Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

The Health, Social Care and Sport Committee

09/11/2016

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Others in attendance

Anita Charlesworth	Cyfarwyddwr Ymchwil ac Economeg, Y Sefydliad Iechyd Director of Research and Economics, The Health Foundation
Adam Roberts	Pennaeth Economeg, Y Sefydliad Iechyd Head of Economics, The Health Foundation

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

Claire Morris	Clerc Clerk
Sarah Sargent	Dirprwy Glerc Deputy Clerk
Philippa Watkins	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 09:30.
The meeting began at 09:30.

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

[1] **Dai Lloyd**: Croeso i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. A allaf i estyn croeso i fy nghyd-Aelodau i'r cyfarfod diweddaraf yma? Ac, yn naturiol, a allaf hefyd bellach egluro bod y cyfarfod yma yn ddwyieithog? Gellir defnyddio'r clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1, neu i glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2. A allaf atgoffa pobl i ddiffodd eu ffonau symudol ac unrhyw offer electronig arall a allai ymyrryd ag offer darlledu? A hefyd a allaf hysbysu pobl y dylid dilyn cyfarwyddiadau'r tywyswyr os bydd larwm tân yn canu, ac os bydd mwg yn ymddangos?

Dai Lloyd: Welcome to this most recent meeting of the Health, Social Care and Sport Committee here at the Assembly. May I extend a very warm welcome to my fellow Members to this meeting? And may I also explain that this meeting is a bilingual one? You may use the headsets to use interpretation from Welsh to English on channel 1, or to hear amplified sound of the verbatim feed on channel 2. May I remind people to switch off their mobile phones and any other electronic equipment that could affect the broadcasting equipment? May I also let you know that you should follow the instructions of the ushers if there should be a fire drill, and if smoke should appear?

Ymchwiliad i Gynaliadwyedd y Gweithlu Iechyd a Gofal Cymdeithasol—Sesiwn Dystiolaeth gyda'r Sefydliad Iechyd
Inquiry into the Sustainability of the Health and Social Care Workforce—Evidence Session with the Health Foundation

[2] **Dai Lloyd**: Felly, gwnawn ni symud ymlaen i eitem 2—ymchwiliad i gynaliadwyedd y gweithlu a thystiolaeth gan y Sefydliad Iechyd. Nawr, bydd Aelodau wedi derbyn, unwaith eto—. Roedd rhai ohonom yn lansiad yr adroddiad yma fis diwethaf yma yn ystafell y cyfryngau, ond

Dai Lloyd: With that, we'll move on to item 2, which is our inquiry into the sustainability of the health and social care workforce, and we're hearing evidence from the Health Foundation. Now, Members will have received—. Some of us were present at the launch of this report in the media

byddwch hefyd wedi derbyn copïau ychwanegol o adroddiad y Sefydliad Iechyd fel cefndir. Felly, beth sy'n mynd i ddigwydd rŵan ydy ein bod ni'n mynd i gael tystiolaeth ar lafar ger bron, ac wedyn cwestiynu o'r llawr. Rydym ni yn ymwybodol fod yn rhaid i'r tystion fod o flaen y Pwyllgor Cyllid am 10.30 a.m., wedyn mi fyddwn ni'n gorffen yn brydlon yn fan hyn er mwyn i chi gael digon o amser i fynd i'r pwyllgor nesaf.

briefing room last month, but you will have also have received additional copies of the Health Foundation's report as background information. So, what's going to happen now is that we're going to hear oral evidence, and then we'll ask questions. We are aware that our witnesses do have to appear before the Finance Committee at 10.30 a.m., so we'll be finishing promptly on time so that you can have enough time to go to that other committee.

[3] Felly, gyda hynny o ragymadrodd, a allaf groesawu Anita Charlesworth, cyfarwyddwr ymchwil ac economeg, a hefyd Adam Roberts, pennaeth economeg y Sefydliad Iechyd? Gyda hynny o gyflwyniad, a allaf roi y llawr i chi i ddweud beth sydd angen ei ddweud, ac wedyn fe gewch chi gwestiynau oddi wrth Aelodau. Nid wyf yn gwybod pwy sydd eisiau cychwyn.

So, with those words of introduction, may I welcome Anita Charlesworth, director of research and economics, and Adam Roberts, head of economics at the Health Foundation? With those words of introduction, I pass over to you to say what you have to say, and then we'll ask our questions. I don't know who wants to start.

[4] **Mr Roberts:** I will start. I will give a very brief summary of the key results of the report that we published last month at the Health Foundation, looking at projections on pressures for the NHS and social care, then a couple of words on what's happened since the announcement of the draft budget and the additional funding for this year for the NHS.

[5] So, it was predominantly a modelling projection exercise from the Health Foundation, looking at pressures for, crucially, the NHS in Wales over the next 15 years. We also take a look over the period to 2019–20 for which the UK budget was set in the comprehensive spending review. The pressures that we examine come with the growing and the ageing population—crucially, the ageing of the population—where, while the total population is expected to rise by around 6 per cent over the next 15 years, those aged 65 and over are expected to grow by over 25 per cent. So, ageing of the population seems to be one of the major pressures within this.

[6] We also look at pressures from hospital activity related to growing chronic conditions, some of which come from the fact that we've got more people living longer, and therefore more likely to develop chronic conditions, but also the likelihood of, for example, an 85 year-old living with one or two or multiple chronic conditions is also rising as well. So, you've got that multiplicative effect there.

[7] Crucially, within that, if you compare the growth of single conditions to multiple conditions, the rate of growth for admissions for people with more than one condition is rising around three times faster than that for single conditions. So, an approach where we continue to look at single conditions in their own right looks more and more difficult.

[8] And then, finally, we look at the rising cost of healthcare predominantly from pay, which, historically, rises by around 2 per cent a year above inflation per head for public services, which is our initial assumption.

[9] If we look at the long-term period first, over the next 15 years we'd see pressures rising by around 3.2 per cent a year just to keep pace with those demands. That's not assuming that the NHS makes any savings within that, which, historically, has not been the case. Historically, the NHS across the UK—we don't have Wales-specific numbers—but across the UK over the last 30 years or so, the NHS has achieved around 1 per cent efficiency growth a year. If it maintains that, that obviously brings pressures down to around 2.2 per cent, which is actually the current projection from the Office for Budget Responsibility for economic growth beyond 2020. Actually, the long-term picture is, just to keep pace with pressures, that the NHS will need additional funding, but if it rises in line with economic growth and continues the rate at which it achieves efficiency growth, there is a real cause for optimism of the long-term sustainability. That doesn't fund any dramatic improvements in care, but at least keeps pace with demand, so then you've got a political decision on whether to spend more to improve care.

[10] There are some major challenges for that. Predominantly, it's the short-term period up to 2019 where actually, instead of maintaining a share of economic growth, we actually expect NHS funding across the UK to fall as a share of economic growth. So, although we expect it to rise above inflation, it will fall as a share of GDP and therefore, crucially, fall in comparison relative to the pressures that we're expecting.

[11] In the report, by 2019-20, making assumptions on what might happen to the NHS budget in Wales relative to what's happening in England, we estimated a shortfall of around £700 million. With the recent announcements of the £50 million within year and the additional around 2 per cent increase for the budget next year, that's going to bring it down to just over £600 million, but it's still a sizeable gap to close.

[12] We looked at options for closing that. We assumed that the 1 per cent efficiency growth would continue, and we also look at the UK national pay deal. They would go some way towards closing it. The fact that pay across public sector is capped at 1 per cent in cash terms would have a big implication, but that wouldn't be enough to close it.

[13] In the report, we look at the need, therefore, to increase it to 1.5 per cent efficiency growth every year. With the new budget, it has fallen to around 1.2, but that's still above the long-term trends. So, there's real need to act now around how we improve efficiency within the NHS. Obviously, if you need additional funding for transformation within that, that either needs to come on top or through greater efficiency elsewhere.

[14] Alongside the financial pressures, and obviously relevant today, we identify real risk around staffing within the NHS, with a large proportion of the savings coming from the UK pay deal. That follows five years of broadly flat growth going back. So, you're looking at almost a decade of broadly flat pay for NHS workers.

[15] Over the last five years, although not great by historic terms, public sector pay has fared broadly better than private sector. That's not likely to be the case going forward. So, we may have some increase in pressures there. We are already seeing a rise in difficulties in recruitment and retention of staff, with many posts going unfilled across the NHS and an increasing reliance on agency staff, with a 60 per cent increase in agency spend in the last financial year. So, workforce issues are at least, I would say, as pressing as the financial issues.

[16] Some of the other risks that we identify—. Obviously, you can't look at the NHS on its own; you have to look at the impact of other public services and, crucially, social care, which we project—using modelling from the London School of Economics—to actually rise faster than healthcare at about 4 per cent a year with potentially less scope. There was money in the budget for social care for next year, which accounts for around half of the pressures,

we would estimate.

[17] Finally, there are two other risks to the sustainability. One is around realistic assumptions and what you can do with a set budget. So, what we model is actually the pressure of just keeping pace with pressures, as I say. If you want to improve dramatically the services, as we did in the period of the Blair Government, you would need funding on top of that to help build capacity and workforce. And then finally, anything that happens around the long-term budget would obviously have implications for the sustainability and the funding challenge long term. So, if the budget is actually lower than we've projected, either because it falls as a share of GDP over a 15-year period or because GDP would fall, then that would have implications for the sustainability of the NHS.

[18] One of the biggest risks potentially at the moment around economic growth not being greater is, obviously, the recent decision to leave the EU. The majority of economic experts across the UK estimate that that will actually have a negative impact on economic growth. So, if that then feeds into less money being available for the Government and, therefore, less money for the NHS, that could increase the scale of the financial challenge over the longer term.

[19] **Dai Lloyd:** Diolch yn fawr iawn i chi am hynny. A oes gyda chi rywbeth i'w ychwanegu at hynny, Anita?

Dai Lloyd: Thank you very much for that. Do you have anything to add to that, Anita?

[20] **Ms Charlesworth:** Yes, just to draw out a little bit more about the workforce. Obviously, as Adam has very clearly set out, the ability to close the gap is very dependent on what happens to pay. But I also want to emphasise that I think the workforce challenges have big implications for the ability to achieve the efficiency target as well. If you are not able to recruit and retain staff, not only do you get a direct additional cost from the agency, but most of the efficiency savings come from teams in the NHS being able to work differently, and where you don't have a stable, permanent staff who are well engaged and well motivated, it is incredibly difficult to realise those efficiency savings. So, actually, workforce issues are at the heart and core of all of the sustainability agenda. Equally, then, the ability of the system to meet the changing needs of an ageing population and all that work on new models of care, again, requires staffing change at its heart, and the willingness and ability of people to engage with new ways of doing things.

So, this really is, at its heart, a workforce challenge.

[21] **Dai Lloyd**: Diolch yn fawr am yr ateb hwnnw, sy'n dod â ni yn ôl at bwynt ein hymchwiliad ni. Dyna beth yr ydym yn edrych i mewn iddo yn yr ymchwiliad arbennig yma, sef cynaliadwyedd y gweithlu. Felly, diolch yn fawr am y cyflwyniad hwnnw. Cwestiynau o'r llawr—Rhun.

Dai Lloyd: Thank you for bringing us back to the point of our inquiry. That's what we are looking at in this particular inquiry, namely the sustainability of the workforce. So, thank you very much for those introductions. Questions from the floor—Rhun.

[22] **Rhun ap Iorwerth**: Bore da i'r ddau ohonoch chi. A yw'n deg inni edrych yn ôl ychydig wrth inni edrych ymlaen? Ym mhle wnaeth dwyster problemau'r gweithlu ddechrau? A ydym yn gallu trasio hynny yn ôl i ryw bwynt mewn amser er mwyn trio gweld beth aeth o le bryd hynny, er mwyn chwilio am atebion?

Rhun ap Iorwerth: Good morning to you both. Is it fair for us to look backwards slightly as we look forward? Where did the intense workforce problems begin? Can we trace it back to some point in time in order to see exactly what went wrong at that point, to seek solutions?

[23] **Ms Charlesworth**: So, I think there's a mixture of, obviously, some very long-term issues that are not unique to Wales or unique to the UK, about profound changes in the demands on our healthcare system with an ageing population with chronic conditions, which mean that you need different sorts of skills. So, the World Health Organization has done a big piece of work looking at shortages of skills. Equally, the Centre for Workforce Intelligence, which is doing some of the analysis on an England basis in its Horizon 2035 programme, has been looking at this and identifying that, with the ageing population and rising chronic conditions, you need many more people at the lower skilled end of healthcare, and you need much more integrated care, obviously, which requires people to work together. Those things have been running along for quite some time and have proved quite difficult, in workforce planning, to address—not just here, but generally speaking—with quite siloed structures of working. So, there are multiple reports talking about trying to equip people with more team-based skills and with more generic skills, and it is still the case that workforce training programmes are struggling to keep pace with that.

[24] Because it takes so long to train healthcare workers, obviously, most of your staff, even in 10 years' time, are people you still employ. I think one

of the criticisms that one can make of healthcare systems across the piece is that they put a lot of resource into the new staff and have under-resourced the development of existing staff. Actually, if you want to transform, that is primarily a task for your existing workforce. I don't have access to a breakdown of this, but certainly, if you look elsewhere, the balance of funding for training and development that goes into new staff compared to existing staff is completely out of kilter with what you would spend if you were looking at this from a service transformation point of view. So, I think that focus on the development of existing staff is a really important thing.

[25] There were obviously some cuts to training places at the beginning of the decade that seemed sensible at the time as a way of cost saving. They were a real example of where cost saving can actually undermine your drive for efficiency in the longer term and that is coming back to bite us. I think that decision is looking like one of the worst decisions that was made in response to the economic slowdown.

09:45

[26] **Rhun ap Iorwerth:** If I could just stop you there. In any particular areas? Are we talking nursing mainly?

[27] **Ms Charlesworth:** So, the big reductions were in nursing and, obviously, they're the big budget and where we're seeing a lot of the agency pressure at the moment. I guess the other thing is that part of the policy for social care has been to try to be very aggressive in driving down cost with private providers and that, for quite a long period, has left social care on a minimum-wage economy with very poor working conditions, which lead to incredibly high turnover rates in social care and make it incredibly difficult to do skill development in social care. So, again, that workforce is looking very fragile and in a very difficult place to do the kind of integrated care partnership that all health boards would talk about as being fundamental to their vision for the future.

[28] **Rhun ap Iorweth:** That's useful. Thank you.

[29] **Dai Lloyd:** Lynne nesaf, wedyn **Dai Lloyd:** Lynne next, then Caroline. Caroline.

[30] **Lynne Neagle:** It was just on the point that you made there. Obviously, the Welsh Government has got a number of things in the pipeline to improve

things for the social care work to professionalise it but also to look at things like ending zero-hours contracts. Have you got any comments on what that's likely to mean in terms of the sustainability we're looking at?

[31] **Mr Roberts:** I can't say anything on zero-hours contracts. I just wanted to come in on the point generally around workforce, in that when we're looking at training, it's absolutely crucial, and part of the reason we look over a 15-year period is that you can do planning for what the health service should be in 15 years' time. Part of the issue around training at the moment is that I think there is still too much of a focus on moving training—hospital staff, effectively, and clinicians. So, part of prudent healthcare and transformation across the world is moving care out of hospital and caring for people with multiple chronic conditions out of hospital, and yet we think we still have a bit too much focus within education services around training staff for hospital care, so not necessarily for the positions. I don't know if you want to come in on zero hours.

[32] **Ms Charlesworth:** We've done no specific work on zero hours, but I think it is clearly the case that trying to stabilise the social care workforce, so that people are able, means that you get much less churn in the social care workforce—providing people with the ability to invest in their own career development, because there is a sense of a career that you can develop. All those things are really important and much of the current employment offer, clearly, for social care staff doesn't provide that sort of route through. Equally, most of the work on integrating care points to the fact that the most important thing in integrated care is not combining budgets or anything administrative, but it's about the skills and relationships and cultures of the people who are delivering front-line services and bringing those and aligning those more together. You just cannot do that with levels of churn and without more professionalisation in social care.

[33] One of the issues that you see across the board is that there are, with varying degrees of success, bodies that look at and oversee and plan the workforce for healthcare. There is much less structure in social care and, even where it exists, it's disconnected from healthcare. How, if we're trying to design a workforce for 2030 and the world that Adam is describing, can we do that without bringing together thinking across the whole of the care workforce?

[34] Also, I guess the other thing to think about is the vital role of informal carers. All of the work that's being done by the WHO and others highlights

that, with an ageing population, the role of informal carers is absolutely vital, and you need to think about the workforce both in the formalised workforce and also worry about how that links in and supports the informal workforce and the support they need to be able to manage.

[35] **Dai Lloyd:** Ocê. Caroline nesaf. **Dai Lloyd:** Okay. Caroline next.

[36] **Caroline Jones:** Thank you, Chair. Good morning. The British Medical Association survey conducted found that over 60 per cent of the respondents did not have a good work-life balance, and that's a lot of people to be sort of dissatisfied with that aspect. I wonder if you could elaborate on that.

[37] **Mr Roberts**: I mean, we looked specifically at the Welsh NHS survey as well to try and get—which is from 2013; I think the next one is coming out this year, isn't it—an update, and we see very similar things. We see the majority of people feeling stressed. But I think if we go back to Anita's point around how important it is to actually achieve transformation in services, you'd need a very engaged workforce who feel supported. Actually, the level of engagement was very low. They use a composite measure across a number of things and, in some areas, it's quite high, and in some areas, it's very low. And actually, overall, they create a composite measure. So, it's the engagement as well as the morale and the stress that I think is particularly an issue within the workforce.

[38] **Ms Charlesworth**: The other thing I would just mention is work that has been done by a number of the trade unions on why people choose to work for agencies. It has identified that pay is a factor, but the biggest factor actually is the flexibility, and the ability to manage your work. With an aging workforce, obviously a lot of the healthcare workers are the informal carers that I was just talking about, caring for their own elderly relatives, and with the retirement age rising, the ability—. I mean, if you think about things like nursing that are highly physically demanding jobs, I'm just about to have my fiftieth birthday and the idea of doing full-time 12-hour nursing shifts at the age of 63 and being able to cope with that.

[39] So, there's a clearly need for NHS employers to think about how they can offer much more imaginative and flexible packages to their workforce, recognising the demands on their lives and what they want to be doing in the later stages of their career. Flexibility, I think, increasingly will be seen, as a key issue in the later stages of our career. We've traditionally thought about it more in relation to women with children, but you can see the pattern of

work and our caring responsibilities changing, and it does feel like the healthcare system is behind the curve of many other private sector employers in thinking about this. One of the things that the health service should be doing, as such an important part of the economic social fabric of our society, is to think about how it can role model some of these good behaviours.

[40] **Caroline Jones**: Yes, definitely. Thank you very much.

[41] **Dai Lloyd**: Dawn nesaf. **Dai Lloyd**: Dawn next.

[42] **Dawn Bowden**: Thank you, Chair. I'm very interested in your analysis around social care workers in particular. I know we're going to be dealing with that a bit later on. Can I just say, in terms of the health service and the lowest paid staff in the health service, the healthcare support workers, the Welsh Government has introduced something that is unique to the NHS in the UK, which is a career development framework for healthcare support workers, to give them an opportunity? But, it still doesn't get away from the fact that they are the lowest paid group of staff in the NHS— they are still paid better than the social care workers, which are in local government. I just want to flag up this contradiction between the forecasts that you're making about efficiency savings and the need to recruit and retain staff and so on, and the contradiction between that and what the Nuffield report was saying— I don't know if you read the Nuffield report into austerity and beyond in the NHS in Wales, which talks about pay restraint beyond three years really being unstainable—and where that leaves your forecasts, if that is unsustainable, because that's the contradiction, isn't it? It needs to happen, but it's unsustainable. And actually, it impacts on our recruitment and retention. So, have you got any kind of thoughts about that?

[43] **Mr Roberts**: Yes. I would say, within particularly the short-term projections that we did, the biggest risk to achieving those saving would be being able to hold that 1 per cent. As I said, you're not talking about three years, you're actually talking about nearly a decade when you add on what's happened.

[44] **Dawn Bowden**: It's never happened beyond three years before.

[45] **Mr Roberts**: No. And that becomes even more of a concern if private sector earnings start to rise relatively, so it's harder to encourage people into the public sector, particularly the NHS. That's possibly a big concern for non-

clinical staff as well. I think it's really important to acknowledge that some of the agency spend is actually on non-clinical support staff as well, who, in some cases, might have more transferable skills. So, it's not just the training of the clinical staff within this; it's the support given to managerial and back-room support staff as well. We do estimate that—. So, we have modelled through the impact of the pay deal, and estimated the savings that would create. Without that, it makes the efficiency challenge much, much harder. You can't get away from the scale of that. I think another risk for that around relative earning power is that we've assumed the current estimates for inflation and there are some suggestions that, in the light of the EU referendum and other issues, we might actually see higher inflation across the economy, and also potentially slightly higher healthcare-specific inflation, which, if that's going to have a further impact on the cost of living and therefore the real terms wage, could add further pressures on recruitment and retention within staff.

[46] **Ms Charlesworth**: So, from 2020 onwards we do assume 2 per cent a year real terms increase for healthcare workers. We can, I think, envisage no plausible scenario where you could continue to hold down a pay restraint beyond this decade. There are two things I would say that the pay outlook really points to as an imperative for the NHS in the short term. One is that pay is one reason why people change jobs, but it's not the only one, and most people work in the health service because they're passionate about healthcare. As you were alluding to with some of the surveys, they often don't feel valued, and they often don't feel that they can do a good job. But in this regard, I think, the efficiency agenda actually is helpful because a lot of what is inefficient are actually practices that are deeply frustrating to staff. You know, we've done a lot of work on flow through hospitals. If you've got patients who you can't get to their scan or to be seen by the consultant, you're spending large parts of your day running around administratively, trying to work out how to get something done, apologising to patients why what you thought was going to happen is not going to happen, and then working out what you're going to do about the fact that this patient who should have been moved on wasn't moved on, as a working environment, as a professional, that must be deeply demoralising when you're there wanting to do a really good job. So, being able to make sure that we are working with staff to help them to do a good job, to feel really valued, engaged, offering them some of the flexibility.

[47] The other thing that is a real opportunity is the apprenticeship levy. The opportunity, particularly for staff at lower levels, to see beginnings of

possibilities for career progression and using that training and development, and that apprenticeship levy, to support people. Those sorts of things would be really important to manage through a very difficult pay environment.

[48] The other thing, obviously, is looking creatively around skill mix. So, primary care, in particular, is looking very difficult to continue to sustain on the historic model, even if we had more money for pay. So, we will have to look, in some cases, at new and different ways of delivering care. You can see some of that in the NHS. Given that almost everybody in social care will be on the national living wage, it's very difficult to see any sort of similar opportunities there. So, we're much more pessimistic about some of the efficiency opportunities in social care, but do think again that the apprenticeship levy is a very important opportunity to seize for social care.

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

[50] **Mr Roberts**: Can I just make two points on that? Sorry. One, if we weren't able to hold the pay deal in the NHS and it went back to 2 per cent historic, you'd be looking at efficiency growth of around 2.5 per cent to keep up with pressures, which is over double what the NHS has achieved historically. Secondly, although we had the data to be able to model in some of the impacts of the new minimum wage and the apprenticeship levy for the NHS, we haven't been able to because of the data available for social care. So, it's really important to say that the pressures, which are high already for social care, don't include the potential impact of, crucially, the new minimum wage, which would add pressures on that. I would say that, actually, at least some work understanding what those pressures are likely to be would be quite important.

[51] **Dai Lloyd**: Ocê. Julie nesaf. **Dai Lloyd**: Okay. Julie next.

[52] **Julie Morgan**: Diolch. You say in the report—you said when you were speaking to us—that you didn't include any projections of new technologies or any increases in abilities to provide care and, I think, certain qualitative sorts of issues, and obviously those are going to be there, aren't they?

10:00

[53] Because we've seen such transformation of people's lives by what has happened, in terms of new developments. So, are you able to make any projections about the sort of resources that might be needed to follow on

from what's been happening already?

[54] **Mr Roberts:** Yes, so the way that we've done that—. There are a number of ways that you can do this modelling. This is very much a bottom-up, delivering the pressures we have now, to get a real understanding of what the baseline pressure is, and then you can add on top of that; it becomes more of a political decision. So, I think that's a sensible approach for the medium term, which is our suggestion. If you look at the Office of Budget Responsibility approach, they take a much longer view up to 2060, where they make assumptions around health spending rising above economic growth, which we know is not happening at the moment. They've just published a series of scenarios where they look at different options. Through working with them to understand the difference between our model and theirs, we would estimate that, actually, the cost of new technologies, if they continue to be adopted as they have been in the past, will actually add about an extra 0.7 per cent. It's quite a crude estimate, but in terms of taking our 3.2 per cent base, you're looking at around 4 per cent, or maybe 3 per cent with 1 per cent efficiency, if that makes sense. That's the best estimate we've got for new technology: about 0.7 per cent a year in real terms.

[55] **Ms Charlesworth:** It is worth saying that one of the things that has probably been unusual over the first half of this decade has been the comparatively low number of new and innovative drugs brought to market, and a lot of the big blockbuster drugs, like statins, coming off patent and becoming generic, and that has been quite a big saving. The indications are that probably the rate of medical advances is picking up again and, certainly, all of the challenges around hepatitis C are a real example of what can happen. You may well be aware that, at the moment, NHS England and NICE are consulting on a slightly new framework for the introduction of new technologies that will, more explicitly, recognise affordability, alongside cost-effectiveness. They are proposing that if any new drug, even if it's cost-effective, has the potential cost to the English NHS, I think it's, £20 million a year, then, actually, there'll be a further additional stage to plan and assess how to introduce that. It will not be subject to the traditional requirement that drugs are then implemented, if cost-effective, within 90 days. So, those are some of the choices that would obviously present themselves, if you don't want to increase spending above what we've said. But we treat them slightly differently, in that we feel they are choices.

[56] **Julie Morgan:** Are they choices then?

[57] **Ms Charlesworth:** Well, in the end you could spend any amount of money on a healthcare system; there is no right sum of money. It's a question of how far you value healthcare spending versus the other things you could be doing, in terms of things like—in the public sector—education, social care, et cetera—those are the trade-offs—or individuals determining what they want to do with their own spending. So, ultimately, you can't get away from the fact that how much you spend on healthcare can be informed by this sort of analysis, but it is ultimately a political choice. It's a societal choice.

[58] **Dai Lloyd:** Ocê, ar y mater yma, Rhun. **Dai Lloyd:** On this matter, Rhun.

[59] **Rhun ap Iorwerth:** Pushing a little bit more on the options, if you like, for making the savings, we mentioned changes in technology and we talk about efficiency savings—good old-fashioned efficiency savings of up to 2.5 per cent, possibly, depending on what happens to pay. I'm a little bit concerned that we're talking a little bit too much about keeping up the pounds and pence going into the NHS to keep the kind of NHS that we have now, going as it is now. What, hopefully, we'd all like to do, is move towards a new kind of NHS that is more adaptive to changing contexts. What is the scope to really transform the NHS, the way it's managed, its very existence, as an alternative to just those efficiency savings? Or is the firefight just going to be too overwhelming to follow that kind of agenda?

[60] **Mr Roberts:** One of the ways in which we looked at the opportunity for transformation was using the initial results from a project we're funding with the Welsh Institute for Health and Social Care, looking at the pace of change that you can get from prudent healthcare. We've done some scenario modelling within the report, based on—they've been out and talked to a lot of clinical experts about what the likely impact of prudent healthcare might be over the next five years. The aim is, as I was talking about, not reducing the amount of hospital care we have now, but reducing the rate at which it increases and replacing that with quite large increases in community spending. So, what we find from that is that level of transformation wouldn't necessarily have an impact on the scale of the financial challenge, but it wouldn't increase it further.

[61] With the investment that they believe you would need in out-of-hospital services, if that could be—and it's a big 'if'—if that could be

translated into reducing the trend for hospital services, you'd end up with a scenario that's cost-neutral. You may need some front-loading of investment and some capital investment within that. It's worth noting that, actually, the budget for next year has quite a large decrease in the capital budget—10 per cent in real terms, I think. So, you might need some investment and front-loading in that. You will need staff engagement, but one of the key messages that's coming out from that work is: actually, the principles of prudent healthcare and what's trying to be implemented gets a lot of positive reaction from staff. So, there is a willingness to work towards that kind of change. The estimates that we have suggest it wouldn't have a major impact on the financial challenge and that, additionally, it could be done within the funding envelope without dramatically increasing the pressure within the budget.

[62] **Ms Charlesworth**: We do think that transformation is really important for sustainability, because without lots and lots of extra money, sustainability is economically affordable, but it's also a service that meets needs. It's not actually that complicated, in a sense, to design a cheap NHS; you can just cut the budget if you don't care what happens to the quality of care and the range of care. The challenge—and I think this is a huge challenge—for the NHS in Wales is to live with a budget in the next decade that is growing but growing modestly, and transforming itself underneath that to better reflect the changing needs of an ageing population with multimorbidity. An ageing population with multimorbidity does require a very, very different provision of care.

[63] Also, when we talk about efficiency savings, over the long term, we are much more interested—. Most of those come, actually, not from what you do to your back office or how you procure services. They are actually about how you deliver clinical care. So, if you look at the last 20 years, where have the big efficiency savings come from? The change in anaesthetics that has meant that we can do much more by day case has been one of the biggest transformations and contributors to efficiency, but then you actually need to change your health service, don't you, to enable people to be seen on a day-case basis. Similarly, there is probably a lot of scope to move from day case to outpatient, but you'd have to provide outpatients in a very different way.

[64] **Rhun ap Iorwerth**: We're talking about workforce in particular. Do the challenges that we face in terms of developing a more adaptable workforce make that transformation agenda more difficult? Are we, because of the acuteness of the problem that we're facing, just having to plan the workforce

for the kind of NHS that we have now?

[65] **Ms Charlesworth**: I think you raise a really important point. We did some work for England with the King's Fund, looking at a transformation fund and talking about—actually, there's huge agreement across healthcare systems about how they need to be different to meet these sorts of challenges, to be adaptive and, as you describe, more fleet of foot. There are some capital issues associated with that, and having buildings that are fit for purpose. But overwhelmingly, what we identified in the work that we did is that the big change is people—are the staff being equipped to work differently, to have time and space to define what that different service is, and to try that service, which often takes a while to get right. People talked over and over again about headspace and time. We looked at a range of other transformation programmes in other healthcare systems internationally and in other sectors, like a lot of what's been done in education elsewhere. Everything that came back said that this is about people changing, it's about all of the people changing. It's not done in a chief executive's office; it is done on the ward, in the clinic, day in, day out. You have to engage everybody in that, and it takes time. So, resourcing that, giving people the time, providing the formal skills in terms of training and development—all these things are fundamental.

[66] So, I would say, with the new budget, one of the key questions over the bit of extra money that has been put in this year is getting that balance right between supporting immediate needs, which are real and pressing—and I in no way want to suggest that they're not—and trying to carve out some money to allow people in the system to be focusing on that adaptive change. I think that's really important for the service, but also for their morale and engagement—the sense in which you're not just running around trying desperately to keep the show on the road, but also able to begin to think and move towards a better place. Everybody needs some hope, don't they?

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

[68] **Angela Burns**: Thank you. I've got two areas of questioning, Chair, but the first is on workforce, again. It seems to me that the human resource element of the NHS transformation agenda is very finite. There are only so many people in our country, and we have a balance of population. So, given that, have you done any modelling at all about what possible effects there could be if we could return stressed-out, exhausted and ill staff back to the front line more quickly? I certainly took on board your comments about the

balance of training and that we don't give the training and the space to the existing staff—it's all about the new people, without capitalising on that. But, we are using so much of our money on agency nurses. They're there not just because we haven't got enough nurses, but they're there because so many nurses, doctors, GPs, healthcare assistants and physiotherapists are on long-term sick leave with issues. Have you done any modelling at all about what would happen if we were to be utterly brave and say, 'Actually, we're going to prioritise healing our own workforce first, because without them back at the front line, we can't heal everyone else'?

[69] **Mr Roberts**: One of the things that have become quite apparent in this project is actually the lack of information around what you refer to, which is the productivity of your workforce—so the lack of information around NHS productivity specifically for Wales. We talk a lot about the UK numbers and the work that's done by ourselves and other organisations in England, but, actually, a good understanding of the level of productivity currently and in the past, both across the NHS, but also labour productivity within that, was really hard to find. So, we haven't to date, and we're not aware of any high-quality productivity measure for Wales, specifically.

[70] **Ms Charlesworth**: There are two pieces of work that are not Wales specific that have tried to look at some of the issues about the health of the workforce and sickness absence. We see that Lord Carter, in his review for the English NHS, looked a lot at sickness absence and the variations in sickness absence, the variation in the quality of management of sickness absence and support. He also looked in there, obviously, at, again, how often that was not very well known to managers and not very proactively managed, and was a big advocate of e-rostering systems and much more real-time data for hospital leaders on what's going on.

[71] The other thing is that Dame Carol Black has done an awful lot of work on the real value of workplace health. This is one of those 'Physician, heal thyself'—surely, the NHS should be an exemplar of workplace health. One of the things we obviously see a lot, generally speaking, is the critical impact that mental health issues have, both on absence from work in their own right, but also, as people are getting more chronic conditions, the very high prevalence of mental health problems when you have a chronic condition, and how far the mental health problem can become the tipping point, and access to support and psychological therapies early to enable people to live with that—all of those things would be a fundamental part of being a healthy employer and a healthy workforce, and it's still very patchy across the NHS.

10:15

[72] **Angela Burns**: It might go some way towards making being employed by the NHS a more attractive prospect, if you know that you're being taken care of.

[73] **Ms Charlesworth**: Indeed, and it also points to the efficiency challenge and the pay challenge and all of that. You can do it in very different ways. You can do it in a big stick—kind of 'Just work harder, just turn up to work regardless'. But actually that doesn't work and that doesn't sustain. Actually, if you want to tackle sickness absence, there are positive ways of doing it that help staff, and given that this is not a one or two year little challenge and then everything's back to normal, and we don't have to worry about it again, this is how we need to work, and we need to worry about these things for the long term. That much more fundamentally positive approach to actually trying to improve your workers' health to support them in their wider lives so that they are able to contribute is a much more sustainable way of tackling something like sickness absence.

[74] **Angela Burns**: Also, I'd like to add on that particular point, before I go on to my next one, that people think of sickness as a big thing, but actually, it's somebody with a chronic back condition who's lifting up elderly people out of beds, or whatever, and taking the odd day, but the odd day is every week or every 10 days, which puts enormous pressure on their team, but then brings other on-costs. So, if we can help people like that.

[75] My second question—I'm terribly conscious of the time—

[76] **Dai Lloyd**: Yes, so am I.

[77] **Angela Burns**: It's about something you mentioned much earlier on in your presentation—it was about silo working. So, for example, if you look at the implementation plans for the 10 key conditions, it's a great idea because it brings the focus onto each of those conditions, but when you look at the fact that the causes of at least four or five or six of them are all absolutely identical, then I wondered if you have a view about—I mean, that's just a very top-level example of silo mentality, and I think it must drive, from what I've seen, all the way through the NHS, in much bigger silos. So, I just wondered if you could expand on that. If we could end that silo mentality through the integration, would there be cost savings—but not just financial cost savings,

but actually time? You're looking after people with that co-morbidity problem that people tend to develop as they get older.

[78] **Mr Roberts:** I think, to get towards it, it comes back again to what we were talking about—transformation. The only way you break down silos is the staff time, and the protected time for staff to work together. I think when you look at where staff can see waste within the health system, nobody in that situation is making the wrong decision for that set of circumstances. The waste isn't there because they're making the wrong decision—it's because they aren't able to step back and work with people to look at the system as a whole. So, I think it comes back to a lot of what we said about allowing, somehow, the ability for staff to design those pathways together. I think the complexity is how you find a pathway that works across lots of different conditions at the same time. It's very easy to find a diabetes pathway—well, not easy—but it's more straightforward to find a diabetes or a chronic obstructive pulmonary disease pathway. We look at 12 conditions in the report. Finding pathways that work across those 12 conditions altogether is going to be growingly complex. The only way it is going to happen is getting staff talking to each other and identifying those savings themselves, and being supported to do so.

[79] **Angela Burns:** Would you say that a barrier to that is also the super-specialisation of the consultants? So, we don't look at people in a holistic manner, so we get that revolving door syndrome all the time.

[80] **Ms Charlesworth:** Indeed. I think one of the challenges—there are a couple of things around the more integrated care. At the moment, the evidence base is that more integrated care tends be associated with better outcomes, but not yet much evidence that it reduces cost. But better outcomes are what we need, so the value of that remains vitally important. Most of the work on integrated care at the moment is looking at care co-ordination. It's looking at someone, isn't it, in the system who holds the ring between all of those silos. And I guess one of the profound workforce challenges is to say, 'Is that enough?', or, actually, do we need fundamentally to re-examine some of the roles here, the balance of the specialist and the generalist? Almost, in primary care, we have the uber-generalist. We need slightly fewer generalists—the geriatric specialist and one in child health in a primary care team who are more skilled in that. And in the secondary care sector, do we need fewer specialists? The other point I would highlight is the boundary between community nursing and social care workers, where very many people now have got large numbers of people coming into their home,

all to do individual tasks.

[81] **Angela Burns**: Yes.

[82] **Ms Charlesworth**: Yes. That cannot be a good use of resources. And, as an individual on the receiving end of that, that must be just so upsetting and unsatisfactory, and where people have had personal budgets, one of the main things that they do is reduce the number of people who are interacting with them and get people who can do more. So, if I was looking at areas where changing some of the skills and multitasking might deliver a quality benefit and, potentially, an efficiency improvement—I won't say a cost saving, because I think social care may be underskilled, and some of the people coming into the home may be overskilled, and I think where that would land out in cost is different. I certainly think it'd be fundamentally better.

[83] **Dai Lloyd**: Ocê. Y cwestiwn olaf gan Jayne Bryant.

Dai Lloyd: Okay. The final question from Jayne Bryant.

[84] **Jayne Bryant**: Thank you, Chair. I think Anita has answered my question—from Angela—on the absences and supporting staff in work, but considering how much data we do have on health and social care in terms of waiting times and things like that, it's quite extraordinary that we have very little information on our own workforce, making it very difficult to plan, which seems evident here. But I just wonder if you could say a bit more about a move to unpaid carers, because of the profound pressures in terms of caring for loved ones on people who aren't necessarily trained to care, but also the extra pressures on their health, because people who are caring for loved ones are actually putting themselves last, often, and I just wonder if you could say a bit more about that.

[85] **Ms Charlesworth**: One of the things that we're seeing through this period is a change in who cares informally, a little bit. So, as men's life expectancy has increased, which is a good thing, there are going to be fewer women living alone, but, obviously, middle-aged women are more likely to be in the labour market. So, there appears to be a shift from, if you like, daughters caring to partners caring. What that means is, very often, you've got an elderly person with their own health needs caring for another elderly person just with more health needs. Obviously, by and large, people desperately want to care for each other, stay together and support each other—it's a fundamental part of loving someone, isn't it, to want to do that?

But if you provide no support to those people, then obviously what you often end up with is people tipping over and they can't cope at all. So, one of the things that worries me about what's happening in social care is, for understandable reasons, we're concentrating care at the highest end of need, and I completely get why we're doing that, but a little bit of investment in supporting lower-level need in couple households where both have health issues, and they are caring for each other, could actually enable them to be able to sustain their life at home for much longer. So, I think trying to understand that unit, rather than just dealing with them individually as a health need and a social care need, and getting much more sense of them as a unit, and the balance of support that they need to be able to be sustained in their home for longer, which, even if you didn't care about them, which I think we should do, must be better value for the system in the long run.

[86] **Dai Lloyd:** Diolch yn fawr. Mae'r cloc wedi ein curo ni, felly a gaf i eich llongyfarch chi ar eich cyflwyniadau a hefyd am ateb y cwestiynau i gyd mewn ffordd mor raenus ac mor aeddfed? Diolch yn fawr iawn i chi'ch dau. A allaf hefyd gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r cyfarfod yma i gadarnhau bod y cyfarfod wedi bod yn ffeithiol gywir, o leiaf? Felly, diolch yn fawr iawn i chi, a dyna ddiwedd y sesiwn yma. Diolch yn fawr.

Dai Lloyd: Thank you very much. The clock has beaten us, so may I congratulate you for your presentations and also for answering all of the questions in such a comprehensive and mature manner? Thank you very much to you both. May I also let you know that you will receive a transcript of this committee's proceedings to check for factual accuracy? Thank you very much to you both. That's the end of this session. Thank you.

10:25

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

Cynnig:

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

Motion:

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

17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[87] **Dai Lloyd**: O dan eitem 3, a allaf i gynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod, er mwyn inni symud mewn i sesiwn breifat ar faterion yn ymwneud efo'r Bil iechyd cyhoeddus? Pawb yn gytûn? Diolch yn fawr.

Dai Lloyd: Under item 3, may I move under Standing Order 17.42 to resolve to exclude the public from the remainder of this meeting, so that we can move into private session and discuss matters with regard to the public health Bill? Is everyone agreed? I see that you are. Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:25.
The public part of the meeting ended at 10:25.