, we'll take it away', and they say, 'Don't take that useless ring fence away, whatever you do'. [*Laughter.*] So, we have to be open-minded enough to ask the question as to whether the ring fence is effective. What is it there for? It is there because, as a Welsh Government and, indeed, as a wider National Assembly, we have a real commitment to mental health services. The ring fence is meant to give us confidence that money provided to the NHS for those purposes is spent in that way. If that is not the best way of giving us confidence, and if there are better ways, we have to be open-minded enough to look at them. So, the ring-fence review is not absolutely guaranteed to say, 'The best way of doing this is to continue the ring fence'. It may well say, 'The ring fence is the best way, but you need to improve it and make it a better ring fence and so on for the future'.

[64] Within CAMHS, as you know, we are taking a number of additional steps this year. We have provided some additional money for CAMHS to try to improve some parts of the service and to repatriate young people who are looked after outside Wales, so that they bring the resource—the very expensive resource—that we spend on services outside Wales back with them and allow us to reinvest that money into wider CAMHS services. We are also having a new professional leadership focus on CAMHS services, because CAMHS services vary from one part of Wales to another. We think that, in some places, there are better ways of providing those services. That is not a financial issue though, Chair, that is a professional practice issue, and we are focusing on that.

[65] **David Rees:** May I ask for clarification? Obviously, we are focused on outcomes. Are you, therefore, confident that the outcomes that you, as a Government, have set for

mental health are being achieved by the ring fence?

[66] **Mark Drakeford:** I think there is some very good outcomes evidence emerging, particularly in relation to the Mental Health (Wales) Measure 2010, where we can see the extra investment that has gone in and we see the extra activity that that has generated. However, we have to move beyond a debate in which we simply say that, if we are doing more of something, that must be better, because, actually, outcomes is a different matter, is it not? So, we know that in mental health there is extra money being invested to back up the Measure—33,000 extra people received a service in primary mental health services last year as a result—but our focus has to be on whether all that extra activity is making a difference to the lives of the people who are now getting that service. I am pleased to say that I think there is some quite strong evidence coming back from third sector organisations in particular that the feedback from users of services is that providing services in that way, in a more—to use the jargon—as it were ‘normalised’ way as part of ordinary, primary care, is making a difference in terms of outcomes in the lives of those people.

[67] **David Rees:** I know that Lynne has a question on another area.

[68] **Lynne Neagle:** Do you want me to ask that now? It is a different area.

[69] **David Rees:** First of all, Kirsty, did you want to come in on this particular topic?

[70] **Kirsty Williams:** Yes.

[71] **David Rees:** Okay and then we will come back to Lynne.

[72] **Kirsty Williams:** The Government is not meeting its 14-week target for initial CAMHS referrals. Do you believe that there is sufficient financial resource in the system to meet that target and, if we continue not to meet the 14-week target, that it is less about money and more about other shortages or issues around capacity in the system?

[73] **Mark Drakeford:** Chair, I have not at all closed my mind to arguments that may emerge about resource. My starting point is not to say, ‘It is not a problem of money’, but my belief is that the fundamental issue facing CAMHS is one of dealing properly with demand. There are twice as many young people being referred to CAMHS in 2014 than there were in 2010. Do we, around this table, seriously believe that there is twice as much mental ill health among young people in Wales in a four-year period? I do not think that that would be a sensible conclusion to draw. So, it is something about working on why those extra young people who were not being referred before are being referred now and whether CAMHS is the right place for those young people to get a service. It is not about saying that those young people do not need a service; it is about asking whether CAMHS is the right service for them. So, while I am not, as I said, closing my mind to the resource issue, I do think that there are some very big questions of professional practice and making sure that the right service is being provided to the right young person.

[74] **David Rees:** I am sure that we all await the report from the Children, Young People and Education Committee as well. Do you want to move on to the other subject, Lynne?

[75] **Lynne Neagle:** Yes. The other questions are about social services. Obviously, the significant increase in funding for the health service has led to other budgets having to see a reduction, including local government. I know from my own discussions with my local authorities that some of the potential mitigations that they are looking at will have quite a serious impact on social services. Of course, we do not now have the protection in place to say that those budgets have to be protected. How confident are you that the welcome increase in funding for the NHS is not going to be jeopardised by the fact that local authorities will

have to cut social services, leading to an increase in pressures on the health service?

[76] **Mark Drakeford:** Chair, I do not think that there is any doubt that, in 2014, the reality of the age of austerity is biting in Welsh public services and it would be impossible to say, in a glib way, that money that has had to be found from the health service has no impact on the services where money has had to be found to assist in that way. However, the Government has found an additional £10 million to go into social services, and we are looking, in that extra small amount of money that we have above the £200 million, particularly at the experience of the intermediate care fund, to see where we have real examples of services being re-engineered so that contributions from health and social services together are making a difference.

11:45

[77] Then we have to look to the Social Services and Well-being (Wales) Act 2014 itself. I do not think that there is any doubt that still, in some parts of social services, too much money is being spent on having to deal with the consequences or difficulties that have already happened. That means that not enough money is invested in preventative work that prevents that larger amount of money being needed later on. The purpose of the social services Act is to shift the dial in that way so that local authorities spend more in those smaller services that maximise people's ability to go on leading independent lives of their own in the way that they would like. There are good examples. If every local authority was not doing it that way you might conclude that the job was not doable, but, when you know that there are local authorities that do spend their money in that way, and are therefore able to live within their means—and there are other local authorities that spend all of their money in the most expensive parts of the service, taking people into residential care and so on at a far higher rate than other places—you know that there is scope within social services itself to re-orientate the way that it spends money to help us to address some of the challenges that they will face.

[78] **Lynne Neagle:** Is the extra £10 million going into the rate support grant?

[79] **Mark Drakeford:** It is.

[80] **Lynne Neagle:** May I just ask about the monitoring, not just for the extra £10 million, but also how the Welsh Government is going to keep a check on the impact of the reduced local government budgets on social services provision locally?

[81] **Mark Drakeford:** Chair, obviously, there is a very formal monitoring process. I think that, yesterday, the independent statistical service published its analysis of local government spending in the past financial year, and that breaks it down by activity so that you can see how much money is being spent on social services in that way. So, there is an independent check in the system beyond what Government does. I will probably ask Albert to set out the way in which we, from our perspective, who are very keen indeed to make sure that every penny of the £10 million provided for social services is spent on social services, go about trying to monitor to make sure that that happens.

[82] **Mr Heaney:** Thank you, Minister. I think that it is very important to say that we have a formal annual reporting process into Government in terms of spend from local government. That spend takes account of social services. In terms of what we do, and on top of that, I have regular meetings with directors of social services across Wales. Those take account of both resources being utilised and the transformation agenda, moving away from where we have been at the high end, going into prevention and early intervention. Importantly, then, it takes into consideration the issues of resource allocation. So, those are the discussions and the details that we go into directly with the statutory directors of social services.

[83] I think that it is important as well that, while we recognise that we are in very austere times, and that there is an impact upon us in the Welsh Government in terms of the funding resources that we have available, it is crucially important that we work together across health and social care to maximise the opportunities to transform. Over the last two years we have monitored very closely a transformational grant of £1.5 million per year, which is now being delivered through our arrangements in place in Wales. We have a national partnership forum, which the Minister chairs, to lead in relation with local politicians, local chairs of local health boards, and the voluntary or third sector organisations. At this moment in time, we are moving those arrangements into a regional approach to support local partnerships in the delivery of the transformation agenda going forward. It will only be by doing things differently that we will be able to maximise both in terms of individual responses to citizens and what citizens need, but also in terms of organisations being able to manage what is a limited funding pot.

[84] **David Rees:** Elin is next.

[85] **Elin Jones:** I just wanted to ask, on the £10 million for social services, was there any consideration given to ring fencing that for social services? Moving on from there, to look at the fact that that £10 million is in the context of the integrated care fund of £35 million, which is no longer specifically in this budget, you did say something quite interesting there, Minister, when you said that you would be looking at the sum of money that was above the £200 million, which is £25 million, on top of the £10 million, which brings you back to the £35 million for the integrated care fund.

[86] What I wanted to ask you, because this is what local authorities have told me—. As part of the integrated care fund that they set up with health boards, but funded via local authorities, there are schemes—virtual wards, acute response teams, and all of that kind of work—that we know are part of the integration of services. They feel that the health service has been given an uplift, and local authorities think that, if those projects are working, the health service and health boards should take on the running and the financing of those services. So, I almost feel that that is where you are getting to with the comment you made that the extra £25 million on top could be looked at to fund these intermediate services, alongside the £10 million that has been allocated as well.

[87] **Mark Drakeford:** Thanks for that, Elin. On the first question—whether we thought of ring fencing the £10 million—that was, I think, considered by the Minister for Finance and Government Business. The problem, as you will know, is that once you ring-fence, the administrative costs that go alongside that mean that that £10 million suddenly becomes very expensive money, because local authorities all have to spend money accounting for it and the Welsh Government has to set up a system to monitor it, to be able to report on it and so on. Small amounts of money going into the ring fence come at a very high price and we are not in that position in today's budgets.

[88] To be clear, the £25 million that is left above the £200 million will have a lot of different claims on it. It will not all be available to fill the gap of not having the intermediate care fund, but we are looking at it to see—. This is the key point that I want to make: I thought that we were very clear with local authorities and the health boards, when the intermediate care fund came about as a result of budget negotiations, that it was a one-year pot of money. It was there to re-engineer the way that services are provided. It was not intended just to add another layer of what they were already doing.

[89] Over the last month, I have met every local authority in Wales, around the footprint of the health boards, and part of the discussion in every one of those meetings has been about the way in which intermediate care fund moneys have been used. There is no doubt that there have been some very imaginative, creative, re-engineering ways that that money has been

used. If we can find a way of using some of the £25 million to support those ways of providing services in the future, I have already talked to Andrew quite early on about making sure that we do that piece of work. So, there certainly will not be £25 million-worth of it, and we certainly are not going to be able to pick up things where social services departments have simply added on to what they were doing.

[90] The good news, I think, is that there is evidence from the meetings that I have had in relation to western bay—to take probably the best example; that is ABMU with its three local authorities—that they have already committed to carrying on with the intermediate care fund projects, whether they have extra money from us or not, because they are convinced that the way they put money together into it has saved them both money, compared with how they were doing things previously.

[91] **Elin Jones:** Just quickly on that, do you expect that the onus for taking the lead on the integrated care work, because of the pressures on local authorities, particularly, and not to as great an extent on the NHS—although there are pressures obviously—is on local health boards, but in partnership, obviously, because some of the responsibilities and the resources are in social services also?

[92] **Mark Drakeford:** I genuinely think that it is a joint leadership. It is not a matter of swinging the leadership from one side of the equation to the other. If we are serious about integrated services, then both partners have to regard themselves as equally responsible. In the best meetings that I have been to, I felt that there was a real recognition by both parties that, when they operate in that way, they both see the advantages. They both see the advantages in budget terms—by doing it that way, you get the efficiencies from it—but, more importantly, you get a better service. For those people in whose lives local authorities and the health boards have an interest, the outcomes are better.

[93] **David Rees:** Darren, you want to add a supplementary question on this issue.

[94] **Darren Millar:** Yes. It is just to follow-up on the social services budget. Obviously, the Social Services and Well-being (Wales) Act 2014 is in place and regulations are being developed. What do you expect those regulations will mean in budgetary terms for local authorities? Do you think that they will create additional burdens, or will they really help to relieve pressures going forward? In addition to that, there has been an announcement that the domiciliary care cap that is currently in place will be lifted. To what extent do you think that might relieve a few pressures on local authority budgets?

[95] **Mark Drakeford:** Thanks to Darren for those questions. I will be bringing the first tranche of regulations under the social services Act before the Assembly early in the second half of this term. We continue to believe that the overall impact of the Act will be cost neutral, although we are providing transitional funding to social services departments to help them with that in this year and the next. When Gwenda Thomas was the Deputy Minister and discharging these responsibilities, I know that she listened very carefully to local authorities in relation to the cap on charges for domiciliary care services, and part of raising the cap is that they will be able to generate some additional income as a result of fees charged in order to reinvest that in the service. So, Darren is quite right to point to that as a factor in the equation.

[96] **Darren Millar:** I appreciate what you say about the overall situation perhaps being cost neutral, but, clearly, there may be sharp increases in costs in some local authorities and big decreases in costs for other local authorities. What analysis has been done of the pressures that might emerge, local authority by local authority, as a result of the national eligibility criteria and other regulations that are going to be made?

[97] **Mark Drakeford:** I might ask Albert to give you the detail of that.

[98] **Mr Heaney:** Of course. Thank you for your question. On the work that is currently going on, we have been working through the technical groups. We have been working directly with sectors, so it is not being done by Government in isolation, but very much in partnership. On regulations, tranche 1 will lay the regulations for consultation on eligibility, and, again, in terms of the costings, we have been doing a regulatory impact assessment throughout, and we need to do that at the point at which clarity has become available. That is the approach that we have taken throughout this. We have looked at where we are achieving benefits, and, importantly, we have had conversations with the Welsh Local Government Association and with the Association of Directors of Social Services on how we capture those benefits, as well as where there are costs and cost pressures. There will be some issues, such as, for example, care and support for prisoners. There will be issues and additional burdens for some local authorities where they have a prison—a custodial institution—available, and we have already entered into what is quite meaningful dialogue on how those issues will be addressed going forward.

[99] Importantly—I come back to the central issue here—the whole premise behind the legislation is to achieve sustainable social services. So, it is about the transformation of what we are doing now, and there are a lot of real wins in the system. We have, in the past, spent 11% of social services spend on assessment, and by reducing the burden of assessment and moving to a much more proportionate response and having portability of assessment, we begin to get into doing business in a transaction with citizens that they welcome, placing the citizen at the heart of it. It begins to move away from a process that has been around them, which has often, in the past, been about completing a process rather than being about hearing what their needs are and responding to the care and support needs of those individuals.

[100] **Darren Millar:** In terms of the financial impact assessment on the regulation, will it be done on a local authority by local authority basis, in order that we can see which local authorities might face more significant pressures than others?

[101] **Mr Heaney:** We will be in conversation with those local authorities, but the regulatory impact assessment will be on the whole of Wales, really, in terms of our overall position.

[102] **David Rees:** Kirsty, and then a question from John.

12:00

[103] **Kirsty Williams:** Turning to the issue of capital within the budget, much of the Government's reorganisation plans for hospital services were reliant on capital investment in new facilities to facilitate the changes to where services will be delivered. Are you confident that the capital allocations are sufficient to deliver for each local health board on the capital that they will need? May I also ask the perennial question of whether the money for the specialist and critical care centre remains within the programme? Are you confident that that new hospital will be built? When can we see foundations in the ground—or bricks even?

[104] **Mark Drakeford:** To take the general question first, Chair, the cuts in resource available to the Welsh Government have been even more savage in their reduction in the capital field than they have in revenue. Those cuts are felt very clearly in the capital that is available to the health and social services portfolio. How are we trying to manage that? We have been very fortunate in the additional capital that we have been able to attract over and above our allocation from those central budgets for which the Minister for finance is responsible. I think that we have benefited to the tune of over £60 million in this year from those extra central resources.

[105] As we move forward, we have to do what the Auditor General for Wales in his report published this week endorsed so very clearly—we have to have a prioritisation exercise. For me, what I have to say to health boards is this: where they put forward bids for capital spending against the central money that we hold as a department, those plans that will get to the top of the list have to do two things. If they do not do these things, it is pretty unlikely that they will find themselves in a place where they will get funding. First of all, they have to show how capital spending drives financial efficiencies, and secondly, they have to show how that capital spend drives service change. Unless you can show me how that scheme will produce revenue savings so that you will be able to do things in a more efficient way, and how that scheme helps us to remodel services so that services go on to be sustainable, you are unlikely to find yourself in the funded list.

[106] This means that some schemes that would have replaced something that we have now with something that would have been better but goes on doing the same as it did in the past is not likely to find itself as high up the list as it would have been. When capital is as scarce as it is, it seems to me that there is no other way of prioritising things other than making sure that your capital is spent in a way that supports your other major agendas.

[107] Finally, as Members will know on the general point, we are committed to innovative funding, where we are able to make that work successfully. We have specifically committed to it in relation to the new Velindre hospital, where the Minister for finance has made those announcements. We are in discussions on innovative funding models in relation to the primary care estate, but those discussions have not concluded to a point where we know whether we will be able to take them forward. Individual health boards are now coming forward with proposals of their own for capital funding outside the conventional public capital way of doing things.

[108] As far as the SCCC is concerned, there has been no change in the position there.

[109] **Kirsty Williams:** It is still not built; there is no change there at all. [*Laughter.*]

[110] **Mark Drakeford:** We have found the money centrally to move the scheme into the next part of the three stage capital process. ABMU is using the money that we have provided to move the scheme along. The scheme is provided for in the capital programme.

[111] **Kirsty Williams:** I am kind of curious as to why ABMU is building the hospital. [*Laughter.*]

[112] **Mark Drakeford:** I am sorry; I meant Aneurin Bevan Local Health Board. It is like alphabet soup.

[113] **Kirsty Williams:** I will let you off.

[114] **David Rees:** Minister, on this issue of capital, we have seen a reduction of £65 million, effectively. I notice in your paper that most of the £65 million was actually projects that had been completed, effectively, or signed off. So, in a sense, they were projects that no longer required funding. However, how much of that capital have you allocated to look at some of the issues? You talked about ensuring that there is a return and improvement, but some of the ageing estate and equipment clearly is an issue that needs to be addressed. They will provide better services, and better services probably mean faster and more efficient services. So, will you be looking at some of the ageing issues as a criterion as well?

[115] **Mark Drakeford:** We inevitably have to, as some equipment reaches the end of its life and simply has to be replaced. One of the discussions that we have been having—and

health boards certainly bring this issue to our door—is the level of discretionary capital that we are able to provide in the system. Lots of routine equipment replacement, for example, is done through discretionary capital allocations and we have not had the wherewithal to increase the level of discretionary capital in the system in the way that we would have liked to. How shall I best put this? I am not in a position for next year to be able to do much by way of increasing discretionary capital, but we have had discussions so that if capital underspends were to emerge—and it is a rare year when none do because of the nature of the way in which capital is spent—a priority for me might be to try and put some money into the hands of health boards directly, particularly where they have approved three-year plans, to allow them to do some of the things that you have mentioned, Chair, in terms of spending money relatively rapidly to replace equipment where replacing would lead itself to better efficiency.

[116] **David Rees:** Okay, thank you. I will go to John now, who has a quick question on the preventative.

[117] **John Griffiths:** Continuing the questions around sustainability and how we could transform the health of Wales, obviously, prudent healthcare and preventative spend are very important. In the context of social services, we were talking about local authority spend. I think that one aspect of this agenda is physical activity and how we get a more joined-up approach between local authorities and others and health spend. I know that there has been discussion around these areas for very many years, and a lot of it has greater intensity now because of some of the pressures that local authorities are facing and concerns about non-statutory services, such as leisure services. At the same time, there are some areas of Wales, such as Swansea Bay, where some interesting discussions are taking place between the health board and local authorities as to how you get a more joined-up approach. Given that, on your figures, something like 2% of the revenue budget can be identified as preventative spend, my question is this: how do we get more onto the front foot rather than being reactive and get this transformation, particularly around getting a more physically active Wales? That would not just produce long-term benefits, but would indeed produce short-term benefits and would ease the strain on the service.

[118] **Mark Drakeford:** Vaughan might lead on that, Chair, if that is okay.

[119] **Vaughan Gething:** Thank you for the question, John. In terms of the broader point that you identify about there being an element in the budget for preventative spend, it covers a range of areas, of course, such as physical activity, which you particularly highlighted, but also things like immunisation, which we would also look at as preventative spend. We actually have very good outcomes now on improving immunisation. In particular for young children, we are now meeting and exceeding our targets. There is still a job to do in terms of some of the catch-up work with teenagers, as you will be aware from last year's measles outbreak, but I think that we actually have a good story to tell about achievement within the NHS. There is still more to do, and I am very pleased that a number of Members took part in the early advertising for the flu vaccine, but we still have more to do there. We have actually increased faster than any other part of the UK in getting more people to take flu jabs, but that is not an area where there is complacency. Obviously, we know that immunisation has very significant health benefits in terms of prevention.

[120] To deal with your point about physical activity, there is a range of schemes that we already undertake with a range of partners. One good example is the Healthy Ageing programme, which is run with Age Cymru and another example is the national exercise referral scheme. The outcomes for that have been very impressive. It is not just about the money going in, but about the outcomes for people who are referred. Over 90% of participants would not have taken up physical activity without the scheme and the referral, and 83% completed the programme and were still exercising at 16 weeks, with 63% still exercising a year later. Thinking about where we need to get to—and we know that some of

our big challenges in public health are about dealing with diet and exercise and other health behaviours—a scheme like that, with those sorts of numbers in terms of improved outcomes for people, is really significant. Our challenge is how we continue to have that referral across.

[121] So, this is about primary care, and the primary care referrals that come in are, largely, in some ways, about recovery and rehabilitation after secondary or tertiary care, but it is about asking how we can help those people to become more active. There is a recognition that health has to have a conversation with other parts of Government, and you will know this from your own time in Government. There is a physical activity executive group, where we are still keen to make more progress, but there are other partners outside Government departments, with Sport Wales being a very important example of that. There are conversations that we still have to have with local authorities. Even with the pressure on budgets, a range of these are social activities that have really significant health and wellbeing benefits. So, there is a wide range of activity that is ongoing.

[122] We know that we are moving in the right direction, but there is all the challenge about the pace at which we are able to do that. We will continue to do the things that we know are successful because, in terms of the wide public health challenges that we have—and this committee, I know, spends a lot of time looking at big public health challenges and conditions like diabetes that come from largely inactive lifestyles with challenges around health and diet choices—this activity area will help towards those. However, it cannot just be a solution for the department of health to undertake, and that is why we place real importance on our relationships across Government and with partners outside it. So, on the work that we were discussing earlier on planning with local authorities and how services are run and put together, having that conversation is really important for us to achieve the outcomes that we want to.

[123] From my former role, in communities and tackling poverty, I know that there is real activity going on within the Communities First programme to try to engender this in our poorest communities, where the gradient in inactivity and the health challenges that go with it are at their sharpest and most difficult. We have to target that activity to have maximum benefit. So, I hope that, over the next year, you will continue to see impressive figures like those for the exercise referral scheme that I referred to, and you can be assured that there is continuing focus within Government on improving this area of activity.

[124] **David Rees:** Just on that, Minister, in your letter to the committee, you indicated that roughly 2% of the departmental revenue budget is allocated to preventative and prudent healthcare, and that you are pushing prudent healthcare very much as a way forward. Is there any indication that you will be increasing the allocation percentage-wise, or do you believe that the outcomes will be achieved, particularly if we have to get that message across on a wider basis?

[125] **Mark Drakeford:** Prudent healthcare is much more than just the 2% that is specifically identified for preventative spend, because prudent healthcare is a set of ideas that runs right through everything that the health service does. So, to give you the most obvious and most recent example, a research report from Cardiff University published a week or so ago, looking at 22 years' worth of antibiotic prescribing by GPs in Wales and in England, found that one in seven of those prescriptions did no good in the lives of the person to whom it was dispensed and probably did harm because of antimicrobial resistance—a topic that I know the committee has been interested in. If you give someone an antibiotic that they do not need and is not going to do anything, it means that, the next time they do need it, it may not be as effective. That is one in seven of all prescriptions. So, that does not appear in preventative spend anywhere. There are some very interesting figures that committee members might be interested to look at—very recent figures published by Professor Phil Routledge in the work that he does—which show that, for the second year running, last year,

antibiotic prescribing in Wales had gone down. That is against a very long trend of its rising, and against the trend of its continuing to rise elsewhere in the United Kingdom.

12:15

[126] Two years does not make a trend, but I think that it gives us some grounds for optimism that the message on prudent prescribing is getting out there to GPs and others, that there are other things that they can do: do not do harm, and do not spend money on things that do not do good either. Prudent healthcare includes a much bigger sense of how we provide services.

[127] **David Rees:** Thank you. We will move on to questions from Darren and then Elin.

[128] **Darren Miller:** I just wanted to ask, if I may, Chair, about contingency planning. Obviously, the world is looking at the developing Ebola crisis at the moment in Africa, and the potential for that to spread. I do not know what contingency plans you have within your budget, but there seems to be a significant contingency for the Welsh risk pool, for example. It is very sizeable indeed, having increased significantly over the past few years. Perhaps you could just explain to us why that is so large, and what else you have in terms of your contingency budgets, should a crisis like Ebola, God forbid, reach our shores.

[129] **Mark Drakeford:** I will take the two things separately, as they are very different. I would like to give the committee an assurance that, here in Wales, we are fully engaged in the UK contingency planning as far as Ebola is concerned. I took part, yesterday, in a lengthy meeting with Ministers for health from the other three home nations. We discussed both the things that we are able to do individually and the things that still lie at a UK level, in terms of airports, ports and so on, and I have further conversations later today with Wales Office Ministers on the same topic. Budgets are not just confined within the health service, but are shared in contingency planning across the whole of Government, in that way.

[130] In relation to the Welsh risk pool, we continue to see, in Wales, as elsewhere, the impact of rising claims. The rise last year in Wales was almost identical to the percentage rise in England, for example. Why is that? Well, we do a lot of analysis every time a claim is settled in the Welsh risk pool. The local health board against which the claim has successfully been made has to provide a report that is shared with all other health boards as to how the problem occurred in the first place, and how we have ended up having to spend money in that way. What are the drivers in it? I do not think there is much doubt that there is a drive from the way in which litigation is a more normal part of life. Every day, when I drive into work here at the Assembly, I pass an enormous billboard that says, 'Were you treated badly by the NHS? Is there any way we could get money for you? Phone this number.' So, there is a sort of recruiting of people into that. Where people have a legitimate claim, it is absolutely right that they should be able to pursue it, but I do think that there is a different attitude to litigation than there maybe once was.

[131] The second big driver in the system, as I understand it, is that, as people live longer and as conditions—sometimes in very, very young babies, for example—are identified, the costs that have to be covered are being construed in a more rigorous way than they once were. For a start, the costs are going to last longer, but you have to factor in things like the European working time directive. So, if someone is going to need round-the-clock care, and they are going to need it for a long time, you now have to calculate those costs in a different way, and that has also been driving up costs within the Welsh risk pool. I am very happy to be advised by others, who may have a more detailed understanding than I do.

[132] **Dr Goodall:** It is probably worth just talking about the arrangements, because provisions need to be made, not just for the current year, but prospectively. So, anything that

is on our books, basically, has to be allowed for: that is under the audit terms that are there. The actual impact within any individual financial year within the Welsh risk pool probably is somewhere around £70 million, which is covered off within our budgets at this stage. However, the provision that you referred to is a large amount of money, but it effectively takes us over a prospective period of nine, 10 or 11 years.

[133] **Mr Sollis:** It is annually managed expenditure from the Treasury. Provisions are made with the Treasury each year because of the demand issue and control issues. It is recognised nationally that it is done in that way. The large figure that you see is annually managed expenditure; £70 million is for the in-year settlements.

[134] **Darren Millar:** What analysis is done of the claims against the risk pool? Are we noticing a shift in certain aspects, perhaps as a result of more complex surgery being required as a result of lengthening waiting times et cetera? It would be interesting to know what analysis you do to see whether there is learning that can be drawn down.

[135] **Mr Sollis:** The learning is very important. There is an expert panel that sits on the pool; it is combined with medical directors and the nursing people that are on there. They review it in quite some detail, and settlements are not made unless organisations can demonstrate their learning and that they have actually fixed the problem that occurred. That is the most important part, because it is about the quality approach to those issues. Some of these go back quite a number of years. It takes time for some of those claims to come through. So, there is a lot of analysis. The files that I see on each case, when I have looked, are really thick in terms of the analysis undertaken for every case. There is extensive legal advice and extensive professional advice. Like I say, there is a whole host of issues around lessons learnt and making sure that they are put right.

[136] **Darren Millar:** How many claims would there be against the risk pool on an annual basis?

[137] **Mr Sollis:** Sorry; I do not have those figures to hand.

[138] **David Rees:** Would you be able to write to us with that information?

[139] **Mark Drakeford:** We are happy to provide—

[140] **Darren Millar:** A bit of analysis would be useful as well, Chair.

[141] **Mark Drakeford:** We can certainly share that.

[142] **Elin Jones:** On general practitioner services, the British Medical Association, in a recent report, said that the allocation of LHB funding to GP services had gone down from a figure of 10% in around 2007 to 7% more recently. Do those figures accord with your understanding of the share of LHB budgets? If so, are you content to see that allocation going that way? Do you think that LHBs are doing enough to shift not just the priority of policy, but that spend away from the services that they are directly running themselves to those services that they are contracting with GPs?

[143] **Mark Drakeford:** I will see whether anybody else wants to say anything different, but my understanding is that I would not dispute that those services have had a smaller share of a growing budget. They have had more money than ever before because there is more money in the system than ever before; but, as a proportion of the total budget, it is less than it was at the start of that period. How can LHBs do more to shift the resource into the primary preventative part of their agendas? It is certainly not easy; we will start from that point.

[144] I had a recent conversation—I do not know whether it is strong enough to rely on formally, but I had a conversation with Professor Marcus Longley, who is now the vice-chair of Cardiff and Vale LHB and has responsibility, as vice-chair, for primary and community services. He said to me that he had approached this year's budget round absolutely determined to find ways of shifting resource from the secondary to the primary care sector. He had really followed the process through in that way and has achieved, in this financial year, a 0.2% shift in spend from one place to another, even with every effort being made.

[145] So, the first thing to say is that it is not just a matter of people not trying—it is a difficult thing to do. I think that you have to have a mixture of push and pull in it all. You have to have LHBs that are willing to try to push services out into the community. Then, as the auditor general's report also says, we all have a responsibility as politicians, as well as the public and professionals, to be willing to support some of the service changes that that involves. I absolutely understand that any individual Member, when service changes are going on in their constituency, will come under pressure from people who are anxious about the nature of that change, and we all have responsibilities to represent some of the views that are put to us. However, the process of change is not easy, and there are lots of voices—public, professional and political—that always get raised, in a way that does not make change easy to achieve, but health boards still have to go on making those plans and doing all of that.

[146] However, you need pull in the system as well, and I try to be optimistic about the fact that, in the major changes that we negotiated with our general practice community this year in the contract, we drew lots of quality outcomes framework points out of what they regarded as handle-turning bureaucratic activity and we have put those points into a new requirement that they meet four times a year in GP clusters and that they produce a GP cluster action plan. Part of the action plan is to show how they, by providing services in a new way, can draw activity out of secondary care and into primary care. I say to them and to LHBs when I meet them that if the clusters succeed in drawing activity that way, the budgetary consequences of that must follow. If they can show that they can provide better services closer to home, and release money in doing so, they need to share in the reward of that so that they can invest in a new range of services as well. So, there is a responsibility on our primary care community as well, not just to point to a way in which things have not happened, but to demonstrate ways in which they, acting collectively, in the structures that have now been provided, can pull activity towards them and then, push and pull, we might do better than we have managed until now.

[147] **Elin Jones:** The majority of spend in the NHS on local GP services is on staff. So, when you are shifting services out into the community or into GP practices, how easily do you think that the system works in terms of staff being able to move out of hospital buildings, possibly, into community settings or GP practices, given the different employment situations as well?

[148] **Mark Drakeford:** It ought to be one of the strengths of the system that we have in Wales, because we have integrated health boards, responsible for the whole of the service that they provide. So, we do not have the institutional barriers that you can have in other systems between primary and secondary care. There are very good examples of where consultants are now holding their out-patient clinics out in primary care, rather than expecting people to go into hospital to have those out-patient appointments, and where some responsibility for things that would have happened in secondary care is now discharged by primary care clinicians. However, Elin is quite right that the cultural barriers to doing things in new ways are very real, and you have to work very hard to shift patterns of ways of doing things that people have gotten used to over many years.

[149] **David Rees:** Are there any further questions? I see that there are not. I have one question to finish. The Welsh NHS Confederation has indicated that the efficiencies are

continuing on a year-on-year basis, but that they are getting more difficult, gradually, as time goes on. Some of the figures that we have received show that, whereas some health boards have been very good at meeting their efficiency targets, which they set themselves, others may not be hitting them by up to about 30%. The ambulance trust seems to be way beyond that, and is only hitting about a quarter of its efficiency targets. How will we ensure that those efficiency targets can continue to be met? While I appreciate that extra funding is going in, there is a continued emphasis on efficiency savings.

[150] **Mark Drakeford:** In the last financial year, NHS Wales made £185 million of efficiency savings, which is only £3 million less than it achieved in the previous financial year. So, while I accept what the Welsh NHS Confederation says, which is that, year on year, making savings becomes more difficult because, by and large, you have taken the easier things first, the actual record of NHS Wales in the round is pretty remarkable in continuing to deliver savings of that volume.

[151] If we look ahead, the Nuffield report, as we said earlier, says that, for at least two years, it will be £200 million or £221 million, but it looks ahead to 2025-26 and it says that NHS Wales will need to continue to make savings at or about the level that it has achieved in recent years, and then, with some other bits of the jigsaw that it puts in place, the NHS goes on being affordable. I do not think that we can expect that every part of the system will find savings in the same way as other parts of the system.

12:30

[152] The ambulance trust, as we know very well, has been under very real pressure. We are trying to enable it to realise savings by the very significant investment that we are making, for example, in the most modern range of vehicles. If you are running an old fleet, you inevitably end up with costs of maintenance, diesel consumption and so on, and we have made a lot of extra capital money available this year to try to help it with the efficiency agenda there. There are other things that it is trying to do, which Andrew could probably set out for you.

[153] **Dr Goodall:** Yes, obviously, our approach there around using the staffing arrangements that are going in, basically, is so that we can make sure that they are substantive staffing arrangements rather than having to recruit in different areas. However, I think that, generally, health boards are having to pursue a number of things; there are still definitely opportunities for people to go at.

[154] We have an open approach now about a prudent healthcare mechanism, which allows us, I think, to bring a whole series of resources to the table in a bit of a different way. There is a lot of change going on across health boards generally in Wales in terms of their ability to change things. Not all of those are about major service change, but we have to recognise that it will get more difficult for individual areas. So, one of the key things, I think, for NHS Wales is to continue to make sure that the health boards, as they all learn about the different levels of savings and opportunities, actually share that among themselves and make sure that that is part of our strategic approach. We need to make sure that the services are sustainable.

[155] **David Rees:** Okay. Thank you, Minister and Deputy Minister, for your evidence this morning. You will receive a copy of the transcript to check for any factual inaccuracies that you may identify. Once again, it was remiss of me not to thank you for your written evidence earlier, so, thank you for that. I am sure that we will contact you again sometime in the near future. Thank you.

12:32

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

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

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

[157] Are all Members content? I see that you are. Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 12:32.
The public part of the meeting ended at 12:32.