Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

The Health, Social Care and Sport Committee

03/11/2016

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The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included. Where contributors have supplied corrections to their evidence, these are noted in the transcript.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Rhun ap Iorwerth Bywgraffiad|Biography	Plaid Cymru The Party of Wales
Dawn Bowden Bywgraffiad|Biography	Llafur Labour
Jayne Bryant Bywgraffiad|Biography	Llafur Labour
Angela Burns Bywgraffiad|Biography	Ceidwadwyr Cymreig Welsh Conservatives
Caroline Jones Bywgraffiad|Biography	UKIP Cymru UKIP Wales
Dai Lloyd Bywgraffiad|Biography	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)
Julie Morgan Bywgraffiad|Biography	Llafur Labour
Lynne Neagle Bywgraffiad|Biography	Llafur Labour

Eraill yn bresennol
Others in attendance

Alan Brace	Cyfarwyddwr Cyllid Director of Finance
Rebecca Evans	Aelod Cynulliad, Llafur, Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol Assembly Member, Labour, the Minister for Social Services and Public Health
Vaughan Gething	Aelod Cynulliad, Llafur, Ysgrifennydd Cabinet dros Iechyd, Llesiant a Chwaraeon Assembly Member, Labour, Cabinet Secretary for Health, Well-being and Sport

Dr Andrew Goodall	Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol / Prif Weithredwr GIG Cymru Director General, Health and Social Services/Chief Executive NHS Wales
Albert Heaney	Cyfarwyddwr Gwasanaethau Cymdeithasol ac Integreiddio Director of Social Services and Integration

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

Sarah Beasley	Clerc Clerk
Zoe Kelland	Dirprwy Glerc Deputy Clerk
Dr Paul Worthington	Y Gwasanaeth Ymchwil Research Service

Dechreuodd rhan gyhoeddus y cyfarfod am 11:30.
The public part of the meeting began at 11:30.

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

[1] **Dai Lloyd:** Croeso i chi i gyd i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. A gaf i groesawu fy nghyd-Aelodau yn ôl? Geiriau cyffredinol i ddechrau: a allaf i estyn croeso i bawb ac fe wnawn ni fanylu ynglŷn â'n holl westeion nawr yn y foment? A allaf i egluro hefyd fod y cyfarfod yma'n ddwyieithog? Gellir defnyddio clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1 neu i glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2. A allaf i atgoffa pobl

Dai Lloyd: Welcome to you all to the latest meeting of the Health, Social Care and Sport Committee here at the Assembly. Could I welcome my fellow Members back? Just a general introduction: I'd like to welcome you all and we'll go into detail about all of the guests in a minute. This is a bilingual meeting. You can use the headphones on channel 1 for interpretation or amplification on channel 2. Please switch off your mobile phones and any other electronic equipment that could interfere with the broadcasting

i ddiffodd eu ffonau symudol ac unrhyw offer electronig arall a allai ymyrryd â'r offer darlledu? Nid ydym yn disgwyl tân y bore yma na larwm tân, felly os ydym yn clywed larwm tân, dilyn cyfarwyddiadau'r tywyswyr a fyddai'n dda, ac fe wnawn ni eu dilyn nhw heb ddim elfen o banig.

equipment. We don't expect any kind of fire this morning, or a fire alarm alarm, so if we do hear a fire alarm, please follow the instructions of the ushers, and we'll follow the guides without any kind of panic.

11:31

Craffu ar Gyllideb Ddrafft Llywodraeth Cymru ar gyfer 2017-18
Scrutiny of the Welsh Government Draft Budget 2017-18

[2] **Dai Lloyd:** Felly, gyda'r rhagymadrodd yna, fe wnawn ni droi at eitem 3, a chraffu ar gyllideb ddrafft Llywodraeth Cymru ar gyfer 2017-18. Rydym wedi gweld y papurau gerbron. A gaf i groesawu'r tystion? Yn gyntaf, Vaughan Gething, Aelod Cynulliad ac Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon—bore da—a hefyd Rebecca Evans AC, Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol, yn ogystal ag Alan Brace, Andrew Goodall ac Albert Heaney. Croeso a bore da i chi i gyd.

Dai Lloyd: So, without any further ado, we'll turn to item 3, scrutiny of the Welsh Government draft budget for 2017-18. We have had the papers that have been submitted. Could I welcome the witnesses? First, Vaughan Gething, Cabinet Secretary for Health, Well-being and Sport—good morning—also Rebecca Evans AM, Minister for Social Services and Public Health, as well as Alan Brace, Andrew Goodall and Albert Heaney. Welcome to you all.

[3] Gyda'ch caniatâd, ac fel sy'n draddodiadol nawr, fe awn ni'n syth i mewn i gwestiynu yn lle unrhyw gyflwyniadau. Hefyd, fel sy'n draddodiadol, fe wnaf i ofyn y cwestiwn cyntaf. Ynglŷn â chyflawni cydbwysedd ariannol yn y gwasanaeth iechyd gogyfer â'r flwyddyn 2016-17, pa mor hyderus ydy Llywodraeth Cymru y bydd byrddau iechyd lleol yn cyflawni

With your permission, and as is traditional now, we'll go straight into questions rather than any introductions. Also, as is traditional, I'll ask the first question. Regarding achieving financial balance within the NHS for 2016-17, how confident is Welsh Government that local health boards will achieve financial balance and how is it intending to address immediate financial issues facing a

cydbwysedd ariannol a sut y bwriedir mynd i'r afael â'r problemau ariannol presennol sy'n wynebu nifer o fyrddau iechyd lleol? Rwy'n ymwybodol, yn naturiol, o beth sydd wedi cael ei gyhoeddi'r bore yma, ond efallai y byddwch chi eisiau amlinellu hynny hefyd. Felly, Vaughan.

number of these local health boards? I am aware of what has been announced this morning, and perhaps you will want to outline a little bit about that as well. So, Vaughan.

[4] **The Cabinet Secretary for Health, Well-being and Sport (Vaughan Gething)**: Thank you, Chair. I'm happy to start on this subject and differentiate between the system as a whole and the challenges that we know individual health boards are facing. This should give people some confidence about the system as a whole: last year the system was in balance as a whole and we lived within our means within the whole budget. The challenge, though, is different in different parts of the system. There's recognition of that both from last year and from the decisions we've taken around planning and the decisions we've taken around targeted intervention on the budgetary challenge.

[5] There are two organisations that we don't think there's any prospect that they will come in on budget, and that's not a secret. That's why we made the announcement today that we'll hold money centrally for Betsi Cadwaladr and Hywel Dda in particular. The challenge there is about not just supporting those organisations for this year and into next year, but about the support that we continue to provide to try and get them into balance in the future, so that this isn't a continual exercise for the rest of this term but, at some point in this term, that we see a turnaround that means they can work within balance. So, there's something about improvement there, which is important. There's also something about recognising if there's a particular context that needs a different sort of recognition.

[6] If you recall—whilst I know you weren't in this place last term around, I know that you've had a close eye on everything that happens within the health world—we had a conversation with Powys about trying to recognise their ability to run the services and whether there was a broader problem. We worked with them, we recognised part of the challenge that they had and we also recognised that part of the challenge was in their own hands. They're now an organisation in balance. So, this is achievable, and that's the point about the conversation that we should have with each organisation about

where it is.

[7] There are pressures in other health boards too, but we think those pressures should be eminently manageable. That's our expectation across the system. We expect that the announcements that we've made throughout the budget process, and the additional announcements today about reserves, should allow us to be in a system where, at the end of the year, we do expect the whole system to balance. But we do recognise that those two organisations in particular have challenges that are unlikely to be met. That's why we're holding an extra reserve against those two organisations.

[8] **Dai Lloyd**: Diolch yn fawr. Bydd yna nifer helaeth o gwestiynau y bore yma a fydd yn mynd i mewn i fanylder, wrth gwrs, wrth inni fynd ymlaen. Mae'r cwestiwn nesaf oddi wrth Julie Morgan.

Dai Lloyd: Thank you very much. There will be a number of questions this morning that will go into detail, of course, as we go on. The next question is from Julie Morgan.

[9] **Julie Morgan**: Thank you very much, Chair. Could you give us your views on how successful you think the planning system is, now that you've got the three-year planning, and how has that worked out?

[10] **Vaughan Gething**: Perhaps if I start and then I think it would be useful to hear from Andrew as well about the system perspective in looking backwards as well as forwards. We introduced this to look at planning overall in an integrated way and finance is part of that, so we've seen a range of organisations that have lived within their means, that have met their duties, and it's been a much more sensible way of planning, both in an integrated way but in financial planning too, so we've gone away a fairly difficult and perhaps not a helpful way of rushing to the end of year to try and meet targets. I don't think that sensible decisions were made and I'm actually pleased that the Assembly as a whole, across all parties, recognised we needed a different approach.

[11] But in doing that, we do honestly recognise that planning is a moving target—it's about understanding your health need but equally about understanding the growing and developing maturity within the system, and that's at different points and different parts of the system as well. It's important to recognise that, too, and not to run away from that reality. So, some health boards have managed better than others. We have seen, I think, progress across the team here in Wales, both the seven LHBs and the three

trusts. For example, the ambulance trust is a really good example of an organisation where it had a real challenge about managing its books as well as managing its ability to turn out a service that people could understand and developing that for the future. It now has an approved plan, where it simply was not in that position—you could not have anticipated it would be a year and a half ago. So, that's again a sign of real progress and ability within the system.

[12] I think we've made real gains, there's more to come, but don't be surprised if there are still some bumps in the road—because when you're managing something this complex, and the interaction that needs to takes place as we expect the system to do even more in an integrated way, I think we could and should expect to see further improvement, not just from those organisations that are either in special measures or targeted intervention, but from those that still have approved plans as well, because the challenge won't lessen as we move forward. I don't know if Andrew wants to say something about where we are specifically on the planning maturity process.

[13] **Dr Goodall:** Obviously, we're coming to the end of the first three-year cycle with organisations, so we've had organisations who've been able to achieve approval throughout that period of time, so, for example, Cwm Taf and Velindre, in terms of their own approaches. I think it's important to show progress over that time, so in the first year when Ministers were looking to approval, it was only four organisations who had an approved plan—that moved up to seven last year. I think this year, actually, was a particular test for us. It's important—although we would like to have every organisation in Wales approved—that actually there is ongoing discipline within the system. We've maintained the standards and the criteria in place and the number of organisations did drop, with two organisations losing their status this year. I think maybe in previous years that wouldn't necessarily have happened, but I think it's the guidance and the discipline in place that has allowed us to move that. It also requires us to then get alongside those organisations to work differently. I just think that approval status needs to mean something, and certainly for organisations who've managed to achieve it, it does allow us to afford some greater levels of flexibility for them, even choices around, for example, use of capital funding, which means that they can operate slightly more autonomously.

[14] **Julie Morgan:** So, you think the targeted interventions that you're taking are proving successful.

[15] **Dr Goodall**: I think there are two processes in place. There's the planning approval mechanism and then, I think, the escalation framework that is in place really does complement it. The targeted intervention approaches that we have put in place do clarify organisations that have given us some concerns, maybe, about the clarity of their plans over the next three-year period, but we think that we can look to get those back on track, but equally highlight some issues of managing within the resources that they've got available. Certainly, those currently on targeted intervention—we're working very closely with them to the end of this financial year, but the real challenge, I think, is to take the progress into subsequent years—it's not just trying to get them over the line in one individual financial year.

[16] **Julie Morgan**: But do you anticipate they will get out of targeted measures at the end of the year?

[17] **Dr Goddall**: Absolutely. The intention is to make sure that we make progress on all of those. The ultimate aim is to have 10 organisations who are able to have an approved status. We think it will probably take us still a bit longer in terms of Betsi Cadwaladr, not least recognising their special-measures status. We probably wouldn't expect that to come through maybe until March 2018 at the earliest, and maybe, in respect of Hywel Dda, it may just take a little bit longer because of the need to really clarify some of their local clinical services strategies.

[18] **Vaughan Gething**: It's important to recognise that targeted intervention recognises the challenges that that health board has, so there are different issues in each of those health boards. So, we'll have more to say about target interventions later in the year, both the work that's been done and our expectations for each health board, that will be understanding in addressing those particular concerns for that particular health board, both for work that's being done and our expectations for each health board that will get understanding in addressing those particular concerns for that particular health board. So, it isn't a one size fits all; it really is about what the particular challenges are here that meant that I made a decision to go into targeted intervention, how that's being addressed, what confidence we can have and in what timescale we think that approval will be made.

[19] **Julie Morgan**: And I wanted to ask you at an early stage, really, of this questioning, talking about planning ahead: how do you take into account the particular needs of children in your financial planning?

[20] **Vaughan Gething**: Well, it's not just financial planning where we take into accounts the needs of children. It's part of that whole integrated planning process. And the money has to lead to outcomes. I think that the challenge always is whether we simply focus on the sum of money in a particular part of the service, and sometimes it can be difficult to level out and just break out sums directed at one particular group, whether children or older people, or other particular groups that we know that the service as a whole has to serve. I think it's really about understanding: are we achieving outcomes that are acceptable and are we seeing improving outcomes? And that's got to be the focus of how we then use the money. And that is an aspect that's taken into account when looking at organisations' medium-term plans. It is an aspect of the accountability mechanism that we have, both in my direct conversations with chairs, as well as in the joint executive team meetings that take place between Welsh Government officials and health boards and trusts as well.

[21] So, when I go through appraisal settings, then this does turn up. I think that it's a regular part of our conversation. I think that that's the important point—we don't just focus on adult and older people services. It's about the whole service and we expect to see funding allow us and enable us to do that, and every organisation are told very clear that they are expected to be held to account for doing that as well.

[22] **Julie Morgan**: I accept the fact that if you successfully treat a mother, that helps a child. So, the funding is that sense is overall. But it is helpful, I would have thought, to know how much money, for example, was spent directly on children. Do you have those figures?

[23] **Vaughan Gething**: Well, no, but then part of the challenge is, when we talk about spending money directly on children, for example for cancer—this spending money in a certain way—

[24] **Julie Morgan**: We'll be going on to that later on.

[25] **Vaughan Gething**: We have specialist paediatric services that spend money in a certain way. But trying to unparcel, for example, how much in primary care is spent on children would be difficult, and I'm not sure it would be very helpful either. I'm rather more interested, actually, in—can we demonstrate that outcomes are right, that outcomes are improving, and that we're directing resources in a smart way, not just with the amount of money but in the use of that money as well to deliver improved outcomes? And

you'll know that we've got formal architecture around decision making, and the UN convention that does play a part, and an important part, in how we make decisions across Government. But, for me, it's got to be about the outcomes—how do we demonstrate across the whole portfolio, in health and social services, that we're improving outcomes for children? That means that it leaks into the very direct and regular conversations that the Minister has with Carl Sargeant and his portfolio as well. So, I really don't want to get drawn away for the outcomes focus, and make sure that resource allows and enables us to see those outcomes improving.

[26] **Julie Morgan**: So, every decision you make about spend, you take into account children.

[27] **Vaughan Gething**: Well, it can't be on every decision because if I'm making a decision, for example, about spending on a particular service for older people, I'm still going to say, 'How I take into account the needs of children within this?', but when we look at the whole system, we do take into account the needs of adults, whether they are older adults, middle-aged adults, younger adults, and we take into account the needs of children, including, importantly, transition services as well, which are often overlooked and are a cause of real difficulty in themselves, not just for the children but their families too. And that's particularly important, for example, in end-of-life care. When we know that children and young people live longer now, and there are real challenges about moving from a paediatric and children's-based service into an adult-based service when you know that someone has a life-limiting condition. So, that's part of the complexity, which is why I really do want to focus on outcomes and make sure that we get the outcomes right for people and see them in the whole context. You don't just see a mother on her own, you see the mother in her whole context, you don't see the child on their own, you see the child in the whole context—their family and social group as well.

[28] **Julie Morgan**: This is the last question now, really—obviously, we do have a duty, under the United Nations, to consider children in every decision that we make. And even if it means—. You look at an older person and you make your decision then. I just want to be sure that that is happening in your department.

[29] **Vaughan Gething**: As we take decisions, we do take into account the needs of children in the decisions we make. I just don't want to overstate the fact that there will be sometimes specific decisions that you make that are

about that individual service in a particular specialist area, for example we'll get on to talking about gender identity services later on—there are real issues there for children and young people. But in particular choices we make, some of that you can't bend just to lever in and say, 'Actually, I can demonstrate here an additional way to say that children have been specifically taken account of in this particular part of the decision making.'

11:45

[30] But in the overall suite of what we do, we certainly do take into account the impact on children, and the services for children, and then that whole context in which children live—in their family, in the street they're on, and the wider community they're in as well. So, that is very much part of it, not just in this department, but across Government too.

[31] **Julie Morgan:** Thank you very much.

[32] **Dai Lloyd:** Ocê. Diolch Julie. Mae Rhun yn mynd i ddod i mewn, ac wedyn Angela.

Dai Lloyd: Okay. Thank you, Julie. Rhun will come in and then Angela.

[33] **Rhun ap Iorwerth**: Rydw i'n meddwl ei bod hi'n bwysig ein bod ni yn dod yn ôl at yr arian ychwanegol sydd wedi cael ei neilltuo ar gyfer Betsi Cadwaladr a Hywel Dda. Eto *bail-out* ydy hwn, ac mae'n siomedig bod hyn yn gorfod digwydd. Dyma oedd union y math o beth oedd i fod i gael ei atal, wrth gwrs, gan Ddeddf Cyllid y Gwasanaeth Iechyd Gwladol (Cymru) 2014. Rydw i'n edmygu eich optimistiaeth chi y bydd pethau yn gwella yn y ddau fwrdd yna. Ond, o ystyried bod ymateb i ymyrraeth wedi'i thargedu ac ymateb i fesurau arbennig yn golygu ffactorau eang iawn ar draws gwaith y byrddau hynny, a allwch chi ddweud mwy wrthym ni am y camau, yn benodol, fydd yn cael eu cymryd rŵan i wella

Rhun ap Iorwerth: I think it's important that we return to the additional funding that has been set aside for Betsi Cadwaladr and Hywel Dda. Once again, this is a bail-out, and it's disappointing that this has had to take place. This was exactly the kind of thing that was meant to be prevented by the National Health Service Finance (Wales) Act 2014. Now, I admire your optimism that things will improve in both boards. But, having considered that the response that there has been to a targeted intervention and the response to special measures means that there are very broad factors across the work of those boards involved, can you tell us a little more about the specific steps that will now

rheolaeth ariannol o fewn y byrddau iechyd yna? Achos mae'n rhaid i ni ddod allan o'r seicl yma lle mae *bail-outs* fel hyn, unwaith eto, yn digwydd pan fo yna ddeddfwriaeth i fod i atal hynny.

be taken to improve the financial management within those health boards? Because we have to get ourselves out of this cycle where such bail-outs are once again taking place when the legislation was meant to stop that from happening.

[34] **Vaughan Gething:** Okay. I'll happily start off, and then I think it might be helpful if either Alan or Andrew come in on some of the specific measures and work being done with the two boards that you focus on. It's inevitable, of course—and I understand this, being a party politician myself—that, when you announce additional money in-year for organisations, it's entirely possible that people either say, 'I welcome this, and I welcome the fact that there's a recognition of the context in which this service is being provided', or the alternative is that people say, 'It's a bail-out, and this is shocking.' Well, that's the honest reality of where we are, as politicians in different parties and our different perspective on it. I just don't think it'd be helpful to get to the end of this year and then say, 'Well, blow me down, Betsi Cadwaladr and Hywel Dda haven't lived within their means.' So, it's a recognition at this point and it's important that we do this at a time that allows the organisation to plan and manage and know there is going to be the potential for support.

[35] And it's held centrally, against what they'll do. We still have real discipline in the system, and an expectation that they will examine critically what they currently do and what they can improve upon as well. That expectation has to be real. We'll need to recognise that you won't resolve this all in one year. Those organisations are in a different place, and it's really important as a system that we recognise organisations are at different stages and in different places. We would not and should not take the same approach with Cardiff and the Vale as we would with Hywel Dda or Betsi. Otherwise, we're going to try and manage the system in a way where we can guarantee there are interventions, which could make things worse rather than better. So, the work's already ongoing with targeted intervention and special measures.

[36] I'll hand over to Andrew in a minute, but I just want to make that broad point that I think this is a good thing, to recognise, within the year, that there are challenges and pressures that are unlikely to be met, to recognise our ability to cover those off, but also to be clear that there is a

time-limited amount of support. We do expect, within the course of this term, that those organisations will find themselves in balance financially, but also delivering the sort of quality of care and services that all of us would expect, within their means.

[37] **Dr Goodall:** And we do have examples of organisations who've been able to demonstrate—despite having a broad and large population and health responsibility working as health boards—that they can actually manage within their means. We've had organisations, such as the Welsh ambulance service trust and Powys, demonstrating that they've been able to improve a position where there's been a lack of a plan and a difficulty around their financial resources, and we've got them to be improved. But I think there are relevant issues for those two organisations, and they are different.

[38] It was quite clear, when we gave advice for Betsi Cadwaladr to be put into special measures—and that was accepted by Ministers—that they had a very difficult set of circumstances. We have not wanted them to make the wrong kinds of decisions as an organisation in the financial context of leading to difficulties around safe services locally or reducing access. We've wanted them to be able to maintain it, but we do have an expectation over time that they need to be recovering within the budgets that are announced, and we'll all be working with them alongside it. Some of this is about recognising some of those pressures—you know, in particular, mental health as an area. That has required some recognition of additional resources into the system, because we've wanted to maintain the local access for that facility.

[39] I think, for Hywel Dda, it just feels that there's been a more long-standing issue over many years that we need to help the organisation with. There are some question marks about the spread and distribution of services. To some extent, there's the context of what remoteness and a growing older population can actually cause as a cost in the system, and I think we actually need to understand that better, in terms of the balance of services. The targeted intervention, and aligning this support this year, which is held centrally rather than for the organisation itself, I think allows us to try to get them on an even keel for the first time. But I would hope as well, Minister, that they can also learn from the experiences of what we've done with some of the other organisations in Wales too. Their plans I don't think will be able to be put up for advice to be signed off until at least March 2018. It will be nice to feel that we can make some good progress on that. But the reality is that I think they've got some longer-standing problems that we'll

need to work through. And, if they can get there sooner, that will be a positive, but I think it will be a longer period of time.

[40] **Dai Lloyd**: Fe fydd yna gwestiynau mewn manylder ar bethau fel iechyd meddwl a CAMHS ac ati yn nes ymlaen. Felly, gwnawn ni gadw pethau yn sych tan hynny.

Dai Lloyd: There will be detailed questions on things like mental health and CAMHS later on. So, we'll keep our powder dry till then.

[41] Angela nesaf.

Angela next.

[42] **Angela Burns**: Yes, thank you very much and thank you for the papers that came with further explanation. But I'd just like to—. My series of questions are all about whether or not we've got enough money going into the NHS in the forthcoming budget. But, to do that, I have to go back to last year's figures as well. Given the deficits in the health boards for 2016-17, how confident, Cabinet Secretary, are you that the 2017-18 budget settlement is sufficient to meet the financial challenges of the NHS? I just wondered if you could also just explain on the record—we talked about the system was in balance and I appreciate that both Betsi Cadwaladr and Hywel Dda have got financial deficits. But we also have in the integrated medium-term plans financial deficits being forecast for Abertawe and for Aneurin Bevan. Between the two of them, that's another £35 million, possibly £40 million. So, you know, there is still money out there that's not sort of—. And I appreciate, I understand, that's not necessarily revenue deficit, but, nonetheless, it's still a deficit. So, how does all of that impact on whether or not we actually have enough money going into the NHS for this coming year, given that backlog that I assume we will have to make up across the piece?

[43] **Vaughan Gething**: It's a really important question that is not just for the health part of the budget, but it's part of the context for the whole Government. Everyone knows that we have less money to work with from a revenue point of view. We'll have our arguments in parties about how and why that is. But it's a fact that we have to deal with. And you'll have heard from local government colleagues their concern about the number of jobs that have come out of local government and the partnership that we need to have to deliver health and care within our context, and the concerns about whether the Government becomes a large health authority with other things added on. Within that context, health has still got an additional cash boost, which meets the gap that has been predicted by Nuffield previously, and recently by the Health Foundation too.

[44] So, the recognition of the potential gap that existed in the recent Health Foundation work has been covered by this budget settlement. And so there are real grounds for cautious optimism about the future. And there always has to be an element of caution, because we know that, even with that additional funding having been found at real cost to other budgets within the Government, that money having been found gives a real prospect of the system being within balance and living within its means again, and, at the same time as living within its means, of being able to change and improve services within that context too. But this does not mean that the national health service is awash with money—far from it; they're not. But I think it reinforces the need for the health service, with its partners, to drive real value out of the money that is spent. That will mean doing things differently, but I think that we should have a level of confidence that the changes, with savings in some parts of the service, can be achieved, because we're seeing some progress made on that already. But the changes will be made with a recognition by the partners that health has got a settlement that it can work with, and can live within its means. And I think that there's a sense of real encouragement, because the challenges we have are not unique to Wales. You look at England, Scotland, and Northern Ireland: lots of the same contexts exist in those other parts of the system. And there are different challenges in other parts of the UK, and, actually, within England, they're forecasting a £2.5 billion deficit at this point in the year. Last year in England, two thirds of hospital trusts came in with a big deficit as well. In Wales, eight out of ten organisations came in on budget.

[45] So, despite the fact that we do have very real pressures and real challenges, there should be, bearing in mind that performance and the budget settlement that we have achieved within the Government, the political priority that the NHS is—but the practical ability to live within its means is there. But I won't pretend to you today or on subsequent occasions that this somehow means it's easy and we're all home and hosed. It's far from that; there are difficult choices to be made. But there's real potential in making those choices to drive greater value from the money that we're spending within the service.

[46] **Angela Burns:** Okay. So, you said that two didn't come in on budget, Betsi Cadwaldr and Hywel Dda. Can you explain to us, though, what exactly is the deficit for for Abertawe, which is actually £20.1 million, and for Aneurin Bevan, which is £12.8 million? So, they're going to go into the 2017-18 budget with that shortfall. What is that shortfall, and do they have to

make that up, because there's obviously no recognition that there is a shortfall there.

[47] **Vaughan Gething:** There's something about the duty going over more than one year, which we touched on earlier, and there's also something about an organisation in targeted intervention within that. But we don't think that the level of forecast deficit that they have at present is really where we're expecting them to be at the end of the year. But I think, to give you some proper detail, it would be helpful if Alan goes through the work he's doing with the organisations that you've mentioned, as well as more generally across the system.

[48] **Mr Brace:** Yes, if I could just pick up on this year, I guess the last reported position from the NHS at the end of September was a £95 million overspend, but £52 million of that was in the two organisations we just referred to—Betsi Cadwaladr and Hywel Dda. So, really, that left a residual pressure across all of the remaining organisations of £43 million. I guess, if you look back to the year before, there still remains plenty of opportunity, and I guess a track record that the NHS has been able to manage some of those pressures. So, at the moment, I think we probably remain confident that the overall main expenditure group will get into balance for the end of this year, and the organisations that are reporting a deficit, and are at deficit at the end of September, will continue to make progress.

[49] If I take Aneurin Bevan, because two months ago I was the finance director and deputy chief exec there, there remain plenty of opportunities for improvement, and probably that forecast is more at the worst-case end, but on the assumption that they won't make progress. So, we remain confident that, this year, the MEG will come into balance and further progress will be made in the NHS component of that, particularly starting to have some certainty over those two organisations that were, at the end of September, over 50 per cent of the problem across the NHS anyway.

[50] If we go into next year, and I think you take the work of Nuffield and the Health Foundation and their assessment that, to continue to deliver the NHS, we'll need about 2.2 per cent real-terms growth and continue to deliver about a 1 per cent efficiency saving, this settlement certainly gives us the growth that is required in real terms in the NHS, and, looking at the track record of the NHS, 1 per cent efficiency savings remain achievable, although some of the work of the new efficiency board is starting to think about how we can take a broader approach to efficiency than just the normal, more

technical efficiency, where you try to do more for less, or you try to do more for the same. So, I'm more than happy to talk about some of that development.

[51] **Angela Burns:** Can I ask you, then, to just develop that argument a little bit more? Because, of course, one of the conclusions that came out of your paper quite strongly was that the low-hanging fruit, in terms of efficiency savings, has gone. The reports that you've referred to, particularly the Health Foundation report, say that NHS Wales must deliver at least £700 million to close the projected funding gap by 2019-20, which is almost 10 per cent of current NHS Wales spending. I've worked in organisations before, and I do understand how complicated and how difficult it is to get a true efficiency saving. It's very easy to make it look like an efficiency saving, but, if you actually want one that delivers the cash—. With that low-hanging fruit gone, how confident are you, then, that the funding you're putting into the NHS in the coming financial year will actually be enough to enable it to sustain and develop where it needs to, but will still give that room that will allow the organisation to deliver that efficiency saving? Because you can't actually deliver an efficiency saving if your back is up against a wall. As I'm sure you all know, from an operational point of view, you've got to be able to have that wiggle room to spend to deliver that efficiency saving. So, that's what I'm really trying to understand.

[52] **Vaughan Gething:** But with the budget settlement that we have, it meets the gap identified by Nuffield and it meets the gap identified by the Health Foundation. That other work ongoing about delivering that efficiency is part of where we are. As Alan said, there are still opportunities for some other technical savings, other than those that have been made, but the point about future savings is that it comes through the work of the efficiency board that Andrew Goodall is chairing, but also comes through a different approach around savings and around efficiency, and about generating extra value from working in a different way as well. Now, that will require some systems analysis and system reform as well, but, actually, that, I think, is the real prize. But the NHS I do think recognises it's not just possible, but there's a responsibility, to go at it in a different way. Alan has led on this not just within Aneurin Bevan, but has seen this across different healthcare systems as well, so there are real opportunities in going after what—. Alan will talk to you at length, if you like, about allocative efficiency as well. [*Laughter.*] But the point to make is that there is a real opportunity to do this. There's a recognition within the whole system that it needs to happen.

12:00

[53] We're meeting the gap identified by the Health Foundation and by Nuffield previously, but it does mean that—. Difficult choices are there, but these are entirely possible choices as well. We have the opportunity to have a system in balance, and if you ask the Health Foundation, they don't think that's a position in other parts on the UK.

[54] **Angela Burns:** I do listen to what you say. This is an area that I don't feel satisfied that we've explored enough, but I don't propose to it now because I am really aware that the Chair gave us very strict rules about questions, because there are a lot to ask you in this very short session. So, can I just—? I do understand how difficult it is to achieve true value for money through efficiency savings. Can I just perhaps ask my final question, which would be: the extra money that you've put in towards the NHS—the £240 million, for example, and the other smaller sums of money that you've popped in here and there where you'd like to add to programmes, and the changes that you've made—how confident are you that that sum of money would be enough to enable you to have that room to drive forward the service reforms that you want, the efficiency savings that you want, and in the meantime to continue to drive an upward trajectory on improvements in delivery?

[55] **Vaughan Gething:** I think I've given a really clear and consistent message to the service, both before the election and a since my confirmation in this post, about where I expect the service to be in terms of delivering some of that headline improvement, and at the same time, being really clear that new money coming into the NHS budget—there's going to have to be something for something in that, in the sense of: there's got to be proper service reform to deal with some of the change and transformation we know needs to take place. We'll have more to say in the new year about an approach on how we'll make use of that money, but this won't be a surprise to health boards and trusts here in Wales. They know that's our expectation and they know that that's the way that chairs and chief execs will have a very high level of expectation and accountability in using that money in a different way to change and transform services. So, it won't simply be going into things as we do now—just put the money into the bottle and do what you want with it. There will be a an approach about tying additional investment into service reform and improvement, and demonstrating that's actually going to benefit the citizen in the way that they receive and take part in the service.

[56] **Dai Lloyd**: Diolch, Angela. Fe wnawn ni symud ymlaen. Mae'r gyfres o gwestiynau nesaf o dan ofal Dawn Bowden.

Dai Lloyd: Thank you, Angela. Dawn Bowden has the next set of questions.

[57] **Dawn Bowden**: Diolch. Thank you, Chair. Minister, I wanted to pick up a couple of the—much of it you've already covered in response to Angela, around NHS efficiencies. Can I just put it to you that, although the report does talk about, you know, most of the low-hanging fruit as already being dealt with, there are still huge inefficiencies in the system that need to be addressed? When you and I were working in a different life, we talked about this—as I did with Andrew in the joint consultative groups and so on—and there seemed to be an awful lot around IT and around procurement, and about wastage around drugs and all of that kind of thing, which appear to be low-hanging fruit and should have been dealt with, but actually, there are still huge inefficiencies in the systems around that. So, what steps are you taking to address some of those areas? Are you confident that we're going to be able to deliver those very clear efficiencies that still need to be tackled?

[58] **Vaughan Gething**: Yes, and I think people that are supporters of the national health service should not be shy to say that we expect it to become more efficient, and to recognise where it can drive greater value in what it does. I'd agree with you that there is more that could and should be done in areas that would still be considered to be low-hanging fruit, and some of it will take a little more time. I'll ask Andrew to talk about the efficiency board, because it's something we've introduced, led by the chief exec of NHS Wales, to make sure that there is a drive about some of that central efficiency. Because I don't accept that we're at a point where everything is too difficult to achieve. There's lots for us to go at, and that's an optimistic perspective to take, because it means that there's further improvements we can make within the system. The new money should unlock some more of that as well—going back to the point you made about whether there's the room and the space to do that. But perhaps you wanted to say something about the new board, Andrew.

[59] **Dr Goodall**: I think we should give some credit to the NHS, because over time it's continued to be able to demonstrate a level of efficiency savings, through both innovative and traditional routes. So, that has helped us over the last five years, for example, and over the last 10 years, and I know it'll help for the future. But I think we can also help the understanding

with individual health boards by work that we're holding nationally. So, we do now have an efficiency board in place, and I've been chairing it. We've been working our way through a number of areas: information and data around productivity and efficiency, challenging ourselves on medicines management, looking at whether we can organise theatres in a better way, taking account of the Health Foundation work. Our next meeting, which is actually happening on Friday of this week, is looking at some of the emerging work that's come through from recent assessments by the Wales Audit Office on medicines management, although we still require that with their local plans as well. We're trying to ensure that we can lay a level of expectation centrally that we expect people to be chasing down some of those numbers on behalf of patients, and on value for money and on outcomes as well. But also they should be drawn into the local plans for organisations as well. So, there's an aspect of support, but there's also an expectation of some compliance with some of these areas. I think it would be right to expect, on an ongoing basis, that we continue to go—obviously, in some of the traditional areas—but I genuinely feel that our opportunity in Wales is that we can look at things through a slightly different lens and be more innovative on our thinking about the value and some of the variation that we see across the different organisations and areas of Wales as well.

[60] **Dawn Bowden**: I think that that's very welcome—the innovation. Can I just ask: is part of the work of the efficiency board actually talking to the staff on the ground that are working? Because it seemed to me that staff were often throwing up all kinds of issues and ideas around the way in which front-line services could be more efficient. Quite often that seemed to be overlooked. It seemed to be that there was a kind of top-down approach to efficiency, instead of actually talking to the people who are delivering the job.

[61] **Dr Goodall**: I would personally expect organisations to absolutely listen to their staff. I certainly did that myself as a chief executive out in the service within health boards in terms of their own reflections on areas that either they were frustrated about or they felt could actually help with resources. We've probably not drawn in specifically the staff perspective around the current discussions. We're also reviewing areas like the Carter review that took place over the border in England, and making sure that we do our own assessment, but my proposal—and I've shared this with the partnership forum—is to use that as the committee that can have an update and an overview of some of the areas that are highlighted here. But I would expect local health boards and trusts themselves to absolutely be drawing in

their staff reflections because they understand what it means on the front line.

[62] **Vaughan Gething:** It might help to have a reflection, a recent one, from Alan as well on how that can be addressed through our national approach too.

[63] **Mr Brace:** If you look at a lot of the work of people like the Health Foundation, although they'll talk about 1 per cent efficiency, they'll also talk about significant variation within organisations around that. I think that probably points to some of your question around—there seems to be some organisations that are more capable of engaging with people who can help them with that efficiency debate rather than trying to issue it as a target that people respond to. If you look at the very practical level with some of the things that we've now put in place, we've got some unique advantages in Wales, I think. We've got a shared service. They run most of our procurement. We've established a clinical procurement board, chaired by a medical director. They are really bringing clinicians in to say, 'Why do we need to use so many different products?'. If we could just think about standardising—but standardising on products that drives the right outcome for patients—and then just let's maximise the benefit of the purchasing power that we would have by concentrating on a narrower range of products that we all agree are the best to use—clinically safe and clinically appropriate. So, there are now more and more mechanisms, I think, where people are being drawn in. As Andrew said, I think, increasingly—and certainly we have benefited hugely in Aneurin Bevan—things like the trade union partnership forum give you a real insight into what's going on. So, you can sit at the board level and think that you're tackling some of these sorts of issues. You get some really almost-live feedback through those types of mechanisms about where things need to change and where opportunities exist. I think Wales now, with a smaller number of organisations doing much more centrally, but also engaging a lot more within individual organisations, will allow us to have a bit more confidence that greater than 1 per cent will be achievable, even on just the basic technical efficiency.

[64] **Dawn Bowden:** That's helpful, thank you. Can I just very briefly ask a couple of other questions, just around efficiencies on staffing, really, and how you feel the balance is going to be struck between maintaining what is effectively a tight pay policy with the dilemma that that presents in terms of recruiting staff—how you maintain that and that efficiency, but also, at the same time, recruit and retain staff, particularly given that you're going to

have to think about as well now the new rate for the living wage that has been announced and at what point that will be implemented and so on? So, you know, how are you going to manage all of that?

[65] **Vaughan Gething:** They're honest and really difficult challenges for us. As you'll know, Dawn, there's the challenge about the NHS being perhaps the one big block of the public sector where people still expect more staff to be recruited. I don't think I've ever had a question session in the Chamber or in committee where people have said 'You need less staff'. It's always about needing more staff, and always the bids come in for that. So, that's part of the pressure that we need to manage and, at the same time, we have got a very tight settlement. And you know, there's a UK perspective and a policy perspective that is being driven by central Government that means that pay restraint is a real challenge, and it means that some workers have not had real-terms pay increases for some time. I don't shy away from that. If we had a completely free hand, and different sums of money, then we'd take a very different approach. But there's something about the pragmatism of those different groups, and the principle point of view as well, and about wanting to make sure that lower paid workers are not left behind. That's why we took the decision on the living wage—and of course, you had an interest in that in a different life—and about wanting to see how we maintain our commitment to low-paid workers, how we make sure that we maintain the pay structures we have and, equally, how to maintain the bargaining arrangements.

[66] So, we're going into now the pay review body evidence—and we'll wait to see what those reports look like—as well as the negotiations we'll need to have with colleagues in the BMA, because we still don't have a clear position on what the junior doctor contract looks like in England. That's a real pay pressure and a challenge for us as well, but we do have sensible and constructive relationships and we're starting the negotiation round on the next GMS contract as well. So, all of these things are with us, and are very real pressures, but what I would say—and perhaps it will give some confidence not just to Members here, but outside as well—is that I recognise there's a real challenge between the pay line moving upwards and the head count as well, and that's a difficult conversation to have. But I also recognise that we're in a fortunate position here in Wales to still be able to have a conversation—and that does not mean we always agree on every single part of it—that is constructive and respectful, with each of those different parts of the workforce and their representatives. But I don't pretend it will be an easy next few months. We're going to have to deal with the practical challenges of all those choices, and the fact that we do some of that despite having a good

settlement, I think, within a budgetary context, from the Government, for the NHS, but it's still a challenging one to meet all those different pressures.

[67] **Dawn Bowden**: Okay, thank you. Just a final brief question, perhaps to Andrew, if I may. There was a considerable piece of work going on around how we were going to deal with agency costs, particularly around nursing, because I think, in the last couple of years, it was the first time that nursing agency costs has actually overtaken medical agency costs. So, can you perhaps just give us an update in terms of where we're at with that piece of work?

[68] **Dr Goodall**: We continue to have the group in place, which you were probably aware of previously, and, yes, we're taking a number of approaches, some of which are national, and some of which are through more regional arrangements across organisations. We've tried to, on an agency perspective, limit some of the use of agencies, so making sure that there's a focus, of course, on existing contractual relationships, rather than through exceptions. A lot of this, though, of course, is about how we steer staff numbers on the ground, and, inevitably, in our system, probably around 4 per cent of our pay budget goes currently on agency and locum use. We, of course, want to convert that to substantive staff as much as possible and work it through. We have other pressures coming through like the more staffing arrangements, for example, that we need to balance.

[69] We have got more staffing in place—about 8 per cent more than 10 years—ago, so it's important to recognise that we've been making some progress, but we also need to keep ahead of these pressures. I think, for an expectation for the system, we need to keep expecting that there should be a stabilisation first, and then a recovery around the current agency and locum spend in the system. But, what we can't stop is that there will be moments when these staff need to come in for safety reasons, not least for local services at this stage.

[70] What I would like to see, though, is perhaps a better understanding about where we make decisions on locum use, for example, for the right kinds of reasons. So, mixed up within some of those figures are some decisions taken to stabilise services where they are planned decisions, rather than exceptional. So, for example, in north Wales, the maintenance of maternity services require Betsi Cadwaladr to recruit a whole number of locum consultants in place. We had our mid-year review with Hywel Dda yesterday, and they were outlining that, actually, in their local services, they

had 17 recent locum consultants who were in post. That secures the service on the one hand, but actually, for them, it does allow them to potentially recruit, and I was really pleased to hear that some of those individuals are actually interested in taking up substantive consultant posts in that area as well. So, sometimes, a locum spend may sound as though it's the wrong kind of spend, but it can sometimes attract in future substantive staff.

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

[72] **Dai Lloyd:** Y cwestiwn nesaf gan Caroline Jones. Cwestiwn 10, Caroline.

Dai Lloyd: The next question is from Caroline Jones. Question 10, Caroline.

[73] **Caroline Jones:** Diolch, Chair. Regarding maintaining NHS performance, I'd like to ask whether the funding will enable the NHS to meet key performance indicators, which are currently proving difficult to achieve.

12:15

[74] If we look at waiting times for treatment, access to diagnostic tests, access to mental health services, and also child and adolescent mental health services, waiting times in A&E, and delayed transfers of care, how confident are you that the level of funding will help us achieve these key performance indicators and meet the targets?

[75] **Vaughan Gething**: I expect that we'll see improvement across the system through the year. We're about to come into winter where actually emergency pressures and unscheduled care are always facing a significant challenge. And part of my challenge in managing that time of year—and I know that I'm going to come to committee in a couple of weeks to talk about that at some more length—is the balance between unscheduled care and elective care as well. So, that's an important planning aspect.

[76] If you look at the history of the national health service within the last five years and more, what you typically see is that, at the start of the financial year, there's a relaxation and a ballooning out of a range of these measures and you need to see if you can come back in the second half of the year. On waiting times, what we've actually seen is a level of real stability through this year. And I still expect that we'll see an improvement in the second half of this year in those headline performance figures, despite the fact that we're going through the winter period.

[77] On cancer, for example, we know that there have been challenges about whether the level of resource allows us to do that. Actually, in that circumstance, it's often more about how the service is organised. Now there'll be difficult choices again in this area about what we do and how we do it. Some of the new diagnostic investment will help us with that. But an awful lot of this is understanding whether the right pathways are in place, and understanding how and where people flow between different health boards at different stages of their treatment.

[78] So, what I think you'll see is a system that will continue to improve through the second half of this year, and that's really important. But in terms of the headline measures that we currently have, I don't think we'll hit all of those through this year, and I won't try and pretend to you that we will. But I do think that you'll see a real improvement across a range of those measures, which is good news for patients, but also it then goes back to the transformation points that came from earlier questions about not just using the money to buy performance in the short term, but about how we see a genuine transformation in the way that services are configured. So, we've directed people to different parts of the system, but are those different parts able to cope and provide a service that the citizens need as well? So, I think that there can be some optimism about the real level of improvement that you are likely to see in the second half of this year.

[79] **Caroline Jones**: Okay.

[80] **Dr Goodall**: And I think there are some foundations here in place, you know, just on diagnostics for example. And the figures are 42 per cent better than the same time last year. All these figures were actually the lowest that they've been since 2011. Our referral-to-treatment time position is actually 24 per cent better than last year. And we need to keep on some progress. You highlighted some other areas. On the mental health side, we've had 110,000 people though the primary care mental health teams and we've seen improvements on the mental health targets in place despite the fact that we've actually reduced the time target, so, we're already meeting 75 per cent on the intervention target, for example. And even on primary care, we know the latest figures for the QOF assessment, that's the quality and outcomes framework for GPs, again shows a very high performance across our system. And access hours have continued to expand and increase too. So, I don't think that any of those are about saying that we're complacent about performance, but I do think that we've got a foundation to keep pushing on

and not least through the next number of months and into next year.

[81] **Dai Lloyd**: Ocê, mae'n amser symud ymlaen i sut rŷm ni'n ariannu llywodraeth leol, ac mae'r cwestiynau nesaf hefyd gyda Caroline Jones.

Dai Lloyd: Okay, we'll now move on to how we fund local government. The next question is also form Caroline Jones.

[82] **Caroline Jones**: Diolch, Chair. Thank you. What is the process for determining the level of funding for social services provided through the revenue support grant to local authorities for social services in 2017-18, and will this keep pace with the additional demands on social care, as identified by the Health Foundation?

[83] **Rebecca Evans**: Thank you for the question about funding for social care to local government. Essentially, the decision as to how funding to local government is taken forward is one for the Cabinet Secretary for Finance and Local Government, but the money does go through the revenue support grant. The revenue support grant recognises the many functions of local authorities, including social care, but the funding within it for social care isn't hypothecated, so, it does give local authorities a certain freedom in order to try and meet the local needs that they identify, which will vary depending on the local populations across Wales. The overall settlement to local authorities, as you know, is £4.1 billion. There was additional funding of £25 million this year for local authorities, in specific recognition of the importance of strong social services, alongside additional funding of over £4 million to fund our pledge on doubling the capital limits—we'll be taking that up to £30,000 next year—and additional funding again for the pledge we had on the full disregard of the war disablement pension, which I'm really pleased to say is going to come into force in April of next year.

[84] **Caroline Jones**: Okay. Thank you.

[85] **Dai Lloyd**: Mae'r cwestiwn nesaf dan ofal Lynne Neagle.

Dai Lloyd: The next question will be asked by Lynne Neagle.

[86] **Lynne Neagle**: Thank you for your answer to Caroline Jones. Of course, we know that local authorities are under tremendous pressure, and they have received a slight decrease in funding overall, so I think there will be a natural temptation to want to use some of the social services money on other things. What steps is the Welsh Government taking to ensure—and to monitor—that appropriate levels of funding are actually spent on social services? Can I also

ask about some specific pressures? Obviously we know that things are in the pipeline, such as changes to domiciliary care staffing that are really welcome—that we're looking at ending zero-hours contracts, and things like that—but that could potentially have a significant commissioning cost for local authorities. What assurances can you offer that the money that has gone into the RSG is going to be adequate to meet those needs?

[87] **Rebecca Evans**: Thank you for those questions. I meet very regularly with representatives of the WLGA, both in terms of social services and the responsibilities I also have for community sport as well, to discuss the pressures. I have to say that they're not backwards in coming forward in describing the kind of pressures that the sector is facing at the moment. They've described the settlement as challenging but fair, which I think is probably an accurate way to describe things given the current financial situation and the pressures facing the sector. But I think that funding for local government is only part of the picture in terms of the picture for domiciliary care staff, because professionalising and making the sector more sustainable is really at the heart of what I'm trying to achieve. To do so, we've undertaken a large piece of work that has looked at the views of people in the domiciliary care sector to better understand what is preventing career progression, and what is preventing people coming into the industry, because we know that there's a turnover of 30 per cent, and every time you recruit a new member of staff in the domiciliary care sector, the cost to the business is £3,500 in terms of training and so on. So, if we take steps such as ending the abuse of zero-hours contracts to support staff in the sector and to make the sector more sustainable and more attractive for people to enter, then I think that will certainly be really helpful to local authorities as well.

[88] **Dai Lloyd**: Jayne Bryant efo'r cwestiwn nesaf.

Dai Lloyd: Jayne Bryant has the next question.

[89] **Jayne Bryant**: Thank you. I was very pleased, just to come in on the back of what Lynne has said, to see your recognition of the pressures on local authorities with regard to social services. Perhaps you could just outline a little bit more how you envisage that additional funding of £25 million for social services, and how that will be used.

[90] **Rebecca Evans**: Well, this would be a matter for individual local authorities to decide. I don't really want to direct local authorities as to how they would want to spend that funding, other than to spend it on ensuring

that we have strong, sustainable social services for the future, because as I said, the pressures will vary from local authority to local authority. There might be pressures, for example, relating to the national living wage introduction, or the increase of that next year, which they might want to consider. But it will be about meeting the pressures locally.

[91] **Dai Lloyd**: Nôl i Lynne Neagle am y cwestiwn nesaf. Lynne.

Dai Lloyd: Back to Lynne Neagle for the next question. Lynne.

[92] **Lynne Neagle**: Thank you. You mentioned the announcement of the extra funding to enable the commitment to increase the capital limit for residential care to be met. Have you made any assessment of how many people will be beneficiaries of that in this first implementation stage? Also, you mentioned the very welcome disregard for the war disablement pension. How many people do you anticipate are likely to benefit from that disregard?

[93] **Rebecca Evans**: Well, in terms of the independent research that we commissioned to look at the state of the sector, particularly regarding those who pay for residential care themselves, we know that there are up to 4,000 care home residents who currently pay the full cost of their residential care. So, increasing the capital limit from its current level of £24,000 to £50,000 has the potential to benefit around 1,000 of these, and increasing it to £30,000, as we will as of April next year, will benefit in the region of 250 people.

[94] **Dai Lloyd**: Diolch yn fawr. A'r cwestiynau nesaf, ar atal, o dan ofal Dawn Bowden.

Dai Lloyd: Thank you very much. The next questions, on preventative measures, are by Dawn Bowden.

[95] **Dawn Bowden**: I didn't have the translation on then, Dai, sorry. Okay, a couple of questions around prevention, please, if I might, and whether you believe that funding for the preventative services is sufficient, well-targeted and able to demonstrate clear outcomes, and to identify whether there's any tangible evidence of seeing benefits from preventative initiatives. So, there we are, I'll leave it at that. It's a fairly clear question.

[96] **Rebecca Evans**: I'll start with this. As we said in our evidence paper to you, representing preventative spend in our resource allocation is actually highly complex because they can take a variety of forms—it's not easily separated from other forms of spend. For example, on spend in primary care, much of that will be focused on preventative measures. But in terms of the

actions that we're taking, we have a wide, wide range of preventative actions that we support, for example, investing in evidence-based preventative healthcare interventions, such as our immunisation screening programmes as well as settings-based approaches to improving public health, so the work that we're doing on healthy workplaces, for example.

[97] We're also seeking to improve health literacy and support individuals to take greater responsibility for their health because we know that this is one area in which Government can't do things alone. Actually, Government can do a great deal, but it will take the individual, local authorities, education and the third sector all to work with us to address these challenges. We can also take legislation forward in order to address public health challenges as well.

[98] I'm pleased to say, as you will know, that I'm introducing the Public Health (Wales) Bill to the Assembly on Monday of next week, with the opportunity for Members to scrutinise it on the Tuesday. We also want to work with the broader public sector and others in promoting health and well-being, which is why we're looking at models for social prescribing, which I think is a turning point, I suppose, in the way that we support people to look after their health and meet their healthcare needs, rather than a pill being for everything—actually, there are other things that can help a great deal. That really recognises the importance of good mental health.

[99] Finally, as well, we're setting a framework and providing assurances over our preparedness to deal with infectious disease outbreaks, environmental hazards and significant health emergencies and so on, such as a pandemic flu outbreak, for example. We would be prepared for those events.

[100] **Dawn Bowden**: Can I just take you back to the point you made then about sport being used in the preventative measures and how you think that an investment in sport can be targeted, particularly to support the public health agenda?

[101] **Rebecca Evans**: I think there are two sides to this: there's sport and physical activity as well, because I think there's always been quite a focus on sport previously, which has led us to think of sport very much in elite terms, but actually, this Government now is bringing back a focus to community sport and to physical activity as well, because sport is only 30 per cent of physical activity. So, the majority of our work that we do on sport is done

through Sport Wales. Sport Wales take up the vast amount of the sport budget. I'll be agreeing their allocation after I've received a copy of the chair's review, which is, I understand, coming to a conclusion at the moment, so I look forward to seeing that. The chair's review will be looking at how the organisation can best support Welsh Government aims, particularly with regard to our interest in expanding our physical activity agenda as well. So, I'll be agreeing Sport Wales's budget as soon as I've had the opportunity to consider the chair's report. But, of course, there are other ways in which we're supporting things, for example, through our Active Travel (Wales) Act 2013 and financial support for that through Ken Skates's department, for example.

[102] **Dai Lloyd:** Rhun, roedd gen ti gwestiwn atodol ar hyn—un byr.

Dai Lloyd: Rhun, you had a supplementary question on this—a brief one.

[103] **Rhun ap Iorwerth:** Dau byr. Un, pa asesiad sydd wedi ei wneud o'r cyfraniad o gyllidebau adrannau eraill yn y Llywodraeth tuag at yr agenda atal afiechydon? Yn ail, pa arloesi mae'r Llywodraeth wedi, neu yn, ei wneud i chwilio am ffyrdd newydd o gyd-gyllido rhwng cyllideb yr adran iechyd a gofal cymdeithasol ac adrannau eraill er mwyn hybu'r agenda?

Rhun ap Iorwerth: Two brief ones. First, what assessment has been undertaken of the contribution from the budgets of other Government departments towards the agenda to prevent diseases? Secondly, what innovation has the Government, or is the Government, undertaking to seek new ways of having pooled budgets between the health and social care budgets and other budgets in order to promote this agenda?

[104] **Rebecca Evans:** If I can begin with the issue of pooled budgets, under the Social Services and Well-being (Wales) Act 2014, there's a requirement on local health boards and local authorities to establish pooled budgets to meet the needs of people in residential care by April 2018.

12:30

[105] Today, there's an event with all of our regional partnership boards attending, looking at what support they might need from Government in order to get them ready for that. Because, obviously, planning has to start now, because pooling budgets is obviously a complex matter. So, we're certainly addressing that through legislation under the Social Services and

Well-being (Wales) Act 2014.

[106] **Vaughan Gething:** In terms of the way in which we work with other departments, I hope you've seen, not just in conversations we've had since coming into office, but, actually, really recently, in the Public Health Wales conference. They don't just talk to public health professionals, they've got links to Community Housing Cymru, and a range of others, including police and crime commissioners as well. So, it does cut across devolved areas and non-devolved ones too. You can think about the partnership we have with Carl Sargeant's department, where we recognise that, actually, having high-quality housing makes a really big impact on someone's health and health outcomes. So, if we're going to look at how we improve health outcomes in the future, it will require that cross-Government approach.

[107] Again, education is another really good example. If we look at our Healthy Child Wales programme—actually, that's got to link into and talk to education. We've got to find a way to make sure that information that is useful goes from the family and the child into the school setting, their early learning years and other childcare offers—lots of different conversations within the Government that need to take place to improve those health outcomes. The recent, and I think very welcome, focus on adverse childhood experiences demonstrates that lots of those are outside the health field, but they have a very real impact on people's health outcomes, and, actually, their whole life outcomes too. So, it's absolutely the approach we take within Government.

[108] So, regardless of all the allocations of the financial part of the budget scrutiny, when we all have the sums of money, actually we're still going to have to focus back on, 'And how do we deliver real value for this money across the whole Government, as well as within our part of it as well?' So, you'll see more and more work, I think, in the future, between this department, housing and education in particular, but it isn't just those areas and it isn't just devolved services either.

[109] I could go on and on and on, but, you know, the police service in particular are really important partners for us on a whole range of these things, whether it's about domestic violence, or whether it's actually about getting into schools again, and having a message that the police buy into as well about different forms of behaviour. So, there's an awful lot that we could do—we could have a whole session on it if you wanted to. But there should be some confidence from them, as part of what goes into both the budget

strategy and then the expectations of how Government will deliver with our partners outside Government, not just in this term, not in this year, but in the future too.

[110] **Rhun ap Iorwerth:** Confidence is all very nice; I'd rather have the evidence. Hopefully, we will be able to return to this.

[111] **Dai Lloyd:** Rebecca, oedd gen ti bwynt?

Dai Lloyd: Rebecca, did you have a point?

[112] **Rebecca Evans:** I just wanted to add that, as part of the public health Bill, which will be introduced to the Assembly next week, there will be the creation of powers to require health impact assessments from all of the bodies in certain circumstances, which are covered under the Well-being of Future Generations (Wales) Act 2015, and that will help us move towards that health in all policies aim that we have.

[113] **Dai Lloyd:** Diolch yn fawr. Symudwn ymlaen nawr i sôn am y gronfa gofal canolraddol, ac rydw i'n edrych ar Jayne Bryant i ofyn y cwestiwn nesaf.

Dai Lloyd: Thank you very much. We'll move on now to talk about the intermediate care fund, and I look to Jayne Bryant to ask the next question.

[114] **Jayne Bryant:** Thank you, Chair. With the intermediate care fund's clear objective, which is prevention and to reduce unnecessary admissions to hospital or residential care, what outcomes have been secured from the extra money?

[115] **Rebecca Evans:** Well, the key outcome, fortunately, meets the aim in terms that we've been able to support more older people to maintain their independence and stay at home and receive care in their own home, and prevent admissions to hospital. In the evidence paper I've provided, I offered some examples of how our revenue fund has been able to do that in different circumstances across Wales. Within that, actually, we're able to demonstrate now the number of bed nights saved to the NHS, for example, and I think that that is quite compelling evidence that the ICF is making a real difference. That's certainly the feedback that we're getting from people, both working in the ICF arena, but also from people who are on the receiving end of the care as well.

[116] **Jayne Bryant:** So, that will continue to be evaluated in the same way

that you've been doing it this time, in the future, will it, or—?

[117] **Rebecca Evans**: Well, actually, we're increasing the evaluation of it from this year forward. Perhaps Albert would like to say a little bit about that?

[118] **Mr Heaney**: Thank you, Minister. We've been evaluating. As you know we're in the third year of the intermediate care fund—very popular with both practitioners and people receiving services, but as we've developed we've realised that we need to get enhanced strengthening around the outcomes that come in to us. So, we've revised the template that we currently use. That focuses much more on outcomes and expenditure value for money. We have been continuing to work with the regions and the regional partnership boards, and there's been a number of site visits to actually see the services, and I know that many of you in the room as well have been out to some of those services. So, we're using that intelligence to actually enable us just to build and to clarify. What we will, therefore be, doing at the end of each quarter—we will be writing back to each regional partnership board, with feedback, in response, so we're able to share intelligence across Wales smarter and quicker, to enable us to be much more effective.

[119] **Dai Lloyd**: Ocê, diolch yn fawr. Symudwn ymlaen nawr i ofal sylfaenol, ac mae yna ddau gwestiwn gan Caroline Jones ar y mater yna.

Dai Lloyd: Okay, thank you. We'll move on now to primary care, and there are two questions from Caroline Jones on that matter.

[120] **Caroline Jones**: Thank you, Chair. Could you tell me, please, what outcomes have been secured with the additional moneys, over £40 million, invested in primary care in 2015-16? And what outcomes or changes do the Welsh Government intend to secure if this funding is continued in 2017-18?

[121] **Vaughan Gething**: Well, I'm happy to confirm that the additional investment that we made in primary care is going to continue—it's a recurrent commitment, so it isn't a one-off addition. And our challenge, then, is about how we continue to invest with, and for, primary care, to deliver improved outcomes. But you'll see that a range of different and new staff are now in primary care as well. One of the big stories, actually, has been the number of GP clusters—well, primary care clusters—that have actually invested in pharmacy services. There are over 240 extra people employed within the primary care system now as a direct result of this investment. And you can see the way in which that's led to people—it's

important that they're getting the right care, and at the right time, and in the right place, and in primary care that isn't always about going to see the GP. So, lots of this is about moving people to see an appropriate professional, who could be a physiotherapist, could be an occupational therapist, or could be a different kind of nurse—there are lots of advanced nurse practitioners in the mix now, compared to five years ago. And that gives better access for lots of people to the appropriate care, and it means those people who need to see a GP are much more likely to see that happen.

[122] And, in fact, in the recent day, I convened a national event on primary care to look at the progress we've made in primary care clusters. So, each of the health boards came and presented, both on where they had real opportunity, real achievement, but also I was really clear with them that I wanted to understand what hadn't worked as well, to try and understand why things weren't working, or why they'd stopped doing things as well. It was actually a very positive conversation about real improvement, and real enthusiasm from different parts of our primary care community. That's been built upon the approach of investing in primary care, the investment that will continue, but, importantly, in the way that we gave primary care clusters—each one of the 64 of them—the opportunity to determine and decide for themselves their own priorities for the populations that they served. And that's actually provided a real element of confidence, because, sometimes, when you announce an investment, people in the field will think, 'That's got nothing to do with me, and I won't believe it, because I won't see it—the decision will be taken somewhere else.' But, actually, having a very direct input into how that money has been spent has been really helpful, and it's changed relationships between people within clusters, so more GPs talk to each other, more GPs talk to other primary care professionals, and it's changed the nature of the conversation in a helpful way, between health boards and those primary care clusters too as well.

[123] So, I'm really encouraged about the progress that we see in this area, and I think Members could and should expect to see more in the future, because I certainly do from my position. I expect to see a greater improvement again in the way that primary care works and delivers even more services, and then how we make sure that the resource follows the service, to make sure that delivery is still of high quality for the system.

[124] **Caroline Jones:** So, communication has been of paramount importance then. Can you tell me how GPs are communicating with other therapies, to bring on board other therapies that they can use—physiotherapy, for

example—as opposed to an ongoing visit with a GP?

[125] **Vaughan Gething:** This has been part of desire, so GPs do talk to other professionals, they talk to each other in the clusters, to design and deliver what they think are their priorities. Some of them—lots of them—have chosen physiotherapy and pharmacists—they would probably be the two most popular choices—about bringing in additional capacity. And there's a really good and strong evidence base about not just how that that's meant that there's more time for the GP to see whoever they need to see, but also a better outcome for the citizen as well, so they get quicker access to the right service as well.

[126] We mentioned earlier about medicines management, and that's been a real positive engagement between pharmacists and those clusters, too, on improving medicines management. We have lots and lots of people who have multiple chronic conditions that they're managing and dealing with, and, actually, those medication reviews, and that input from the pharmacist, have been really important for the individual, who has been going and taking part in that treatment, as well as from the GP as well, and understanding how those different choices work. So, you can see also that it's not just physios and pharmacists, but a range of other people being brought in as well. And the challenge is how we make sure and continue to learn from the most successful clusters, and how we make sure that we understand why the clusters that aren't as successful—understanding why that is. That's what part of the national day that we had was about—about taking that learning and putting it into the system. So, I really do think that you'll see change again over the next year in the way those clusters work, but also in the choices they make about how to meet the health needs of their local population.

[127] One of the most encouraging things about the day was that people didn't just turn up and say, 'Everything's fine', because the easiest thing is to say, 'Here are six examples of good practice and now we can get out and leave the room.' There was an honest engagement about the improvement that's needed in health board areas and how they want to work with their local professionals to actually see that delivered. There's lots of really exciting things to happen but some of this is necessary as well, because just running our current system on our current model won't deliver against the real demands that we have in primary care and the wider system. So, there will be remodelling, but it's important that local practitioners take charge of that. That's why we've seen a different model in Bridgend, for example, with

the federation. It's why you'll see not just independent contractors delivering the majority of our care, but you'll see different models happening as well. And that mix of different ways of delivery with different professionals will be an important part of the future that I'll think you'll recognise, not just this year, but next year and the one after that.

[128] **Dai Lloyd**: Ocê. Mae amser yn carlamu ymlaen, so bydd rhaid inni symud ymlaen ar yr adeg hon. Ac o hyn ymlaen, cwestiynau byr ac atebion byr—nid fy mod yn edrych ar Jayne Bryant, ond rŷm ni'n mynd i sôn am drawsnewid gwasanaethau ac mae'r cwestiynau yn dod oddi wrth Jayne.

Dai Lloyd: Okay. Time is getting on, so we'll have to move on now. So brief questions from now on, and brief answers—not that I'm looking at Jayne Bryant specifically, but we are going to talk about service transformation and the questions comes from Jayne.

[129] **Jayne Bryant**: I think that I'm doing well on being brief. [*Laughter.*] Thank you, Chair. How well do you think service transformation in health and social care is being achieved, both in terms of the extent and the pace of change?

[130] **Vaughan Gething**: Perhaps the Minister could say something about the transformation that she's looking to oversee in social care and the partnership between health and social care. I think the honest perspective is that we've seen real change in service transformation across the health sector but we'll need to see a lot more, and part of my frustration is the pace of that change—I don't think it's where it needs to be. And I'm really looking for a significant step forward in the pace of that change. It's why, for example, in the planning frame, which we talked about earlier, I've been really clear, not just in the document that's gone out, but in the direct conversation with health boards, about the fact that I expect to see more happen on transforming services. And I expect to see that wider conversation take place, not just within health boards but with all the different actors within health and social care, but also between health boards as well. Because the range of our really big services are not just emergency services but they will go across health board boundaries. And in primary care we all know that there are GP surgeries, GP practices, that work across health board boundaries, so people need to talk at the margins. But on some of the big elective, planned care services as well, I've been really clear that there needs to be a change in approach—that means organisation across different health board boundaries. So, the acute alliances that are going to be delivered with

the south Wales programme, they need to work and the services need to be developed and delivered in a certain way to make sure that they'll deliver the efficiency that we want to see, which we talked about earlier, but also a real improvement in outcomes.

[131] So, there's plenty that's been done, but I expect much more to be done and I really do expect to see that, over the next year, there's a real step up in the pace of that as well.

[132] **Jayne Bryant**: Do you think there's sufficient capacity within the health and social care sector to support the drive and change that's needed?

[133] **Vaughan Gething**: Our expectation is that that capacity does exist, and where it doesn't, that we can try and find support around it. Part of the reason for the challenge and accountability mechanism we have is to really understand whether health boards can deliver, and if not, that we understand at an earlier stage whether they can do. And it's the planning, it's the accountability, and it's also the escalation frame that allows us to try and understand and do that.

[134] Part of the challenge that still exists is whether that capacity is where it needs to be. But that's also why health boards need to work together to pool their resources, to understand the shared challenges that they have and about how those patient flows will work, because every health board trying to do everything on its own isn't going to deliver the sort of outcomes that we want to see, and it won't deliver the best use of money and it won't make the best use of the staff resource we have as well.

[135] So, I think that there's real opportunity to improve that, but I think that there's got to be an improvement too. As I said, the Minister might want to say something about the improvements in integration, but also the moving forward on social care as well.

[136] **Rebecca Evans**: Thank you. With regard to the social services and well-being Act, as you know, it's only been in force for six months, but, actually, there's, I think it's fair to say, a real buzz in the sector. People who are working on the front line in this field actually feel that there is a real change in terms of the way that we are seeking to transform the care that we deliver to people, and it's quite exciting to talk to people who are working in the field. It seems like they've been waiting for this a long time. There's quite a relief, actually. People do genuinely say to me all the time, 'I'm so glad that I

work in Wales with the social services and well-being Act, as opposed to across the border. So, that's really heartening.

12:45

[137] But I also wanted to draw Members' attention to the Welsh community care information system, which is something that the Welsh Government has invested heavily in. We've provided £6.7 million of capital funding for the initial set-up costs and for the all-Wales licence, and that basically is an IT system that integrates health and social care by providing for a shared record of care for somebody who's receiving both health and social care. So, we've confirmed as well that we'll add an additional £2 million from the intermediate care fund for that for this year, but also for next year, to see it rolled out across further counties as well.

[138] **Dai Lloyd:** Diolch yn fawr. Mae'n dod â ni yn neis ymlaen i sôn am integreiddio iechyd a gofal cymdeithasol, ac rwy'n credu bod rhai o'r cwestiynau yma eisoes wedi cael eu hateb, Dawn—ond y ddau gwestiwn cyntaf beth bynnag. Dawn.

Dai Lloyd: Thank you very much. That brings us neatly on to talk about integration between health and social care. Some of these questions have already been answered, Dawn, but the first two anyway. Thank you.

[139] **Dawn Bowden:** Thank you. I will just follow on from Jayne's question, really, and your answer there, Rebecca, in terms of integration, and whether you think the budget is sufficiently incentivised to encourage integrated working across health and social care, including the independent sector. Could we just deal with that bit first—on the budget?

[140] **Rebecca Evans:** Well, I'm really pleased that, again, this year, we've been able to allocate for next year £50 million revenue and £10 million capital for the intermediate care fund, and obviously this meets one of our programme for government commitments, to maintain our support for it.

[141] The changes in the ways of working and the improvements that have been seen under the intermediate care fund actually are things that you don't just have to do under the intermediate care fund. I think, when health and social care are working very closely together and realising these benefits, actually, these things can be done outside of the intermediate care fund. This is pump-priming money for innovation and innovative ways of working. When you see the benefits to the NHS and to the individual concerned in

terms of their outcomes, and so on, then actually there's a compelling case for local authorities and social services to work more closely together, beyond the formal scope of the ICF.

[142] **Dawn Bowden:** So, are you happy with the pace of integration, or do you think, potentially, that there's a greater role for Government in pushing the pace of integration and possibly looking at some of these areas where we've seen integration? I wouldn't call them pilots because, actually, they're working properly, but where we've got integrated services working really well, whether they could be used as a kind of model to roll out in other areas. Do you see a role for Government in maybe facilitating that?

[143] **Rebecca Evans:** I think the ICF certainly gives us the opportunity to test innovative models and new ways of working, and certainly there's a compelling case then to roll out models that are working and are delivering not only improved outcomes for individuals, but cost savings to the NHS as well.

[144] In terms of the role of Government, as I mentioned earlier, under the Social Services and Well-being (Wales) Act 2014 we are requiring joint commissioning for care home placements as of April 2018, and, obviously, we'll provide the guidance and support that local authorities and health boards might need in their regional partnership boards to make that happen. But that's a clear sign from Government that we need to see further integration as well.

[145] We are seeing lots of innovative new ways of working. I did provide in the evidence paper some examples of the capital improvements that we're seeing. In Cardiff and the Vale, for example, capital funding has allowed the setting up of step-down accommodation, which facilitates earlier discharge from hospital, and new respite units for people with learning disabilities and complex needs as well. So, they are meeting those needs locally. In Western Bay, which is Neath Port Talbot and Swansea, for example, we've got closer-to-home and supported housing, and that helps the local authorities to find placements for people with quite complex needs closer to where they live. So, that's good for the individual in terms of maintaining their networks and so on, but also is money saving as well. So, that's for people with complex needs who would previously have been sent well out of county or beyond.

[146] **Dai Lloyd:** Okay.

[147] **Dawn Bowden**: Sorry, just a final point on that—you mentioned earlier the arrangement for moving towards pooled budgets by 2018 for residential care. Is that likely to be extended? Because I'm conscious that some of the pressures or concerns coming from colleagues in local government, is the apparent imbalance in terms of funding in local government as opposed to health, and whether the implementation of pooled budgets across the integration programme would assist with that.

[148] **Rebecca Evans**: This is a first step in terms of joint commissioning. Then we would consider, or we are looking to increase that then onto people of the autistic spectrum. Albert's going to provide us with some more information.

[149] **Mr Heaney**: Absolutely, the regional partnership boards are statutory. Within that statutory, the Minister has asked the regional partnership boards to look at pooling budgets across a number of areas. But the Minister has actually, in law, prescribed that there are certain areas that must be pooled. At the moment, we have the integrated family support service, which is an integrated pooled budget, and by 2018, then, in relation to care homes. But there's nothing at this moment in time, given the legislation and given the intent by Ministers, to stop and prevent those regional partnership boards. I know a number of them—because it is a new approach, it has created a culture change. We're seeing not just health, local authority, social services and the third sector working together, but we're seeing other partners come in to begin to look at things very differently from how they have worked previously. I think your question leads to the opportunity to doing more things together as we go forward, but it is bearing in mind that we also have been supporting the capacity to do that through the delivering transformation grant, and that will now transfer into the RSG in the next financial year under the draft proposals.

[150] **Dai Lloyd**: Ocê. Mae amser yn carlamu ymlaen ac rwy'n benderfynol o gael cwestiynau dwys ar iechyd meddwl a CAMHS. Fe wnawn ni ddechrau efo iechyd meddwl yn gyntaf. Caroline ac wedyn Angela. Felly, Caroline Jones.

Dai Lloyd: Okay. Time is moving on and I want to have quite detailed questions on mental health and CAMHS. We'll start mental health first, from Caroline and then Angela. So, Caroline Jones.

[151] **Caroline Jones**: Diolch, Chair. Can you please clarify the total amount of NHS funding to be ring-fenced for mental health in 2017-18, and the

proportion of health funding this represents?

[152] **Vaughan Gething**: The ring fence for 2017-18 should be £620 million plus, representing a bit over 10 per cent of total health board allocation. But as from previous conversations, the ring fence is not the maximum or the minimum—it is a minimum, it is a protected sum. We know that more gets spent on mental health services than simply the ring-fenced amount.

[153] **Caroline Jones**: Okay.

[154] **Dai Lloyd**: Angela.

[155] **Angela Burns**: Thank you. The question I wanted to ask you about mental health, Cabinet Secretary, is: where is the money that is going to help the young people who do not fall inside CAMHS—and I don't want to talk about CAMHS because that's going to be spoken about later? You talk about funding to have an extra £0.3 million to work with young people between 14 and 25, but there are an awful lot of younger children like that who do not fit the CAMHS criteria, and find it almost impossible to access decent mental health services, ranging from looked-after, adopted children, children with complex needs that—. There is still this view that if a child is in a wheelchair and a child had a mental health condition, one precludes the other and they don't fit into this bracket or that bracket. I'd like to understand where money is coming from, or in what department those children will be able to access those kinds of services, so that I can have a good examination of the funding element there.

[156] **Vaughan Gething**: Well, since we introduced to mental health Measure, you've seen a significant expansion in local primary care mental health services, and these are for children and young people too. We've invested specific sums in that for children and young people too. I would not find it acceptable for any part of the health service to prioritise physical healthcare needs above mental health care needs, or to simply say that they will only deal with, for the person in front of them, and only prioritise one need over the other. You have to see that person has a whole, in the way that they access support and treatment. It's difficult to unpick it from CAMHS, because part of our challenge is that, for CAMHS to work more effectively, we need to get people out of the CAMHS stream who are inappropriate referrals, which means that there do need to be other places for them to be seen and supported. If you look at what we're investing in, I think that, over the next year or two, you'll see that happening—an improvement in CAMHS and that

improvement in the local primary mental health care services for children and young people who do need some support that is not in the specialist CAMHS area.

[157] **Angela Burns:** A lot of those children actually need quite a lot of support that isn't in the specialist CAMHS area. So, to put my question slightly differently: are you content that there is enough money in the system to support children who are under 14 years of age to access additional mental health services?

[158] **Vaughan Gething:** Yes, I think we should be confident that there is enough money to support those children. The challenge will be making sure that money is well used and it gets to people who need it. Within that, we recognise that there is a challenge of improvement for us to deliver upon. Going back to all those earlier conversations about how much money there is, and what we will and won't deliver, this is absolutely an area of priority for the Government where we see that improvement is required and we've invested significant sums of money to do so, and we're doing something that isn't replicated in every other part of the NHS family across the UK in making this level of commitment. The challenge exists for us to make best use of the system that we have, the integrated services that we have, to make it a real integrated service and not one that we talk about in theory and doesn't get delivered in practice. That's why we see a range of different workstreams taking place, and it's why Together for Children and Young People is not just looking at the CAMHS services as well.

[159] It's a really important area, but it will remain a commitment for the Government and it will remain a ministerial commitment and a commitment for the service, because we do know that, until we get to that improved position, Members will have their postbags filled with these certain challenges and problems, and I expect they will continue until we reach they genuinely improved and sustained position.

[160] **Angela Burns:** I totally appreciate what you're saying, but it is the one area where children and young people fall between the educational stool and the medical model, and I still don't see that safety net coming in. But I appreciate your comment on it.

[161] **Vaughan Gething:** We're improving a range of services with education for children and young people in the education sphere. That's part of the point about the greater buy-in across the different parts of not just

Government, but actually services on the ground as well. So, I recognise the level of challenge there, but it is about making sure those people don't fall through cracks between services, and that we do have appropriate services outside CAMHS where that isn't appropriate. I'm sure that there'll be a continued focus in this committee and your partner committee, the Children, Young People and Education Committee, to make sure that the Government understands that this is a continuing priority for Members. That's not something to avoid.

[162] **Dai Lloyd**: Diolch yn fawr am hynny. Rydym ni'n symud ymlaen i CAMHS nawr, a Lynne Neagle fydd yn gofyn y cwestiynau.

Dai Lloyd: Thank you very much for that. We now move on to CAMHS and Lynne Neagle's questions.

[163] **Lynne Neagle**: Thanks, Chair. The additional funding that was announced last year for CAMHS was made recurrent. When you came to the children's committee, you were reluctant to give a timescale for meeting the CAMHS waiting times targets, but you must have made some sort of assessment of what that money is going to buy. Are you able to say a bit more about when you expect those waiting times to be met? We know also that the waiting times are worse in some areas than in others. How is that money actually going to be allocated to deliver the maximum improvement in specialist CAMHS waiting times?

[164] **Vaughan Gething**: We expect each health board area to be compliant within the course of the next calendar year for the new 28-day and 26-week targets. We expect most to be compliant at the start of the next financial year. So, from April onwards, we expect to have seen—over the next two quarters of this year, this financial year, sorry, as opposed to calendar year—we expect to have seen continued improvements. We expect by the end of the next calendar year to see each health board in balance and delivering against those deadlines. That's why the investment going in was important. It's always important to make sure it's recurrent and that the new staff who will come on board will be delivering against those demanding but necessary targets, because too many people are on the waiting lists. It's a challenge to get people out if they don't need to be there, but too many people who do need that support wait too long, as well. That's why we've made the investment and I fully expect that there'll be questions on whether that expectation about the timescale for improvement is going to be met in this committee and in the children's committee, too.

[165] **Lynne Neagle**: Can I just follow up on what Angela said? We know that GPs are still making inappropriate referrals to CAMHS, which is log-jamming the whole system. But, to some extent, they should be providing that sort of service locally. So, to what extent are you actually monitoring specific delivery on children's provision by primary care under the Measure?

[166] **Vaughan Gething**: Do you want to come in on this one, Andrew? It's important to recognise that is something that we're taking account of—where are those referrals coming from?—because it's a different picture across the country and locally as well. So, that sort of intelligence has to be there. But it's also why, if you like, from a leadership point of view, I've made very clear my expectation for the vice-chairs, that they need to be on top of this, that I'll come back to it in each meeting that we have, and that they need to understand locally where those different pressures exist and how they're going to be managed within the system.

[167] **Dr Goodall**: We know, for example, that between April 2015 and June 2016 around 2,200 young people came through the primary care gateway, and were referred in at that stage. Obviously, we can try to give a more updated position at that stage, but we are looking at aspects of the system as well. In particular, we've had a concern about where children are getting referred out of area, because that's been a historical concern and problem.

13:00

[168] In fact, over these last 12 months in particular, we have seen reductions in those numbers of children being placed in those kinds of areas. So, actually, the numbers over the last two months or so have actually been some of the lowest that we've seen at this stage. Traditionally, around 25 to 30 a year are going out, but that's been much reduced at the moment—probably below six patients at the moment. I think we just need to look at the system, but certainly we do have some monitoring information around the primary care activity that's going on as well.

[169] **Lynne Neagle**: Would you be willing to share that with the committee?

[170] **Dr Goodall**: I'm very happy to give the update to September.

[171] **Dai Lloyd**: Ocê. Mae'r amser yn prysur dod i ben felly rwy'n mynd i neidio ymlaen a jest cael un adran

Dai Lloyd: Okay. Time is quickly coming to an end, so I'm going to jump forward and we're just going to

arall i orffen, gyda'ch caniatâd. Rydym ni'n mynd i sôn am gynlluniau cyfalaf ac mae Rhun yn mynd i ofyn cwestiwn 37.

have one other section before closing, with your consent. We will talk about capital schemes and Rhun is going to ask question 37.

[172] **Rhun ap Iorwerth:** Yn syml iawn, a oes yna ddigon o gyllid cyfalaf ar gael er mwyn cyflawni, os liciwch chi, dyheadau byrddau iechyd a chi fel Llywodraeth?

Rhun ap Iorwerth: Quite simply, is there sufficient capital funding available in order to achieve the aspirations of health boards and you as Government?

[173] **Vaughan Gething:** Well, we can always make use of more capital, so let's be upfront about that. But in terms of the service transformation that we wish to see, then capital is an important lever for us, both for the secondary and tertiary care estates, the hospital sector. Importantly, I want to see more focus on what we can do to help transform primary care as well, and the way in which we work with different partners in local government and housing, as partners in doing some of that. So, I think the capital will be an important lever, but I wouldn't just want—. The question is, if you don't mind me saying, a little loaded, on whether there is enough capital, but it's always about how it's used, whether the plans are there that are underpinned by evidence about how they will transform services so that people really do have the best setting to deliver care, as well as the right number of staff to deliver that care as well. It isn't just a capital question; it is about the whole system and about planning and understanding what the whole system could and should deliver.

[174] **Rhun ap Iorwerth:** A lot of capital spending can be seen in an invest-to-save kind of way. If there are capital projects that would be desirable and that aren't deliverable now, have you made an assessment of the savings, if you like, that you're not able to make in the longer term?

[175] **Vaughan Gething:** Some of this goes back to the project-based nature of some of this as well. With each bid you get coming in, understanding will that deliver the sort of savings we want in terms of revenue and outcome terms as well, and then if there's slippage in there, you know, that isn't being delivered at that point. We can provide you with an update on more of how we see the capital picture moving forward and I can come back and have another session on capital if you like, given we're only talking about it at the end. We can identify challenges in projects not going ahead and what it then means in terms of running with a different sort of system, but to try and take

a whole-system approach, we need to look at each of those different areas that aren't happening, or aren't happening at the pace we want to see, and at the same time we'll be looking forward to those things we think will happen, whether it's a new centre in Flint, Blaenau Ffestiniog, or whether it's a new primary care estate in Mountain Ash that we're looking to deliver. With the health board and partners as well, there's lots and lots you can look at that should remodel that in a positive way. This is actually really exciting for professionals as well, because when we talk about some of the challenges of delivering primary care in our GP estate as well, it's one of the big issues the royal college raise and the BMA raise as well. So, we could actually move people into a new estate, a new setting, where they don't have financial liabilities coming with them, where the ownership is in a different place so it's not something for them to worry about and it's a better setting for them to deliver care, and, as I said, where we design in a multidisciplinary team to deliver that whole service. So, there are real opportunities for improvement as well. Anyone who's dealt with capital schemes across a large organisation knows that at some point there'll be slippage. So, part of our challenge is, when that happens, do we understand at an early enough point in the year that's not going to take place, and do something else in the queue that can replace it and make use of that money within the year to deliver a different one across the system.

[176] **Rhun ap Iorwerth:** Finally, can you point to elements of this budget in terms of capital spend where you believe that the result will be transformation in the kind of NHS that we have? Rather than just improvements here—any capital spend leads to an improvement in delivery of healthcare in whatever way it might be—but in search of transformation and a better, new kind of NHS, can you point to where the capital spend that you have in mind is going to make that difference?

[177] **Vaughan Gething:** Well, I think the capital spend in the intermediate care fund will do that as well. That really is about transforming the way we deliver services—why we deliver them, who we deliver them with. You'll definitely see a whole range of products. If you had another half hour, the Minister could talk to you about each of those that are already delivering, and we expect that to happen more in the future. I guess the other obvious one is the SCCC. We delivered that commitment to a huge investment to transform the service and it's part of a whole picture—it isn't just that one decision—it's part of a whole picture in Gwent and across south Wales, where that capital investment should transform the whole nature of how the system works in driving some of those services out into the community and

changing the way that the Royal Gwent and Nevill Hall work, but also then changing the way the SCCC works and fundamentally changing the way primary care works as well. So that isn't just one capital investment simply for one part of the system; it is supposed to be, and designed to be, transformational for the whole system.

[178] **Dai Lloyd**: Diolch ac mae'r anrhydedd o ofyn y cwestiwn olaf yn disgyn i Jayne Bryant. Cwestiwn 39.

Dai Lloyd: Thank you, and the privilege of asking the last question falls to Jayne Bryant. Question 39.

[179] **Jayne Bryant**: I was thinking that I was too slow here.

[180] **Dai Lloyd**: Efallai nid y cwestiwn olaf, Julie.

Dai Lloyd: Perhaps it's not the last question, Julie.

[181] **Jayne Bryant**: I just wanted to mention—. You mentioned about the money for the new neonatal unit at the Royal Gwent Hospital, which I am really pleased about, and the SCCC as well. But just wanting to move on, do you think that there's sufficient future capacity within neonatal care services?

[182] **Vaughan Gething**: Yes, we're planning for it. We're planning for it, both in terms of the—. The investment in the Royal Gwent is a medium-term investment, if you like, because we recognise that there will be change, particularly with the SCCC now being confirmed for the future. We're planning for an expansion in neonatal capacity in Cardiff as well, and that's based on our best understanding of both staff numbers, but also the numbers that will need neonatal care and the ability to meet standards of care and outcomes for people as well.

[183] So, we're planning for it, and I think that you'll find in our cancer programme, that we're aiming to deliver that increased capacity as well. I know that you visited the unit in the Royal Gwent, and hopefully you'll see, on a future visit, the additional space and capacity that that's going to create for people in the here and now, as well as in the future. This is part of the challenge in how we make sure that the system that we have now continues to deliver appropriate care as best as possible, as well as a transformational change to what we see in the future as well.

[184] **Dai Lloyd**: Diolch yn fawr. A sôn am anrhydeddau, Julie Morgan.

Dai Lloyd: Thank you very much, and talking about privileges, here's Julie Morgan.

[185] **Julie Morgan**: Just quickly on the capital spend, I'm very pleased about the Velindre development, and I would certainly say that that was linking to a transformation of the way cancer services are delivered in a way beyond the capital building. But my actual question was: since we have Brexit on the horizon, have you considered at all in terms of your financial planning for the health service what implications there will be for the health service due to Brexit?

[186] **Vaughan Gething**: I don't think there's any measured assessment of Brexit being a positive for the health service. But it's one of those great unknowns and challenges, particularly if it interrupts our ability to make workforce decisions—not just about recruitment, but about the ability to understand qualifications across the piece. There's lots and lots of facets to this. But the uncertainty was highlighted by today's decision on article 50 as well. So, we can't know when Brexit will be a reality or what form it will be. And that makes it incredibly difficult to plan, and not just for Government. I guess the public will say, 'Who cares about a man in a suit who's a politician?' but when it comes down to planning the service that they receive and take part in locally, I think people will be very interested at that point in why they can't or whether they can get the service that they expect to receive, now and in the future. So, this is one of the big challenges for not just this Government, but for every tier of government right across the UK, and understanding in amongst the fog of uncertainty about where we are going and what the ultimate end-point that the UK Government wishes to reach is, and what the impact will be, and not just for every public service, but also in our private sector as well, and the jobs that we all rely upon here. Health is involved in the work within Government, about trying to plan for what Brexit does and doesn't mean, but I can't give you clarity where we don't have that at a UK level at this point in time. What I can say is that it's something that is very much in the minds of everyone who leads and runs the health service.

[187] **Dr Goodall**: Minister, just in respect of workforce rules, it could be a very strong area, but there are other aspects around the research field and how many work in that community, about regulation around medicines which operate through a European prospective, and procurement rules, for example. So, as the Minister said, we are working those things through centrally, but it will be on some of the headline issues, perhaps on workforce, that we need to understand.

[188] **Julie Morgan**: And so you're not really doing anything in any detail at the moment.

[189] **Vaughan Gething**: The challenge is that we can't do much in significant detail now because we don't know. We don't know enough to make that sort of level of detailed plans. We were talking about shared services in procurement, which have generated significant savings that you can see. If you look at shared services just over the last 12 months, they can say how much they've generated in terms of savings for the health service by the procurement route they're taking. But actually the procurement rules will probably change. But they may possibly not because that depends on our deal with Europe about our trading relationship in the future. Because actually, as you know, one model is that, potentially, we'll have entirely different procurement rules, or it could be that we'll still effectually stick to the same procurement rules as part of the deal of having continuing access to that market. So, it really makes it incredibly difficult to properly plan in detail about what that could mean, but we have to try and understand what different scenarios might mean. I couldn't give details now because we don't have them, and that is because they don't exist. You know, no-one here could say with certainty what the Government of the UK wants to achieve, and the effect it will have on the devolved nations, on our public services and all the very different multifaceted aspects of running a highly complex healthcare system in this part of the world, let alone anywhere else.

[190] **Dai Lloyd**: Rhun, a oeddet ti eisiau dweud rhywbeth?

Dai Lloyd: Rhun, did you want to say something?

[191] **Rhun ap Iorwerth**: I was just going to ask: you are investigating what steps you might have to take in the face of a whole set of different scenarios. I accept entirely that we don't know which scenario it's going to be.

[192] **Vaughan Gething**: Broad scenario planning, of course, takes place across Government on a range of different things, and of course we're having conversations with different parts of Government, and the First Minister and the Cabinet Secretary for Economy and Infrastructure are leading on Brexit. But I'm just being honest about the fact that I can't give you detailed certainty because we don't have it ourselves. If and when we get to a better level of certainty, then we can do more work and have a much better level of preparation. But when there's a vote in Parliament—

[193] **Rhun ap Iorwerth**: I think you've got a fair bit of time.

[194] **Vaughan Gething:** We've got a fair bit of time before we get to the endpoint, but the challenge will be, ultimately, to change lots of our systems in these areas, and actually it does take time to do that. So, the less time we have, the less prepared we can be, and the more risk there is for all of us that will be driven into the system, and that's not a comfortable place to be. I won't pretend I'm happy about it, but that's the challenge we have being in Government and actually having responsibility for delivering the system.

[195] **Dai Lloyd:** Diolch yn fawr iawn i chi, Weinidog. Mae'r amser, ac mae'r sesiwn yma, wedi dod i ben. Diolch yn fawr iawn i Ysgrifennydd y Cabinet a'r Gweinidog, a hefyd y swyddogion, am eu tystiolaeth ysgrifenedig ac ar lafar.

Dai Lloyd: Thank you very much, Minister. Our time and this session have come to an end. Thank you to the Cabinet Secretary and the Minister, and also the officials, for their evidence, both written and oral.

[196] A allaf i gyhoeddi, fel buasech chi wedi deall, nid ydym ni wedi gallu gofyn pob cwestiwn yr oedd angen eu gofyn y bore yma? Gyda'ch caniatâd, mi wnawn ni ysgrifennu llythyr atoch chi efo'r cwestiynau ni wnaethon ni lwyddo i'w gofyn y bore yma. Hefyd, fe fyddwn ni'n danfon trawsgrifiad o'r cyfarfod yma i chi ei wirio.

I'd like to announce, as you may have understood, that we've not been able to ask every question that we wanted to this morning. With your permission, we will write a letter to you with the questions that we didn't reach this morning. We'll also send you a transcript of this meeting to check for accuracy.

[197] Felly, gyda hynny o eiriau, a allaf i ddiolch i chi unwaith eto a datgan bod y sesiwn yma ar ben? Diolch yn fawr iawn i chi.

So, with that, could I thank you again and say that this session is now closed? Thank you.

[198] **Vaughan Gething:** Thank you very much. Take care.

13:12

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

Cynnig:

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

Motion:

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

Cynigiwyd y cynnig.
Motion moved.

[199] **Dai Lloyd**: O dan eitem 4, a allaf i gynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod? Gyda'ch caniatâd, fy nghyd-Aelodau; nid ydwyf yn gweld unrhyw un yn ymwrthod, felly mi awn ni i sesiwn breifat. Diolch yn fawr.

Dai Lloyd: Item 4, under Standing Order 17.42, I resolve to exclude the public from the remainder of the meeting with the permission of my fellow Members. I don't see anyone disagreeing, so we'll go into private session. Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 13:12.
The public part of the meeting ended at 13:12.