Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 18 Mawrth 2014
Tuesday, 18 March 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

David Sissling	Cyfarwyddwr Cyffredinol, Iechyd a Gwasanaethau Cymdeithasol/ Prif Weithredwr, GIG Cymru, Llywodraeth Cymru Director General, Health and Social Services/ Chief Executive NHS Wales, Welsh Government
Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

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

Fay Buckle	Clerc Clerk
Claire Griffiths	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

Dechreuodd y cyfarfod am 09:04.
The meeting began at 09:04.

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Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **Darren Millar:** Good morning and welcome to today's meeting of the Public Accounts Committee. I would remind all Members and Mr Sissling that the National Assembly for Wales is a bilingual institution and, obviously, people can contribute to the proceedings of this meeting through either Welsh or English as they see fit. I encourage Members and everybody else in the room to turn off their mobile phones and other electronic equipment as, of course, it can interfere with the broadcasting and other equipment. The final housekeeping notice is in respect of an emergency: if there is an emergency just follow the instructions of the ushers. We have received one apology today, from Mohammad Ashgar,

and I am very pleased to be able to welcome William Graham to the committee in his place today.

09:05

Papurau i'w Nodi
Papers to Note

[2] **Darren Millar:** We have a number of papers to note, most notably the covering teachers' absence paper, which is a letter from Owen Evans in respect of the informal analysis work that is being done on the Master's in educational practice. In relation to the senior management pay inquiry, we have a letter from the Auditor General for Wales giving us some commentary or reconciliation information on the Welsh Local Government Association's evidence. We also have a letter from the Permanent Secretary in respect of our correspondence on grants management in Wales, which we had with him regarding the code of practice for the third sector, grants monitoring and the levels of qualification in local authority grants. I will take it that those papers are noted.

09:06

Sesiwn Ymadawol: Cyfarwyddwr Cyffredinol, Iechyd, Gwasanaethau Cymdeithasol a Phlant, Llywodraeth Cymru
Valedictory Session: Director General, Health, Social Services and Children, Welsh Government

[3] **Darren Millar:** Members will be aware that Mr Sissling has announced his departure from NHS Wales. I am sure that all of us would want to take this opportunity to thank David Sissling for his service to the NHS and the public sector in Wales. He will be popping over the border to work in NHS England and I am sure that we wish him all the very best for his future and thank him for the way that he has contributed over the years, while in post, to various inquiries that this committee has undertaken.

[4] As Members will be aware, this is the first valedictory session of its kind. It is hoped that we will have these opportunities for valedictory sessions in the future with other directors general when they leave post in Wales. We have an open question session with you, Mr Sissling, but perhaps you would first of all just wish to give us some comments on a media report this morning in respect of a leaked report on Healthcare Inspectorate Wales, which the Health and Social Care Committee is intending to publish towards the end of this week. It would obviously be inappropriate for comments to come from members of this committee, but do you want to put on record a response in your capacity as the chief executive of NHS Wales?

[5] **Mr Sissling:** First, may I preface any comments that I will make by thanking you for the opportunity to come to talk with you today? I am looking forward to it. You will notice that I have fewer papers than I normally have, because I could have come with a pile. So, apologies in advance if my in-depth knowledge is slightly less than it has sometimes been in previous attendances at this committee, which I must say I have always found very helpful and constructive. I am looking forward to the next hour and a quarter. In response to the specific request, I am not really in a position to comment on a leaked document. I know nothing about the document, so I will wait to read it with huge interest on Friday, I believe, when it is due for publication.

[6] **Darren Millar:** Thank you for that, Mr Sissling. I will start the questions off before I invite Members to contribute. Can you tell us what you think your key achievements have

been over the last few years while you have been in post in NHS Wales and what you think the challenges are, going forward, for the health service?

[7] **Mr Sissling:** Thank you for that question. I will try to keep it balanced. I will try to give the committee a very honest appraisal of both the achievements and those areas that I think are still in the 'challenge to be addressed' box. The first thing that I would draw attention to is the progress that we have made in legislation, which I think is of enormous significance. When I took up this post three years ago, I think that we were at a very early stage in developing, certainly within health and social services, as a department that could take forward complex, significant pieces of legislation. If we just look at what we have achieved in terms of the Human Transplantation (Wales) Act 2013, Food Hygiene Rating (Wales) Act 2013 and the National Health Service Finance (Wales) Act 2014, they have all been passed and approved by the Assembly. I think that, just today, attention is being given to the Social Services and Well-being (Wales) Bill and there are more Bills in the pipeline, for example, a public health Bill, and further legislation that is due. I think that that is an enormous achievement and I know that it is one that has received an awful lot of attention and has been high profile. Legislation is the first thing that I would draw attention to.

[8] The second thing, over the last three years, it that we have seen the NHS system begin to realise itself. The decision to establish a system that is based on planning and integration, and to move away from the previous system, which had much more of a market emphasis, with more transaction and a separation between commissioning and provision, I think, has been shown to be a wise course of action. The system has shown that it can focus on enabling new models of care, on population health, on prevention and better partnerships. There may be an opportunity to discuss more of that over the course of the next hour or so.

[9] I would also draw attention to the progress that we are making in terms of integration. I have always felt that if our system is not enabling integration between different parts of health, which traditionally have been separate—primary, community and secondary care—and social services, we would be not succeeding. I think that we are making progress. There is still more to be done. However, at one point, we talked about the Gwent frailty project as perhaps the only example, and now we can talk about examples that all health boards have developed. The challenge is now less about pioneering and more about wide-scale comprehensive adoption of these particular examples of good practice.

[10] I have attended this committee before to talk about unscheduled care, and I think that it is fair to say that, like other parts of the UK, in 2012-13 we experienced some significant challenges. I think that it is to the credit of the system as a whole—and it was a whole-system response—that we mobilised a different way of approaching unscheduled care, characterised and distinguished by good clinical leadership, good partnerships, particularly in terms of social care, good planning, good clinical engagement and good escalation and intervention, all in the context of a clearly defined ministerial priority, and the results this year have been significantly better; we have seen improvements in all areas.

[11] There are a couple of other areas to mention before I move on to the areas of concern. First, I think that the three-year planning system that we have introduced will prove to be an enormously strong legacy. The NHS in Wales will only work effectively if there is strong planning, and we have developed a three-year planning system that I think is robust. It is challenging and it sets the bar high, as it should do, but it is one that will bear dividends. Some of the difficulties that we have experienced will now be properly addressed through plans that put together the right combination of not only money, but service development, the workforce and all the other enabling elements, and that will stand us in very good stead for the future.

[12] I will just mention a couple of final things. There has been an enormous degree of

progress in terms of developing our quality and safety systems—necessarily so. The world of the NHS is clearly one that has had to reflect and respond, not only to the Francis report on the Mid Staffordshire NHS Foundation Trust, but to a general awareness of the need to develop robust, resilient systems in terms of quality and safety, and I think that we have made significant progress there. There are still some areas that need further development, but in terms of where we were and where we are, I think that it is in a much improved position.

[13] The final issue that I want to raise is in terms of service change. There has been progress in terms of service change—not without its difficulties, clearly. Much of the very significant service change has happened when planned locally, characterised by good engagement and good communication. Much of it has been to enact changes from within non-hospital settings or to move services from hospital settings, and we are also clearly making some progress in the hospital sector. So, that is just a flavour of some of the things where we have made progress.

[14] There are some issues that I would still categorise as being 'maybe of concern'. One relates to what I said about integration. It is still a matter of frustration that good practice in the NHS is not always adopted as quickly as we would want throughout the service. On this issue of making the local national, the piloted general, and this in-built, the fact that at times it feels disinclination to do that is a huge source of frustration. If we could only adopt, not all of it, but 50% of the proven good practice throughout the NHS, we would make a better place. Why reinvent the wheel when it has already been demonstrably not just invented, but there has been the first turn of the wheel?

[15] While I say that the system is working, there are areas that we need to develop further. I believe that we need to see more emphasis on, and the more centralised influence of, primary care in the future. I still think at times that the system tends to be dominated through a perspective that is through the lens of the hospital.

09:15

[16] The emphasis that is now being placed on developing primary care, not just on general practice—although that is clearly significant—but the whole network of primary care will be critical for the future. The increasing emphasis that we will place on prevention and population health will also be critical; we have made progress, but there is more to do. Clearly, that will require and test our partnerships with local authorities, the third sector and, to an extent, a new relationship with the public.

[17] Another area where I think that there is either work in progress or more to be done is on some of our information technology systems. Much of the enablement of some of the new models of care, particularly those linking different parts of health and health and social services, rely on IT systems that enable that. I suspect that we will see the benefits of moving away from the big, massive set-piece five-year programmes to something that is much more nimble, knitting together existing systems, so that they can communicate with one another.

[18] I think that there is more work to be done in some areas with some of our boards, in the light of the very wise recommendations that came out of the work between HIW and the Wales Audit Office and your report on Betsi Cadwaladr University Local Health Board, to make sure that our boards, as the central governing bodies of our planning and delivery systems, are able to discharge that role as effectively as we want them to. I think that most of them are doing so and are developing, but I still think that there is some work to be done to enable that in one or two areas.

[19] There are two further things. One is in terms of planned care, to make sure that we adopt the rigorous approach to planned care that we adopted for unscheduled care. I am very

pleased that the Minister announced an investment in diagnostics to remove the long waits. I hope that the improvements that we are currently seeing in planned care will continue and be driven forward, but we need to adopt an approach that is not simply more of the same, more of the traditional; we need to be thoughtful in terms of how we look at planned care and the best ways in which we can align resources with effective care.

[20] I suppose that I must mention the financial environment—a sustained period of austerity. I feel that it would be an omission not to say that that will bring its own challenges for the future. Of course, there will need to be a continuing focus on efficiency and the elimination of waste, but the approach signalled by the Minister—the notion of prudent healthcare, to make sure that we are deploying resources in a way that is aligned with good clinical practice—is the right way forward, I am sure.

[21] I will pause there, but I hope that that gives you a flavour.

[22] **Darren Millar:** You touched on finances at the end of your contribution. Thank you very much for giving us such a wide overview of the picture within NHS Wales. You touched on the financial environment, which has been very tough. During your tenure, it has seen the largest real-term reductions in health spending ever in Wales, which presents a huge challenge at a time of rising demand. Part of the response to that has been the introduction of the NHS Finance (Wales) Act and you welcomed, as did this committee, the opportunities that that presents in terms of the three-year planning system and cycle for NHS finances. Very soon, we will start the new financial year. Can you tell us how many health boards have their three-year plans in place and have they all now been approved by the Welsh Government?

[23] **Mr Sissling:** By way of background, I think that it is important to explain the rigour with which we have approached the three-year planning process. It would have been very easy just to do what we had done before and to say, 'This is just a development of one-year plans; let us have three one-year plans'. However, it has been very significantly different. Work started some significant months ago and culminated in the development of plans by each of the health boards and trusts in January. They were subject to very rigorous road testing by Welsh Government that allowed us to look at all the integral parts, be it workforce, finance, quality, performance or IT aspects, to make sure that they were not only appropriate in their own rights, but that they knitted together. We want an integrated plan, not a series of chapters that do not talk to one another.

[24] We also pursued two approaches to quality assurance. First, we worked through a very intensive session with the Wales Audit Office and Healthcare Inspectorate Wales to make sure that our assessment of the plans accorded with their views and we felt that it did. We also got some external assurance from the Good Governance Institute. It took us through a process of testing these plans from its perspective to make sure that they fitted together well in the context of good governance. So, the plans have been put through a fairly rigorous process, which I think is right—we need to make sure that these plans are the basis on which we have confidence in the future.

[25] The current position does not quite allow me to answer your question, but I can give you some important and, I think, helpful background in terms of where we are. The position that we have reached is that we are looking at all the plans, and there will be some that we will be able to—and have been able to—approve, and say that they tick all the boxes, or that there are some small amendments that need to be made to allow them to do so; three-year plans, which have the right characteristics, in the way that I described earlier. There are some plans that need a little bit more than that. So, we are giving the health boards, or the trusts, in question an opportunity—very quickly—to address those identified areas of development, and that would put us in a position, where, in the very near future, within the next month or two, we will be able to sign them off.

[26] So, that will be a further iteration of the plans, because we want to get as many as possible to a point of approval. However, if we are unable to do that, then we are going to give them a little bit more time to get them over the line. There will be some small number of plans, potentially, where we feel that the work that they have done does not allow us to sign off the three-year plans, and we think that it would be wrong to do so and to do anything other than to say that they need to focus on a one-year perspective to make sure that they have a solid plan for this coming year and should spend some further time developing a three-year plan. That is a process that is currently in play, and the outcomes of it, I think, will be subject to a ministerial announcement in the not-too-distant future.

[27] **Darren Millar:** So, some health boards will be working to a one-year plan, rather than a three-year plan.

[28] **Mr Sissling:** Yes, they will be.

[29] **Darren Millar:** There will be some that will not get their three-year plans signed off until a few months into the three-year process.

[30] **Mr Sissling:** Oh, no, not a few months—a few weeks, probably, rather than a few months. It is important—we cannot allow things to drift into the year with any degree of uncertainty. So they need to make sure that there is clarity about what is happening in April, May, and June. However, if there is some further work to make sure that we are clear about what is happening in 2015, 2016 and 2017, equally, I think that it is right to do that, because these are plans that are close to getting over the line, but what we do not want to do is to lower the bar, and just say, 'We will get you over the line, because it is convenient to do so'. This is really significant work.

[31] **Darren Millar:** I have a number of Members want to come in. Alun Ffred is first, and then I will go to Sandy.

[32] **Alun Ffred Jones:** A gaf i fynd â chi yn ôl at un peth a ddywedoch chi yn gynharach ynglŷn â rhwystredigaeth o ran yr anhawster ynghylch rhannu arfer da—

Alun Ffred Jones: May I refer you back to one of the points that you made earlier about frustration regarding the difficulties of sharing good practice—

[33] **Darren Millar:** It is channel 1. Are you getting the translation now?

[34] **Mr Sissling:** Yes. My apologies.

[35] **Alun Ffred Jones:** I fynd â chi yn ôl at un peth a ddywedoch chi yn gynharach ynglŷn â rhannu arfer da, a'r anhawster o ran gwneud hynny, pwy sydd ddim yn fodlon rhannu arfer da—byrddau iechyd, yr arbenigwyr, meddygon teulu, neu bwy?

Alun Ffred Jones: To take you back to something that you said earlier regarding sharing good practice, and the difficulties related to doing that, who is not willing to share good practice—the health boards, the experts, GPs, or who?

[36] **Mr Sissling:** I do not think that it would be right to say any one part of the system; it would be wrong to say that there is a sort of ingrained resistance. In fact, in many cases, there is an enthusiasm to accept and share best practice, so perhaps I have portrayed it in a particularly dark light. I will just say that it is a matter of frustration at times that good practice does not get adopted as quickly as it might. At times, it can be at an organisational level, or it can be at an institutional level, or even within professional groups. So, one of the tasks at the moment is to make sure that we promote best practice in the right way and share best practice within peer groups and that we identify the benefits of doing so. However, I said

it as something that I think a lot of people comment on—at times the frustration, the slowness, or the degree of disinclination to adopt best practice.

[37] **Darren Millar:** Sandy is next.

[38] **Sandy Mewies:** Thank you, Chair. May I give you my personal good wishes for the future? I think that you have been very helpful to this committee, in the past, in the way that you have handled some quite intense questioning.

[39] You just gave us a very useful overview, I think, of what is, and what could be, happening. I am going to ask you some questions about that. Just talking about integration, you have talked about the need for more of an emphasis on primary healthcare, rather than acute care in hospitals. Of course, that does need the co-operation of the medical professions, but it also needs the co-operation of local authorities within social services, for example, with extra care provision, which will be vital, I think, for the future. So, my first question is—I have a couple: do you have any sight of what is happening on a Wales-wide basis with co-operation between local authorities, because they do have a big part to play in primary care, and, looking to the future, do you see any difficulties within this, with the Williams commission report that has just come out? That was my first question.

[40] You have talked about preventive health medicine. We have had evidence about preventive issues in the health service itself, such as flu injections, for example. They are at a pretty low level. It is 20:20 vision, looking back, is it not? Is there any way that you can see that that can be improved in the near future, again on a Wales-wide basis?

[41] In terms of data collection, we have heard many times in different ways about the way that data are collected. It is not useful. Data are not collected in a useful fashion. Again and again you hear it. It does not matter whether there is a pilot scheme going on in a hospital accident and emergency department or whether it is within health boards themselves; a lot of what they are doing is not useful and data are not comparable. Do you see some improvement in that for the future? In terms of monitoring, one of the things that we had coming out of the Betsi Cadwaladr University Local Health Board inquiry was reflection on how some of the governance issues that had come up there could be reflected back to other health boards and be helpful to them in the future. However, my question is more specific: are you happy with the monitoring now that is going on following that inquiry? There have been new appointments to chair and vice chair. I think that the chief executive post is imminent, or was last week. I think that it is imminent. Are you happy that there are now monitoring procedures in place for that board, specifically, to see that the issues that came out of the report will be continuously monitored?

[42] **Darren Millar:** May I suggest that you let Mr Sissling—

[43] **Sandy Mewies:** That was the last one, actually.

[44] **Darren Millar:** Okay. I am sure that he is relieved. Mr Sissling.

[45] **Mr Sissling:** The first question, I think, was about the relationship with local authorities. I have been struck by the extent to which relationships—and not relationships in anything other than a meaningful way; good, proper working relationships—have improved over the past 12 months. There is some commonality of objective in the way that we are working with local authorities. Unscheduled care, I think, has been a very good example of that, but there have also been new models of care, preventive care, and reablement models of care, which I think have been very impressive, and they need to characterise the future. At the moment, I have not seen any instances where the impacts—the specific question asked about the Paul Williams review—have in any way affected that. People are focusing on the needs of

the patient, the public, the citizen. That seems to be the continuing point of emphasis. So, that is my observation at the moment.

[46] In terms of preventive healthcare, there are a number of things—it is almost a subject matter in its own right—about the base on which Wales, as a country, can mobilise and engage with the public in terms of lifestyle and in terms of all of the lifestyle behaviours that we know can have a profound impact on health. That plays into all of the things about smoking, eating habits and exercise. So, there is an enormous amount that needs to happen to build on all of the good work that is currently happening.

[47] You asked specifically about flu vaccinations, where we had some improvements, but probably not sufficient. Efforts will be redoubled in future years. I think that there is a link there with some of the things about primary care. To get that grounded and driven out of primary care, rather than a more centralised national message, would, I think, have much more impact. In my experience, things have much more impact if they have at least a degree of momentum from the local rather than the national perspective. People tend to associate with the local to a very significant extent.

09:30

[48] On data collection, to an extent, I would agree. There is always more that we could do, should do and will do. A refresh of the information strategy is going to take place. I think it is very important. At the moment, we probably have too many points of data collection and manipulation, and there needs to be more of a single portal through which that can be managed so that we are clear about the specification aspects and the way that data are used. 'Data' sounds like a very dry word, but data are critical because they provide information, enlightenment and action. In the absence of good data, we are unable to take the action we need. So, that is a point of clear emphasis for the future.

[49] On the final questions about Betsi Cadwaladr, I would just like to confirm that, yes, the interview for the chief executive is this Friday. We are hopeful and confident of a good outcome to that, with an appointment of a director of finance to follow shortly thereafter. So, it is an organisation that now has a new chair, a vice chair, and that will be reshaping its executive team. It has been subject to very close monitoring over recent months. There have been weekly discussions between me and the chief executive and other interactions to make sure that we are in a position to support, as appropriate, the health board. I suspect that that will continue for some time, until we are in a position where we believe that the health board is in a different position where it can work with the right degree of autonomous self-direction—and it is 'we' in a collective sense, because all those who are involved in the processes of oversight and supervision, including the Wales Audit Office and Healthcare Inspectorate Wales, need to be satisfied of that.

[50] **Sandy Mewies:** When you say 'suspect', do you mean 'will'? When you say that you suspect that that will go on in future, do you mean that it will go on?

[51] **Mr Sissling:** It will do. For example, the successful appointment of a chief executive on Friday will not mean that, on Monday, monitoring will finish. It will need some time to prove itself. I would like, if I were still here, to be personally assured from the perspective of the Wales Audit Office and HIW and others that this is now an organisation that is in a position where we can perhaps de-escalate the degree of attention we are paying to it. I think that that is an entirely appropriate process. There was a process of escalation and a heightened grip on the organisation, and there will be a point where it needs to be able to manage its affairs in a much more conventional way.

[52] **Sandy Mewies:** Thank you, Chair.

[53] **Darren Millar:** Mike is next and then we will come to Aled.

[54] **Mike Hedges:** I have two questions on health delivery and one on finance. I will ask the two health delivery questions first. As Mr Sissling will know, for more than 10 years now we have had the hub-and-spoke model for renal services in west Wales based in Morriston Hospital. Why has that type of service not been expanded into other areas? Secondly, we talk about A&accident and emergency departments as though they are all the same. Mr Sissling knows as well as I do that, if anyone has a serious accident anywhere in west Wales, the first place they get taken to is not one of the accident and emergency hospitals in west Wales, but Morriston Hospital, and quite often by helicopter. Why do we not start getting the message across that not all A&E departments are the same and that not all hospitals are the same? Perhaps then we might be able to reconfigure without people being so committed to keeping something that, in the event of their being seriously hurt, they would not want to go to anyway?

[55] **Mr Sissling:** I have two points on that. First, the hub-and-spoke model is one that has been proven. It provides a basis on which healthcare services can be appropriately networked with some centres of regional specialist expertise, supporting and supported by those providing services more locally. It is a model that I think will become more prevalent in future, and it is supported where it is appropriate to do so. It is not right for every service. It is right for renal services and perhaps for other services. I think we should never say that the hub-and-spoke model is right for all services, because that could take us into a formulaic approach and every service needs to be treated on its merits. The hub-and-spoke model in west Wales and rural mid Wales is different from what it might mean in the Valleys or urban areas. So, we need to adjust and refine different models of care to meet the population and make sure that it is right for the population, and as always, make sure that we rely on good clinical advice and engage with the public.

[56] On the comments that you make about A&E services in west Wales, I just want to make it clear that all of the hospitals in west Wales provide a very important service and manage very seriously poorly people, and will continue to do so. I just want to make sure that that is clear. The trauma services at Morriston, and equally in Cardiff, are distinctive and necessarily respond to the needs of patients who have had very serious injuries, in particular at times that need helicopter transport, but not always. That is a model that I would agree we need to emphasise more and explain why there is a differential response to differential clinical need, because that is in the interests of the patient. We know that outcomes and, at its starkest, survival rates are improved if patients who have the most serious trauma or multiple trauma go to areas that have the right combination of clinical service—diagnostic and treatment services—and swift intervention.

[57] **Mike Hedges:** On finance, health expenditure in Wales has increased by 56% over the last 10 years. The percentage of the Welsh budget being spent on health the year after next will be 4% higher than it was 10 years ago—it will be up to around 44%. Is there a limit on what percentage of the Welsh budget can be spent on health? At our current rate of progress, some time around 2030, it hits 50% and somewhere around 2150-60, it reaches 100%. That is not sustainable. Do you have a view on what is a reasonable percentage of the Welsh budget to be spent on health?

[58] **Mr Sissling:** No. I do not, to be quite honest. I would not have a view on a figure and, ultimately, some of the decisions that are implied in your question would be for Ministers to take, clearly. However, I suppose that how I would respond, in a sense, just accepting the thrust of your question, is to say that it does, I am sure, prompt a need to think about quite fundamental issues about how healthcare and care is planned and delivered. In a way, what you have suggested is an extrapolation—pre-existing trends go up—so there needs

to be a way to disturb those trends. That is where I think that the Minister's emphasis on prudent healthcare is quite a significant change in the way that we plan and consider healthcare, and is welcome and important. So, I suppose that that would be my answer. I cannot give you a precise figure of x%, but I do understand the thrust of the question and what it means in terms of planning across Welsh Government, in a sense. It needs to be done in a very clear and thoughtful way.

[59] **Darren Millar:** I suppose that the same problem is faced by all western nations, is it not? It happens as the demographic ages, in some respects.

[60] **Aled Roberts:** Wrth i'r Llywodraeth drosglwyddo mwy o gyfrifoldebau ariannol i lawr i fyrddau iechyd, rwy'n meddwl bod nifer ohonom, fel Aelodau, wedi synnu. Er enghraifft, pan oeddem yn ymchwilio i Betsi Cadwaladr, nid oedd gan y bwrdd, bump neu chwe mis i mewn i'r flwyddyn ariannol, gyllideb gadarn wedi ei chytuno. Mae'n ofynnol ar lywodraeth leol i gael cyllideb gadarn ar gyfer dyddiad penodol ym mhob blwyddyn. Felly, o ystyried yr hyn a ddywedoch ynglŷn â chytuno cynlluniau ariannol y byrddau iechyd, a ydych yn meddwl ei bod yn amser i'r Llywodraeth symud i gyfundrefn lle mae gan bob bwrdd iechyd gyllideb gadarn wedi'i chytuno â'r Llywodraeth ar gyfer y tair blynedd? Rwy'n derbyn nad yw hynny'n bosibl ym mhob achos eleni, ond mae pryderon gennym o hyd ynglŷn â pha mor gadarn yw rheolaeth ariannol o fewn y gwasanaeth iechyd.

Aled Roberts: As the Government transfers more financial powers to health boards, I think that a number of us, as Members, have been surprised. For example, when we were looking into Betsi Cadwaladr, five or six months into the financial year, the board had no firmly agreed budget. It is a requirement on local authorities to have agreed a firm budget by a set date every year. So, given what you said about agreeing financial plans in health boards, do you think that it is time now for the Government to move to a system where every health board has a solid, robust budget that has been agreed with the Government for three years? I accept that that is not possible in every case this year, but we still have concerns about how robust financial management is within the health service.

[61] **Mr Sissling:** I would completely agree. That is what the three-year plans have been predicated on. We have been absolutely insistent that there are clearly agreed budgets and that those budgets—. In a way, again, this committee has been very helpful, because we have been reminded of the need to make sure that budgets do not just sit at the high superficial level and that they are signed up within all constituent parts at the points of delivery and that £1 billion organisations are in clinical service management areas and that the budgets, therefore, have traction and are approved at all appropriate levels in the organisation. So, that is one basis on which they are being signed off: that they have fully robust, resilient budgets that we can see and that we are approving. That is done through the boards in order to ensure that we do not diminish the boards' responsibility to own and deliver on those budgets. So, I could not agree more and that will be the very clear basis on which we approve these plans.

[62] **Aled Roberts:** Wrth fynd ymlaen, a fydd pob bwrdd iechyd yn gwybod, erbyn dyddiad arbennig, y bydd yn rhaid iddynt ddod i gytundeb efo'r Llywodraeth? Rwy'n derbyn yr hyn rydych yn ei ddweud, mai dyma'r hyn rydym yn symud tuag ato, ond yn amlwg, eleni, mae rhai byrddau iechyd nad ydynt wedi eich darbwyllo chi bod y cynlluniau hynny'n gadarn.

Aled Roberts: In moving forward, will every health board know that, by a certain date, they will have to reach agreement with the Government? I accept what you have said, that this is what we are moving towards, but, obviously, there are some health boards that have not convinced you that these plans are robust.

[63] **Mr Sissling:** I am sorry, I would just like to confirm that no health board will be

without a budget. In some cases, there will be a three-year budget that we have agreed and, in other cases, it will be a one-year budget. We have said that, if they cannot get over the line in terms of the three-year budget, it does not mean that they will not have a budget. They will then need to focus on the one-year budget, and that needs to be as rock solid as we would want it to be.

[64] One thing I should say is that planning over a three-year budget in the context of the kind of change we all know is necessary is quite a complex task. This is not simply an extrapolation exercise. We want to see some of these shifts of care into primary care, a focus on prevention, and some of these big high-policy areas that are drilled down into very specific articulations in terms, for example, of what that means in terms of the workforce. That is, what will this mean in terms of the number of community nurses and district nurses needed, and what this means in terms of the medical workforce. We are looking at granular detail in terms of, over three years, how a health board can show that it has not just got the hang of the policy and vision stuff, but that it can demonstrate that it can deploy that vision and understanding into the lines of a budget that show as much in July 2017 as in April 2014 that it has a trajectory of improvement. We do not want it to get fuzzier and fuzzier as we go into the third year, as that is not a three-year plan; it is a one-year plan with a bit of ambition behind it. So, it has to be as precise about month 36 as month three. That is why we are setting the bar high. We are looking at it in great detail. We want to look at individual lines relating to the workforce, we want to see how the capital knits in with the revenue, and we want to make sure that this is a plan that will be resilient to the test of time. If it cannot persuade us of that, we will have a one-year budget. So, there will be no organisation without a budget. That is where we are now.

[65] **Aled Roberts:** Symudaf ymlaen at drefniadau llywodraethu. Rydych yn dweud bod trefniadau mwy cadarn, gobeithio, yn eu lle yn awr ar gyfer y byrddau iechyd, ond pan gafwyd adolygiad dan Edwina Hart, pan oedd hi'n Weinidog dros iechyd, roedd llawer iawn o sylw yn cael ei roi i newid y trefniadau llywodraethu canolog. Rwy'n bryderus iawn ynglŷn â rhai o'r trefniadau gyda'r *Welsh Health Specialised Services Committee*, lle mae dal gwasanaethau sy'n cael eu rheoli'n ganolog. Mae'r Pwyllgor Plant, Pobl Ifanc ac Addysg wedi dechrau ymchwiliad i wasanaethau iechyd meddwl plant, lle mae llawer iawn o'r cyfrifoldebau yn eistedd yn ganolog. A allwch esbonio pam nad yw rhai o'r newidiadau o ran llywodraethu'n ganolog wedi cael eu gweithredu? Beth yn union yw'r strwythur, wrth gofio bod cryn dipyn o feirniadaeth ynglŷn â'r byrddau iechyd? Fodd bynnag, mae'n rhaid bod beirniadaeth ar y gwasanaeth iechyd yng Nghymru a'r math o reolaeth sydd wedi cael ei weithredu gan y rhai yn y canol ar weithredu gan y byrddau iechyd.

Aled Roberts: I will move on to discuss governance arrangements. You have said that there are, hopefully, more robust arrangements in place now for the health boards, but when a review was undertaken under Edwina Hart, when she was the Minster for health, a lot of attention was paid to changing the governance arrangements centrally. I am very concerned about some of the arrangements relating to the Welsh Health Specialised Services Committee, where there are still services that are managed centrally. The Children, Young People and Education Committee has begun an inquiry into mental health services for children, where many responsibilities sit centrally. Could you explain why some of the changes to central governance have not been implemented? What exactly is the structure, given that there has been considerable criticism of the health boards? However, there has to be criticism of the health service in Wales and the kind of management undertaken centrally with regard to the work of the health boards.

[66] **Mr Sissling:** I would like to make one point that will, hopefully, offer reassurance, namely that the planning process that has been described previously to the committee today applies equally to the Welsh Health Specialised Services Committee. So, that is not

something that is left outside; it is subject to the same rigour.

[67] **Aled Roberts:** It is very difficult to get information regarding being reassured on that rigour.

[68] **Mr Sissling:** I understand that. I just wanted to make the point that we are not neglecting to focus on what is clearly a very important part of the overall operation, which constitutes not just, as it is, hundreds of millions of pounds of spend, but equally the care of some of those people who need the most specialised care. So, it is on the radar—I suppose that is what I am saying—which it needs to be.

09:45

[69] In terms of governance, the committee is constituted by each of the health boards, which are represented at chief executive level. It has a chair and two non-executive members, and it meets within the context of a governance structure, which is settled by virtue of delegated authority from each of the health boards. It is hosted within Cwm Taf health board, and it conducts the business of planning, commissioning, securing and monitoring the relevant services. One of the issues that became a matter of clear ministerial concern was the extent to which that body could properly discharge its responsibilities in terms of ambulance services, hence the decision he took to set up a separate commissioning entity that could focus specifically, without any distraction, on the needs of the Welsh ambulance service. This is something that is subject to attention, as is the whole area of specialised services, and will continue to need to be so for some of the reasons that you have described.

[70] We, as Welsh Government, through the health boards, monitor its performance. For example, this afternoon, when I am meeting with the chief executives of the health boards in our regular monthly meetings, it is one of the areas that will be discussed, both in terms of the development of the ambulance commissioning arrangements and, moreover, the more general arrangements to commission plans and secure specialised services.

[71] **Aled Roberts:** Mae'r dystiolaeth i'r pwyllgor plant o ran y gwasanaeth iechyd meddwl ar gyfer plant a phobl ifanc, sy'n rhan o gyfrifoldebau'r gwasanaeth hwn, yn eithaf brawychus.

Aled Roberts: The evidence that we have had in the children's committee on mental health services for children and young people, which is part of the responsibilities of this service, is quite frightening.

[72] **Mr Sissling:** I am not familiar with that evidence. I would be keen to understand more about that so that I can take appropriate action.

[73] **Jenny Rathbone:** Going back to governance of health boards, which is a crucial part of improving health services, how can you convince us that we now have health boards that really are fit for purpose? Betsi Cadwaladr was a terrible experience—otherwise successful people really did not seem to understand what their duties and responsibilities were. I am particularly interested in how we are going to give primary care a bigger voice on health boards. It is well known that, where you have a powerful teaching hospital, it is extremely difficult to liberate the money into primary care. How are we going to get boards strong enough to face down the powerful consultants in the teaching hospital?

[74] **Mr Sissling:** First, to locate my answer in actions rather than just general generalities, the Betsi Cadwaladr reports by HIW and WAO, plus your own committee report, led me to seek reassurance from every health board, formally at chair level, through discussions around the board table, to ensure that they were satisfying every recommendation. All the recommendations made were in terms of the governance management of board meetings about the board secretary, and so on and so forth. Everything was subject to very detailed and

formal responses from every health board.

[75] A particular and separate area of interest to me was the matter of board training. It is fine to state the expectation of good, but the training and development of boards, as we know, is absolutely critical so that they have the skills, capabilities, competence, culture and relationships. They were also asked to commit to some mandatory training programmes and some that were bespoke to their own particular needs. Those plans are being enacted. The assurances that I was given are subject to monitoring. We are also working in an environment where there are other intelligent perspectives on boards. The Wales Audit Office's structured assessment is relevant in providing us with an understanding of the governance arrangements and effectiveness of the boards. The Wales Audit Office, Health Inspectorate Wales and ourselves have been working on the escalation and support framework, which is just about reaching its final stages. It will provide a much more systemic clarified arrangement by which we can share intelligence, pool our information and draw conclusions about health boards in terms of them as governance entities and the services that they provide. So, we are strengthening the systems.

[76] Looking at this from the other end, we are also clearly focusing on information that gives us more reassurance about the quality of the services that they provide. That is the other side. Governance has to be in the context of the purpose of the organisation and its high-quality services meeting ministerial and Government policies. We are looking at it from both sides and we have strengthened the systems. There was very specific and focused attention given to the Betsi Cadwaladr arrangements—which I am sure that this committee would have wanted there to be—in terms of us seeking assurance and holding the organisation to account. We also want to be in a position where our health boards can, to a significant extent, be self-governing and not subject to perpetual and intrusive insight. Our oversight should be one that is based on assumption of capability and competence, hence why it is important that they train and develop as boards to allow them to discharge their functions effectively.

[77] On the issue of primary care—I was talking about ticking the boxes of the three-year plans—one of the boxes that had to be ticked was that there was a demonstration with the plans, not just of aspirational rhetoric in terms of primary care, but a demonstration of what that meant in terms of shifts in activity and a plan to make that happen. There was a particular focus on the development of locality networks, which would become increasingly empowered, which would have budgets and that would have proper responsibility management support, where GPs and others in primary and community care could be much more empowered to plan and deliver services. This is an integral part. At times, we need the architecture within the structure to make sure that the policy can be taken forward. That is part of the approval process, so that it does not perpetuate a hospital-based model. Clearly, as well, as we know, to reinforce it, we have to look at the incentives and the levers. The 2014-15 GP contract is one that emphasises that. It enables and encourages GPs to work in clusters and to work together as networks. It pays particular attention to some of the care delivery models—pathways of care, unscheduled care and end-of-life care—which we know are critical. The liberation of some of the contract from the quality and outcomes framework, and releasing some of the points that were locked into that, to allow much more of a relationship based on trust and professional contributions, will reinforce that.

[78] **Jenny Rathbone:** Okay, that is excellent. The very specific recommendation of Williams was that there should be smaller health boards, but that the cabinet member for social services, or at least a cabinet member for social services, should be on the board—ex officio, if you like—plus the director of social services. Is that something that you think would be helpful, or do you think that there is already sufficient communication with these people?

[79] **Mr Sissling:** The success that I indicated earlier of joint working between health

boards and local authorities has, to an extent, been a reflection of who sits round the board table of health boards. To a greater extent, I would argue that it is about relationships that have been worked hard at between the local authorities and the health boards at leader level, as well as with chairs, chief executives, chief executive officers of health boards and appropriate cabinet members. There has been, I think, an awful lot of discussion to forge the right kind of relationships and to crystallise those in some joint plans for the future. I am probably not in a position to comment on the Williams recommendation at the moment. I can understand the need, but I think that the main thing is that there is a growing sense that solutions are best shared, rather than being, in some way, a matter of separation. So, I have been really encouraged by what I have seen between local authorities.

[80] **Jenny Rathbone:** I want to go back to Alun Ffred's question about how we make good practice travel. I wonder how much health boards have established bottom-up approaches with their staff, to ensure that they are involved in reshaping services to better meet the needs of patients.

[81] **Mr Sissling:** I think the answer is 'To a variable extent', and by that I mean probably not enough. You have hit a really good point that there is a danger that we see everything from the Welsh Government downwards. It is about, in a way, inverting that and seeing the massive potential of a different relationship with staff, who we know are the experts and who we know have an enormous sense of value, motivation and drive. Liberating that energy, enthusiasm and wisdom is a real task. It does happen and it needs to happen more. It is part of an organisational development approach that will need to be accelerated throughout the Welsh NHS, and, I suspect, public services more generally. I think that it is a really vital point that the answer is, of course, around the board table, but it is also, as we speak, on the ward, in the clinic, in the community team and in the general practice. We need to make sure that colleagues there have the encouragement, space, permissions and the support to innovate and to change things. An awful lot of small changes can contribute much more than our search for the big change—the big eureka moment that can change things. In many ways, it is the thousand small changes that make the profound and enduring difference.

[82] **Jenny Rathbone:** Finally, we did some specific work, which was published at the beginning of last year, on maternity services, and much of that was around the failure of health boards to fill vacancies, and instead leaking money to agencies. Do you think that that problem has been resolved, because it was one that seemed to have been going on for years and years? Do you also think that we have the right approach to skill mix, because the patient does not always need someone who is super-qualified to do the simplest task?

[83] **Mr Sissling:** One bit of preparation that I did for this meeting, because I suspected that it would be a matter of inquiry, was to look at the staffing numbers. Between April 2013 and December 2013, the overall numbers of full-time equivalents increased by 265, the majority of which were nursing staff. So, our staffing numbers are increasing. It might seem small, but it is significant that they are increasing rather than decreasing, and it is in the right areas, is it not? It is nursing staffing in particular. That is partly a reflection of the ministerial announcement of £10 million to increase nurse staffing levels in medical and surgical wards.

[84] Some of our health boards are currently seeking to recruit more nurses, and they are finding it, to varying degrees, difficult and they are waiting for new releases of student nurses from colleges. They will continue to increase nursing staff numbers in the short term to avoid the very requirement to use agency staff. So, are we moving in the right direction? Yes. Are we there? No, but the trends are encouraging. At a time of financial austerity, there is a huge temptation to do the opposite, which is to bear down. That would be wrong, because ultimately we know that the staffing numbers on a ward in our hospitals in communities need to be determined by the needs of the patients, rather than by a financial parameter.

[85] **Jenny Rathbone:** What about the skill mix?

[86] **Mr Sissling:** At times, we are preoccupied with staffing numbers rather than talking about staffing roles and contributions. I am not an expert to talk about the skill mix, but alongside the staffing numbers, we need to accept the need for more flexibility between areas of staff, in looking, for example, at one of the defining challenges of the NHS, which is caring for an increasingly elderly population. Some of their needs are medical/clinical. Many of the needs for that group can be non-medical/clinical and can require a different form of interaction support, which is more continuous and much more accessible at home or in the community. In a sense, we need to avoid a situation where the construct of our workforce almost creates a centrifugal pull into our institutions. We need to be much more able to see a community-based workforce, which may not be one that is characterised by specialised or sub-specialised skills, but one that has much more flexibility. So, this whole issue of reshaping the workforce to meet the health needs of a population that is changing, and which we know is going to become predominantly elderly and have particular health needs, as well as thinking about the trauma issues—the big trauma centres—means that we need to keep all of these different areas under close attention.

[87] **Darren Millar:** Julie Morgan is next.

[88] **Julie Morgan:** Good morning. I think that you gave a very good overview at the beginning of all the developments. I have a general question. Looking back at your time here, is there something that you could say that you feel most proud about achieving during your period?

[89] **Mr Sissling:** I do not think that there is one particular thing. To an extent, looking at all the things I mentioned. The job, the role and the NHS are so complex, and there are so many moving parts, that I think that it is difficult to focus on one thing. Just keeping everything moving forward is in itself a task. Even with those issues that cause frustration or concern, you want to feel that there is work in progress, or that there are things that provide a solution, if not actually settled solutions, job done. The thing that I will look back on is just the job of keeping things moving forward, to be quite honest, rather than one specific thing.

10:00

[90] **Julie Morgan:** Do you have any regrets? Do you wish that you had done something differently, or that you had handled something in a different way?

[91] **Mr Sissling:** There are probably a thousand things, to be quite honest. I am serious. The job is such that, almost on a daily basis, there are important decisions that you have to make. I think that the job is also such that you have to take decisions and, to an extent, you have to make the decisions work well. So, there is no single big regret. There are things that, with all the benefit of hindsight, you could think that you would do differently, but I do not think that that is the true test. The test is whether, at any point in time, you took decisions that were right in the circumstances that existed. However, I would not say that there was one massive regret that I would have that meant that, given my time again, I would do something incredibly different.

[92] **Julie Morgan:** Thank you. The responses are as I would have anticipated. I was going to say that it is very good that you said that quality and safety in the NHS have improved a lot. I wondered whether you could tell us a bit more about the response to the Francis review, and also, perhaps, touch on the issue about the English director of the NHS, and the letter that he wrote to the Minister.

[93] **Mr Sissling:** This is not just a response to the Francis review. Part of it is also our

own approach to quality and safety. Clearly, that has had a very significant impact. I think that I would want to describe it both in terms of the board level responsibilities and our national assurance and improvement system. The board is critical in this, and your work has emphasised and underlined the extent to which boards' local responsibility is absolutely critical, and that intrudes down to local points of delivery. However efficient the systems are that I or others have in Cathays park or other points, they cannot substitute for good, local, strong governance and engagement locally. So, it is about health boards adopting appropriate standards; monitoring the right data and the right information regularly to assure themselves that delivery is occurring; taking action where there is variation or when there is any evidence that services are not being delivered to the right standards; seeking external advice where it is appropriate to do so; being open to the external, outside voice; auditing; engaging with clinicians; and engaging increasingly with service users, because the voice of the patient needs to be one of our guides or our lights in this.

[94] For example, one of the things that I think is particularly important, which is being taken forward locally, but which has some national context, is the case note review for mortalities, which all health boards are doing. So, within the context of that, all deaths in hospitals are reviewed. There is a two-stage review. The first one is conducted by a clinician who will undertake a review against some core questions, and who, if there is cause for any concern, will escalate that to stage 2, where there could be a multidisciplinary detailed review. The goal is to get 100%. We are approaching that. Some organisations are doing 100% and others are in the high 80s and 90s. That is very important. It goes beyond and almost tilts the whole thing on its head in terms of mortality. One number for a hospital, one number for a health board: every death is reviewed. It is really important. That is the way that you get real insight into the quality of care, and, of course, you take action in the light of any understanding. So, that is the local side of things. The national system that is developed has an element of quality improvement. The 1000 Lives Campaign, I think, is acknowledged as a very impressive endeavour that has improved quality in particular areas. One of the important things that it is doing now—and this reflects a question asked earlier—is to mobilise our workforce. We now have over 6,000 staff who have been trained in quality improvement technology, so this is not the experts—. This is disseminating expertise among our staff. We want 6,000 to become 10,000 to become 20,000, all of them active practitioners in quality improvement. It has to be distributed and disseminated, but I think that that kind of development is unique in the UK.

[95] Our assurance systems are, I think, strengthened, but there will always be areas where we can strengthen them further, but they range from the monitoring that we do nationally of serious untoward incidents, of ombudsman reports, of any service reviews of the work of Health Inspectorate Wales to the structured assessments of the Wales Audit Office or any reports that the Wales Audit Office does on particular areas. We obviously monitor mortality. We have some of our tier 1 delivery areas being clearly founded on quality. Hospital infections, for example, are a tier 1 measure, as is dignity and compassion, to make sure that we have adopted and pursued the recommendations that the Commissioner for Older People in Wales gave in her report. Where necessary, we intervene. Intervention can be through internal review or by external review, as, for example, happened in Hywel Dda—we got an external review in to look at its cardiac services—and in Betsi Cadwaladr, where we got Public Health Wales to undertake a review.

[96] Other areas are openness and transparency, which I think are critical, and the development and continuing development of My Local Health Service and annual quality statements. What all that means, I think, is that there is some degree of grip. The detection rate of problems is, I think, high. That can feel discomforting at times, because we are detecting problems—at times, long-standing problems—but we are right to do so and we should continue to shine a fierce light onto the system on matters of quality and safety. We will continue to do so.

[97] **Julie Morgan:** So, the systems are in place to ensure that there is quality and safety.

[98] **Mr Sissling:** Absolutely. The systems cannot guarantee quality to the level that we would want at all times, but they should guarantee that any issues are detected and that there is immediate response. That is the real test: are we able to detect the problems that occur and take appropriate, proportionate and responsive action?

[99] **Julie Morgan:** In the—

[100] **Mr Sissling:** It has to be—. I am sorry. The main thing is that the ingredients or the inputs have to be varied, in the way that was recommended by the transparency and mortality taskforce. It cannot be one single indicator. There are a number of indicators that, together—it is this thing about turning information into intelligence—allow us to assure ourselves that quality and safety are in the right place or, if they are not, will give us the insight into where we need to take action. Much of that relates to individual services, rather than consolidated figures, and would relate to individual areas of care rather than higher level health board figures.

[101] **Julie Morgan:** Where you have had to take action, that has arisen as a result of the systems showing the problems.

[102] **Mr Sissling:** I think so. We should always be open to challenge on this, because that is a healthy position to be in. However, there is increasing evidence, where problems have arisen, of proportionate action. In some cases, that can be very immediate and local—in most cases, it would be and should be—but in other cases, we might need to invite the royal college of whatever to come in, or we might need to get an independent, external review of particular issues. That would be difficult to be too prescriptive about, because each individual case needs to merit its own response.

[103] **Julie Morgan:** What about Sir Bruce Keogh's letter? Do you have any comments on that?

[104] **Mr Sissling:** I think that the Minister has responded to that quite clearly.

[105] **Julie Morgan:** Okay, that is fine. Thank you.

[106] **Darren Millar:** I call on William Graham.

[107] **William Graham:** Thank you, Chair. Could I just ask you for an overview on how you think that the NHS in Wales coped with winter pressures, particularly in terms of any cancelled or postponed operations and the results of that?

[108] **Mr Sissling:** I think that I mentioned in my opening remarks that we saw improvement—which we have seen—and the extent to which that was due to excellent planning is large. That is what I would attribute it to. What happened was that planning started at the right time, which was spring, rather than autumn. The Minister made it very clear that he wanted to see very robust, well-worked-through plans that were road-tested and properly resourced. So, that started with winter plans starting to be produced in May, which were subject to peer review and review by the Welsh Government and others. We also took action to make sure that we had the right quality of clinical leadership, so I appointed a clinical lead, Dr Grant Robinson, who I know has appeared before this committee and has, I hope, provided assurance of the right kind of clinical leadership.

[109] An enormous amount of attention was paid to the development of our relationship

with social care, because we know that this unscheduled care is, of course, importantly focused on A&E departments, but in terms of the real challenge to get the flow through the hospital and avoid delayed discharges it is absolutely critical to develop the right understandings and work processes. So, we have work focused on flow, capacity, leadership and information. It is a really good example of how we have developed an information system that is in real time. I have on my desk, and I showed it to the auditor general recently, a screen that can show me, at any point in time, the escalation status of any hospital, the number of ambulances waiting, how long they have been waiting for, the number of patients waiting and the degree of problem that the ambulances are having in offloading. This is real-time information; not information from a week post the event, but in real time. That is enormously important to manage the pressures and to do it in a collaborative manner, because at times the pressures require some system response rather than organisational response.

[110] The other thing, to be quite honest, is that we have made this a clear priority and there has been a level of performance and leadership attention to it. So, there are daily phone calls, once or twice a day, with every health board to get intelligence. I have a weekly phone call with all the chief executives, the chief nursing officer, the Welsh Government's director of social services and Grant Robinson, so that I can assure myself and we can assure ourselves that appropriate action is taking place and that footnotes and a discussion on sharing good practice on a real-time basis are also happening. The results, I think, are impressive. We have seen a 36% reduction in long waits in A&E departments, a 32% reduction in some of the cancelled operations and improvements in delayed transfers of care, which I think are at a 10-year low. I think that it is something of that order. The area that has not quite had the same improvement is some of the ambulance performance. There has been some improvement in terms of handovers, but it has been fairly flat lining in terms of the eight-minute response rate. So, I think this is an example of where we saw an issue, got hold of it and really devoted the management energy to produce improvement.

[111] **William Graham:** So, you are confident that the national unscheduled care board is working well and will continue to improve.

[112] **Mr Sissling:** Yes, continuing to improve is the—

[113] **Darren Millar:** I am sorry to interrupt, but I am conscious of the time. We have a couple of minutes left, so if you could be brief in your response.

[114] **Mr Sissling:** Absolutely. It will continue to improve. That is the emphasis.

[115] **Darren Millar:** Okay, thank you. I know that two people want to come back in. So, I call Ffred and then Aled, very quickly, and then I am going to ask one final question.

[116] **Alun Ffred Jones:** A gaf i ofyn dau gwestiwn? Mae'n arfer, ers 10 mlynedd a mwy, i'r Llywodraeth drosglwyddo swm o arian i'r byrddau iechyd i wneud iawn am ddiffyg cyllidol neu orwario. Ydy hwn yn arfer da? Ydy hwn yn dangos diffyg yn y cyllido neu ddiffyg rheolaeth ariannol?

Alun Ffred Jones: May I ask two questions? For 10 years and more it has been practice for the Government to transfer a sum of money to the health boards to compensate for budget deficits or over-spending. Is that good practice? Does that show a shortcoming in budgeting or financial management?

[117] **Mr Sissling:** It is difficult to generalise in terms of the circumstances in which money has been made available to the health boards over a 10-year period. The most satisfactory situation is where the resources made available to the health boards at the beginning of the year are sufficient, clearly, for them to meet all appropriate quality, safety and performance issues during the course of the year. There have been occasions when we have had to respond to particular issues, be it the year before this one in terms of unscheduled care pressures or

this year, when there was the ministerial decision to look in particular at some of the quality Francis issues, which led to a decision to make further resources available. I think the point that I would make is that the position we are reaching is one where the Minister, Mark Drakeford, will be taking a very careful look at the end of this year at the merits and individual circumstances of each health board's position as they end the year, and take decisions on the extent to which there should be a bespoke approach to those that may not involve the provision of additional funding.

[118] **Alun Ffred Jones:** A gaf i ofyn—

Alun Ffred Jones: May I ask—

[119] **Darren Millar:** Very briefly.

[120] **Alun Ffred Jones:** Mae'n gwestiwn cwbl wahanol. Un o wendidau'r gwasanaeth yw diffyg gweithlu dwyieithog o ran gofal henoed, seiciatryddion a seicolegwyr ac ym maes gofal plant. Faint o sylw sydd wedi cael ei roi i ddatblygu gweithlu dwyieithog yn ystod y cyfnod diwethaf hwn?

Alun Ffred Jones: It is a completely different question. One of the weaknesses of the service is the lack of a bilingual workforce in terms of care for elderly people, psychiatrists and psychologists and in the field of childcare. How much attention has been given to the development of a bilingual workforce in this recent period?

10:15

[121] **Mr Sissling:** There is an increasing level of attention to that. The Deputy Minister has taken a particularly leading role in this, both in terms of health and social care. We are building on good practice and have identified good practice in all health boards. All health boards have a designated lead with emphasis on training and development of the workforce to make sure that we can develop a bilingual workforce that can meet the needs of patients and users of the service. So, there is an increasing level of emphasis on this.

[122] **Darren Millar:** Be very brief, Aled.

[123] **Aled Roberts:** Yn dilyn yr ymchwiliad i mewn i Betsi, roedd rhai ohonom yn siomedig nad oedd adolygiad Hurst ac adroddiad Allegra wedi cael eu rhannu yn fewnol. A ydych chi fel Llywodraeth wedi newid eich canllawiau i fyrddau iechyd ynglŷn â rhannu canfyddiadau clinigol allanol neu fewnol—roeddech yn sôn am rhai mewnol hefyd—fel nad yw hynny yn digwydd eto?

Aled Roberts: Following the inquiry into Betsi, some of us were disappointed that the Hurst review and the Allegra report were not shared internally. Have you as a Government changed your guidance to the health boards in terms of sharing external clinical findings or internal ones—you mentioned some internal ones as well—so that that does not happen again?

[124] **Mr Sissling:** The guidance has been clarified. It is presumed that there was guidance that prevented that happening, and the simple answer is that it should have happened. I think we said at the time that such reports should have been distributed and disseminated widely and that there would be the very clear expectation that any reports are shared widely within the organisation, and in an appropriate way with other organisations that might equally have an interest in the recommendations that could be made. So, the emphasis has to be on openness. There is a very clear expectation to make sure that any report is shared widely.

[125] **Aled Roberts:** O ran y gwasanaeth ambiwlans, mae trefniadau ariannol newydd i fod mewn lle erbyn cychwyn y flwyddyn ariannol. Yn dilyn beth ddywedoch ynglŷn

Aled Roberts: In terms of the ambulance service, new financial arrangements are supposed to be in place for the start of the financial year. Following on from what you

â'r cynlluniau ariannol, a ydych yn fodlon y bydd y trefniadau hynny ar waith o 1 Ebrill?	said about the financial planning, are you satisfied that those arrangements will be in place from 1 April?

[126] **Mr Sissling:** Yes, I think that they will be. The work to develop the new commissioning arrangements is quite well advanced. Again, today, I will be talking to health boards to reassure myself that, on 1 April, the ambulance service is very clear about the financial resources made available to it. To an extent, that has occurred already. There have been one or two cases, as I am sure you are aware, where it has been in-year rather than pre-year, so this year, the arrangements that are being made are being clarified in this month rather than in future months, as has to be the case.

[127] **Darren Millar:** Okay. Thank you very much indeed for that. The clock has beaten us. There were some questions that I wanted to ask you on mental health services, but perhaps you can send us a little note just in terms of where you think the landscape is for those. I will ask you one final question, Mr Sissling. The roles of chief executive and director general have been split in other parts of the UK. Here, the roles are very much cemented together, in you, at present. Have there ever been any times of conflict between those roles that you have been aware of, or tensions?

[128] **Mr Sissling:** I think, at times, that there is a productive tension. The benefits of doing the two roles—and perhaps it is wrong to describe them as two roles because, in many ways, it more often than not feels like one single role—I think far outweigh any disadvantages. Having worked in systems where they are separated, I think that bringing them together into a single set of responsibilities is right. It allows ministerial decisions to be conveyed and transmitted into the service very quickly and for there to be appropriate communication from the service into ministerial offices. It ensures that Welsh Government and the NHS are integrated. It ensures that the Welsh Government workforce is grounded in the needs of a public service that is focused on delivery, so you get the right balance between policy and delivery. It also allows me, as chief executive of the NHS, to be very cognisant of my additional responsibilities as director general, which extend into social care and things like substance misuse and the Children and Family Court and Advisory Support Service, for example. So, the director general role is broad and the NHS role is broad in itself, but slightly narrower. However, I think that on the whole, if asked, I would strongly recommend the two remain coalesced.

[129] **Darren Millar:** Okay. On that final note, David Sissling, thank you very much for your attendance today. We are very grateful to you for making your time available to us and we wish you, sincerely, all the very best for the future.

[130] **Mr Sissling:** Thank you very much.

10:20

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

[131] **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(vi).

[132] Are there any objections? I can see that there are no objections, so we will move into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:20.
The public part of the meeting ended at 10:20.