Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 11 Tachwedd 2014
Tuesday, 11 November 2014

Cynnwys
Contents

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

The proceedings are recorded 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

William Graham	Ceidwadwyr Cymreig Welsh Conservatives

Mike Hedges	Llafur Labour
Alun Ffred Jones	Plaid Cymru The Party of Wales
Sandy Mewies	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Julie Morgan	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Gillian Body	Swyddfa Archwilio Cymru Wales Audit Office
Simon Dean	Dirprwy Brif Weithredwr GIG Cymru, Llywodraeth Cymru Deputy Chief Executive, NHS Wales, Welsh Government
Dr Andrew Goodall	Prif Weithredwr, GIG Cymru Chief Executive, NHS Wales
Martin Sollis	Cyfarwyddwr Cyllid, Llywodraeth Cymru Director of Finance, Welsh Government
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

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

Claire Griffiths	Dirprwy Glerc Deputy Clerk
Meriel Singleton	Ail Glerc Second Clerk
Joanest Varney-Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

Dechreuodd rhan gyhoeddus y cyfarfod am 09:22.
The public part of the meeting began at 09:22.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** I welcome everybody to the formal part of our Public Accounts Committee meeting today and just remind Members and witnesses said the National Assembly for Wales is a bilingual institution and that everybody who contributes to this meeting should feel free to do so through either English or Welsh, as they see fit. There are, of course, headsets available for sound amplification and translation. I encourage everybody to switch off their mobile phones, as these can interfere with the broadcasting equipment. In the event of a fire alarm, we should follow the directions of the ushers. We have not received any apologies for absence today, so we shall go straight into item 4 on our agenda.

Papurau i'w Nodi
Papers to Note

[2] **Darren Millar:** This item is to note a number of papers that we have received since our last meeting. We have the minutes of the meeting held on 4 November. We have a letter from the Minister for Health and Social Services on unscheduled care. There is some interesting information in there, of course, on the 111 service. The Children's Commissioner for Wales has submitted some further information, as we requested, on the car leasing arrangements. I take it that those papers are noted.

[3] We have also had a response from Nick Shooter, who is undertaking the review of the Children's Commissioner for Wales post—we wrote to him about the accountability arrangements for the post. The Arts Council of Wales has sent some further information, following the evidence session that we had with it. Also, of course, we have received, formally, the letter of 4 November that we received from Andrew Goodall last week on the escalation status of Betsi Cadwaladr. In addition to that, we have a further paper to note, which was received yesterday, on the escalation status and clarification of additional resources for health boards announced by the Welsh Government's draft budget prior to this particular session. If Members are content, I will take it that those are noted and we will move on to item 5 on today's agenda.

09:23

Cyllid Iechyd 2013-14
Health Finances 2013-14

[4] **Darren Millar:** I am very pleased to be able to welcome Andrew Goodall, director-general for health and social services—welcome to you—and chief executive of NHS Wales. With him is Simon Dean, the deputy chief executive of NHS Wales, and Martin Sollis, the director of finance at the Welsh Government. Welcome to you all.

[5] Obviously, we have received a report from the Wales Audit Office. There has been an annual report from the Wales Audit Office on NHS finances in recent years. This report touches on some aspects of NHS performance as well. We have a number of questions that we wanted to ask you in relation to the report. Can you tell us, Andrew Goodall—. The report paints a very challenging picture in terms of NHS finances, not just for the 2014 year, but also going forward into the future. It seems to suggest that there are many hundreds of millions of pounds that we are going to need to find from taxpayers' resources if the NHS is going to make ends meet further down the line. How on earth is the Welsh Government responding to those challenges?

[6] **Dr Goodall:** Just to open, thank you very much for the invitation to attend here today and the chance to talk about the overview report. Yes, the report is very clear about the challenging environment that we work in. We are having to respond to a very austere environment for public services in general terms and, obviously, the NHS has to make its own contribution. We have had to work through a whole series of different approaches over the last five years, from the time local health boards were created in Wales, back in 2009. There has been a need to balance the funding, along with the quality and the performance during that whole period of time, and for a real step up, I think, in terms of those expectations, based on what organisations were probably focused on over the last 10 to 15 years in particular. However, I think that you are right; it is important not just to look back, which I know that we will do today in part of looking at 2013-14, but to actually look at the agenda and the environment ahead of us as well. The auditor general has made very clear that there are expectations of it still being very difficult to work through for public services, and there are

some expectations that the NHS also needs to make sure that it actively responds to.

[7] However, what we have received this year as well is some very specific work from the Nuffield Trust and an update on a decade of austerity ahead of us in terms of what that means in the Welsh context. Your point, Chair, is right; we are looking at a sum of funding that has both worst-case scenarios and best-case scenarios. I think that the NHS in Wales has done well over the last five years, since the inception of the health boards, to basically manage a whole series of savings expectations, and I think that the Nuffield Trust was able to give a feel that it felt that £1 billion had already been able to be saved or cost-contained at this stage. However, as we look forward, in the best-case scenario, there could be pressures of hundreds of millions of pounds, but, in the worst-case situation, if we do not end up with the economy improving on a UK basis, we could actually see gaps that could be over £2 billion. We are not the only system working in this aspect; we have obviously seen other systems across the UK reporting their own pressures in terms of what this next decade will mean. I think that our responsibility, from both a Welsh Government and an NHS Wales perspective, is to make sure that we are aware of those pressures and that we do everything possible to focus on them, and that we continue to respond, of course, to the resource envelope that we work within, but, of course, we have responsibilities to balance the quality and the performance agenda in there.

[8] I think that one of the critical issues for us is that, over the last five years, it feels as though it has been getting more difficult to deliver some of the savings out of the system. Some of the easy pickings, if you like, have been taken very early on. I think, despite that, in 2013-14, the NHS in Wales managed to deliver a consistent level of savings. However, we are moving into an agenda that I think is more about taking different approaches to our financial management, as well as good underlying budget management. So, there is a challenge around transformation of services—it is an easy label to use, but it can be very difficult to achieve. There are changes going on across Wales but, equally, new concepts that I am happy to pursue during the course of the meeting. We are developing areas around prudent healthcare and what that means in terms of allowing perhaps a different discussion, more broadly with the public and with communities as well, which I hope will underpin some of the savings approaches for the next five years. However, undoubtedly, it is a very challenging environment ahead of us for the next 10 years and it has been a very challenging environment over the last five years as well, Chair.

[9] **Darren Millar:** The report goes to some length to point out that some of the impact of the financial challenge appears to be manifesting itself in slippage against targets—some of the tier 1 targets, in particular around waiting times and, indeed, around the sustainability, if you like, of some of the savings and whether they are recurrent or not. Do you want to just comment on what you are doing as a Welsh Government to ensure that the NHS does not take its eye off the ball in terms of those tier 1 targets, and, if they are really tier 1, what sort of arrangements do you have to hold boards to account for them?

[10] **Dr Goodall:** Simon, do you want to outline the performance management arrangements and the frequency of those?

[11] **Mr Dean:** Thank you. We have regular contact with all of the health organisations to discuss performance and we have quality and delivery meetings that happen as a routine every two months. Where an organisation has performance challenges, we meet with it more regularly. On a day-by-day basis, there is contact with individual organisations and groups of organisations on aspects of performance. So, on unscheduled care for example, either Andrew, or myself in his absence, chairs a teleconference with chief executives every Monday. There is an operational teleconference every day of the week, including weekends, which talks in detail about performance and actions that have been put in place to address concerns. We bring organisations together to focus collectively on, for example, unscheduled

care. So, I meet with the chief operating officers from the south-east Wales health boards, together with the ambulance commissioner and the ambulance service to discuss unscheduled care.

09:30

[12] We have similar discussions about unscheduled care, about all aspects of performance. I think that one of the important points to stress is that health boards are big organisations and their job is to manage complexity. There are currently tier 1 targets, which are some of the markers that we use to judge quality and performance, but it is very important to remember that there are many, many responsibilities that they have to deliver services for their populations that are not captured under the tier 1 target banner. So, one of the things that we are increasingly focused on is developing a broader understanding of what health boards and trusts are doing and how they are delivering across all aspects of their portfolios for the benefit of their population. We have very detailed performance management of the specific tier 1 target.

[13] **Darren Millar:** When we refer to tier 1 targets, they are the ones that are the most important: they are tier 1 targets, are they not? So, I appreciate that there may be other measures of quality, of service and of how those are being delivered, but the tier 1 targets are the most important targets for the NHS to meet, and many of them appear to be slipping back against the targets, particularly in this last financial year. The trend looks to be worsening against many of them. Lots of them are indicators of patient experience as well, particularly in terms of timeliness of access. So, are you taking your eye off the ball, as a Government, in holding health boards to account for these, because they do not appear to be turning around, in spite of your regular monitoring meetings?

[14] **Mr Dean:** The position against targets was variable in 2013-14 compared to the previous year. So, in some areas, performance improved. So, for example, in relation to postponed procedures between December and January, there was a reduction from 1,423 the previous year to 752. So, that is nearly a 50% improvement. The A&E four-hour performance improved by 1.8%, and the number of 12-hour waits in A&E reduced by 5,250 over a comparable period for the year before. So, there are areas where performance did improve. There is more to do, and there are areas where performance in 2013-14 was lower than it was in the previous year. So, it is a mixed picture, which I think is the message that comes through from the auditor general's report. So, there are some areas of improvement, and there are some areas where performance slipped. There is clearly more to do. We expect health boards and trusts to be focused on delivering, and increasingly we are driving that both through the performance management process and through the three-year planning process. However, we expect organisations to be developing competent and comprehensive plans that show us how they will deliver across the full range of their responsibilities—

[15] **Darren Millar:** Do all health boards have those plans?

[16] **Mr Dean:** Not this year. I think that the committee has had a discussion on this previously. We have four organisations this year that have approved three-year plans. We have just—

[17] **Darren Millar:** Sorry, in terms of performance now, dealing with these aspects of performance where there is a clear trend that is in decline against most aspects of performance, what plans do health boards have? Presumably, you collate those, given your bi-monthly meetings.

[18] **Mr Dean:** Yes, we discuss those in detail, and we are refreshing those plans alongside discussions about the financial position. So, we are in the middle of the cycle of

meetings with each health organisation to discuss where they are in terms of the quality of the services they provide, their performance position against targets and their financial position. We need to have a blended discussion that brings all of those factors together so that we can work with the organisations to determine how their performance will improve through the remainder of the year. So, the position is mixed. There is a lot of work under way. We met one organisation yesterday, we met two towards the end of last week, and we are discussing with them where we can expect their performance to be at the year-end, together with any quality concerns they may have that sit alongside that performance and, of course, taking account of their financial position.

[19] **Darren Millar:** But the tier 1 targets are the priorities for the Welsh Government in terms of delivery, yes?

[20] **Dr Goodall:** They remain a focus for our targets, and, Chair, we have just been going through our mid-year reviews and our joint executive team meetings. We have only got a couple left to do at this stage, but, absolutely, in the course of those meetings, we are focusing on the tier 1 priorities. I just want to acknowledge that, in the context of the performance overview that the Wales Audit Office gave, it did stretch out some of those measures, and, from our perspective, in relation to the inclusion of some of the prevention measures, the immunisation kind of areas, these are things we want to focus on as we try to ensure that the tier 1 measures going forward can be more outcome-focused as well. We will be utilising some of that balance that the Wales Audit Office introduced in our own performance monitoring too.

[21] **Darren Millar:** Okay. I am going to bring in Julie Morgan.

[22] **Julie Morgan:** Yes. Thank you very much. We have had a letter from you since the last meeting. You list the latest month's financial position for all of the different boards and trusts and you say that the £200 million will offset the above position—the allocations to each LHB have not been made yet and are currently not reflected. How will those allocations be made? How will it be decided what will go to each board or trust?

[23] **Dr Goodall:** I will ask Martin to fill in the detail. Just to say, Chair, I responded to the letter yesterday; it was requested by the clerk for yesterday. Hopefully that was okay just to give some additional information in advance of the committee meeting as well. We have given some provisional allocations out to health boards at this stage, so that they would at least have some understanding of the position. However, obviously, the publicly reported positions will be as incorporated within their three-year plans and their local monitoring arrangements.

[24] Martin, perhaps you could outline the current approach to allocations that have yet to be finalised?

[25] **Mr Sollis:** The picture is explained in the letter, but it is quite complex. We started a process endorsed by this committee last year. We want to move to population shares and resource allocation shares of any funding going out, because that is the only way, really, to fund the NHS in the long term. In terms of doing that, we developed three-year plans. Where people are not able to meet them within the population share, we need them to return to that process. So, we gave a clear message. For example, in the four cases where there were approved plans, some of those were living within their population shares and some were not and received assistance last year. So, the allocation is both a combination of population shares and a continued monitoring against population share, but also looking at what they need to deliver within those plans.

[26] For example, last year, Cardiff was unable to balance its position at the end of the

year. It has developed a three-year plan to deliver that position in this year and, again, what we aim to do is to provide the flexibility for it to balance over that three-year period. So, that is important because, in the long term, the only way to work with all organisations is to try to drive them to deliver within their population shares. In 2015-16, although it is not formally conveyed yet, we are looking to fund on a population basis the allocation that has been made in terms of the draft budget. That is important, because we need to return to those principles, and, as the committee has requested and recommended in previous years, look at the deficits for individual organisations. We have to get that long-term sustainability.

[27] **Julie Morgan:** Where does the Townsend formula fit into this? Is that what you are saying?

[28] **Mr Sollis:** The Townsend formula is the allocation formula.

[29] **Julie Morgan:** Could you explain to us how the Townsend formula works—very simply, not in great detail?

[30] **Mr Sollis:** There are many factors in the Townsend formula, but it is based on a needs basis. So, there are things like the Welsh health survey that is included within the analysis, along with birth rates. We are currently updating it in terms of the age and sex distribution, making sure that we can look at the growth in the elderly population and that that is included. We look at population trends—for example, Cardiff has had an influx of population recently. So, again, it is important that we update those data sets for all of those reasons.

[31] It is based on the level of spend in terms of programme cost currently across a range of specialties. It is really quite a complex formula, but it includes all of those factors in terms of calculating what the needs of individual organisations are.

[32] **Julie Morgan:** So, this £200 million will be distributed according to that and will also look at the three-year plan.

[33] **Mr Sollis:** In terms of next year, it will be on a full resource allocation basis. What we have started this year, as I explained, for example, in Cardiff—. Its population share of the £200 million this year would have been higher than what it would have received, but in its three-year plan it asked for lower, because, again, what it is doing is driving to a recoverable position against its population formula. Cardiff, for example, had £19 million of assistance last year that we need it to recover in terms of living within its population and resource allocation share going forward.

[34] So, in Cardiff's case, we are funding per the plan, and it is important that we do that. In other cases, we are also looking at what the plans mean in terms of comparability with the resource allocation formula this year. What is available to distribute this year in many cases is consistent with what people have got within the original plans that the boards have approved. I am sorry, it is quite complex, but that is what we are doing. It has to be combination of both, because where people cannot live within their population allocation, we have to put them on a recovery trajectory, which always used to be the case in the past, until recently, when we started to look at the deficit aspects. So, we have tried to address that over the last two years to get back to a population basis. This year it is a combination of recovery plans and a resource allocation basis that we have to fund.

[35] **Dr Goodall:** Chair, we are working, obviously for the first year, within the three-year planning flexibility that we have introduced. As much as we approach this through the allocation mechanisms, what we are constantly looking to do is, of course, to make sure that we are reinforcing the three-year planning principles and that there is an emphasis there for

organisations to want to be the next organisations that can be approved as we go into January 2015 and receive the plans for 2015-16. So, we are really mindful about continuing to reinforce the messages, not least those that are outlined within the auditor general's report too.

[36] **Darren Millar:** So, you are not just giving dollops of cash where dollops of cash are not needed is what you are saying to us, is it not, in terms of those three-year plans?

[37] **Julie Morgan:** I just have one more question. Velindre has no deficit and no surplus according to this list. How do you calculate for a trust such as Velindre, whose population is widespread over south Wales, in terms of those that use it? How do you make those calculations?

[38] **Dr Goodall:** If I comment initially and, again, Martin will pick it up, obviously its funding regime as a trust will be different in terms of the receipt of the funding through the health boards themselves. However, all of the same disciplines of the system still apply to Velindre as an organisation. So, it still has to develop a three-year plan, it still has to manage within its means, but it will be reliant on health boards coming together to pass on the money on behalf of their populations at this stage. However, whether it is the monitoring arrangements that we have in place or the three-year plan process, Velindre is an organisation that is in a good place. It has an approved three-year plan, it has clarity, and it has a track record of delivering on its rounded performance as well as its financial agenda, and it will continue to liaise with those health boards for the funding that is necessary on the part of their respective populations. I still think that Velindre has opportunities to reach out beyond that. It clearly has a predominant focus on south-east Wales, but there is some more specialist cancer services provision there more broadly for the Welsh population as well. However, it will still continue to receive the money not directly from Welsh Government but through the individual health boards. I do not know whether you want to add anything there, Martin.

[39] **Mr Sollis:** I do not think that I can add anything to that.

[40] **Julie Morgan:** Thank you very much; that is good news about Velindre.

[41] **Darren Millar:** Okay. I am going to come to Mike, then Sandy.

[42] **Mike Hedges:** I have two questions. You talked about the Nuffield Trust report, but can I refer you to the other Nuffield report, 'The four health systems of the UK: How do they compare?' Are you familiar with that? It showed that, between 1999-2000 and 2011-12, the impact of increasing the number of doctors and dentists in the health service meant that crude productivity collapsed by over 25% in Wales, which was greater than that in England and Scotland. Has that collapse continued? Can you explain why we keep employing more doctors to do less per doctor?

[43] **Dr Goodall:** In terms of your last point on fewer doctors at this stage, obviously, all health systems in the UK have to respond to the European working time directive, which puts a limit on the hours that doctors need to perform. I know that that is predominantly around junior doctors or middle doctors within the structures, but it does affect others as well. The numbers simply require an approach to recruitment that means that more doctors need to be put into the system. Doctors do not work in isolation either, so there is a perspective about the way in which they work in support of the multi-disciplinary teams that they lead in an environment that clearly should have expectations about performance continuing to focus on quality issues as well. However, I think that the predominant driver over the last 10 years is the European working time directive in terms of driving that.

[44] Yes, we are aware of the four countries report from the Nuffield Trust. I think that the

output of that shows that performance is variable across the four systems. Most systems are broadly in line with each other. Some systems are doing better than others within the context of the report, and, actually, we have responded ourselves as a Welsh Government to those issues in terms of having that broader understanding.

[45] **Mike Hedges:** It shows that you are doing less well than everybody apart from Northern Ireland, and there are problems with the Northern Ireland data. However, I will not take it any further than that. The other question I have is on the fact that the Cochrane centre for meta analysis concluded in 2012 that treatment in the borderline range of blood pressure is more likely to harm patients than help them, except in people with diabetes, yet it was still in 2012—tell me you have stopped now—one of the quality and outcome framework contracts for GPs.

[46] **Dr Goodall:** I am probably unable to comment on the specific detail of that one at this stage. I am happy to give a note back on it as an issue. Clearly, clinical practice and evidence moves on at various stages. The Minister has focused a lot on prudent healthcare as an approach, and, if Members recall his original announcement, he emphasised that there was a whole series of interventions that even the guidance was saying should not be utilised any more across the whole of the NHS generally, yet they are still part of clinical practice anyway. However, you are right that, as far as frameworks are concerned, people will look to utilise the frameworks at this stage and they do need to be revisited on a constant basis.

[47] **Mike Hedges:** I have great confidence in the Minister for health and his commitment to prudent healthcare; I am just not convinced that his commitment to prudent healthcare is making its way, even if it gets as far as you, down through the health service to GPs. How can that start to happen? If we started to deal with prudent health effectively, then health would not keep on coming with this begging bowl every year.

09:45

[48] **Dr Goodall:** From the perspective of prudent healthcare, the Minister made his announcement on this in January 2014 and we re-launched it recently, in October. The framework that you referred to was in 2012. We obviously need to make sure that those do get ingrained. I think that we are finding a different reaction actually about prudent healthcare, not least from professionals, who feel that it is a way in which they can engage and understand some of the pressures on the services and actually manage within the money. We were able to make a number of changes to the quality and outcomes framework process for the current financial year that we are in, to actually drive differences to take some of the bureaucracy out of the monitoring system, as well, and that was done in liaison with GPC in Wales. No doubt, we will be able to continue that. However, certainly, even among GPs generally, we have seen a good reaction to some of the possibilities on prudent healthcare, even led by areas such as prescribing.

[49] **Mr Sollis:** The Minister announced his primary care plan last week in terms of driving that agenda. Planning at a local level is going to be very important in driving that primary care plan.

[50] **Mike Hedges:** I have full support for what the Minister is trying to do. My concern is that what the Minister is trying to do, and trying to get that down through the system, is not happening. I know the Minister's views on polypharmacy because I have talked to him often. People are taking 14 or 16 different medicines at the same time, which may well be interacting. No-one knows how they react together because none of the trials ever had people taking lots of them at the same time. There is evidence again in one of these booklets that I have read that actually says that, in some cases, by taking all these medicines, they are actually making people more ill than they would be otherwise. I know the Minister's view on

it, but in getting it down to GPs and to where the problem seems to be, making its way down through the health boards to the GPs, we seem to be losing something in translation.

[51] **Dr Goodall:** Well, we do have a responsibility to make sure that it is not just about strategic approaches. Actually, it does need to be pushed right down through the structures. We would expect boards to take that responsibility. I think that with the development of the GP clusters in Wales and the locality networks, there is an opportunity to gather GPs to reinforce some of that. We have been seeing them focusing on their variation in their prescribing practices at this stage. I do think that your point is right. Certainly on prescribing and medicines management, there is a whole series of outstanding opportunities still for us to focus on, which is why, in the launch that we did in October, there was a whole focus actually on prescribing and medicines management.

[52] **Darren Millar:** Have you estimated the total that you expect to save as a result of the introduction of the prudent healthcare policy?

[53] **Dr Goodall:** At the moment, we have not assessed it. We are seeing organisations taking on the original expectations from the Minister. Certainly in our three-year plan process, we are expecting that to be quantified, probably for the first time for the plans for 2015-16, so that we see the proper numbers emerging. We do see organisations able to comment on areas that would fit with the prudent healthcare approach, so there are historical things that have been done that do fit with this arena. From the auditor general's own report, you can see £30 million-worth of savings there on prescribing, for example, which would very much fit with this environment. However, we are wanting to make sure that we are able to focus on it. Members may have seen a report that came out from the medical colleges last week, in the whole of the UK. There was a focus there on inappropriate clinical approaches or interventions. In that particular context, which I know was, of course, beyond Wales, they were talking about £2 billion of opportunity to go out there. I think that we need to frame it by those kinds of areas. Certainly, Chair, as we look forward over the next 10 years, we clearly do have expectations for boards and for the system to be properly looking at all of these opportunities, and to convert them into practical, better use of resources at the front line.

[54] **Darren Millar:** So, that £2 billion is the estimate of what could be saved as a result of the introduction of prudent healthcare in Wales alone.

[55] **Dr Goodall:** That is not for Wales. It was just the medical colleges that reported, mainly focused on England, but they obviously have a UK approach. What was interesting for us in receiving that report, with all the work that we have done on prudent healthcare, was that it fitted with parts of the agenda that we have described. They had come at that through a clinical lens, a clinical perspective, and actually defined that they felt that there was a material amount of opportunity that could be got at. Now, we can obviously convert that into Welsh terms, but it absolutely fits with the different criteria that we have been setting for prudent healthcare in Wales.

[56] **Darren Millar:** However, you expect health boards to have specific actions to accompany their three-year financial plans to raise the profile of this agenda and delivery against it.

[57] **Dr Goodall:** We would, and we are continuing to engage with people practically on what prudent healthcare means at this stage, which is why we have continued to do the launch, for example. We have built on all of those announcements over recent times. However, we are expecting the three-year plans to capture that properly.

[58] **Darren Millar:** Do the current three-year plans for the three health boards that have got them capture the prudent healthcare agenda?

[59] **Dr Goodall:** I do not think, in terms of their status, that they really capture prudent healthcare in the numbers at this stage, but they do demonstrate a number of different approaches. It was still emerging probably as our Welsh Government approach at that stage, because the original plans had been put in in the autumn of 2013. We were looking to finalise some of these from January, and obviously the Minister had made his particular speech in January of this current year. There is reference to some of the underlying principles and concepts there, but the budget opportunities are not properly outlined at this stage because it was still in development at that stage.

[60] **Mr Sollis:** Both the prudent healthcare and primary care aspects are covered within the planning guidance that went out at the end of October for this current round of plans. So, again, the drive to develop those within the three-year plans is there. I would also say, Andrew, that at every meeting that we have, at the moment, in terms of Team Wales, through the chief executives, the prudent healthcare agenda is building with momentum, with the launch of the site and the examples of good practice that are on that site. So, again, getting that message down across the board in terms of supporting those plans is very important. There is a real heavy focus on driving that agenda, and in terms of three-year planning guidance.

[61] **Darren Millar:** However, at the moment, there is no specific action anywhere that anyone can point to as 'This is our action plan to achieve prudent healthcare and this is what we are holding you against'.

[62] **Mr Sollis:** Not fully.

[63] **Darren Millar:** Your question was on this, was it, Julie, because I want to bring in Sandy?

[64] **Julie Morgan:** It is just an example of prudent healthcare in my constituency, I think: the diet and exercise sessions offered in the University Hospital of Wales before orthopaedic surgery. Is that measured anywhere in the plans, what that is likely to achieve?

[65] **Mr Dean:** On the specifics, we would be expecting the organisation to be measuring the success of that initiative. For me, prudent healthcare is an organising principle rather than a planning heading. So, we will be expecting organisations to approach all of their work through that prudent healthcare perspective, and we will be testing plans similarly. So, I would not necessarily expect to see a specific action plan headed 'prudent healthcare'. I would be expecting—

[66] **Julie Morgan:** So, that particular initiative would not appear anywhere in the plan, and with the money that it would save.

[67] **Mr Dean:** It should appear within the organisation's plan. I mean, I think that this is a pyramid and we would expect to see the top level of the pyramid. Most of the plans that we received last year were in excess of 100 pages, which you could argue is very long, but actually you cannot capture the complexity of a £1 billion organisation in 100 pages in fine detail. So, what we will be looking for is the building blocks that sum to that overall position. So, the specific sort of scheme that you talk about I would not necessarily expect to see drawn out in a three-year plan, but I would expect to have confidence that, within that service area, there are plans that are being developed through a prudent healthcare focus: looking at the way in which professionals work, looking at building the multidisciplinary teams, and in discussion with the public about their expectations of care and what their responsibilities are as they engage with the health system. There is something about having confidence that the organisation, at a very granular level, has those detailed plans in place that can sum to a plan

for the organisation in which it can have confidence, its public can have confidence and so can we.`

[68] **Dr Goodall:** We will want to make sure that these different experiences across health boards are shared and promoted.

[69] **Julie Morgan:** Yes. You do not want it lost.

[70] **Dr Goodall:** There is a very simple example in ABMU, which introduced overnight dialysis, for example, which took place in the patient's home. Typically, it would cost around £35,000 per patient per year, and that actually reduces the cost of that monitoring by around two thirds, so there is a saving of £20,000 to £25,000 just on that one initiative. So, we need to continue to make sure that these are promoted, and that is one of our responsibilities centrally, of course.

[71] **Julie Morgan:** Then, of course, it can be share, can it not?

[72] **Darren Millar:** I am going to bring in Sandy and then Alun Ffred.

[73] **Sandy Mewies:** Thank you, Chair. I was going to come in in the first instance, but I will ask all my questions now. On prudent healthcare, it is a principle rather than an organisational issue or specific issue. What concerns me slightly is that people still go along to their GP when they have a worry, and they expect something. They expect either a tablet, a referral, a test or something. With prostate, for example, if they have a test and their blood levels show that they have raised levels, they then want to go and see a consultant. Prudent healthcare, I think, would suggest that perhaps that should not be happening on a regular basis. You have been talking about health in the round, and I totally agree with you that it is totally complex. It is a huge issue and it needs to come under control. The only way of doing it is to think ahead, actually. With prudent healthcare, you have got to tell the public what prudent healthcare is. I think that there is a deal of understanding about what prudent healthcare is. People think that it is being prudent looking after yourself and being prudent looking after finances, and it is not. I presume that public health will have a role to play in this.

[74] I think that some of the public health campaigns that have been carried out in the past have not been successful. I do not think that the message has got across. Are you already thinking about how public health will make sure that the public do understand? GPs have a very difficult job. There are excellent GPs, and I am lucky enough to know some of them, who would explain carefully the implications. Some are not as able to do that, so you do need the public health care thing. That is my first question.

[75] My second question is from when we were talking about three-year planning. I am just wondering. This is an overview of what has happened. From the overview, you will be taking lessons learned for the future. What I want to as you is what will happen in year 3. If we have still got health boards on the skids, what will happen then? Is that why the escalation programme has been changed? I suppose that, if that is the case, you could say that Betsi Cadwaladr University Local Health Board, for example, has been picked up early. It has gone on to level 3. Is that the way you are going to work it? It is no good, at the end of year 3, as has happened sometimes in the past, thinking, 'Gracious me, this is a mess', and we have got no time to do anything about it. Your figures, if things are not reined in, are frightening. They could bankrupt Wales as a country. They are frightening. So, that is my second question.

[76] I wondered whether allowing boards to have their accounts qualified has worked, and whether you have got any evidence to show that. I also wondered about unscheduled care, because we saw an improvement last year, but there has been a deterioration since. Again,

you have a publicity issue, I think, with elective surgery. We have already got the red tops threatening Wales and the world with terrible weather through the winter. They have frightened me to death already. How is the work that is being done informing what comes next? Are you happy as Welsh Government that health boards are looking now? It is November. We are coming quickly into winter and people always seem to think, 'Oh God, Christmas is here'. It happens every year. Winter happens every year. It is not new. Bad weather comes, sometimes, although it does not always come, but people have to be ready for it. So, is that work going on? Are you confident that that work is going on now?

[77] **Dr Goodall:** I will pick up the four individual issues. I will start with the involvement of the public and the population. I will move through them and I will involve Simon and Martin as appropriate.

[78] I think that your points are absolutely right in terms of the public. We do need, moving forward, to ensure that it is not simply a discussion among professionals, and not simply a discussion among the boards themselves. Of course, they have to discharge their own governance, but to use the label that we have outlined in support of prudent healthcare, we need a 'co-produced approach', so co-production becomes really important. What that really means is ensuring that we have commonsense conversations with the public more broadly, but also, obviously, in terms of their individual contact that takes place with health services. That does need an openness and a frankness about what is happening, and I think that we need to manage some of their expectations. I think that you are right that members of the public will have their own expectations, particularly these days where internet searches are possible and people will have done their own revision before they attend, but I do think that we need to be clear with people. As the Minister himself has outlined, prudent healthcare does not mean that there is no responsibility for patients themselves, their carers and their families in terms of how we manage the situation.

[79] From a public perspective, we have tried to get into these areas over time. Examples like Choose Well, which we have done on a national basis on the pressures around unscheduled care, are a way of getting into that. We actually had a really good conference at the time of the launch of the prudent healthcare approach, which was facilitated by Public Health Wales. One of the commentators that we got to speak was someone from the Canadian health system, which has had an approach that is chiming with prudent healthcare, Choose Wisely, which was very much about promoting a discussion with clinicians and professionals, but actually more broadly with the public and individuals in terms of the care that they need. So, we are looking to use that evidence and that experience to make sure that this happens, too.

[80] However, it does require constant reinforcement. Although Public Health Wales will have that all-Wales approach on behalf of the public health responsibilities, it is also to remind us all that, of course, health boards are population health organisations themselves, and we would also expect them to be generating this. To strip this away, whatever we do to talk to the public, it will still come down, I think, to an individual member of our health team, a clinical team, talking to somebody and just understanding that this is a concept that can help with the individual and them, in terms of what they need to apply.

10:00

[81] In terms of the three-year planning process, there was a very broad discussion among Members when the financial flexibility arrangements were going through as a piece of legislation and for discussion. I know that there were genuine worries at that time that this was, potentially, just an ability to defer pressures into three years' time hence. In any one of our years, we always need to have the flexibility and finances available to allow us to give support to those organisations that may need more support, so we always have to deal with it

within the budget terms. However, your point is right—the escalation framework, and certainly the refinement of the way in which we can liaise with regulators and pull in additional levels of support as necessary, is to ensure that we do not simply wait for three years to elapse. It is about having a very regular approach to the three-year planning approach and making sure that we can step in as necessary. Yes, I am afraid that the Besti mechanisms that we outlined to the committee are part of that, in terms of us saying that we need to ensure that the in-year financial position is addressed, but it is also really for us to make sure that the three-year plan approach that it is likely to be taking for January can also be resolved at the same time as part of that process.

[82] **Mr Sollis:** Three-year plans are a rolling three-year planning process, so, again, we have to keep monitoring that. People can slip off track and we need to get them in to support arrangements where we get that back on track. It is important that we keep on focusing that year-on-year, because of the agenda that we have ahead of us. So, it is a rolling three-year planning programme as well.

[83] **Dr Goodall:** On the qualified accounts and whether there is a change of attitude, I would say that, yes, that was a very different message out to the service in Wales. Martin, you might just want to give your own reflections, having been in the central team here.

[84] **Mr Sollis:** The qualification applied to three organisations last year. Cardiff, as we have discussed, has put a plan in place and, already on agenda, it was ahead of the pack really; it was already looking at its population share and looking to drive an agenda of efficiency that drove that agenda anyway. However, in terms of the assistance it received last year, it has a three-year approved plan. We hope that, by the end of this year, it will not be in that sort of position. So, again, we will keep monitoring Cardiff in relation to its plan, making sure that it delivers against that. That is one of the reasons why the allocation is going in, in accordance with the plan.

[85] The other two organisations are more difficult, but again, we have had recent meetings with the joint executive teams, bearing in mind, they only got qualified at the end of last year, so that was June/July time. In effect, on the three-year plan process that we are currently involved in, in terms of those two organisations, we are already getting good feedback from them that they are developing the three-year plans and that we are going to see that level of improvement for both of those organisations when those plans are submitted in January. Whether there will be balance, or whether we will look at those in terms of a longer time span, we need to work with them on those three-year plans. However, we can see definite improvement and we are seeing that they are taking this seriously. They are seeing that the three-year plan is the way of driving that agenda, and we hope to see the improvements in January when they come in, but obviously, we have not received the plans yet.

[86] **Dr Goodall:** I was genuinely really pleased, certainly in discussions with Powys, to see some opportunity to have the ability to have discussions on a three-year plan potentially being signed off. Certainly, with more organisations in Wales, we are seeing a better focus, so we should have an expectation that, by January 2015, more organisations should feel that they can be contained within the criteria for the three-year plans.

[87] Your final question was about winter planning and it being with us, and on us, and the way in which we move forward. I can partly reassure you that, even as we were coming through the last winter period, the planning for this winter occurred almost immediately afterwards. There was a set of review meetings and discussions involving not just the health service, but local government, very immediately after that. So, we do not simply wait for the weather report, as you indicated; we make sure that we are focusing on those plans. Simon, you probably want to outline the winter planning approach that we have been taking over

these recent months.

[88] **Mr Dean:** Yes, thank you. We have been working with health boards as they develop their plans. We have had a number of events with them to review their plans and they have all been tasked to produce a plan and to publish it, so you should find plans available on health board websites. The key will be to make sure that they have flexible approaches that allow them to put in place capacity to meet anticipated demand. You are absolutely right that Christmas does come with monotonous predictability, as does Easter and other bank holidays, and we need to make sure that organisations are planning across the partnership as to how they will respond over those periods.

[89] The Minister has met with each of those communities—the health board and the relevant local authorities—to have a discussion about the importance of winter planning. Those meetings, which happened over the last six weeks or so and finished about three weeks ago, were to reinforce the importance of organisations working together to discuss with health communities the areas of fragility and concern in their systems. So, you will not be surprised to hear that one area that was raised quite regularly as an area of fragility was the care homes sector. So, it is very important that health boards and local authorities work together to support the care homes sector, throughout the year, but particularly perhaps in the winter period. There is a lot of commitment to working together in partnership. We have the integrated care fund, which helps, and that social care agenda. So, work is well under way to prepare for the eventualities that winter might throw at us.

[90] **Dr Goodall:** Although we have pressures all through the year, it is true to say that we always have to particularly focus on the January and the February period. That has been part of winter planning, in my own operational experience, for the last 20 years. There is always a need to focus on that, although, of course, we do have pressures spread throughout the year, in terms of demand.

[91] **Darren Millar:** Before I bring Alun Ffred in, you made reference to the fact that a number of health boards did not break even last year. The deficits that they each carried, which were around £19 million, if I recall, at the end of the financial year, they are having to recover in this accounting period, up until the end of the financial year.

[92] **Dr Goodall:** It is one of the differences with the financial plan and the three-year flexibility that we introduced—it allows a different discussion.

[93] **Mr Sollis:** It allows a different discussion. For example, Cardiff is getting £15 million of flexibility this year, but it is looking to repay the £19 million within its three-year plan.

[94] **Darren Millar:** So, it has three years to repay it.

[95] **Mr Sollis:** Yes.

[96] **Darren Millar:** So, it is likely then to have—. How do you factor in the fact that it has to find an extra £20 million over that three-year period? Is that not going to cock its plans right up?

[97] **Mr Sollis:** Sorry, that is part of its plans, in terms of returning to its population share—

[98] **Darren Millar:** So, you signed off a three-year plan on the basis that it knew that it was going to carry forward £20 million of deficit at the end of the year.

[99] **Mr Sollis:** It is how they recover towards—

[100] **Darren Millar:** No, I am sorry; I have asked you a specific question. Did you sign off a three-year plan for Cardiff and Vale, knowing that it was going to be £20 million short at the start of the financial year, as a carry-over from the previous period? In the three-year plan, which was signed off in the January before the end of the financial year, did it show that it had to repay this £20 million over the period of the plan?

[101] **Mr Sollis:** Chair, in its plans, it is showing that it is repaying over the three-year period, and it is—

[102] **Darren Millar:** So, has it changed its plans? That is what I am asking you.

[103] **Mr Sollis:** Sorry?

[104] **Darren Millar:** Has it changed its plans? Has it modified its plans?

[105] **Mr Sollis:** No.

[106] **Darren Millar:** So, it was anticipating a £20 million overspend at the end of the last financial year, and it anticipated that it would have to repay that over the three-year period.

[107] **Mr Sollis:** That is right, Chair. The assistance that it is receiving this year is £15 million, as part of that arrangement, and it then returns into surplus to repay the £19 million in year three. That is part of the flexibility arrangements.

[108] **Dr Goodall:** Given that it had been in deficit at the end of last year, we felt that that was a good sign about utilising and understanding the three-year planning approach, and wanting to convert itself from an organisation that had been in deficit, to one that had a very strong three-year plan—

[109] **Darren Millar:** The point that I am making is this: you said that it sent a strong message to health boards that you did not bail them out, as it were, at the end of the financial year, yet you signed off a plan knowing full well—and it knew full well; it gave it comfort—that you were giving it permission, effectively, to break even over that three-year period, accounting for the £20 million deficit that you were expecting it to have. That is not a strong message, is it?

[110] **Dr Goodall:** I think that it is a very strong message, to take an organisation from deficit.

[111] **Darren Millar:** How is it a strong message if you are giving it permission to spend over its limit, by £19 million, and then to recover that position over the three-year period? That is not a strong message, is it?

[112] **Dr Goodall:** I think that it is a strong message. It is in line with the financial flexibility—

[113] **Darren Millar:** How is it a strong message? You effectively gave it a blessing to exceed its expenditure limits.

[114] **Dr Goodall:** It has enforced a need for it to come out with a very clear three-year plan that enables it to manage within its total resource envelope, and to respond to its needs, on behalf of its population.

[115] **Darren Millar:** I think that many people will question the duplicity of that message, given that you effectively gave it a blessing to exceed its expenditure limits at the end of its financial year last year.

[116] We are going to move on.

[117] **Alun Ffred Jones:** Mae gen i dri chwestiwn. Mae'r cwestiwn cyntaf yn ymwneud ag arbedion. Mae'r archwiliwr, yn ei grynodeb, yn cyfeirio at arbedion wedi eu gorddatgan, ac yna mae'n dweud bod tystiolaeth bod cyrff yn dibynnu ar arbedion untro anghynaliadwy, ac addasiadau cyfrifyddu technegol, er mwyn mantoli'r gyllideb. Yn yr adran gyntaf, paragraff 24, mae graff sy'n dangos sut y mae'r arbedion wedi eu cyflawni. Mae'r rhan fwyaf yn cael eu cyflawni trwy foderneiddio'r gweithlu—beth bynnag yw hynny. Yna, yr ail arbediad mawr yw caffael a pheidio â thalu. Ers pryd y mae peidio â thalu yn rhan o raglen arbed? Y cwestiwn yw: a ydych yn derbyn sylwadau'r archwilydd bod arbedion yn cael eu gorddatgan? A wnewch chi ateb y cwestiwn: sut y mae peidio â thalu biliau yn arbedion?

Alun Ffred Jones: I have three questions. The first question is on savings. The auditor, in his summary, refers to savings that were over-estimated, and then he says that there is evidence that bodies depend on unsustainable non-recurrent savings, and technical accounting differences, to balance the budget. In the first section, paragraph 24, there is a graph, which shows how the savings have been achieved. Most are achieved through workforce modernisation, whatever that is. Then, the second major saving is procurement and not paying. Since when is not paying part of a savings programme? The question is: do you accept the auditor's comments that savings are overestimated? Will you answer the question: how is not paying bills a saving?

[118] **Mr Goodall:** We will pick up the latter issue. I think that that is just a point of clarification, because all bills are paid. I think that the language is around non-pay, and we will pick up on that in terms of the environment. However, on the overall savings and on how we focus, clearly our expectation—again, reinforced by our three-year planning approaches—is that, as much as possible, we continue to have recurrent levels of savings and are increasing that number as the years emerge. There will always, inevitably in any health system, be some in-year opportunities that occur and an ability to look at some non-recurrent level of savings. I think that it is just about trying to achieve the right kind of balance to make sure that they are handled.

[119] In terms of the estimation on savings, Martin, could you just comment on their materiality? We have seen the NHS in Wales deliver a very consistent level of savings over this last two years in particular. So, £185 million during last year was actually generated from within a system. You may want to comment on the forecasting, Martin.

[120] **Mr Sollis:** Obviously plans are developed in terms of saving plans and things change over that period, so you have to adjust the savings throughout the year in terms of arriving at a year-end position. So, in terms of the plans that are received at the start of the year, there may be reasons why those savings targets shift. However, the aim is to drive those savings targets to what was promised that would be delivered. As, I think, the auditor general's report has picked up, within £3 million of the overall savings achieved last year were what was deemed to be in plan. Individual organisations may have different elements to that in terms of how they will then recover the position.

[121] In terms of the overall aim, it must be to develop recurrent plans that identify recurrent savings that drive that into the long term and those should be identified as early as possible in terms of the start of the financial year. We should not go into year trying to identify gaps in savings plans. The recurrent focus on that is needed, but there will always be changes in-year, which I think has to be recognised, in terms of things that will come up, for

example, the cost-avoidance issues—the other targets that will always be on a non-recurrent basis. Those things are a matter of course in terms of financial management. Those are things that everybody deals with in terms of every organisation and it is about how we manage within the overall resource. Some of those can be technical advantages and some of those can be changes in provisions and other things that could occur for natural reasons, but they have to be tested out and they have to be justified. We should not focus on non-recurrent savings in terms of being a long-term measure, because we have to rely on getting the right balance to achieve sustainability in the long term. The recurrent ones are the ones that we need to focus on.

[122] **Alun Ffred Jones:** Rwy'n clywed yr hyn rydych yn ei ddweud ac, wrth gwrs, rydym yn deall bod y sefyllfa'n un anodd a bod heriau mawr a'ch bod yn gobeithio bod y cynlluniau yn rhai cynaliadwy, ond y cwestiwn sydd gennyf i yw: a ydych yn derbyn sylwadau'r archwilydd cyffredinol bod arbedion yn cael eu gorddatgan, yn enwedig rhai ar gyfer y gweithlu, a bod cyrff yn dibynnu ar arbedion untro anghynaliadwy? A ydych yn cydnabod hwnnw fel sylw teg ynteu a ydych yn ei wrthod?

Alun Ffred Jones: I hear what you are saying and, of course, we are understand that the situation is difficult and that there are major challenges and that you hope that the plans are sustainable, but my question is: do you accept the auditor general's comments that savings are overstated, particularly those for the workforce, and that there are bodies depending on unsustainable non-recurrent savings? Do you recognise that as a fair comment or do you reject it?

[123] **Mr Sollis:** In terms of manpower savings, I think that the report is quite right in identifying that we need to make our manpower planning more robust in terms of the three-year service planning. I think that, in terms of the pay bill in every year, that remains a focus and has to be a focus of the costs of any organisation, because it amounts to 64% of all costs. In terms of the pay savings that are anticipated, there will be things in terms of ensuring that any savings to staff do not have a negative impact across other parts of the plan. So, things will change through the year. Are they over-estimated? I would say that they have been over-optimistic in the past and I think that they have had to find other measures to address those issues. So, I think that the auditor general's comment is probably right. I know that we are, through the three-year planning, trying to improve the manpower planning approach. That is important because we need to get into the sustainable issue in terms of financials.

10:15

[124] **Dr Goodall:** Also, Chair, to reinforce that, what I would not want to do, however—and I think it is about bringing judgment to this—is to supress the opportunities that do exist. Sometimes, organisations are ensuring that they are stretching themselves and pushing further, not least where there see an evidence base that says that there is something that they could go to. I think that we do need to make sure that judgment is brought to it, but not to forget opportunities, as we have already outlined during the course of the committee.

[125] On a point of clarification, the graph that you referred to is procurement and non-pay. It does not mean deferring the targets; it is simply that it is the budget that is not about our workforce. It is driving our non-pay budget approaches using procurement as an enabling mechanism. We will never be in a situation of looking to defer bills, I would say.

[126] **Alun Ffred Jones:** Is non-pay not pay?

[127] **Dr Goodall:** Yes, exactly.

[128] **Alun Ffred Jones:** That is not a saving.

[129] **Dr Goodall:** Procurement is actually the approach, but it is within our non-pay budgets. [*Interruption*.] It is the contracting arrangements that we put into place—negotiating for disposable blades, for example, in Wales. It is those types of issues.

[130] **Alun Ffred Jones:** Gofynnaf fy ail gwestiwn. Mae cyfeiriad yn yr adroddiad, ac rydych wedi cyfeirio ato hefyd, er mwyn ymateb i'r heriau sy'n wynebu'r gwasanaeth iechyd, bod newid trawsffurfiannol yn hanfodol. Beth ydy newid trawsffurfiannol er mwyn inni gael esbonio i'n pobl?

Alun Ffred Jones: I will ask my second question. There is reference in the report, and you have referred to it as well, that, in order to respond to the challenges that face the health service, transformational change is essential. What is transformational change so that we can explain to our people?

[131] **Dr Goodall:** Colleagues may want to add some aspects, but I think that it is a label that is easy to use, but you need to describe it. It is about being challenging of the way that we provide our current system. On service opportunities, it is allowing us to think very differently about the range of services that are in place. It allows us to develop some of the arguments about where specialist services need to be put in place, because they can achieve an outcome, whether it is around efficiency in a system, but particularly around mortality and outcome for patients. I see the agenda around the focus on primary and community services and outlining that, not just as a strategic aim, but allowing us to show that not everybody needs to be cared for within a hospital environment. Some of the dementia care challenges that we have with the impact of a growing older population, inevitably with dementia being a bigger feature, require us to think differently about how you promote independence for people who will be struggling with those types of conditions, as they emerge, but also in their most severe forms.

[132] From a service change perspective, it is allowing us to say that it is not always about the bricks and mortar in the traditional way that we have understood health services to be provided. In my experience, over the last five years in particular, it would also be about embracing the opportunity to work differently with our public services. I have spent more of my time working closely with the police service, local government in particular and the third sector, and trying to engineer services that can really focus on citizens in that route.

[133] Thirdly, transformational change would be us asserting the prevention approach that we know is part of the NHS in terms of our focus on health and wellbeing, and allowing us to ensure that we can focus on the broader population requirement by putting in preventative schemes early, again through the NHS, but through the range of public services that are in place. They are just some examples of how I would say you would define transformational change.

[134] **Alun Ffred Jones:** Diolch. Yr unig beth yw, mae'n anodd iawn, hyd yn oed o'ch ateb chi, gwybod beth yw ystyr hynny o safbwynt y gwasanaethau yn lleol. A ydych yn derbyn bod dyletswydd ar y byrddau iechyd i drio esbonio hyn i'r bobl? Os ydw i'n ei chael yn anodd gwybod beth yn union yr ydych yn ei feddwl, sut mae posibl i bobl nad ydynt yn gwrando ar y trafodaethau hyn ddeall beth sy'n digwydd i'r gwasanaeth sydd i fod i'w gwasanaethu nhw?

Alun Ffred Jones: Thank you. The only thing is that it is very difficult, even from your answer, to know what the meaning of that is in terms of local services. Do you accept that there is a duty on the health boards to try to explain this to the people? If I find it difficult to understand what you mean, how is it possible for people who are not listening to these discussions to understand what is happening to the service that is supposed to serve them?

[135] **Dr Goodall:** Diolch. I think that it is a very fair comment, and it does need to be captured and reinforced. We would expect, in our improvement on our three-year plans, that

there is better public description of what these kinds of changes mean so that that can be shared. However, it is not about just producing a document in itself and submitting it to us and having it approved; it is actually the mechanisms through which people should be describing that more broadly within their populations, and it being part of ongoing contact. One of the dangers that we have had is that we perhaps go out for a set-piece discussion on consultation, when, sometimes, it is having an ongoing discussion on a routine basis with the community and stakeholders. In terms of our criteria for signing off the three-year plans this year, we would take the point that we need to also give a test around the public language and description that is actually used within those documents.

[136] **Alun Ffred Jones:** Diolch yn fawr. Yn olaf, a gaf gyfeirio at eich llythyr heddiw, ac at y diffygion tebygol ar ddiwedd y flwyddyn ariannol bresennol? Mae dau ffigur yn sefyll allan, sef y rhai ar gyfer byrddau iechyd Betsi Cadwaladr a Hywel Dda, fel ffigurau uchel iawn. A oes unrhyw arwyddocâd yn y ffaith bod y ddau fwrdd hynny'n gwasanaethu ardaloedd gwledig, neu ai jest cyd-ddigwyddiad ydy e?

Alun Ffred Jones: Thank you. Finally, could I refer to your letter today, and to the likely deficits at the end of the current financial year? There are two figures that stand out, that is, those of Betsi Cadwaladr and Hywel Dda health boards, as very high figures. Is there any significance to the fact that those two boards serve rural areas, or is that just a coincidence?

[137] **Mr Sollis:** I think, for the problems behind where people are, financially, there are a multitude of reasons. The nature of the set-up of services in rural areas can be a contributor to that. There are issues around the historical set-up of some of those issues. There are approaches to the way that they have made changes in the past. For example, in some areas, there have been lots of transformation of services that have taken place over many years. So, it is hard to just focus on the nature of them being rural issues. It is more around how some of that history has developed to where those organisations are in terms of their current service configuration. Our aim must be to try to redress that through the planning approach and to ensure that we have appropriate service models in place across the whole of Wales. That is the issue that we face.

[138] Through the three-year plans, we will work in the same way with all organisations to try to do that where they need to address that in terms of population share. I think that the Minister gave an undertaking to look at the very issue of the resource allocation formula and the rurality of some of those issues. So, again, we are looking at that in terms of the resource allocation share.

[139] **Dr Goodall:** We will also be looking at the mid Wales review that came out two weeks ago and making sure that that can reinforce some of our expectations for the three-year planning process too.

[140] **Alun Ffred Jones:** So, are you suggesting that the transformational programme has not actually been enacted within these boards?

[141] **Dr Goodall:** You have organisations in different places. As we tend to focus on the major service change areas that are inevitably about the future of hospitals, there is a lot of change that has been happening anyway as a good, normal approach within health boards anyway. I have certainly seen more change happening over my five years as a chief executive, in this most recent period of time, with job descriptions changing and people changing their settings at this stage.

[142] I think that you have organisations in different places. The south Wales plan required consultation that happened over and above an individual health board area, but we are seeing aspects of these changes coming in. So, in Betsi Cadwaladr health board, there are changes

that have been committed to, we have seen changes in West Wales General Hospital over this most recent period of weeks and months, putting in place some of the changes that have been consulted on for a very long time. However, we need to continue to increase the pace and I think that the auditor general made that point within his own commentary anyway, which is that we just need to make sure that this is done with further pace and urgency.

[143] Members might be aware that a report was announced yesterday, which was done by Ann Lloyd, about lessons learned from service change and configuration. One of the challenges outlined there is about how we can speed up some of these discussions, because of the resource environment that we work in, but also our responsibility to deliver safe and quality services.

[144] **Darren Millar:** The auditor general does say that it is unclear, in terms of the scale of the savings that might be achieved post transformation, but it would be helpful if you could send a note to the committee on how rurality is being catered for within any future allocation of resources. Mike is next on that issue and then I want to bring in—

[145] **Mike Hedges:** I have two very brief points on that issue. You are familiar with this document, I understand. What gets me when I look at it is that recommendation 5—

[146] **Dr Goodall:** I am sorry, but I could not see what the document was.

[147] **Mike Hedges:** It is '10 Steps Towards Future NHS Wales', a discussion paper by Professor Tony Beddow and Julian Tudor Hart. Recommendation 5 is to stop doing old work categorised by NICE as ineffective or harmful to outcomes. How much of that work is being done and what are you doing to stop it? You might want to send us a written reply to this: how much did getting rid of out-of-date medicines cost the NHS last year in Wales?

[148] **Darren Millar:** Perhaps if you could send us a note on medicines management that would be very useful.

[149] **Mike Hedges:** Yes, on the cost of actually dumping medicines that have been bought and then went out of date, because they had not been used.

[150] **Dr Goodall:** We will do a note on the latter point. On your first point, in terms of the study that was introduced by the Welsh Institute for Health and Social Care, we would agree; we are focused on that. That is part of prudent healthcare and it is one of the arms on there. I indicated that, at the moment, there are, I think, 900 interventions outlined by NICE on a UK basis that should not be used any more, even if they were seen to be clinically effective in the past. If you go into many NHS organisations across the UK, you will still see clinicians actually practising some of these. We are very good at starting new things, but what we are not often very good at is stopping some of the original practices. However, it absolutely fits.

[151] **Mike Hedges:** How many are being done currently in Wales, and how much is it costing?

[152] **Dr Goodall:** We could probably go away and review that and give you some—

[153] **Darren Millar:** If you can send us a note on how—. We have discussed prudent healthcare at some length this morning, but if you could send us some further information on how you are holding health boards to account for the delivery against that objective, that would be very helpful. I now turn to Aled Roberts; then I want to bring in Jenny.

[154] **Aled Roberts:** Mae'n rhaid imi gyfaddef fy mod yn deall fformiwla **Aled Roberts:** I have to admit that I understand the local government formula

llywodraeth leol yn llawer iawn gwell na fformiwla Townsend. A allwch chi fy atgoffa pryd gafodd y fformiwla ei sefydlu, a beth yw'r broses o ran adolygu'r fformiwla? A oes rhaid i'r byrddau iechyd unigol gytuno ar unrhyw newidiadau yn yr un modd ag y mae cynghorau lleol yn ei wneud?

much better than the Townsend formula. Can you just remind me when was the formula established, and what process is in place to review this formula? Do the individual health boards have to agree on any changes in the same way as local councils have to?

[155] **Dr Goodall:** I suggest that Martin answers on the formula, but certainly even with allocations we do try to make use, if possible, of the latest available information just to ensure that it is current and not just something that has been based in the past. Martin, do you want to just outline the Townsend approach?

[156] **Mr Sollis:** The Townsend approach goes back quite a number of years to 2002, I think, in terms of when it was actually first established. That was subject to quite a lengthy study by Professor Townsend who engaged quite a lot of people throughout the service in terms of the set-up of that service, and it was accepted by the National Assembly at that time.

[157] In terms of the current work that we are doing and the commitment that the Minister is giving, I would have to say that we will be doing that in stages. The first stage is really to update that formula and to ensure that we take on board the current issues around the changes in datasets that exist within that formula. So, for example, the Minister has given a commitment, as he did in the health and social services committee, to update the age and sex element of the dataset within that and to use the latest information that we can to try to reflect the change in the elderly population issues. In terms of the population shifts, again, updating in terms of population projections, because there has been quite an influx in terms of that; so, changing the basis around some of those population issues. So, those are really around changing the dataset issues.

[158] The more fundamental review of the resource allocation formula, in which we are talking about how we take that forward, is in the next stage, because at the moment things like the Welsh health survey are likely to change, going forward. Again, we need to keep reviewing that resource allocation formula. We have been looking at evidence across other resource allocation formulas that are used internationally and across the UK to see whether we can take any of those issues, but the consultation on the wider, more radical reform of the resource allocation formula is something that we are embarking on, and we will be looking to consult with local health boards and others on going forward. A group will be formed to do that.

[159] **Aled Roberts:** A oes rhaid i bob bwrdd iechyd gytuno? Dyna'r cwestiwn. Gallwch ymgynghori, ond os yw un yn mynd i golli arian mae'n debygol y bydd yn gwrthwynebu. Dyna brofiad llywodraeth leol.

Aled Roberts: Does every health board have to agree? That is the question. You can consult, but if one is going to lose money it is likely that it will disagree. That is the experience of local government.

[160] **Mr Sollis:** I agree. I think that one of the recommendations that this committee made—and it is similar to the recovery plans that we talked about earlier—was that you cannot destabilise services by taking wholesale changes to some of the stuff in terms of the resource allocation formula. As we have looked at updating those datasets, we have looked at making sure that we do not have those issues. When Townsend was first introduced, it was on the basis that the changes would be done through additional growth. That is what we are actually doing. So, in terms of what we are returning to in terms of the population share, where we have additional growth moneys going in, then the resource allocation should be the basis of doing that as it moves towards those issues, so that we do not destabilise services wholly by one losing and the other gaining. So, we do that over a smooth period. That is

exactly what they are doing across other sectors in the UK and in the English resource allocation formula.

[161] **Aled Roberts:** Ond, mae gwasanaethau arbenigol ar draws y gogledd yn ddibynnol iawn ar wasanaethau ar draws y ffin. Mae yna farchnad ar draws y ffin. A ydyw'r fformiwla yn cymryd i ystyriaeth y costau ychwanegol o achos nad yw'r gwasanaethau arbenigol hynny ar gael yng Nghymru? Mae'n rhaid i fwrdd iechyd Betsi Cadwaladr drafod efo byrddau iechyd neu *primary care trusts* yn Lloegr, ac mae pwysau, a hwyrach bod y costau hynny yn cynyddu yn waeth na'r costau os yw'r gwasanaeth ar gael yn uniongyrchol yng Nghymru.

Aled Roberts: But, specialist services across north Wales are very dependent on services across the border. There is a market across the border. Does the formula take into consideration the additional costs because those specialist services are not available in Wales? Betsi Cadwaladr health board has to discuss with health boards or primary care trusts in England, and there is pressure, and perhaps those costs are increasing at a worse rate than would be the case if the service was available directly in Wales.

10:30

[162] **Mr Sollis:** I shall again try to avoid the complexity in terms of the answer. The resource allocation formula actually takes into account spend levels in terms of services and specialties. Again, we call those 'programme budgets'. So, in terms of those issues, as we update the data sets in terms of our programme budget issues, it reflects how things are actually purchased and what the existing cost base is of trying to drive that agenda. So, there are elements where those issues are actually considered. Whether it is satisfactory in terms of the way, the method, currently works is something that we will look at in terms of the resource allocation formula. But, the whole basis of Townsend was that it took on those specialties and looked at the programme costing, and that is used as part of the formula in driving the service need and population need formula. It is inbuilt in terms of the way that the formula works.

[163] **Dr Goodall:** The specialised services committee is able to have an overview of the costs, both for north Wales—yes, accepting that there are patients who will go over the border to England—and, actually, for those services provided in the south of Wales. Actually, it is not always the case that it will always be more expensive to go across the border. So, we always look at the resources and the funds that are available in those terms, but it is reviewed within the specialist services committee.

[164] **Aled Roberts:** Mae gen i jest dau bwynt arall, yn fyr. Mae eich llythyr chi'n dweud bod cynnydd o ran y gorwariant ym Metsi Cadwaladr, rhwng mis 5 a mis 6—cynnydd o £27 miliwn. Os yw'r trefniadau ariannol hyn mor gadarn, sut mae bwrdd iechyd yn gallu dweud o un mis i'r nesaf fod cynnydd o £27 miliwn? Pa esboniad yr ydych chi wedi ei gael ynghylch sut yn union yr oedd cymaint o gynnydd? A yw ei ffigurau am y pum mis cyntaf yn hollol annibynadwy?

Aled Roberts: I have just two further points, briefly. Your letter states that there is an increase in the overspend at Betsi Cadwaladr, between months five and six—an increase of £27 million. If these financial arrangements are so robust, how can a health board say, from one month to the next that there is an increase of £27 million? What explanation have you had with regard to how exactly there was such an increase? Were its figures for the first five months totally unreliable?

[165] **Dr Goodall:** I will just start generally, and I will again ask Martin to pick it up. The board had reported its monthly spend position, and it was quite clear that, as it was going forward, if it was not able to get its position under control, it would end up with a higher spend. Now, our expectation in the context of its having a one-year plan was that its position

would have been recovering and that, certainly, by the time that the mid-year would have been happening, we would have seen some element of progress happening. So, I think that the board has had to make a judgment, not least in governance terms, to actually understand that there is a financial risk now that it has to actually manage and be supported to deliver towards the end of the year. It is where our escalation action came from.

[166] **Aled Roberts:** The question that I would ask is: why was it not there for the first five months?

[167] **Dr Goodall:** I think that the board had a one-year plan. It is not part of the three-year planning arrangements. Certainly, for colleagues in Welsh Government who were signing off the plans, they did not feel that the Betsi Cadwaladr organisation had a plan that could be signed off at that point in the balance of the service expectations, the quality pressures and, equally, the performance measurement generally. So, it was a one-year plan that we have been monitoring. I think that the board does need to discharge its governance at this stage. They would have signed off a one-year plan also, and we would have had an expectation. I know that, in terms of a contact with the chair of Betsi Cadwaladr and a discussion that took place with the Deputy Minister, the board would not at this stage expect that to be simply a position to the end of the year and that it will be expecting improvement itself, but the board would be expected to oversee that progress, and we do have our own financial monitoring arrangements. Martin, do you want to comment on that?

[168] **Aled Roberts:** Os ydych yn monitro mor effeithiol, sut gallwch chi ddweud yn eich llythyr nad ydych yn casglu data a gwybodaeth ynglŷn â faint mae'r bwrdd iechyd hwn yn ei wario ar ddoctoriaid dros dro a nyrsys asiantaeth? Os ydych am gael y ffigurau, mi wnaeth Betsi Cadwaladr wario £12.498 miliwn y llynedd ar ddoctoriaid. Mae wedi gwario £8.298 miliwn yn ystod y pum mis cyntaf, ac, ar nyrsys, mae wedi gwario mwy yn y pum mis cyntaf—£600,000 yn fwy—nag y gwnaeth y llynedd. Sut mae hynny'n digwydd? Sut nad ydych chi'n cwestiynu sefyllfa lle mae'r bwrdd iechyd hwn wedi bod yn gorwario ar ddoctoriaid dros dro a nyrsys dros dro am flynyddoedd a lle mae cwestiynau dwys ynglŷn â sut mae cynllunio o ran ei weithlu mor aneffeithiol?

Aled Roberts: If you are monitoring so effectively, how can you state in your letter that you are not collecting data and information in relation to how much this health board is spending on locums and agency nurses? If you want the figures, Betsi Cadwaladr spent £12.498 million last year on doctors. It has spent £8.298 million during the first five months, and, on nurses, it has spent more in the first five months—£600,000 more—than it spent last year. How does that happen? How do not question the situation in which this health board has been overspending on locums and agency nurses for years when there are serious questions in relation to how its workforce planning is so ineffective?

[169] **Dr Goodall:** First of all, we expect that the boards have that information. Martin, you might just want to comment on the availability of information, because we still have organisations that have to discharge their own responsibilities, too.

[170] **Mr Sollis:** We obviously collect quite a lot of information in terms of monitoring, so I have the global agency spend across Wales and across individual boards. That has shown, just like any other country across the UK, a growing pressure in relation to agency and locum spend. It is about how the organisation works to try to address that and to try to identify measures to address that.

[171] The point about not having the information was more around the detail around consultancy support and the individual detail behind every aspect of that. We do not go into collecting information on every support or consultancy arrangement that the organisation gets into. We have high-level spend figures, but not in terms of the detail that Betsi would have.

So, in terms of giving the information, what I can provide you is the spend detail, but not in relation to the detail. I would have to go back to Betsi to do that.

[172] **Aled Roberts:** Have any of you actually been on wards and discussed how chaotic the whole situation is, where, basically, they decide at 5 p.m. in the evening how many nurses they are going to phone up for? Is this £4 million spend all through one company in Manchester?

[173] **Darren Millar:** I think the point has been made We are going to have to move on, as there is another Member who wants to come in before we wrap this evidence session up. The point that has been made is that there is significant potential here that the committee sees for cost reduction, while maintaining levels of service and the staff complements that the board needs. It is a concern to us that we are seeing rising agency costs at a time when we would anticipate that this is one of the areas that needs to be focused upon in terms of cost reduction. What are you doing to support them to be able to achieve the maximum outcome from the focus on agency in the future?

[174] **Dr Goodall:** This is one of the areas that we will be focusing on with the intervention. Yes, we do have an expectation that locum and agency spend is reduced, that it is stabilised and that it does improve. I do think that some of this does fit with a view about some services across Wales that do feel fragile as well, in terms of the expectations on them too. We should have an expectation that locum and agency expenditure can be reduced.

[175] **Darren Millar:** So, the 12-month figure—. We will see this six-month figure for the final six months of the year reduce costs, as far as agency is concerned, compared with the first six-month period?

[176] **Dr Goodall:** It is one of the areas that we will be pressing the organisation on, and we would have expectations that that could be reduced because others have had that experience and have done that. It is also for the organisation to deliver and discharge that, and we will keep that under very close monitoring and supervision.

[177] **Darren Millar:** Okay. I think that is as far as we are going to get on that. Jenny is next.

[178] **Jenny Rathbone:** Sticking with the pay bill, which is obviously the majority of the cost, I want to question, really, following up a little bit on what Aled Roberts was saying, the adequacy of human resource management in the NHS, because the constant reliance on agency costs reflects inadequate planning for staff needs. The failure, anecdotally—this is what I have heard—is just to ensure that you have got a proper throughput of nurses and healthcare assistants who are appointed in a timely fashion. The anecdotes are that nobody ever starts recruiting, for example for maternity cover, until that person has actually left and that the whole process of recruiting is just far too ungainly, instead of appointing a bunch of nurses and healthcare assistants and saying, 'Right. You're all above board and we'll get you to start as soon as we've got a vacancy'. How do you know that your HR management across the NHS is up to speed?

[179] **Dr Goodall:** Certainly, we have expectations to take our general workforce planning approach and improve it. I would say that things have improved over the last two or three years or so, but I think we need to see more improvement over the next two or three years. It will be the three-year plans, I think, that focus that attention. It is this blend of ensuring that we do not just take quality on its own merit, or the finance or the performance; it is making sure that the workforce is part of that situation as well.

[180] On your point on recruitment generally, there is the opportunity to take more flexible

approaches and make some judgments, because we generally know what our turnover is within organisations. We know which professional groups to approach. If you do not mind me just reverting to put on my more operational hat as a chief executive, but, for last winter in Aneurin Bevan, we recruited an additional group of nursing staff to give us flexibility for opening beds as necessary during the winter period, and then they converted to be part of our ward-based nursing from April, in terms of the recruitment that was going to be necessary at that time. So, it is possible to take some active approaches.

[181] I think some of what we are experiencing at the moment still reflects, actually, what is happening in the general recruitment market. There are clearly difficulties being experienced. Again, it is a UK-wide issue, not just with junior doctors and medical staff recruitment in general terms, but we are actually seeing nurse recruitment being a factor and an issue. I think that you are finding the NHS generally across the UK looking at its staffing levels on wards and looking to enhance those generally. I think that we are perhaps slightly out of step with it. But you are also right to challenge some of the routine recruitment approaches we take. If a member of staff is on a one-month contract that means that they can leave within four weeks or so, having a process that can take you beyond four weeks means that, clearly, you are going to be left with a gap at that time. We have expectations through our workforce directors, but also through our nurse directors, that a far more active approach should be being taken to these because we have large organisations represented in Wales and they should be able to work through some of the turnover and the vacancies that are created.

[182] **Jenny Rathbone:** Yes. Our processes are just not fit for purpose in terms of what any normal business would expect. The other issue I would like to raise is around the disciplinary procedures where somebody is suspended and the length of time it takes to either get them reinstated because it was a false allegation or to show them the door. That represents neither justice nor cost-effectiveness. What are we doing to speed that up?

[183] **Dr Goodall:** We have a disciplinary policy. It is signed off. It is a regular point of discussion between Welsh Government, employees and the unions as well. We do need to make sure that people can appropriately return to work as necessary. There are also approaches that can be taken under the disciplinary policy to allow other duties to be undertaken sometimes, depending on the context. I think that we always have to balance the responsibility between the individual as an employee and the employer making sure that safe services can be delivered at this stage. However, through workforce directors in Wales, we are focusing on making sure that that can be dealt with speedily and quickly. However, I know of examples in Wales where that has gone beyond what I would accept as being reasonable limits at this stage, and we need to use those as examples to ensure that we return it. I am happy to outline, if it helps, Chair, a note, working with workforce directors in Wales, on their approaches to disciplinary policies and how we speed up that process. In our current environment, we also have a duty to make sure that we are acting if concerns are raised, whether it involves individual staff or teams or services. Sometimes, I think that it is the balance that causes us the difficulty on that rather than the policy itself.

[184] **Jenny Rathbone:** You need to act, but it should not need to take two years. So, I look forward to your note. The other area where I think potential savings should be made is around the unnecessary length of stay in hospital long after medical care has been completed. I recently visited a ward for elderly patients in Cardiff and the Vale, and they are still not getting social workers involved until the doctors say, ‘This person is ready to go home’, and this is absolutely ridiculous. We know that it is best practice to start preparing the discharge procedures on day 1 of somebody arriving at the hospital. As you are head of both health and social services, what are you going to do about that?

[185] **Dr Goodall:** We focused on this very specific issue as part of the winter planning arrangements and, over this last 12 months, I would say that that has felt different in terms of

allowing Ministers outside of health equally to hold both the health service and local government to account for the plans that they are putting together. We monitor across Wales through the individual health boards the long-stay patients, where they are staying beyond their time. I agree with your point. I think that discharge starts on admission; that is when the process starts. Some of the success of the intermediate care fund has been about putting in these joint teams at the moment, but we have to have an expectation that it works right across the system rather than just in these individual areas of good practice at this moment. I think that there is more that we can still do about the extended lengths of stay at the moment, and we will continue to focus on that. We would expect that to be a feature within the three-year plans. However, more integrated teams are certainly needed, and we will be looking forward to being able to feed back on some of the evaluation around the intermediate care funds as well at some point.

[186] **Jenny Rathbone:** Well, this feels like groundhog day. We have known for years and years that this is the way of ensuring that people do not stay in hospital longer than they need to and that, when they do stay in hospital for longer than they need to, they become less able to live independently.

[187] **Dr Goodall:** I think that your point is exactly right and I would not dispute it. I think that your point is right that the system must need to improve. Obviously, we are having to make sure that that happens in the context of the increasing demand that is happening as well, so it has not just been a static position. However, I would have the same expectations as you—that people target those lengths of stay and put in place effective integrated teams.

[188] **Jenny Rathbone:** So that social workers are employed from day 1.

[189] **Dr Goodall:** Yes, and social workers should be part of that, whether they are employed in the NHS part of the system or the social services side or, actually, hopefully just simply within integrated teams. That is part of our solution, yes.

[190] **Jenny Rathbone:** Okay.

[191] **Darren Millar:** I am afraid that the clock has beaten us. We are very grateful for your evidence this morning. You will receive a copy of the transcript of proceedings and a note from the clerks on the information you promised to forward to the committee for our consideration. Thank you, Andrew Goodall, Simon Dean and Martin Sollis for your attendance.

10:45

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

[192] **Darren Millar:** I move that

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

[193] Does any Member object? I can see that there are no objections, so we will move swiftly into private session.

Derbyniwyd y cynnig.

Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:45.
The public part of the meeting ended at 10:45.