Thank you very much for the opportunity to be with you this morning. This is my first chance to address the Confederation’s annual conference, although, having been the Cabinet health adviser in Wales since 2000, working with every previous health Minister, I am a veteran of many previous such occasions.

Just let me say very briefly to start with that a constant across the years in which I have been involved in health in Wales has been the presence of Chris Martin, successively in organisations in West Wales. To have worked at the front line of health services in a period of such change is a tremendous tribute for anybody who has managed to do that over that extended period. Hywel Dda himself had difficulties with certain parts of his local population, so it’s hardly surprising that those things continue into our present day, but Chris, your presence there has always, I know, for successive health ministers, been a tremendous reassurance that there was somebody there who understood, who lived with and through, who never ducked away from the difficult conversations that are there to be had.
We lose the institutional memory of people who have worked in health in the post-devolution period at our peril, and I look forward very much to continuing to work with you well beyond the time that your chairing of the health board and of the confederation comes to an end.

Now as you heard from Bethan when she recounted some of the headlines of the 2004 annual conference, there’s never been a time when making health policy has been easy, just as there has never been a time when the delivery of health services has been anything other than a challenge.

But, let me give you one way in which 2014 is very different indeed to 2004. In 2004, we were just moving beyond the first term of the National Assembly, a term in which, in cash terms, the budget of the National Assembly and of the health service had grown by 10% every single year. We were moving into the difficult era of the second Assembly term when growth was being reduced to only 6% every single year and budgets across Welsh public services, including the health service, grew in every year of the first three terms of devolution. And the fourth Assembly term is very different indeed in that way. The age of austerity in 2014 means that it is a year which is quite different in fundamental ways despite the commonalities to what we faced a decade ago. And the effect of the age of austerity, the
deep and sustained cuts in our public budgets, is a reality. It’s a reality that impacts on the lives of individuals who work in the health service, and it’s a reality that impacts on the lives of those who use our services too. And with the Chancellor of the Exchequer promising a further £25bn worth of cuts, if he remains in office during the rest of this decade, it is no wonder that the Auditor General for Wales has concluded that the financial outlook for public services in Wales is “bleak”. Now as Chris has already said, and as I say wherever I go, there is no choice but change in the Welsh NHS. The only choice is between planned change, in which we attempt to take our destiny into our own hands and shape our collective futures, or change that will happen to us in an unplanned, unpredictable, ungovernable way. The choice is not between change and no change, it’s about the sort of change we want to have and how we go about it. And for this audience in particular, despite the scale of the challenge, there is no option to shrug our shoulders or to turn our backs on addressing the challenges that we face. There is no cavalry coming over the hill. Our destiny really does lie in the skills, the experience, the commitment of staff at all levels in the NHS. And we are hugely fortunate in having that enormous reservoir to draw upon, just as we were fortunate, I believe, in having the maturing experience of devolution itself now at our disposal.
And just to put some of the challenges we face in context, I want briefly to reflect upon that period.

The arrival of the devolution coincided with the end of a period of sustained under-investment in public services. When I became the health advisor to Jane Hutt in 2000, at a time when the National Assembly was not yet a year old, the public capital programme for the National Health Service in Wales was having to be re-established from scratch. There simply was no programme. In service terms, too, the failure to invest in the workforce, in particular, had led to real strains in areas such as mental health, waiting times for treatment, all of which was corrosive both of professional and public confidence in the service.

And we should not forget the major achievements of the ten years that have followed:

In capital expenditure, there has been major investment in all parts of Wales and across the range of clinical disciplines. My old boss, Rhodri Morgan, was fond of reminding me that the first time a commitment to replacing Caerphilly Miners’ Hospital was made was in Labour’s Plan for the Valleys of 1962. Now, it only took 40 years and devolution to make that actually happen, but now it’s there, the change is made. I think when
the history books are written, the first decade of devolution will turn out to have been a stand-out period for reinvestment in the infrastructure of health services in Wales. Now of course there is more to be done, and despite the fact that capital expenditure is taking an even greater share of cuts than other parts of our budget, we go on investing in our health service here in Wales. And we do so, moreover, without the burden of PFI debt, eating every year into the money available for providing a service. The annual cost to the NHS of paying PFI debt in Wales is a tiny fraction of that faced in Scotland. It is less than some single Trusts have to face paying off annually in England. And as repayments continue to rise elsewhere, so the comparative advantage we have in being able to use the revenue stream that we have in our health service to go on providing services, rather than paying off debt, will be ever more apparent.

And just as we’ve managed to invest in the capital side of the service so there has been major investment in services and revenue services as well. The number of doctors employed in the Welsh NHS after a decade of devolution has risen by 1,700. There is a 33 per cent increase in staffing right across the Welsh NHS. And it’s not just a matter of the numbers of extra people who work in our service but it’s the nature of those jobs too. The Ambulance Service, for example, has seen a rise in staffing at almost twice the rate of the service as a whole but in
doing so it is remodelling its workforce so that it becomes that emergency medical service with a wider group of people able to provide clinical services to patients at the point at which those are most needed. The last time I spoke in this very building was to celebrate the success that Wales has had in developing Advanced Practitioners, somewhere where we really do lead the rest of the UK. And while for the rest of the UK 2013 was a year in which the aftermath of the Francis review brought patient safety to the foreground, here in Wales, through the Save 1000 Lives campaign and its successors, we have already been engaged in that quality and safety agenda for many years.

And, finally in this rehearsal of the positives, just to remind ourselves that we are in a period of essential structural stability in the Welsh NHS. We have a national service, based on planned responses to assessed needs. We have integrated organisations, capable of mapping patient journeys across primary, community and secondary care, and to do so more closely than ever before with our partners in social care and in the third and voluntary sectors. Now it’s not for me to cast aspersions on what goes on across our border in other parts of the UK, but in terms of structural stability, the contrast between the position we have in Wales and the turmoil in England could not be more striking.
I am very pleased to re-confirm today that that period of structural stability stretches beyond us here in Wales. We will use this opportunity that we have to concentrate on the things that really matter and matter to patients.

I mentioned at the outset that the challenges facing public services in Wales is as formidable as they ever have been since the emergence of the welfare state. Any of us in the room who heard Michael Trickey at the reception last evening talking about the work of Wales 2025 will have been left in no doubt at all that that really is the scale of the challenge.

But I do say to us in this room, we do ourselves no favours, nor do we do justice to what has been achieved, if we talk ourselves into a cast of mind where because we live in Wales, every hill is higher, every climb is steeper and where every second-best solution is thus rendered acceptable. We simply cannot, and will not, consign the long-term future of the NHS to the “too difficult” box because the daily fight for survival is all-encompassing.

Now I have very few opportunities, strangely enough, to talk with an audience about some of the bigger picture ideas, to stand back from the daily turmoil that goes with being involved
in health, to think about the future. So I am very grateful to have the opportunity today to begin a discussion in the Welsh NHS about some ideas that will help us to go on providing an equitable service for the future, capable of being sustained even under the impact of the age of austerity. And as Nye Bevan himself undoubtedly would have said, it comes down as ever to the question of priorities.

The NHS has always been clear that in urgent or unscheduled care, prioritisation comes by clinical need. Lower needs are trumped by higher ones; those who are in most urgent need get seen first. In other parts of the system, however, we continue to prioritise by time: those who have waited the longest move to the top of the queue.

Now, it’s is my belief that as austerity bites more and more, so time as currency in healthcare will become less and less useful or usable. Instead, we have to find new ways of prioritising the services we provide, and to align them, and access to them, more directly on clinical grounds.

And that’s why I am keen that the NHS in Wales embarks on shaping our future on the basis of the principles associated – as Chris has already trailed with you – with prudent medicine and prudent health care.
For those coming across these terms for the first time, I ought to make it clear that I am not claiming any great originality for the ideas which I am about to set out.

The prudent medicine approach is already well established in some aspects of contemporary clinical practice in our own country, as well as being widely rehearsed in other jurisdictions such as Canada. Here in Wales, I am indebted to the work of the Bevan Commission setting out the first concerted attempt to provide an account of prudent healthcare in the UK, together with some opening thoughts as to how such principles might be applied to the practical business of providing health services.

Now, I’m going to try and do two or three things. I will start by outlining some fundamental principles, core principles derived from the work of the Commission, which I think sum up the essence of the prudent health care approach and them I’m going to go on to look at, in a very preliminary way, at how those principles might be applied to the health services that we have here in Wales.

Now the principle is one which will be very familiar to you, and which no doubt will seem un-contentious, and that is that it is the first obligation of any service, and of any individual
providing that service, to do no harm. And yet, despite the un-
contentious nature of such a proposition, however, we know
that in practice, the avoidance of harm requires action across
the whole system. That is why we have embarked on the Save
1000 Lives campaign and its successors in the first place. It's
why we continue to bear down with such determination on
health care acquired infections here in Wales, but I think that
we have to move beyond the ‘do no harm’ principle to one
which is focused on what is normally called minimum
appropriate intervention. The principle that treatment should
begin with the basic proven tests and interventions, calibrating
intensity of testing and treatment consistent with the
seriousness of the illness and the patient’s own goals. How
many times have we heard people say, in Wales, after they’ve
had an encounter with the health service, “oh, they’re trying
everything they can do for me”, as though somehow volume of
activity was the touchstone by which we measured our
success? Now prudent medicine provides an ethical
underpinning for conversations with patients, because who
actually in practice would wish to undergo a greater level of
treatment than that necessary for addressing their condition? It
means that the conversation that we have with patients cannot
open with the question “what can I do for you?” as though the
encounter is one in which the health service takes onto its own
shoulders the whole of the responsibility for that encounter.
The first question that we should ask, I believe, is that co-productive principle, “what can we do together to address the difficulties and the problems that you are experiencing?” and if we do that, that principle of minimum intervention, I think, becomes part of the conversation which relies on reinforcing people’s strengths and is always focused on maximising their own abilities. It’s a very natural human reaction when we see someone who is in distress or in difficulty to wrap our arms around them and say “there, there, don’t you worry, we'll do this for you”, and actually we know that despite that human impulse, it leads if we are very careful indeed, to stripping people that person of their abilities, to removing their capacities from them and in the short term expedient we end up doing long term harm.

And on this point let me be absolutely clear that the prudent approach to health care is not about rationing. Instead it aims to deliver healthcare that fits the needs and circumstances of patients and actively avoids wasteful care that is not to the patients benefit.

Of course it means being attentive to the intervention to outcome calculation or the prudent principle that resources should be expended wisely but it is about an ethical approach to treating patients in which clinical need and clinical prioritisation determine how services are provided.
And because of that my third essential principal of prudent healthcare is that it is infused with a sense of equity. It provides us with a way of going on matching need and spending so we put our maximum resources where our needs are greatest and it allows us to go on preserving and promoting that fundamental Bevan principle that it is your clinical need and nothing else that matters when it comes to deciding your treatment by the National Health Service.

Now, I want to move on and say something about how such principles might be applied. And I want to say to you that the principles that I’ve just outlined we will hear more about and in more detail later in the morning apply to the whole of the way in which we think about health services and health care. It begins, I believe, in recalibrating the relationship between the citizen and the state or between the patient and the Service. Here is what the Western Mail said about this in a very useful recent editorial:

‘The NHS cannot afford to pay for life saving treatments in the future if giant swathes of us continue to make destructive lifestyle choices.’

We have to work harder to explain to people the responsibility they have for creating the conditions for health in their own lives. That is very much a prudent medicine principle.

The Caerphilly cohort study that many of you here will be familiar has published some new data in the last 24 hours. The
cohort study for those of you who don’t know it looks at the lives of a large group of men in the Caerphilly area over a 30 year period. It looks at the choices that people make in their own lives and the impact that has on their health as they get older.

And they look those basic health behaviours that you’ll all be familiar with. Not smoking, not drinking to excess, eating sensible taking exercise all sorts of basic things. In their conclusion published in the last 24 hours they say that had men in that cohort simply added one extra healthy behaviour to the repertoire that that they actually used in their lives then 30 years later that cohort would have had 13% less dementia, 12% less diabetes and a 6% reduction in vascular diseases. It’s an astonishing real life example of what prudent medicine principles lived in the lives of us not as patients but as citizens make to health and healthcare here in Wales.

Now if we move beyond the level of a citizen and move to the realm of public health and population based health what have we learnt about public health education over the last 30 years. Well on European scale the lessons are very similar indeed and I think very clear.

30 years of public health education has succeeded hugely in changing peoples attitudes. People understand now very well those basic healthcare messages that we have just been rehearsing. It has even succeeded in changing peoples
intentions. People know what they should do and have intentions to do things differently. What it has not succeeded in doing is changing actions. It has not succeeded in changing behaviours. That is a major conclusion of the Caerphilly Cohort study. So I believe that in a prudent medicine world we have to change the way we think about public health and population based health too. We have to move from education to motivation. We have to move our attention those things that we can do to change the environment that people live their lives and then enable them to turn those good intentions to actions that they can take which make such a difference.

So if we move beyond public health and think next on primary care then if 2014 is going to be a year in which we talk of prudent medicine then I feel very determined that it has to be a year as well in which we move primary care services to the centre of the stage. Because if we are serious about the principles of prudent medicine then primary care is the single most important place where we can start to make this happen.

I was very grateful to colleges in the primary care community for the time they took and the commitment they showed to help us reach an agreement for the contract for the next financial year. One of the parts of the new contract that I am most excited about is the new incentives it puts into the system for
practices to work together in clusters and for practices to work beyond the cluster to our partners in social care and the third sector too.

If we think in a crude way, and I know it’s an awful summary of the real position, but if you think of the traditional way that people think of health services you can think of them an escalator in which we are always pushing people up the levels of intervention and somehow the higher up the intervention levels you go the more prestigious it becomes and the more you feel you’ve got something good out of the health service.

Now I really want to reverse the escalator and prudent medicine’s really all about this. It is about saying the more we can do at a citizen level, the more we can do at a population level, the more we can do at a primary care level then the better the service we provide to patients.

And by providing new ways in which primary care is able to work together and as that system matures and I’m confident it will mature quickly so our primary care colleges will be able to act to pull services out of secondary and down closer to where people live their lives.

Primary care is centre stage for me in the way that prudent medicines will work in wales over the coming years. They apply of course equally at hospital levels to. And there are many things that happen already at hospital level that are entirely consistent with the principles that I’ve outlined this morning. All
hospitals have a document which is called interventions that are not normally undertaken, the INNU document. I’m glad to be able to say to you this morning that we have already began to work on drawing these different documents together, that we provide a national list of such interventions, that we draw greater interventions to them and we make that side of our secondary care a more effective and lively to the way the daily business goes along.

Now we are all well aware of NICE guidance and recommendations there’s a huge attention in the media and on the floor of the assembly as well as on whatever what next new intervention or treatment that NICE is going to approve for the National Health Service.

I think it will come as quite a shock to many members of the public to know that NICE has published 867 don’t do it clinical guidelines. 867 things that NICE say are no longer clinically worth doing in the health service.

If prudent medicine is about not doing things that don’t do any good and avoiding things that do harm I would like us in secondary care to pay more attention to those sorts of pieces of advice alongside doing things that are necessary as well for the future. Let me just summarise three core things that link these core things together.

What is the essential case of the prudent medicine approach in practice?
Well first of all it chimes entirely with the age of austerity because it really means in a serious way that every pound we spend in the NHS is really spent to maximum effect. Secondly it puts clinical decision making closer to the heart of everything that we do. And puts clinical prioritization at the forefront of the way that we govern access to services in the NHS and provides us with a key new way of conceptualizing and then putting into practice health inequalities here in Wales. Now as well as the things I’ve already mentioned to you as a key next step we have already agreed with Public Health Wales that over the next two months we will run a series of workshops mounted by clinicians and in close partnership with the BMA here in Wales in which we will bring people around the table in a desktop exercise to begin with and we will start with four different areas of treatment and conditions. We’re going to look at Orthopaedics, we’re going to look at prescribing, we’re going to look at ENT services and we’re going to look at the services we have for pain management. And we’re going to subject each one of those areas to a desktop exercise in which working with clinicians we ask ourselves the question if those services were to be organised on prudent medicines principles what would they look like for the future. And then because change is not a choice and because we cannot afford to stand back and simply watch the unfolding film of the NHS in Wales we will use the learning from
those exercise when we are confident that we have got the right set of guidelines to move forward and make a difference to the services provided on the ground.

I began by thinking Chris Martin for all the work that he has done over the years and I’d like to end by thanking everybody in the room today because as we face the challenges here in Wales it is the people that are in this room and all the others who represent and work with who provide the key to success in the future.

I know that every single day right across Wales huge efforts are made to provide the services that people rely on and to find some of the thinking time that we need collectively and between us to go on shaping the service for the future. To have new ideas, to look at new sets of principles that allows us to remain true to the fundamentals of healthcare here in Wales and to shape those for the future.

Without you and without all that you do none of this would be possible and yet it’s the single most important service people in Wales have, day in day out, and is hugely appreciated by them.

END.