HOUSE OF COMMONS

Welsh Affairs Committee

Oral evidence: Cross-border health arrangements between England and Wales, HC 404

Thursday 8 January 2015

Ordered by the House of Commons to be published on 8 January 2015.

Written evidence from witnesses:

- Welsh Health Specialised Services Committee
- Welsh Government

Watch the meeting

Members present: David T.C. Davies (Chair); Guto Bebb; Geraint Davies; Glyn Davies; Stephen Doughty; Jonathan Edwards; Nia Griffith; Simon Hart; Mrs Siân C. James; Jessica Morden.

Questions 297-381

Witnesses: **John Hill Tout**, Interim Chair, Welsh Health Specialised Services Committee, **Stuart Davies**, Director of Finance, Welsh Health Specialised Services Committee, and **John Palmer**, Director of Specialised and Tertiary Services, Welsh Health Specialised Services Committee, gave evidence.

Q297 Chair: Good morning. I'm not sure whether I should be saying "Mister" or "Doctors" Davies, Hill-Tout and Palmer.

All witnesses: No doctors.

Chair: Thank you very much for coming along and giving evidence. I have met some of you before. May I start by introducing myself as the Chair of the Welsh Affairs Select Committee, with colleagues here from all the political parties in Wales? We are not here in an aggressive way; we are just seeking information, as much as anything, about cross-border services. Obviously, there is a time limit, so if I may say gently to everyone, although the first couple of questions usually take a bit longer, after that, I may try to hurry things along a bit depending on the time.

May I begin by asking what sort of tertiary services are available within Wales to treat patients?

Mr Palmer: Shall I pick that up? The first thing to say is that we are here reflecting a very positive set of relationships between Wales and England. The things we have in Wales are reflected in a big financial commitment. We have contracts of up to £100 million running across the border, and most of that is contracted activity. We have a small amount of non-contracted activity that goes through IPFR, which runs to about £6 million. When you look at

the overall Wales position, you will see that North Wales and Powys are very big users of English services, because they do not have a lot of specialised services on their own patches. What you will see in South Wales is a comprehensive package of specialised services, broadly across Swansea and Cardiff, and therefore quite limited flows across to England.

Q298 Chair: In a nutshell, your job is to provide the services that we cannot get from within Wales and to find somebody else to do it.

Mr Palmer: Yes, absolutely. We are the specialised services commissioner that makes sure that there are contracts reaching across Wales and then into England where we do not have that provision.

Q299 Chair: Do you use any private sector providers in England to provide services?

Mr Palmer: To an extent. I will turn to Stuart in a second, just to run through that bit. It is not the most typical part of our work, but for instance, we do some work on cardiac services. We have done that over the last year, where we have had to improve our cardiac position, so there was some limited use of the private sector in doing that—as there was NHS provision from England and NHS provision from Wales, so it is usually a mix.

Q300 Chair: As I understand it, whereas in England, the CCGs have to look equitably at using either NHS providers or private sector providers and end up going on quality and cost, within Wales, you do not have to do that, but you choose to do that in some instances. Is that more or less right?

Mr Palmer: Yes, I think that is fair to say. Stuart, do you want to pick up on that?

Mr Davies: Yes. The use of specialist services in England in the independent sector is very small. We tend to rely on the NHS because they are the centres of expertise. However, we do have occasion to use non-NHS providers for very specialised mental health care, where the numbers of those patients are so small that there is not even NHS provision within England. For very small numbers of children, for example, with learning difficulties requiring in-patient care, there are very few facilities, so we have occasional use of those and occasional use of secure mental health services for, again, sub-specialities that are generally not available in Wales, but there is very little. The final thing is that we use independent sector providers outside England for such things as proton beam therapy. We will fund a child to go to the USA, because they are obviously independent sector.

Q301 Chair: How many English patients use tertiary services within Wales roughly?

Mr Palmer: I think we are looking at quite small numbers generally. We have some strong relationships in South Wales on paediatric cardiac surgery that run between Bristol and Cardiff, and we also have a designated UK-wide service for burns and plastics in Swansea. You would see about 20 patients a year coming in to utilise that service, but overall, the flow is much more the other way.

Q302 Chair: My daughter had to use that and I must put on record how very, very good the staff were in Swansea.

Mr Hill-Tout: Just to add to the introduction, you asked what our role was. I want to be very clear that what we are commissioning—what we are providing—is tertiary care, as you understand from our brief. We are doing that for all of Wales, whereas other LHBs also commission in England, but for secondary care, so there is a distinction there.

Q303 Geraint Davies: Would you agree that as London is a global clinical centre as opposed to a national one, where some of the leading clinicians in the world go, it is not unnatural for Wales,

Yorkshire or anywhere outside London to have people migrating to London hospitals for specialist treatment? That is why the flow into London and out of London is not equal, including Wales.

Mr Palmer: I don't know if we can answer that directly. Essentially, if you look at any of the international literature, it would say that you need a critical mass of population to deliver specialised services. I think we put it in the brief, but you need a population of 1 million to be able to have a viable centre. What you have seen historically through the last half of the century and from the 1990s, as we started to commission more consciously in the NHS, are clusters and centralised, specialised services forming in a limited number of spaces around the UK. One of the positive things we want to say is that specialised services is a UK business. We naturally depend on each other to be able to get it right. London is a big centre, and we work with London on a number of fronts. We work with the Brompton on transplantation, cardiac and that sort of stuff.

Chair: That's great; thank you. I will keep strictly to time. Siân James is next.

Q304 Mrs James: Thank you. I wanted to come on to access to services. Can you explain the two processes? There are two avenues. What are the differences, and how can you be referred to specialist care centres in England?

Mr Davies: Do you want me to take that?

Mr Palmer: Just to clarify, when you say two processes, you are talking about IPFR and prior approval, I presume.

Mrs James: Yes.

Mr Palmer: Okay, yes. Stuart, fire away. You are the expert.

Mr Davies: The vast majority of our care in England is secured through service level agreements with our English providers. Between 95% and 99% is provided directly on the basis of a direct clinical referral, usually from a secondary care clinician or a tertiary care clinician in Wales, to one of the designated centres in England. They will automatically list that activity and treat the patient without any further intervention by commissioners. The activity is then recorded and we assess the quality after the event. We have a small number of new interventions or drugs that are contentious, in that they are not approved by NICE or the AWMSG, and for those we require either prior approval or an individual patient funding request to be made to us, because they are usually non-compliant or not commissioned. We consider those through the IPFR panel process.

Q305 Mrs James: One of the problems that I have come across is clinical trials. You talk about people accessing clinical trials in Wales, but I have had a problem in the other direction. There was a free clinical trial in England, and it was very difficult for a cancer patient to get access to that. What would happen in those circumstances?

Mr Davies: Wales participates in access to clinical trials, so as long as the referral has come from one of our tertiary clinicians into the trial—they have awareness of the trials—we as specialist commissioners will fund the NHS care associated with the trial. What normally happens is that that the drug therapy or the other intervention, be it a device or a drug, is provided by the independent sector or the company as part of the trial. All the NHS facilities are covered by us.

Q306 Mrs James: So it should go smoothly.

Mr Davies: It will go smoothly, so long as the patient falls within the narrow definition of the trial, and that often can be the problem. These are small subsets of the population.

Q307 Mrs James: And we can always come to you with those circumstances.

Mr Davies: Absolutely, yes.

Q308 Jessica Morden: As you just said, in England, there is the cancer drugs fund and there is a different system in Wales. During the course of the inquiry, there have been calls for a single system across England and Wales. What is your view on that?

Mr Palmer: John, do you want to start and I will continue?

Mr Davies: At a policy level on the cancer fund issue, in Wales, the Government have not introduced the cancer fund. That is a policy issue. In terms of what we do as part of NHS commissioning, we do not recognise any distinction between cancer patients and others, so we would treat cancer patients through our systems in just the same way. We do not, however, have a cancer fund, because that is a political decision.

Mr Palmer: I think it is important to say that we have a good IPFR process with clear methods. We look at all the cases that come through that process on an exceptional basis. Rare cancers are considered alongside many other rare presenting diseases and rare treatments that need to be matched to them. We have had a good review on the basis that that is an ethical and well-balanced approach that promotes fairness across specialisms.

Chair: A tiny supplementary, perhaps?

Q309 Mrs James: Are you happy that the process that you are operating and that you are implementing is actually timely and appropriate for particular types of cancer, because some people do not have the luxury of time?

Mr Palmer: I think we endeavour always to be very timely in the processes that we run, so we have a two-day turnaround for our prior approvals; we do not hold back on emergency approvals; we have a monthly IPFR panel that meets with clinicians around the table; and we will call a virtual panel if there is something absolutely urgent. I would say, actually, we have got really good examples in the last six weeks, really, where we have looked at exactly the sort of issues on cancer treatment, around HIPEC heated chemotherapy, where we have done exactly that sort of virtual panel to expedite a treatment.

Q310 Nia Griffith: On that very issue, we have had some sort of conflicting evidence—Betsi Cadwaladr saying it is very easy to access the services, but individual patient groups highlighting cases where there have been delays. Obviously, what you have just said there is that highly urgent cases you deal with very quickly; but what is this business about the panel meeting once a month? Is there any way that there could be a consistent time frame—for example, a maximum of 30 days, or whatever, that patients would hear? Is there any way that possibly things could be speeded up along the line? We do not know if these delays are coming from individual health boards, doctors—or what they are coming from. How do you see that as working, because there is still a public perception that there are delays?

Mr Palmer: I think it is true to say that most of the delays that happen through the IPFR process are about having proper clinical information from secondary care referring clinicians, or, indeed, tertiary referring clinicians. Our job is to make sure that the treatments we sign off are safe, are going to deliver the absolute best outcomes for the patients and have been through a set of dialogues with our nurse director and with our medical director, to make sure we are doing the right things. So within the context of a monthly panel we usually find,

actually, if we have a concern, if we have challenged back, that we need two or three weeks to get the right diagnostics done, to get the right preparation of the case brought forward, so when we do make a decision it is the right decision for the patient. There is a strong focus on that; but, as I said earlier, if the evidence is clear and the evidence appraisal comes through and the clinicians have said this really is something we must do urgently, and there is agreement from our medical director, then we will hold a virtual panel and we will expedite the decision.

Q311 Nia Griffith: So is there any way that the system could be improved? Would you, for example, think that better understanding of the system by some clinicians, so they make the right application and give you the right information in the first place—is there a case, perhaps, for educating them as to how to get the system to work faster for patients?

Mr Palmer: I think I would agree. I think there is a case for pushing further on education with clinicians. It is something we endeavour to do. We try to make sure our website is very clear and easy; but, yes, I think we are constantly looking to improve that, and I think an education programme is a good idea.

Q312 Simon Hart: That's really helpful. The question I was going to ask, really, is about advice—about what to do when that does not work. I know we have probably all got individual examples, but I will just use one quick one to help frame the question. In one particular constituent's case, where the clinician has said that the surgery that they need is actually routine, they have failed in their funding request for treatment in England because of that description. Yet, actually, while it may be routine and while it might be available in Wales, the waiting list is such that actually her consultant cannot give any date. She has already been over a year off work, on expensive medicines, etc., and has been given no date, so is caught in a cleft stick situation, where technically they will not qualify for the funding, because the operation is routine, but there is in fact no foreseeable likelihood of it ever happening. Therefore, what the hell do they do, basically? I wonder if you could advise us on that.

Mr Palmer: In all honesty, I think I would need to understand the individual case a little bit better.

Q313 Simon Hart: Well, it is more general; it is a case of where the system falls down. You have given a very good description of how it works, but what I would like to know is what people like us need to do when it does not work. What can we do?

Mr Palmer: If someone has been through the process: let's remember that for something routine—that is 97% of our activity and 94% of the budget—we would expect that to go ahead on prior approval. When it comes through IPFR, we are dealing with non-routine activity, on an exceptional basis, so an argument is made for exceptionality and we either sign that off or we don't. If there is a concern about the decisions that have been made, in either the prior approval process or the IPFR process, a local review process can be put into action and the case can be considered further, but from what I have heard, that would be a fairly rare instance.

Q314 Simon Hart: It may be unique.

Mr Palmer: But I would be happy to follow up on that.

Simon Hart: That is helpful; thank you.

Q315 Jonathan Edwards: In your testimony—we have received evidence as well—there seems to be a lack of knowledge among some medical practitioners in Wales of how to access specialist treatment. In your view, whose responsibility is it to ensure that medical practitioners know how to work with you? Is it your responsibility, the LHBs' responsibility or the Welsh Government's responsibility?

Mr Palmer: I think it's collective responsibility. John, you might want to come in on this. We are an integrated health system in Wales, and I think that is one of our great strengths. WHSSC is not a separate, independent body from NHS Wales. We serve the health boards; we are a sub-committee of the seven health boards, so we work in a very collaborative way. I would not want to paint a picture of an IPFR process in which we have competition between secondary referrers and tertiary decision makers. These are usually very collaborative processes, in which we are going back and forth between the referring clinicians and potential provider clinicians, to make sure we have absolutely the right take on what we should do in the best interests of the patient, to ensure they get the right outcome. I think there is something about making the most of that. As I said, it is a collective responsibility, but I take the point made earlier: I think we should look at an integrated programme of education.

Mr Hill-Tout: Let's say there was a consultant in secondary care in Haverfordwest or elsewhere who was unsure. We have a medical director in our committee. There is a medical director in the LHB. My expectation is that there would be good dialogue between them. If a consultant is unsure, we need to make sure that the medical directors are keeping their staff informed. I am certainly happy to take that back to our medical director, so that he can raise it.

Chair: Thank you. Geraint.

Geraint Davies: Which question? *[Interruption.]*

Chair: It's Glyn. I'm sorry. That is what comes of everyone having the same initials. I'm sorry; that was entirely my fault.

Q316 Glyn Davies: I used to get Whips' notices sent to Geraint coming to me. *[Laughter.]* If it was still happening, I wouldn't have said that.

I just want to ask about service level agreements and the difficulties that you have. I suspect that this is just a policy difference issue. I'm talking about the difficulty you have in developing service level agreements over the border when there are different policies relating to waiting times and so on. You might have the competition element over the border. How could you resolve that? Would it make a difference if you had to have the same systems on both sides?

Mr Hill-Tout: If I may, I'll make a general response to that. Our expectation is that, with devolution, there are bound to be differences in the two systems; that is inevitable. The collaborative protocol that has been developed is really designed to make sure that those differences can be smoothed as much as possible. You will see from our evidence that we feel that the protocol has made an improvement, but there are technical aspects—for example, English hospitals understanding that Welsh waiting times are different and applying the methodology. Stuart was telling me the other day he has to deal with problems about invoicing, because English hospitals don't necessarily understand the Welsh system and, whereas we understand their system, they don't comply. There are all sorts of issues around that. I think our position is that the protocols that exist between England and Wales have to be very good, very comprehensive, and there is room for improvement there. Do you want to say anything, Stuart?

Mr Davies: I would say that the commonalities between our systems are a lot greater than the differences, so we are always able to secure agreements, despite the differences. We find there are differences. Sometimes, the English organisation may not wish initially to sign our SLA proposal because it refers to Welsh waiting times—they are maximum Welsh waiting times—because they are different from the English ones. They feel it causes an operational difficulty for them to prioritise patients in a different way, but through the dialogue, we

always reply to them that the Welsh waiting times are indeed maximums; they are not minimum waiting times. And the vast majority of our patients generally get treated within the normative standard applied within the English provider. So more than 80% of our activity gets done within 18 weeks, which is the English standard, even though we have to incorporate into our SLA that there is a Welsh minimum and that we will hold you to account if you don't deliver those minimums.

Q317 Glyn Davies: How difficult—I mean, it's just an extension of the point—is it if you have a sudden change? I'm just thinking of 12 months ago, when Powys instructed English hospitals—I suppose some of those could be specialist hospitals; well, they would have been—that they shouldn't treat anybody. The period was extended to 38 weeks instead of 28. But if anybody treated anyone before 33 weeks—I think that was it—the hospitals wouldn't be paid. I saw the letter sent to English hospitals. How on earth would you manage SLAs and arrangements in a situation such as that, which might be different in the differing health boards?

Mr Davies: I think the practice tends to be that when a situation such as the Powys contract situation happens, where the situation is overheating and there is too much expenditure or activity compared to what you have set out, you start that dialogue with that organisation. But it very much is a dialogue. So we often request an operational plan to come back into line. If that's not possible, though, because of the urgency, for example, of the specialties that we deal with—our specialisms are paediatric surgery or cardiac surgery—we don't tend to apply those longer waits; we tend to make exceptions. So, in practice, we make exceptions and those exceptions are such that, in reality, very few patients actually have extended waits.

Mr Hill-Tout: The consequence, financially, of course is that we can overspend in year if that occurs, and then that has to be borne by the fees. It happens occasionally.

Mr Palmer: Have you finished your line of questioning?

Q318 Glyn Davies: Yes, I think so. I could carry it on, but I think we'd be saying much the same sort of thing. I just don't think it's as easy to resolve as—I was sitting in the office of a chief executive on the morning she had the letter, and it was the first that that chief executive, in a specialist English hospital, had heard about it. It just came completely out of the blue, in the morning, and as from that day, nobody was to be treated until 33 weeks—I think that was it—or else the hospital wouldn't be paid. How you can cope in that situation must be incredibly difficult, I think. However, that is understanding the difficulties that we face cross-border.

Mr Palmer: I just wanted to make a final point on this issue, if it's okay. Just to reinforce our submission to you, I will say that we run into quite a lot of technical difficulties around contracts and SLAs, and I think we would propose that it might be sensible to have some kind of technical review—obviously, we can drive that from our side—to look at how we ensure that payment by results, for instance, is properly accounted for in contracts and SLAs and through to the protocol, so that PBR is reflected properly there, too, and so that Welsh arrangements are properly understood. I say that because often we find at the national level, and then as it drops into local arrangements, that those understandings are not there in the technical documents, and that creates a lot of transaction, and we shouldn't be slowed down in these endeavours.

Q319 Stephen Doughty: The wider issue is the submission of invoices from providers in England. You mention in the evidence that some English providers have submitted invoices several years after treatment. Could you just say a little more about that and what is being done to address it, because obviously that strikes me as a particular problem in terms of managing financial flows and reporting?

Mr Davies: It is, yes. We adhere to the English rules set out for the English financial framework for PBR, and within those rules it is quite clear that invoices must not be submitted after the 30-day period, to ensure that you can validate appropriately, validate the activities that have occurred and test the outcomes. If something is provided that late—outside of 30 days—we don't pay. We make a strong point about that. So in those instances where we have had events where either a year or two has elapsed before the invoice has come to us, we will follow the appropriate Government line and not pay those invoices. It can cause difficulties, obviously.

Q320 Stephen Doughty: And in your understanding, what are the reasons for those delays?

Mr Davies: Some of the reasons that have been quoted in the past are uncertainty from the English provider as to who to invoice—it may have been that they have originally assumed that an English CCG is the responsible body—and for that to enter into some sort of dispute process, and by the time that is resolved between the two parties, they have realised that maybe it is a Welsh resident and they have therefore brought the problem to us very late on. In those situations, we are quite within our rights to decline them. So uncertainty is often the root cause of it.

Chair: Thank you. If I can be a bit cheeky, I wouldn't mind having a chat with you about a constituency case for two minutes afterwards. It has just reminded me of something. *[Interruption.]* Yes, Chairman's prerogative. I will not do that now.

Q321 Nia Griffith: Just to conclude on what you have been saying—both the Chair and John Palmer—are you suggesting a sort of review of the SLA agreements and the protocols, to make sure that all the t's are crossed and the i's are dotted and to make it a more efficient system? Would you like to see that initiated?

Mr Hill-Tout: Yes, there are a range of technical issues—financial, SLA, contractual—and also even issues around patient complaints. You have probably seen in our evidence that there is sometimes confusion over to whom a patient might complain, if they want to do so. We are saying that there is a range of technical issues that would benefit from much more clarity. The protocol, which is already in existence, covers some of those, but not all. As John says, we will play our part in that, but obviously it needs an approach from across the border as well.

Mr Palmer: And ours is, I think, a relatively simple system: seven integrated health boards, three trusts, and a joint committee that is doing specialised commissioning. So I think it is important for us to frame that in the technical documents that exist cross-border, especially while the English system is having an experience of complexity around creating a new commissioning framework that has CCGs, commissioning support units, and so on, supporting it. So I think we need to be on top of that, to make sure that we do not drive complexity into the patient pathway.

Q322 Nia Griffith: Are you saying the English system has become more complex as a result of some of the changes that have been occurring?

Mr Palmer: I think it remains to be seen, but when you have a large number of commissioning organisations that did not exist before that are in a debate with NHS England about how they now are delegated authority to do this kind of work, then that is a risk.

Q323 Stephen Doughty: Just a quick follow-up. Going back to the specific example I mentioned and some of the quirks in the system or problems. Since the changes have come into place in England, has there been an increase in such confusion or unawareness because, for example, an individual does not know what is going on in England and understands what is going on in Wales even less?

Mr Davies: We have seen things go in two slightly different directions. We have seen the instances of delays due to CCG differences of opinion decreasing, because responsibilities now transfer to NHS England for specialised commissioning. However, we have seen differences in the clarity of responsibility between CCGs and NHS England, and those have caused delays and been the root cause of two of our disputes.

Q324 Chair: You have answered already the questions I wanted to put to you, but let me ask you one more on this. You have mentioned the complexity of dealing with invoices from England. Is it not also the case that there have been problems within Wales over invoicing between health boards who have had to have patients treated elsewhere? Specifically, I have been given information that one of the health boards has been almost blacklisted by other health boards when it has sent people off for specialist treatment. Are you aware of any problems like that at all?

Mr Davies: Not within Wales, no. We do not have any outstanding disputes. If you are referring to cross-border flows, that is not something that would be visible to us.

Chair: No, I am talking about patients with specialist illnesses who, for example, may have had to travel to Cardiff or somewhere for a specialist treatment and have been told that it is going to be difficult to treat them because the health board has not been paying its invoices. But possibly that would not go via you anyway.

Mr Davies: If it is specialist, it comes to us; we have contracts in place with all our providers and we wouldn't enter into blacklisting or anything like that. We would resolve it.

Chair: I think the next GD is Geraint Davies.

Geraint Davies: I don't think so—

Chair: To be fair, what has happened is that we have jumped through quite a lot of things and we are running quite short of time, so let us go on.

Q325 Geraint Davies: I will ask a question then. We heard in previous evidence from Andrew Wilson-Webb of the Rarer Cancers Forum that, according to a leading Welsh cancer hospital, 90% of all IPFRs are refused. Do you have any figures to confirm or counter that claim? I should add that I am aware that this organisation is trying to promote its own drugs, obviously.

Mr Palmer: We had that feedback as well. Our current IPFR to the month in the year is that we are on about 45% of approving IPFR requests that come through. That would be within our anticipated range, from previous experience.

Q326 Nia Griffith: Do you have any feeling or evidence, because we have seen this in Parliament, of drug companies pushing vulnerable patients to try drugs, perhaps for 10 days or two weeks of extra life, not necessarily even offering a palliative or painkilling solution?

Mr Palmer: Our contact tends to be with referring clinicians, rather than drug companies. Of course when you work in the NHS, you are aware of the drug lobby at all times, but that is not something that tends to come directly into contact with our organisation. As I say, we speak directly to clinical referrers, so our responsibility through IPFR, prior approval or any route is to make sure that the proper clinical conversations happen so that we secure the best patient outcome.

Q327 Geraint Davies: Is there a danger of having these non-NICE-approved drugs in England? Pharmaceutical companies can basically lobby patients through the internet and other ways, saying, "This can cure your problem. You can live weeks, months, years longer", so patients would demand

the drugs that are not clinically approved from the Welsh health service, and then we get into that problem. Is that the logic of not having this extra thing?

> ***Mr Palmer:*** Of course that is a risk. However, as I suppose Stuart would prompt me to say, we work very closely with AWMSG and AWTTC, which are the medicines bodies. They look at all the new emerging drugs that are coming through. We are involved in the evidence-appraisal processes that support advice to the Minister. You will have seen that for some innovative medicines that have come through the system in recent times, Wales has made proactive decisions to bring some of them on board, either in full decisions or in interim commissioning decisions, sometimes ahead of NICE. Certainly we keep in line with NICE. Those are our mechanisms—the AWMSG and the AWTTC—for attenuating that kind of risk, if you like.

Q328 Geraint Davies: And this goes beyond cancer as well, doesn't it?

> ***Mr Hill-Tout:*** It does. It's comprehensive.

Chair: I understand that the Minister is outside at the moment. I do not want to keep him waiting too long. Perhaps I could quickly ask if anyone would like to fire off a few more questions.

Q329 Jessica Morden: On the cancer drugs fund, of which there has been criticism today, because of the overspend and the various 42 drugs that have been reassessed—

> ***Mr Hill-Tout:*** In the English NHS?

Jessica Morden: In the English NHS. Albeit it is not your system and you have a completely different one, but I wondered if you wished to offer an opinion of the criticism of the cancer drugs fund.

> ***Mr Hill-Tout:*** I think that we would say, as officers, that what we would try to do is to apply the same criteria to whatever disease anyone is subjected to, so it is no different if it is cancer, a neurological disease or a cardiac disease. The argument is that we apply the same evidence-based, clinical judgments, and that is what we should do. It is a political decision whether one would fund a specific illness to a greater degree, but what we have to do is to ensure that we are even-handed and evidence-based for whatever disease that anyone presents with.

Q330 Chair: If everyone is satisfied with that, I will call this meeting to a close. I had one question, but I would not want to keep you waiting and it is a very specific issue, which the Committee will not want to hear about. Perhaps I could give someone a phone call later on today.

> ***Mr Hill-Tout:*** Sure, we will leave a phone number.

Chair: Thank you, much appreciated. Thank you very much.

Examination of Witnesses

Witnesses: **Mark Drakeford AM**, Minister for Health and Social Services, Welsh Government, and **Dr Andrew Goodall**, Chief Executive, NHS Wales, gave evidence.

Q331 Chair: Bore da. Diolch yn fawr. Thank you for joining us today, Minister.

> ***Mr Drakeford:*** No problem, of course.

Chair: We have no need to introduce ourselves, so I will ask Simon whether he would like to begin the questions.

Q332 Simon Hart: You have been incredibly patient with a number of inquiries that I have been making at a constituency level, Mr Drakeford, and I put on the record how much I appreciate your response. You may be familiar with the evidence on page 7 of your document. You said very clearly that, although the desire for comparisons between certain things is increasing, the ability to make sensible comparisons is actually decreasing. You then list six or seven bullet points on the differentials between England and Wales. I have two questions—I should say that it is one question in two parts, otherwise I will be reprimanded. If you were a patient reading that evidence, would you be filled with frustration that these are quite dry and technical distinctions? If you were on the receiving end as a customer of the health service in Wales, you would be left with a sense of frustration.

> ***Mr Drakeford:*** I don't think I would, to be honest. I simply don't think that patients think about the health service in that way. In my experience they are not interested in the technicalities of how things are measured or in comparisons; patients are interested in whether they receive a timely and effective service, normally as close to their home as possible. Technical explanations of how the health service accounts for its work and how it measures what it does, by and large, leave people feeling that the answers do not address the issues that they sometimes have with getting treatment in the way that they would like to receive.

Q333 Simon Hart: I agree. Do you accept, though, that comparisons, often quite superficial ones, will inevitably be made, particularly through the media? Perhaps it is the comparisons that we read in the media that cause the frustration, rather than the more technical elements that you have described here. How do we avoid the fact that that seems to be the dialogue at the moment, whether we like it or not?

> ***Mr Drakeford:*** I agree much more with that. People pick up broad messages that are often not accurate but can seep into the way that people think about the service. I don't know that there is an easy answer because, as Mr Hart has said, what people are reading very often turns out not to be accurate once the detail is exposed. When I correspond with individual patients or talk to larger numbers of people who use the service, my aim is always to focus on what I think actually matters to them, which is not the headlines that they read in the newspapers but the quality of the service that they receive. They have fierce affection for the local health services that they receive today, and I sometimes have difficult discussions with people to explain why change has always been, and always will be, a necessary part of the way that services are provided.

Q334 Simon Hart: While we are on these crude comparisons, my last point, which almost contradicts my previous two, concerns some helpful details about A and E waiting times which were published on 15 December. Are you able to update the Committee now, or perhaps you could do it by way of follow-up, on where A and E targets are being met or missed in Wales as of today? Do you think that these comparisons—crude, accurate or otherwise—are having an impact on GP recruitment in Wales?

> ***Mr Drakeford:*** We will certainly provide the Committee with the latest A and E waiting times. The proportion of patients seen within the four-hour target in Aneurin Bevan and in Powys is higher than in the neighbouring English NHS areas of Arden, Hereford, Worcester, Bath, Gloucester, Swindon, Wiltshire, Shropshire, Staffordshire, Cheshire, Warrington and the Wirral. I will say straight away that Powys is, of course, a special case, having no major A and E department, but it does have minor injury unit departments.

Guto Bebb: You specifically excluded Betsi Cadwaladr.

Simon Hart: And Hywel Dda.

Q335 Guto Bebb: My understanding is that the Wrexham Maelor figures are very low. Could you provide figures for Betsi Cadwaladr as well?

Mr Drakeford: Of course. We will provide figures for the whole of Wales.

Q336 Guto Bebb: You made a sweeping statement in your comparison. You have actually said that you are opposed to comparisons, but you just made one. I think that you excluded the Betsi Cadwaladr health trust, which has some of the worst accident and emergency performance levels in Wales.

Chair: The Minister has offered to send us the figures.

Mr Drakeford: I will send the figures, of course. Just to say to Mr Bebb—I was very clear in saying that I was not including Betsi Cadwaladr.

Q337 Guto Bebb: But you did include the Wirral and Warrington, which are comparable.

Mr Drakeford: But the ones I mentioned, I did—

Chair: We have probably exhausted that one. If I could just ask—

Guto Bebb: I'm not sure that we have, Chairman, to be honest.

Q338 Glyn Davies: I'm not sure that we have exhausted it either. I don't want to be awkward, but I take a specific interest in Shropshire. You will understand that, Minister, because they provide nearly all of the service for me. I talk to them on a regular basis, including about A and E. The last week has been disappointing. I think that it was about 87% or 88% in Shropshire, yet I am told that it was 63% in Wrexham Maelor, which also treats a significant part of my constituency—the northern part. In fact, the last recorded figure we have is 70%, which is pretty disastrous.

Chair: That is probably correct. It may not be correct, but the point is—

Glyn Davies: But the Minister made a reference to Shropshire.

Chair: Yes, but we are covering cross-border health care. The Minister has come along to give evidence. I do not want to—

Glyn Davies: I have said what I wanted to.

Chair: Okay. If the Minister wants to respond, that is fair enough. If not, that is also fair enough.

Mr Drakeford: I will respond in this way. Systems across the board have been under huge pressure over the last couple of weeks. That is true in Wales; it is absolutely true in Wales, as it has been elsewhere. My original point to Mr Hart was that I do not think these sorts of comparison mean much to patients or are very sensible ways of thinking about the challenges faced on either side of our border. When I was asked specifically about A and E waiting times, I just wanted to make that point.

Chair: I think that there are perfectly fair issues that both sides may want to pick up and discuss with each other in a political sense. I have obviously been involved in arguments about the health service between England and Wales. But I would say, with respect to everyone here, that we are not here to attack either the Assembly or the coalition Government on it. I just want to try to keep it on track a little.

Glyn Davies: Can I just say, to put a bit of balance in, that I have very strongly supported the A and E department when they have failed to meet targets through an incredibly difficult time? In some cases,

it is wonderful that they managed to keep the whole show on the road with the number of extra patients coming in. That applies to both sides of the border.

Q339 Chair: Moving on, Minister, in the light of the difficulties in recruiting GPs, would there be an argument in your opinion for having a sort of unified performance list for England and Wales?

> ***Mr Drakeford:*** Yes. I have been following the evidence that the Committee has taken on that issue. It is undoubtedly true that there are parts of Wales where we face recruitment challenges in relation to general practitioners. It is important to say, for the record, that the number of GPs that we have in Wales is at a record high. It went through the 2,000 barrier for the first time last year. There are places, particularly the further north and west you go, where that is a challenge.
>
> I regard the performers list issue as a problem that needs to be solved, particularly in relation to people who are on one side of the border and who are willing to do, not whole-time jobs, but out-of-hours work or occasional sessions on the other side of the border. It is not acceptable to me that a separate performers list gets in the way of people who are willing to make that contribution. I have asked my officials to find a way in which we can solve that issue. It will require some legislative activity because these performers lists are set out in statute and in regulations. We will move to amend the regulations in Wales to remove some of the anomalies that I know have been drawn to the Committee's attention, and which I do not want to see as barriers to GPs providing services on either side of the border.

Chair: That sounds very positive. Thank you for that.

Q340 Jessica Morden: Perhaps following on from that, we have heard evidence about how people are registered with a GP and where that GP is determines which health service they go to. What are the advantages and disadvantages of the service following where they live or where their GP is?

> ***Mr Drakeford:*** Thank you. Andrew Goodall might want to add to my answer here, but I suppose my starting point is that, in a way, the system we have hasn't been built up on an objective analysis of whether one system is better than the other. We have inherited a system that was set up in 1948 and we still have it today. GPs are funded on the basis of the number of patients that are registered with them rather than where people live.
>
> We work with that system. We have 20,000 people who live in England and who are registered with Welsh GPs. We are very pleased to welcome them to use that service and are very happy that they choose to do so. I saw some of the evidence that you had from patient groups that said that people value the service they get very much. I notice that you took some evidence from the Gloucester service, which reported that where Lydney GPs in England had been able to extend their boundaries, very few people had chosen to move from the GP they had been registered with over many years.
>
> So we work with that system. We do so in a pragmatic way and try to ensure that the border isn't what matters to people, but that they get the service that is provided in a timely way, meets their needs and does so in a way that gives them satisfaction. By and large, I think that is what we succeed in doing.
>
> ***Dr Goodall:*** I think the Minister's covered the historical aspect of this. Certainly, as the evidence has indicated, there is a good appreciation of the standard of care that is being offered by the GPs. From a Welsh perspective, as we have adopted an integrated set of structures, we have organisationally put our hands around all of the services from the GP through to the secondary care service aspects, so there is a little bit of a fit with that. The background is probably more about the historical nature than it is about whether we have weighed that up over recent years.

Q341 Nia Griffith: Could we just explore that point? Obviously if you are signed up with a Welsh GP you follow through with the services. How does the funding work for that? How does it work if patients sometimes perceive there to be differences on the two sides, or seem to think that they could have perhaps got something different elsewhere?

Mr Drakeford: Thank you, Nia. You know that the system works in different ways at primary and secondary care. At primary care, we essentially operate on a knock-for-knock basis. The Welsh NHS picks up the costs of primary care for some patients who live in England and the English NHS picks up the primary care costs for some patients who live in Wales.

At secondary care, there is a formula in which Wales receives payment from the Department of Health to recognise the fact that there are 5,000 more English residents registered with Welsh GPs than the other way around. One useful thing that I feel this Committee has done in its investigation is to expose the fact that the formula that we use has not been updated since 2008.

Q342 Chair: You're jumping the gun a little, because our next question is on that very point.

Mr Drakeford: I'm sorry. Nevertheless, we are interested in those findings.

In relation to what people get, my view of the protocol and the Welsh part of it is that we are perfectly happy. Patients get a choice of primary care. If they choose to register with a Welsh GP, they get the Welsh package deal; if they choose to register with an English GP, they get the English package deal. You cannot choose the best elements from both. To repeat something the Chair said in an earlier hearing, you can't have the penny and the bun.

Q343 Jonathan Edwards *(Translation):* I would like to ask a few questions about the cross-border protocol. The Welsh Government receive some £5.8 million per annum from the Department of Health in England. Can you explain what that funding is for? How do the Welsh Government distribute it to the LHBs—is it part of the wider budget in Wales or is it specifically targeted at services?

Mr Drakeford *(Translation):* Well, as I said in response to Nia Griffith's question, the funding comes to us to acknowledge the fact that there are more people who live in England receiving treatment in Wales—to help us to pay for the costs that arise not in primary care but in hospitals. It is now £5.8 million. I have seen some calculations that show that, had the figures increased over the past five years, the total would now be almost £9.1 million. We allocate funding to the local health boards that treat those people who live in England but receive treatment or services in Wales. For example, people who live in England might receive primary care at Aneurin Bevan, but if they are treated at a hospital in Cardiff, the funding will go to Cardiff. The funding goes where the treatment is given.

Q344 Jonathan Edwards *(Translation):* You say that that figure has not been updated; what should it be now—£9.1 million, as you suggested?

Mr Drakeford *(Translation):* That is the calculation I have done. Had we increased the funding by 5% every year, because that is how much the costs have increased, it comes to £9.1 million this year.

Q345 Chair *(Translation):* I am tempted to suggest that it might have been important enough to take funding out of the budget in Wales and provide the money directly to the health board, such as Aneurin Bevan.

(Continued in English) But it is not for me to make suggestions about health policy.

I want to ask about invoicing. Perhaps I should put this question to Dr Goodall as the former chief executive of the Aneurin Bevan health board: are you aware of any problems with other boards not wanting to deal with Aneurin Bevan because of issues over payment for services that have taken place outside the Aneurin Bevan health borders?

> ***Dr Goodall:*** If I put on my old hat of chief executive of Aneurin Bevan health board, I would generally say that there are good and constructive relationships with providers, with which all LHBs deal across the border. That is really important, because we are dealing with pathways of care for patients and relationships need to be in place.
>
> As part of the service level agreements that are put in place and the way they work, generally speaking, they will ensure that the money is provided over. We will obviously pay the tariff rates from the English system. That gives us a degree of certainty about the nature of the discussions that happen. There will obviously be discussions throughout the year. I know that there was a problem with Bristol at some point last year, where probably a lack of understanding meant that there were some invoicing issues that were seen to be more administrative as a concern, but they were picked up very quickly at the time and dealt with in literally a matter of days, having been raised in a discussion. But I know that that attracted some profile at the time.

Q346 Chair: What about within Wales? Is it conceivable that someone seeking treatment from outside of Gwent ever face the prospect of being turned away from another hospital in Wales because Aneurin Bevan had not paid its bills?

> ***Dr Goodall:*** In principle they could. I cannot even recall one example having been a chief executive of Aneurin Bevan for five years where that was actually the case.

Q347 Chair: No, it seems very strange to me. I am not suggesting that it happens. I am just asking if it could hypothetically be an issue.

> ***Dr Goodall:*** Yes, we tend to take a set of very pragmatic relationships. There will be occasions where there is a one-off contact, perhaps with a provider or a commissioner organisation in England, simply because somebody has been visiting the area and may be less aware. Certainly, with a cross-border trust, for example, ongoing relationships allow a lot of operational contact to take place. I genuinely cannot recall one that was a particular issue or problem in my five years as a chief executive.

Q348 Stephen Doughty: Going back to the cross-border issues of invoicing and funding, in the previous session we heard evidence from the Welsh Health Specialised Services Committee, and it has provided written evidence, about some of the challenges in terms of invoicing from across the border and things coming in very late—sometimes invoices are presented years late. The committee volunteered that some of that was due to fragmentation and changing the system on the English side of the border, creating confusion about where invoices should be sent. That was a context not just of devolution, but of confusion within the English system. What experiences have you had and what cases are you aware of? What is being done to address some of those issues, and is there an issue with change going on more generally, affecting payments and funding transfers?

> ***Mr Drakeford:*** Chair, may I answer it in one way, and Andrew will probably answer it in terms of the detail? The question points to one issue of principle that I have heard raised before the Committee: how should we organise payment for the normal—not the tertiary—primary and secondary traffic across the border? Largely, we organise payment on what the Department of Health calls, in its evidence to you, a "knock-for-knock basis" and, on the whole, I still think that that is the sensible way to do things.

The alternative is to bill one another for all the different treatments that go on. My view is that that would create a big industry of accountants following bits of activity and we would end up paying more to create the system than we would save in other ways. On the whole, the system is satisfactory to both sides as it is. We pick up costs in Wales for some people who live in England, and the English system picks up some costs in England for people who live in Wales. Those costs are not sufficiently significant to erect an industry around them to pursue them in an accountancy way. The system broadly balances itself out.

At the tertiary level, however, that is different because those costs are very significant, sometimes for individual patients. You heard the evidence from the Welsh Health Specialised Services Committee that the increasing difference between the two systems can sometimes cause complexity for WHSSC in ensuring that the bills arrive in a timely fashion and that it is able to order its finances to meet the obligations that it has entered into.

Q349 Stephen Doughty: WHSSC was quite clear in saying that, in one respect, changes on the English side of the border had simplified some things, but in other respects had made them massively more complex. Therefore, for an individual practitioner, for example, deciding where to send an invoice, that had got worse. Is that your understanding?

Mr Drakeford: I think that's my understanding. The way that the health service is organised in England is for the people who are responsible for it there. They will set out the advantages that they think they have obtained from the way that they do it. One thing that they would not dispute is that their system is now more complex than it was when things were organised differently.

Q350 Chair: I get what you are saying—that you prefer a planned system over a market system. I understand that but, ironically, as a result of devolution, with the need to send patients to England for specialised treatment and, indeed, for some patients from south-west England to come to Swansea, you have to have a market mechanism, don't you? You need to know how much it will cost to send patients for a certain treatment in England and vice versa. You need to know how much to charge English boards for the patients who are being seen in Swansea. One of the ironies of devolution is that you have to have some kind of a market mechanism, and you—somebody who opposes it—would still recognise that it needs to be there.

Mr Drakeford: You have to expose costs in order to make sure that you can be charged fairly for services that you are receiving somewhere else, and make sure that those costs are covered. I still think that by and large WHSSC's relationship with the English NHS is a planned relationship. We do not go around seeking the cheapest price for every activity that WHSSC looks at, because we look at things like convenience for patients. We look at relationships between clinicians in different parts of the system. So we are looking at issues to do with quality and patient experience as well as cost. Sometimes long-term relationships between different parts of the system produce benefits for patients that mean that simply shopping and getting a cheaper service—and we are far more remote—where none of those relationships have been built up, would not be to the patients' advantage.

Chair: I probably ought to bring in Jessica, I think. Can I come back to everyone afterwards? We are not getting through these very quickly; I am aware of the Minister's time.

Q351 Jessica Morden: Okay, very quick. You mentioned in your written evidence an emerging concern that you had about English local authorities sending looked-after children with specialist mental health needs for placement in Wales, which I think in the written evidence you refer to as being difficult to resource in rural areas. Do you want to expand a bit on that?

Mr Drakeford: Thank you. Well, that is a different point, obviously, but it is an important one and an emerging one. Wales is a net importer of looked-after children. We probably have been for quite a long time; but there is increasing evidence recently of large numbers of looked-after children being placed in private looked-after settings in Powys—north Powys—and in North Wales in particular: 16 private residential care homes for children in Wrexham, for example.

I think we are right to be concerned about the density of looked-after children in any one place. If you look at what happened in Rochdale, the young people who ended up in such difficulties in Rochdale were not from Rochdale at all. They were from London boroughs, being placed far away. When young people with significant needs end up being placed across the border, and those needs—in mental health, for example, but in learning difficulties and other things too—suddenly erupt, in rural areas in particular, services are not equipped to respond to very significant and unexpected needs. Now, there is a protocol across the border in relation to looked-after children too; but we have given it far less attention than we have to some of the protocols that have been talked about here.

Within 10 days of that young person being placed in Wales, all the information about that young person's needs is meant to arrive with them. What I am told—and I absolutely accept I am just relating to you now the information I am given by the practitioners on the ground—is that the pressure that English local authorities are under in terms of budgets means that, although they do not tell you something that is not true, in seeking a placement in Wales they may not tell you the whole truth about the complexity of a young person's history. Some of those complexities only emerge after the young person is there, and local services are left stretched to try and respond to their needs.

We recognise we need a better discussion with counterparts in London to make sure that that system is working properly, and that young people are not left in a disadvantaged position as a result of it.

Q352 Geraint Davies: Moving on, you have already mentioned examples where complexities in England can bring about costs in Wales. In general, there has been stability in planning in Wales in the health system, and a lot of change and confusion and cost in England. Obviously, that is bringing about extra costs of change in England, but is there a knock-on cost for Wales, as we are bearing the cost of endless change in England?

Mr Drakeford: Well, I always try and explain to people that the effects of changes that happen across the border do not remain at the border; and we have to be sensitive to the way that we negotiate those things. You will have heard, for example, the way in which—I know Mr Davies, particularly, has pursued this line of questioning—services in England are moving east. They are moving to the Telford side of the border, which has an impact on people who live in Powys. The midwife-led maternity service in Betsi Cadwaladr University local health board, for example, now provides for a larger number of mothers because of the way that that service has changed, but it happens in other places, too.

Training across the border in a particularly important issue for me. Historically, in North Wales, nurses trained in Chester have often taken up employment on the Welsh side of the border. As commissioning numbers have reduced in England, fewer nurses are being trained along the border, which has had an impact on the ability of BCU to recruit the nurses it needs. The idea that change happening on one side doesn't have an impact on the other side is clearly not the case.

Q353 Geraint Davies: May I ask you something different? Obviously the Welsh health service is meant to be wholly devolved, but some 10% of the Welsh budget, and £10 billion across the UK, is spent on diabetes. I published a Bill yesterday requiring that sugar be expressed in teaspoonfuls on

packaging. Once people know that men are supposed to have only nine teaspoonfuls, which is a can of Coke, and women are supposed to have only six teaspoonfuls, equivalent to a light yoghurt, they could navigate themselves towards lower sugar. There would therefore be less obesity and lower diabetes costs. Do you support that sort of thing? Do you accept that some of these initiatives are UK-wide?

Mr Drakeford: That is a public health issue.

Q354 Chair: It is probably not one for this Committee, but, as before, you may quickly give your thoughts.

Mr Drakeford: We work closely with our counterparts in the Department of Health on the public health agenda. We recently did some close work with them on smoking in cars with children, on which we want to move together to ensure that we have a common system on either side of the border. I correspond regularly with the Secretary of State for Health.

Q355 Geraint Davies: But do you support the idea?

Mr Drakeford: I have been trying to persuade the Secretary of State to take stronger action in relation to sugar, and Mr Davies's Bill is very interesting in that context.

Chair: We cannot go off, Geraint, otherwise other people might do so, too.

Geraint Davies: Thank you. That's all I needed.

Q356 Stephen Doughty: I just want to address some of the cross-border arrangements. We have talked about funding, but I know that you have taken an interest in informatics and how information is shared not only within the Welsh NHS but across the border. I have experience of that on a personal level, but I understand that the evidence from the Welsh NHS Confederation and others shows the difficulties with patient information not being transferrable electronically. When attending an English hospital, for example, information cannot be transferred back to a Welsh GP. I have experienced that myself, and it caused delays and affected the quality of the treatment that I received when I came back to my home hospital and GP here in Wales after receiving treatment in England. I understand that you have been doing pilots to try to ensure that it works for information going from us to England, but what is your understanding of the situation from the other way around? How is the Department of Health involved?

Mr Drakeford: Thanks, Stephen. Andrew will give some of the detail, but in Wales we are very keen to have single national systems that mean that patient information flows with the patient. Patients do not observe LHB boundaries, and many of Mr Hart's constituents will receive their treatment for certain conditions in Swansea. We want to ensure that, if someone turns up in Swansea, the information system that Hywel Dda uses allows the clinician in Swansea to see that information quickly, easily and accurately, and so on. That is the direction we are moving in Wales. Cross-border issues are more complicated, because historically the English system is even more fragmented than the Welsh system, but Andrew will tell you more about the pilot work we are doing.

Dr Goodall: Information systems have been more about individual organisations making their own decisions on their IT systems, and we have had to work that through. To reinforce what the Minister has said, on the Welsh side we have been able to take a wide variety of GP systems, and we have now brought them down to two key products being used, so there is some consistency. We are working on pilots, and our approach in Wales has been about trying to reinforce electronic referrals so that everything is more automated and speedier for patients. You are aware of the pilots on which we have embarked in Powys, and we are looking to roll those out further. We have extended that for discussions with Shrewsbury and Telford on the

NHS Wales perspective. We can do more, but the Welsh pattern and the way forward is that we are looking for social care and community care systems to come together. The Minister was launching things around unscheduled care and emergency care records yesterday, to create some standardisation. Of course, we will need to link that together with the border areas too.

Q357 Chair: And you are trying, as far as you can, to ensure that everyone who lives in Wales is treated in Wales—is that correct? It is certainly correct in Aneurin Bevan.

Mr Drakeford: I don't think that that is a principle, no. We don't have that principle. Our aim is to make sure that people get the treatment they need in the best place for them. Sometimes, that will mean that we are able to move treatments closer to people's homes and to bring services back across the border. But sometimes, services across the border will still be the best for Welsh patients. So I do not have a principle that says, "Treatments for Welsh patients should be provided in Wales." That is not my starting point.

Q358 Chair: That is the principle being followed by the Aneurin Bevan health board in respect of certain treatments. They have actually said that they will treat people in Wales if they live in Wales, although some English patients will continue to be able to be treated in England. Is that not the case?

Dr Goodall: Again, I would look to clarify it. I think it was where the local service can be developed and would still wish to be that the Aneurin Bevan health board will continue to develop a local service. When the cross-border policy was originally determined by that particular health board, the intention was to recognise that there were Welsh residents going out of area for services that could probably be more localised and did not necessarily have to be of a specialist nature. That is where some of the cross-border issues have emerged at this stage. From a practical perspective, if we look at the fact that WHSSC is spending £100 million on specialist services across the border in England, the fact that £25 million is being spent over in Chester and the very significant proportion of Powys's budget being spent—clearly, a very material amount of money is being invested because it is about balancing the right access to services.

Q359 Guto Bebb: On that specific point about spending the Welsh health pound in Wales, I obviously do not think that that is the case because many of the changes put in place by the Betsi Cadwaladr trust have actually identified the need to use more specialist providers which happen to be in England. That brings me back to the question of information flows with patients. We have had many complaints in my constituency office of that information flow not being up to speed. Your aspiration to have an integrated system in a Welsh context must, in the context of North Wales, also take into account the various providers in England. Could you give us some more information on what is being done on that cross-border issue?

Mr Drakeford: Yes, certainly. Maybe I could illustrate the point that I was making in relation to that question. Historically, the population of north-east Wales has received the bulk of its services at the Countess of Chester. Since 2010, Deeside hospital has been able to develop some services in cardiology, dermatology and obstetrics, for example. Those services are now capable of being properly provided closer to people's homes, so they now happen at Deeside hospital. But that does not mean that we do not still spend £25 million at the Countess of Chester for services that are better provided there. The test for me is always where you can provide the best service for the patient, not whether it is one side of a boundary or another.

That means, as Mr Bebb says, that for those patients who do go across the border, information flows are very important. They are not good enough; I definitely agree with that. They are not good enough in either direction. We do not always communicate quickly enough with providers in England, and providers in England are not always able to send information back quickly enough to Welsh GPs, for example, about treatment that has been provided there. We have

some very significant pilots going on that are organised at a local level. It may well be that we need to have a bigger conversation at the Department here and at the Department of Health level, to accelerate some of the progress we need to make in that area.

Q360 Glyn Davies: Can I just say how much I welcomed the very strong statement by the Minister about the need to treat patients in the best location for them? That is not what I have always heard, but it is an incredibly important principle. I really welcome the powerful way that it has been put to the Committee today.

I want to just go back to waiting times, which we discussed a bit in the beginning of the evidence session when Simon Hart was asking questions. I would think that it is probably more stark in Montgomeryshire than anywhere else in Wales, because the vast majority of patients or secondary care patients are treated in Shropshire. Some in the west will go to Bronglais in Aberystwyth, but the vast majority will go to Shropshire. Nearly all the complaints I have about health relate to waiting times. The official waiting times which we have and which we are told are 18 weeks in England and 26 weeks in Wales, but it is currently 28 weeks in Powys, supposedly. The Powys local health board told me about a fortnight ago that it was currently 28 weeks and was aiming to come down to 26 from the 36 it was last year. That is the position, and everybody knows that.

To the west of the county, people don't write to me, despite the fact that they are waiting longer, but where you know that people living 2 miles away are under a different regime, everybody is very aware of it. I get letters on a regular basis about waiting times. It is a huge perception. I would just like to hear you put to us the case, which I think the local health board intends to put to me when I meet the new chief executive—I think that is planned for about a fortnight's time—that, in fact, this is not quite as straightforward as it seems. It would be really helpful to us if you could tell us why a position that seems obvious is not quite so straightforward.

Mr Drakeford: Well, I definitely understand that when you are at the border with a different system, comparisons between the two become more apparent to you. One of the reasons why this is not as straightforward as it seems is that the discussion often appears to be based on the idea that people have to wait 26 weeks or 18 weeks—that these times are required of people. Actually, the median waiting time, the standard waiting time in the Welsh NHS from referral to treatment, is about 10 and a half weeks, so within 10 and a half weeks, half the people who have started treatment have had it and finished. Although it is difficult, for the reason we discussed earlier, to compare these things properly, the best comparison you can make with the English system is that their like-for-like comparison is about nine and a half weeks. The difference is about seven days at the standard level, but people are misled by the headlines into thinking that everybody in Wales has to wait 26 weeks and everybody in England has to wait 18 weeks. It is actually not like that at all. That is just for planned physical care. For mental health services for your constituents on the Welsh side of the border, we already beat the waiting times that the Prime Minister and the Deputy Prime Minister set out as aspirations for the English NHS in the autumn. Mental health users of secondary care services are very significant in terms of numbers and they are treated more swiftly in Wales.

My view is that people get a package deal. They get some things in Wales that they won't get in England, and no doubt in England people get some things that they might not get in Wales. When you are closer to the border, those differences are more apparent, but in the round, people get a very good service in both places.

Q361 Glyn Davies: My only follow-up question—I don't mean it as a challenge—is this. It's probably 12 months since I went to a hospital. I think I referred to this in the earlier evidence session. The issue wasn't just the hospital being informed, the chief executive having a letter from the local health board and being informed, that the waiting times would be 36 weeks. This must have been about 12 months or 18 months ago. It was that if people were treated in less than, I think, 33 weeks,

they wouldn't be paid. There was a straightforward letter to a chief executive out of the blue, and that was operating from that date. It seems to conflict a little with—maybe that was the position 18 months ago, isn't the position now and won't happen again; I don't know. Have you any comment on that?

> ***Mr Drakeford:*** Well, the only comment I would have—Andrew would be better than me on this—is that if you have a contract with a hospital to treat patients within a certain time frame, that is the deal that you have struck with them and that is what you must expect them to deliver. If they want to do things in a different way that creates more costs and therefore the bill to you is higher, they can do that only with your agreement. They can't say, "Actually, we managed to do it in a different way. Sorry. That cost several million pounds more than our original contract, and we're only telling you afterwards." Those discussions about what you have agreed and what you are delivering go on all the time.

Chair: It sounds as though you are coming round to the idea of a price mechanism, Minister.

> ***Dr Goodall:*** What I would add on that is that there would have been discussions about a contract around the Welsh waiting times. In that sense, there would have been some potential differences, because clearly there is a target that is around 26 weeks. I can see that forming part of the contractual arrangements, but I am not aware of the individual example that you gave.

Glyn Davies: I am not going to pursue it, but it wasn't just that hospital, because I then rang up the other ones in Shropshire and they had the same letter. It was to them from Powys local health board. But maybe that was one specific instance. If it is not happening regularly, it isn't so significant.

Q362 Geraint Davies: Anecdotally, I've been told that people coming from Swansea, certainly, can see a GP virtually the following day and, when they go to London, it might take two weeks. Indeed, in terms of pharmacies, in terms of getting the drugs, it actually takes hours of wait, apart from the fact it is free in Wales. Are these anecdotal differences borne out in the round?

> ***Mr Drakeford:*** Well, we aim to have as rapid access to general practice as possible. General practice is under pressure too at the moment, under the general winter pressures, but our aim is to give people access to a member of the primary care team as rapidly as possible. It might not always be the GP. Certainly, in pharmacy services, we regard community pharmacy as a very central player in the primary care team and we are aiming to have community pharmacies do more routine primary care work than they do at the moment, because there you can just walk in from the street and receive the service you need. So our community pharmacies in Wales, for example, provide the morning after pill service, which they do not in England, and we have discharge medicine review services through our pharmacies, which are available in some parts of England, but not everywhere.

Q363 Geraint Davies: Secondly, on A and E, if I may, it has been said in terms of the crisis in England that part of that has been caused by the abolition of walk-in centres and the cuts in social services, so people cannot move through the system. I think I am I right in saying that in Swansea, which I represent, they introduced a permanent medical centre, for example, in Wind Street, so people who are drunk do not end up in A and E, and this is saving thousands of pounds a night. Obviously, there is more integration with social services and health. Would you agree then that, in Wales, we are moving in the direction of helping that problem, through social services integration and walk-in centres, and in England they are going in the opposite direction and that that is part of their increasing problem?

> ***Mr Drakeford:*** Well, it has been an ambition of the Welsh NHS, certainly, to integrate health and social care in a more direct way. Our delayed transfers-of-care figures were at an all-time low earlier this year. They have crept up a bit again, as you get into the winter. One of the ways

in which we are coping with the very real pressures of the winter is by making sure that our social services departments play the fullest possible part.

I was in Nia's area earlier this week. They said to me that they had had a very difficult Monday this week—and with a bank holiday last week the pressure had come on very significantly—and they got through the day and managed to keep the hospital open and doing all the things it does because of the help that social services departments had given them in finding extra places for people to be discharged and working together across the boundary. That is a real ambition of the service in Wales: to do that in a planned and co-ordinated way.

Q364 Geraint Davies: And having innovation either side of the border can be helpful for both, can't it? Rather than have a monolithic waiting time target? Do you agree with that?

Mr Drakeford: I think there's lots for us to learn from one another and experimentation is a good thing.

Chair: Excellent. Nia Griffith.

Q365 Nia Griffith: Just following on from some things that Glyn Davies mentioned. The risk people were clear that more work needs to be done on the SLAs and the protocol, and so forth. Would you support further revision or clarification of those types of documents?

Mr Drakeford: Yes, I think there is always work to be done, and when the pattern in England is changing rapidly, the need to keep those up to date is even more urgent.

Q366 Nia Griffith: In terms of access to services across the border and the people who are very much affected within a couple of miles, and so forth, the BMA suggested—it has had talks with you—a website that would make things clearer for patients and GPs. How is that progressing? Are there any other ways that awareness could be raised, so that people know what is happening, from when they sign up initially, rather than when the emergency happens, which is the only time most people think about the NHS?

Mr Drakeford: Well, I think real-time information for people about how the system is running can be very helpful. Andrew mentioned that yesterday I was in Neath Port Talbot hospital, which has a minor injuries unit, where the average turnaround time is less than an hour, from going in to being seen and being out again. I was talking to a man from Bridgend who had driven past the Princess of Wales hospital, which is a major A and E, because he had looked it up and seen that there was lots of people there. He had something wrong with his arm. He had driven to the Neath Port Talbot minor injuries unit. He had been seen, plastered and back in his car within 20 minutes, and he had done it because there was that information available to him to make the right choice. Giving people the information they need and then persuading them to act on it, rather than just doing what they have always done, is a really important part of the way we can make more rational use of services that are under pressure.

Chair: Okay, thanks. I'm going in order, so Siân.

Q367 Mrs James: Very quickly, I would just like to echo what you said about the Neath Port Talbot minor injuries. I was there 20 minutes having my X-ray, my finger dealt with and sewn up, and being on my way. It was absolutely brilliant. Mind you, I think Morriston A and E is absolutely fabulous as well, and it is my constituency.

We have heard a great deal about the cancer drug fund. One of the big questions that I would like to ask you, Minister, and you, Dr Goodall, is how do patients in Wales gain access to new and innovative treatments that are not routinely available on the NHS? Some witnesses have already told

the Committee that they would like to see a single system across England and Wales for treatments that haven't been approved by NICE. What is your opinion on that?

> ***Mr Drakeford:*** Well, the Welsh system is the IPFR system. Public Health Wales publishes an annual report on it. Last year, for every four applications that were turned down through IPFR, five were approved, so the idea that the IPFR process is one that doesn't give access to drugs is simply not borne out by the facts, and that is on hundreds of applications.
>
> You have to remember that our IPFR process allows these drugs to be prescribed to patients with any condition. One of the real problems with the cancer drugs fund is its unethical nature in the way that it prioritises people with one sort of awful condition over other people who have equally awful things happening in their lives, but have no access to that fund at all. In Wales, all patients are treated on the basis of their clinical need, and all needs can be referred through the IPFR process.
>
> We had a review of the IPFR process last year, and we are putting quite a bit of money into improving it for the future. One way we will improve it, and you could say that it is one way that the cancer drugs fund operates—my business is not to say that everything is rubbish in one place and everything is right somewhere else—is to allow some drugs to be prescribed on what they call a cohort basis. When sufficient people have had it, you don't need to make an individual application anymore; you can just approve that drug for that purpose. In future, we will approve more drugs on a cohort basis through the IPFR process than we have in the past because we will have better co-ordination of the way that the panels work across Wales. We are improving the system, but we think that the system is fair—fair to everybody—and gets people the drugs they need when they need them.
>
> Should there be a single system? Well, we are very firm supporters of the NICE process. We back it up through the all-Wales medicine strategy group, which allows faster access to some drugs in Wales as a result of its work. One real problem with the cancer drugs fund, to quote from the editorial in the *Financial Times* just before Christmas, is the way that it undermines NICE and "gives the impression of benefiting patients, but in fact rewards poor quality drugs while benefiting a handful of pharmaceutical companies." If NICE was to do things, that wouldn't happen.

Chair: I know you feel strongly, Minister, but I just gently point out that your time is probably quite precious and a few people want to speak on this. I saw Guto first and then I am literally going to work my way down on the other side.

Q368 Guto Bebb: Well, first of all, I'd like to make it clear that I believe that cancer services in Wales are actually very good. Alaw ward in North Wales and Bodelwyddan hospital do fantastic work and I think it is appreciated.

I have a concern over your use of the word "ethical" and your claim that the system is fair to all and clinically driven. I recently dealt with a constituent whose consultants advised him of a form of treatment that was the most effective option for him. He was then advised that that form of treatment was not available because he was a Welsh patient. He was subsequently advised to get an English postcode. That individual had the ability to purchase a residential property in the north-west. He is now getting a clinically prescribed course of treatment that is not available to other patients in Wales because he has the ability to buy a residential property in the north-west. How can you say "fair to all" in the context of someone who can afford to access the best clinical advice, which is not available to him in Wales?

> ***Mr Drakeford:*** Well, on the ethical issue, perhaps I can offer a quote from Sarah Wollaston, the Conservative Chair of the House of Commons Health Committee. She said: "The whole

problem with the cancer drugs fund is that it excludes other equally unpleasant conditions and undermines the whole point of NICE." That is the point that I would make. We have a system in Wales where no matter what the condition is, you are able to make an application through it, and if it is thought to be clinically effective, you will get the drug. That is not the case where you have a fund for only one type of illness. The Bristol study, which is the most authoritative, says that patients in Wales get faster access to drugs that are clinically effective and cost-effective. Patients in England get faster access to drugs that are neither. If I had to choose between those systems, I know which one I would prefer.

Q369 Mrs James: Is there a mismatch in the advice that patients are getting directly, from consultants and so on, about the postcode lottery? I have to be honest and say that I have not had so many recently, but in the past I have had people come to my surgery and say that they have been advised to come to see me because their consultant told them that if they lived in another part of the country they would get the treatment that they would like. Are we happy that we are getting the proper message out to all parts of the NHS and that everyone is signed up to what you have just said?

Mr Drakeford: Well, it is very difficult to be confident of that. It is undoubtedly the case that some clinicians are better able than others to have those very difficult conversations with patients in which they have to say to someone. "I'm sorry, but we have come to the end of what we are able to offer you." Some clinicians are not very good at having those conversations and want to imply to people that if they were somewhere else, things would be better for them. In fact, there are far wider differences between the four regions of the cancer drugs fund in England than there are between England and Wales. On the IPFR part of the cancer drugs fund, you are seven times more likely to be prescribed a drug through the cancer drugs fund in the midlands than you are in London. The differences between the regions in England are far wider than the gap between England and Wales.

Dr Goodall: In terms of the consistency issue, one reason why the review of the individual patient treatment process occurred was some of the improvements that the Minister has outlined. There was an issue with consistency across some of the different areas, with individual reviews taking place. We will hopefully be able to demonstrate an improvement on the back of the changes that have been made.

Q370 Stephen Doughty: Minister, since you started, I feel that you have been refreshingly honest about where difficulties exist in the Welsh NHS and where we need to learn. You have mentioned a number of comments from elsewhere about where we can improve things. I want to ask specifically about staff, particularly those in border areas who treat patients on both sides of the border, and the terms in which some of the debate has been conducted. What is your sense of morale and how individual staff, particularly those who treat English patients who come across the border, feel when they are told that they are providing a second-class service, or that they are on the side of death on the Offa's Dyke? Some of those terms have been very unhelpful. In the end, the vast majority of NHS staff I have met on either side of the border want to provide the best care to their patients, regardless of where they are from. What is your sense of morale and feeling among staff?

Mr Drakeford: I deeply regret those sorts of comments. They are absolutely untrue and entirely unnecessary, and they do have an effect on morale. There is no doubt that if you are coming in every day, doing your very best, often in difficult circumstances, and you turn on the radio to hear those sorts of comments—people do not just shrug them off and ignore them. They have an effect on how people feel about the job that they do. Worse still—

Q371 Chair: Are we discussing Wales now? Or England and Wales?

Mr Drakeford: Well, I have never made comments of that sort about health services elsewhere, nor would I, but there is no doubt that people feel able to come across the border into Wales

and make remarks of that sort about the Welsh NHS with impunity. That is deeply regrettable and offensive. Not only is it regrettable and offensive, but it has a deleterious effect on the morale of staff and, worse still, allows some patients to worry about the treatments that they would receive, absolutely unnecessarily. I want a respectful and pragmatic relationship across our border. I have tried to answer the Committee's questions in that spirit, and I regret it when others do not follow in the same way.

Q372 Simon Hart: Chair, can I just add to the very honest political question? I share the Minister's frustration. Those of us who sat through Prime Minister's questions yesterday listened to a series of questions from the Labour Opposition making exactly those comments about the NHS in England. I accept those that this is a natural feature of the political debates as we approach the election, but I suspect and hope that you would condemn all party leaders with equal venom, because we have to listen to this dialogue weekly. I ask the Minister to endorse the views of people around the table that we, as politicians, must be able to raise concerns and criticisms—I hope in a respectful way—when we spot or receive reports of failures in the system. We would be neglecting our duty if we did not; I hope he would agree. To make a distinction between policy and management failures and the quality of front-line activity is the key. It is a bit sweeping to suggest that criticisms are of staff; actually, most of the political criticisms are of management and policy. Does the Minister agree?

Mr Drakeford: The way that I see it is that we have a very vigorous debate in Wales between the political parties, and I do not mind that at all. I never worry about the fact that people in other parties in Wales will come to the Assembly Chamber wanting to ask me robust questions. That is absolutely fine, and I am quite sure that it is proper that that goes on in England among those who have responsibility for the English NHS. The line needs to be drawn with people on either side of the border—or, at least, on one side of the border—throwing brickbats at people on the other side about things that they have no responsibility for and often very little knowledge and understanding of.

Q373 Nia Griffith: May I come back to the NICE debate? A problem that some people encounter is the issue of orphan drugs because nobody wants to fund trials for new uses of them or for different conditions. Can you explain just a little bit about how you are tackling the issue and if there is any way that you can help patients to get better access?

Mr Drakeford: One of the very early decisions that I faced when I became Health Minister here was over the funding of an ultra-orphan drug, Kalydeco, which is very expensive and benefits around 13 people in Wales. The price is in the millions, but I believed that the impact on the quality of life of those people was such that we had to fund it in Wales, and we have. I did not want to be in the position of having to make an individual-type decision like that again, so we have now set up a dedicated way of making such decisions, meaning that when further drugs come up in the future, we will be making it on a regular and routine basis, rather than a one-off basis as we were before.

Chair: Okay. I know that you are quite pressed for time, Minister, so I am going to move on to Jessica.

Q374 Jessica Morden: When we did our public evidence sessions, one of the issues raised by patients was about having a say in decisions being made in the English NHS. The kind of example being given was the Future Fit consultation in Shrewsbury A and E. The other issue to do with that was the new housing development plan for Tutshill in Gloucestershire, just over the border, and what impact it would have if there was a Welsh GP there on the Welsh NHS. The Welsh NHS Confederation and some English CCGs have called for formal protocols on consultations like this. Would you support that?

Mr Drakeford: Yes.

Chair: Yes, great.

Q375 Jessica Morden: Yes, and leading on from that, what is your relationship like with the Department of Health on a day-to-day basis? Do you raise these kinds of issues?

> ***Mr Drakeford:*** On a day-to-day basis I think we conduct business in a normal sort of way. I have more contact with some Ministers than others. I have very regular contact, for example, with Jane Ellison, who I know gave evidence to you. I particularly have recently, because she chairs the four-nation committee on Ebola, which I am a member of, so when we have business to conduct, by and large we manage to do it in an orderly and a proper way.

Chair: Excellent, thank you.

Q376 Glyn Davies: It is not very often that we get the opportunity to have the Minister before us, so we can seek reassurances, which is what I am hoping to do now. We talked earlier about the importance of treatment in Shropshire to Powys patients. Secondary care depends on treatment in Shropshire; and a huge issue is whether developments in Shropshire occur to the west of the county or to the east of the county. Clearly, to the east they become incredibly inaccessible. Two or three years ago there was a huge debate and big change in this area. In a fortnight's time there is a £38 million new obstetrics and paediatrics centre opening in Telford—which was a massive blow to the people of mid-Wales, when that was moved away.

Next year and the year after, Shropshire are looking at Future Fit. They are going to completely review the systems in Shropshire, with one emergency care unit, almost certainly, instead of two, because it isn't workable. Will Powys local health board, and the Government in Wales, take part in that debate and make their views known? Last time they turned up to the meetings with a watching brief, took no position and gave no advice, and it was a huge blow to us when the investment went. I was incredibly disappointed that the Welsh side made no contribution. Will you make a contribution to the current debate, which is equally important, if not more so?

> ***Mr Drakeford:*** Of course we are very keen to make that contribution. This time Powys LHB is a full and voting member of the group that has been brought together to oversee those changes, so it is a more integral voice at the table. It is only the one voice, and there are others too, but it is entirely in our interest to be engaged in that process as much as we can.

Q377 Chair: Minister, are you prepared to recognise the rights that English residents are afforded under the legislation, such as choose and book, and shorter waiting times?

> ***Mr Drakeford:*** Well, this is not a matter for me, Chair. The system we have, as you know, as I explained earlier, is that if you sign up with a Welsh GP you get the package that goes with that, and if you sign up with an English GP you get the package that goes with that. I understand that in England the Department of Health believes that this causes some difficulties to them in terms of English law. It causes no difficulties to us in Wales; but we are having discussions. We have them with Jane Ellison as the Minister. I am happy to be as helpful as I can, but the problem is not mine, and the solution is not mine; but we are happy to contribute where we can.

Chair: Right. I am trying to get these questions done as briefly as I can. Nia.

Nia Griffith: I think I have covered the BMA.

Chair: Did anyone else have any further questions?

Q378 Guto Bebb: I failed to catch the Chairman's eye when we were talking about GP levels in North Wales and the west, and one of the key areas, obviously, is Blaenau Ffestiniog. You will be well aware of the fact that there is a huge problem there, and parts of my constituency are served by Blaenau so this is not an attack question in any way shape or form. I was privileged to chair a meeting there this summer, with Marcus Longley from the university of South Wales, who is doing the report into rural GP services in Wales. Could you give us an update as to where that report has got to, and when we will see action? The surgery in Blaenau Ffestiniog is crucial not only to Blaenau, but to a large part of my rural Conwy valley.

Mr Drakeford: Yes, I am happy to do that, Chair. It is not a cross-border issue, exactly, but I am happy to do it.

Q379 Guto Bebb: Well, actually, they tell me that one of the problems is that GPs are reluctant to come to Wales because of the lack of specialist services in north Wales.

Mr Drakeford: I am happy to answer, and it does have a cross-border link in this way. I could have said this in answer to Glyn Davies as well. The mid-Wales study that Marcus Longley has produced is relevant to the whole debate about where Powys patients will receive secondary care in future, as changes happen on the border. I am very determined that we will push ahead rapidly with that review. I am determined that we will answer the first recommendation in particular, which is a joint committee of Powys, Betsi Cadwaladr and Hywel Dda, independently chaired to make sure that the needs of that part of Wales are properly attended to. We will have a conference that the Welsh Government will fund early in the new year to give impetus to the whole idea, and I am optimistic that if everybody plays the part that they can play in making a success of services in that part of Wales, we have got something very special to offer to people who are willing to come and work there.

Q380 Simon Hart: Thanks for being so frank with the Committee this morning. It has been a great session. Earlier on you said—I hope I am not misquoting you here—that Welsh patients get some things that English patients do not get and vice versa. Essentially the whole debate over the last few months has been about differences, comparisons—genuine or not. If you look at this from the point of view of a patient or just a taxpayer, would you think that this is a great advertisement for the devolution settlement?

Mr Drakeford: I do. I think people get the system that they have voted for through the ballot box and which best suits their own needs and circumstances.

Q381 Chair: And a final quick one from me, then. Would you say that your role as the Welsh Minister is basically that your responsibilities are really only to Welsh residents and not to the health care of English residents?

Mr Drakeford: Well, my primary responsibilities, quite certainly, are to the health needs of people who live in Wales. Because of the porous nature of our border we have relatively significant numbers of people who live in England but who access services in Wales, and I feel a responsibility to them as well.

Chair: Okay. I think that just about covers everything, which means that we have finished by 11.30. I am sorry it is a bit late, but I do want to thank you again very much, Minister, for coming along today and giving evidence in that way.

Mr Drakeford: Thank you for the questions. Diolch yn fawr.