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

11/10/2017

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd. Lle y mae cyfranwyr wedi darparu cywiriadau i'w tystiolaeth, nodir y rheini yn y trawsgrifiad.

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

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

Eraill yn bresennol
Others in attendance

Huw David	Llefarydd dros Wasanaethau Cymdeithasol ac Iechyd, Cymdeithas Llywodraeth Leol Cymru, ac Arweinydd Cyngor Pen-y-bont ar Ogwr Spokesperson for Social Services and Health, Welsh Local Government Association, and Leader of Bridgend Council
Lynne Hamilton	Cyfarwyddwr Cyllid, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Director of Finance, Abertawe Bro Morgannwg University Local Health Board
Alex Howells	Prif Swyddog Gweithredol Dros Dro, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg

	Interim Chief Executive Officer, Abertawe Bro Morgannwg University Local Health Board
Hywel Jones	Cyfarwyddwr Cyllid Cynorthwyol, Bwrdd Iechyd Lleol Aneurin Bevan Assistant Finance Director, Aneurin Bevan Local Health Board
Judith Paget	Prif Swyddog Gweithredol, Bwrdd Iechyd Lleol Aneurin Bevan Chief Executive Officer, Aneurin Bevan Local Health Board
Jon Rae	Cyfarwyddwr Adnoddau, Cymdeithas Llywodraeth Leol Cymru Director of Resources, Welsh Local Government Association
Carol Shillabeer	Prif Swyddog Gweithredol, Bwrdd Iechyd Lleol Addysgu Powys Chief Executive Officer, Powys Teaching Local Health Board
Dave Street	Llywydd Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol, a Chyfarwyddwr Gwasanaethau Cymdeithasol yng Nghaerffili President, Association of Directors and Social Services, and Director of Social Services in Caerphilly
Eifion Williams	Cyfarwyddwr Cyllid, Bwrdd Iechyd Lleol Addysgu Powys Director of Finance, Powys Teaching Local Health Board

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

Stephen Boyce	Ymchwilydd Researcher

Amy Clifton	Ymchwilydd Researcher
Sarah Sargent	Dirprwy Glerc Deputy Clerk
Sian Thomas	Clerc Clerk

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

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

[1] **Dai Lloyd**: Croeso i chi gyd i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. O dan eitem 1, wrth estyn croeso i'm cyd-Aelodau, rydym wedi derbyn ymddiheuriadau oddi wrth Julie Morgan ac nid oes dirprwy i Julie y bore yma. Gallaf ymhellach egluro bod y cyfarfod yma'n ddwyieithog. Gellir defnyddio clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1, neu i glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2. A allaf i atgoffa pawb naill ai i ddiffodd eu ffonau symudol ac unrhyw gyfarpar electronig arall neu i'w rhoi ar y dewis tawel? Rwyf hefyd yn hysbysu pobl y dylid dilyn cyfarwyddiadau'r tywyswyr os bydd larwm tân yn canu

Dai Lloyd: Welcome to you all to this latest meeting of the Health, Social Care and Sport Committee here at the National Assembly for Wales. Under item 1, in welcoming my fellow Members, we have also received apologies from Julie Morgan and there is no substitute today. Can I also explain that this meeting is bilingual? You can use headphones to hear the interpretation from Welsh to English on channel 1 or to hear verbatim on channel 2. Can I please remind you to switch off your mobile phones or any other electronic equipment, or to put them on silent? I will also let you know that you should follow the directions of the ushers should the fire alarm sound today.

09:32

Paratoi ar gyfer craffu ar gyllideb ddrafft Llywodraeth Cymru ar gyfer 2018-19—Sesiwn Dystiolaeth 3—Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg, Bwrdd Iechyd Prifysgol Aneurin Bevan a Bwrdd Iechyd Addysgu Powys

Preparation for scrutiny of the Welsh Government draft budget 2018-19—Evidence Session 3—Abertawe Bro Morgannwg University Health Board, Aneurin Bevan University Health Board and Powys Teaching Health Board

[2] **Dai Lloyd:** Gyda chymaint â hynny o ragymadrodd, fe wnawn ni symud ymlaen i eitem 2 a pharatoi ar gyfer craffu ar gyllideb ddrafft Llywodraeth Cymru ar gyfer 2018-19. Sesiwn rhif 3 ar y craffu ar y gyllideb ddrafft ydy hwn, ac yn gyntaf y bore yma, o'm blaenau mae bwrdd iechyd prifysgol Abertawe Bro Morgannwg, bwrdd iechyd prifysgol Aneurin Bevan a hefyd bwrdd iechyd addysgu Powys. Yn benodol, felly, rydw i'n falch iawn i groesawu Alex Howells, prif weithredwr dros dro bwrdd iechyd prifysgol Abertawe Bro Morgannwg; Lynne Hamilton, cyfarwyddwr cyllid bwrdd iechyd prifysgol Abertawe Bro Morgannwg; Judith Paget, prif weithredwr bwrdd iechyd prifysgol Aneurin Bevan; Hywel Jones, cyfarwyddwr cyllid cynorthwyol bwrdd iechyd prifysgol Aneurin Bevan; Carol Shillabeer, prif weithredwr bwrdd iechyd addysgu Powys; a hefyd Eifion Williams, cyfarwyddwr cyllid bwrdd iechyd addysgu Powys. Nid oes lot o amser ar ôl nawr yn y sesiwn yma, wedi mynd trwy hynny i gyd, ond dyna ni. Rydym wedi darllen y papurau gerbron, ac mae yna res o

Dai Lloyd: With those few words of introduction, we move on to item 2 and preparation for scrutiny of the Welsh Government draft budget 2018-19. This is evidence session 3 on the scrutiny of the draft budget. First of all this morning, in front of us, we have Abertawe Bro Morgannwg university health board, Aneurin Bevan university health board and Powys teaching health board. Specifically, therefore, I'm very pleased to welcome Alex Howells, interim chief executive officer, Abertawe Bro Morgannwg University Health Board; Lynne Hamilton, director of finance, Abertawe Bro Morgannwg university health board; Judith Paget, chief executive officer, Aneurin Bevan university health board; Hywel Jones, assistant finance director, Aneurin Bevan university health board; Carol Shillabeer, chief executive officer, Powys teaching health board, and also Eifion Williams, director of finance, Powys teaching health board. We don't have much time left in the session now, having gone through all of that, but there we are. We have read the papers that you have given

gwestiynau gan Aelodau, felly, gyda'ch caniatâd, fe awn ni'n syth i mewn i'r cwestiynau. Nid oes rhaid i bob un ohonoch chi ateb pob cwestiwn, neu mi fyddwn ni yma drwy'r dydd. Fe wnawn ni ddechrau efo Caroline Jones.

us, and we have a series of questions from Members, so if we may, we'll go straight into those questions. You don't all have to answer every question, or we will be here all day. If we can begin, please, with Caroline Jones.

[3] **Caroline Jones:** Diolch, Chair. Good morning, everyone. Bore da. Just a general question, first of all: what do you consider are the key areas and challenges in the current year, the forthcoming year, and for the rest of the future for health boards?

[4] **Ms Howells:** Good morning. Obviously, from an ABMU perspective, we are one of the health boards that has some significant financial challenges at the moment, along with some of our service delivery pressures, and we are facing, unfortunately, an overspend position this year, of no more than £36 million, and we are hoping to bring it down from that, if at all possible.

[5] I think, as I know you've heard from previous evidence, one of the key drivers affecting our position at the moment is our workforce cost and the cost of our current workforce model, and there are a number of reasons for that: in part, a shortage of staff in key specialties, which requires us to rely on more expensive agency and short-term staff, but also, I think, certainly in our case in ABMU, we would recognise that we need to change a number of our service models to adapt to the requirements of a workforce that's now coming through the system, and to also adapt better to our patients' needs. So, I think, to some extent, at the moment, we've got a premium cost, because we've got a traditional workforce providing more traditional service models and we need to modernise that. That's certainly something you see not just in the hospital sector, but certainly we see it in our GP population as well. People don't want to do the same kinds of jobs in the future; we've been a bit slow to respond to that. So, I think, for us, the workforce pressures are a key priority, but also the way in which we need to adapt our service models to change to the population's needs as well.

[6] **Ms Paget:** From an Aneurin Bevan point of view, there are similar issues, really: ongoing pressures around the availability of workforce, which are driving costs in our system, but also the need to reconfigure and redesign our services. The ability to continue relying on efficiency savings to support the delivery of our financial plan becomes more difficult each year,

and so, really, the need for us is to—and we have our plan to do that—completely redesign the way in which our services are delivered, focusing greatly on the delivery of care outside hospital, integrated care with colleagues in local government, housing and the third sector, and focus on the redesign of our workforce, the way in which our teams work together, and how services integrate across the system as well. So, looking for opportunities, really, to transform the way we serve our population, continuing to deliver the best possible outcomes we can, but doing that in a different way.

[7] **Ms Shillabeer**: I'll try not to repeat those answers, because they are universal issues and challenges to us. So, the sense that we've got, certainly for Powys, is that we are predicting a balanced position at the year end, although there are significant pressures that we are trying to manage at this stage. Those have been outlined by my colleagues. I think the biggest challenge for us is moving forward and taking the opportunities that are presenting themselves in terms of those shifting models of care. We've been able to do some of that in Powys, but we've not yet done enough of that. We've not yet focused enough on well-being and prevention, and put enough of our resource in that area of work. We're very mindful that we buy a lot of services from other parties for the Powys population, and that those services are fragile as well. So, our opportunity to work with our other partners will help us to meet some of the financial and service challenges we've got.

[8] **Caroline Jones**: Okay, thank you. You've partly answered my next question, because my next question is for ABMU. But I'd like to probe a little deeper, if I may. From 2009 to 2016-17, you had a break-even financial position. At the moment, you've said that you've got a £39.3 million overspend against a forecast deficit. The forecast was £20.1 million. So, we went over that. You also say in your evidence that there's slow progress in delivering unscheduled care at Morriston Hospital, and you're working from an unapproved medium-term plan. So, can you please tell me how you're going to deal with these issues that you haven't mentioned in the future?

[9] **Ms Howells**: Yes, of course. We were, as you're aware, put into a targeted intervention status by Welsh Government about 12 months ago. There were a number of reasons for that. One was the deficit position in our plan and the fact we didn't have a balanced plan, and the other one was specifically around unscheduled care pressures at Morriston Hospital. I'm pleased to say that, during the course of this year, we are seeing solid improvements in Morriston, and in fact they've just had their best month in

terms of unscheduled care performance. So, we are confident that, after an awful lot of work by front-line staff right along the pathway—because this isn't, as you know, just an A&E issue; this spans primary care and social care as well as hospital-based staff—we are seeing the improvements coming through there. But that's certainly been something that, in the past, we have tried to invest in in order to improve services, and as you'll see from our evidence as well, that's one of the reasons why, in the last couple of years, we have got into a deficit position—because we've probably invested that money without having the robust savings plans behind those investments that we have made, and obviously now we're in a position where we're trying to recover from that.

[10] The financial position that you've quoted was last year's position. So, this year we are estimating a £36 million maximum overspend position. Clearly, from an organisational point of view, we are keen to get back out of that deficit position as quickly as possible. As you note, for a number of years we have been in balance, so we haven't got an agreed plan to do that at the moment, but our ambition is very much that over the next 18 months to two years, we need to get back out of that situation. We will need support to do that, but we really feel that it's not a constructive environment for the whole of our workforce to be working under that shadow of being in a deficit position all of the time. So, we really need to get back on that improvement curve.

[11] **Caroline Jones**: And I'm concerned, where there are going to be savings made, that it isn't at the cost of the patient.

[12] **Ms Howells**: Absolutely. One of the things that we have learned from looking at experiences elsewhere is very much that, to be successful in these very difficult situations, you have to put quality and safety at the forefront and you have to put staff engagement at the forefront as well. It's no good my finance director coming up with great savings plans. It's got to be that whole-organisation approach.

[13] **Caroline Jones**: Thank you.

[14] **Dai Lloyd**: Ocê. Rydym ni'n symud ymlaen. Mae'r cwestiynau nesaf dan ofal Lynne Neagle. **Dai Lloyd**: Okay. Moving on. The next questions are from Lynne Neagle.

[15] **Lynne Neagle**: Thank you, Chair. Good morning. Can I ask Aneurin

Bevan—? You say that you're currently tracking a year-end deficit and say it is essential to identify break-even plans in order to deliver the integrated medium-term plan. Can I just ask what progress you've made in developing those plans?

[16] **Ms Paget:** Our plan going into the year was that we would break even again this year. We are currently, at month 6, operating an in-year deficit position of around about £3 million. So, we're in the process at the moment of putting in place plans to recover that position. If I could put just that £3 million in context, we're an organisation that has an annual budget of £1.1 billion. So we actually spend £3 million a day. So £3 million for us as an in-year pressure is doable in the sense that we can achieve that. We have every expectation of getting back on track to break even.

[17] We are focusing very much on the things that are driving some of that expenditure, which is about variable pay, the use of high-cost premium agency staff, where we can make efficiencies, doing things differently, in some cases using technology to improve efficiency and productivity, but also making sure that we're focusing our resources on the things that deliver the best outcomes for patients. And, as my colleague just said, one of the things that we're really keen to do is, as we redesign and reconfigure services, to make sure actually that that's based on good evidence about what is good-quality care and what will deliver good outcomes for patients

[18] **Lynne Neagle:** Okay, thank you. And can I ask all health boards what you think you need from Welsh Government in order to tackle the financial difficulties, and whether you think there are any lessons to be learned from the recent financial governance reviews?

[19] **Ms Howells:** Shall I kick off on that one, because obviously we were one of the health boards that had the financial governance review? There are a number of recommendations that we are now actively taking forward. One was clearly around financial controls and governance arrangements, which Lynne might want to pick up on. One was around making sure we plan our services in an integrated way so that we're not planning finance in isolation of some of the service pressures and the workforce pressures that we've just talked about. And one was much more around the organisational development issues—so, making sure that the leaders at all levels of the organisation have got the skills they need to operate in this very, very challenging environment, where we are seeing quite considerable change all of the time, and how we deal with that effectively with our staff, with our

staff organisations and with the public. So all of those actions we are currently taking forward.

[20] I think the thing that occurs to me when we look at where we've been successful in the past is, sometimes, you're so busy doing the day job and keeping services on the road that, actually, you don't have that extra resource to really think about how to do the improvement. So, I still think that there's a role for transitional funding to help us, really, with that management of change process and to enable our front-line staff to have a bit of free time to think about all the improvements that they really want to make to our services.

[21] **Ms Hamilton:** I think I would add to Alex's comments in terms of the controls and governance response that we're making to the financial governance reviews. We've been very proactive in the past few months in developing tighter financial control and board governance fora to better control our expenditure and to ensure that there are higher levels of visibility around the investments and expenditure that we're making and the clinical and financial benefits that we'll derive from that.

[22] So, picking up Alex's earlier comment about some of the investments that we've previously made that have contributed to the financial position at the moment, we've introduced an investment and benefits group, where we're adopting a much more rigorous approach to testing requests for further expenditure or investments and identifying the financial and non-financial benefits and developing methodologies to track them so that we're much more confident that we're getting the appropriate clinical and financial return on the money that we spend. We've also established our performance and finance committee, and we've also established panels to examine our non-pay expenditure, both clinical and non-clinical, to have much better transparency and confidence so that the board and the executives know precisely where our money's being spent and can make more informed decisions.

[23] **Ms Shillabeer:** From my perspective—and Eifion may want to come in—there are four things, really, for us. From a Powys perspective, it'd be very helpful to have continued support around flexibility. The reason I say that is that, as a health board, we are mainly a commissioner and we do some provision, and we work with every organisation in Wales and some in England. So, there's that need to recognise that the construct of our organisation is a little bit different. So we welcome the flexibility shown to us

over recent years. I think there is, just to support Alex's point, a need to enable and support us to keep our head up to enable that medium and longer-term change to happen, rather than always being—we've got to manage both—always being in the short term.

[24] The focus is on the population and to encourage and support us to shift our resources, where we can, much more on the prevention and early help and support agenda. And I think that's coming through more and more in things called 'allocative efficiency'—so where we best put our money.

[25] And then, I would also encourage Welsh Government to give a strong encouragement and direction around integration of services across the public sector.

09:45

[26] **Mr Williams:** Briefly as well, I'd like to add that, as a finance director, I'm extremely appreciative of the baseline funding uplift that, alongside with our savings programmes, allows us to actually meet the costs that arise year on year. So, it allows us to actually sustain our services. So, that baseline funding uplift is key for us. And alongside that, the targeted investment in capital projects and some of the key priority programmes that the Cabinet Secretary is actually able to approve for us is helping us modernise and move our services forward.

[27] **Mr Jones:** From an Aneurin Bevan health board perspective, I'd just echo some of what's been said already. I think, for us, it's about clarity of funding assumption going into the next financial year, which we've had in this financial year. But, in our approach to developing integrated medium-term plans, it allows us to be very clear on the resource envelope we've got, to plan our service and workforce within that, and also to look for support on our transformation plans, really. So, we've got a very clear Clinical Futures strategy and approval around the development of the Grange university hospital, which is a core component of our future plans. And we're looking to develop quite ambitious plans around value-based care. Carol touched on allocative efficiency then, but that's going to be a cornerstone for us going forward. So, support in terms of some of those transformational plans, really.

[28] **Lynne Neagle:** Okay, thank you. And how significant do you think the financial impact of the recent funded nursing care ruling will be for health boards, and what plans have you got to mitigate the impact?

[29] **Ms Shillabeer**: Thanks very much. Just to say, I'll take this one; I lead on behalf of the chief execs on this issue. We're currently working through with local government and with Welsh Government the implications of the Supreme Court judgment that was made a few months ago. There is a working group with external expertise helping us to look at that. We hope to be in a position to know the implication of that financially and how that might be dealt with by the end of this calendar year. And I think it's fair to say that both local government and the health service have committed to ensuring that we can move through and beyond that. There may well be implications for individuals in funded nursing care, so we will clearly be having a look at that, particularly where that relates to people who have funded their own care or part of their own care. So, that's a key consideration, but there is a clear plan of work to get to that point.

[30] **Lynne Neagle**: Are you anticipating then there being a major hit on budgets as a result of this? It sounds like that's a possibility.

[31] **Ms Shillabeer**: So, that work hasn't been finalised but there is likely to be a financial implication, but we're, at this stage, unclear as to the extent of that. Clearly, there have been numbers put around. We, at this stage, don't anticipate it's the extent that is being put in the media, but I wouldn't want to give any assurances around that figure whilst that work is still under way.

[32] **Dai Lloyd**: Symudwn ni ymlaen rŵan. Gyda llaw, nid oes eisiau cyffwrdd â'r meics; maen nhw'n gweithio ar eu pennau eu hunain. Rhun—sydd yn gwybod hynny eisoes.

Dai Lloyd: Moving on therefore please, and you don't have to touch the mikes, by the way; they will come on automatically. Rhun—who already knows that.

[33] **Rhun ap Iorwerth**: Ydw, mi ydw i. Bore da i chi i gyd. Yn pigo i fyny ar y sylwadau wnaethoch chi ynglŷn â newid trawsnewidiol a'ch uchelgeisiau chi ar gyfer newid trawsnewidiol, rwy'n gwybod bod Abertawe Bro Morgannwg yn gwneud sylw yn eich tystiolaeth chi bod diffyg arian cyfalaf yn amharu ar eich gallu chi i greu newid trawsnewidiol. Beth

Rhun ap Iorwerth: Yes, I do. Good morning. Picking up on the comments you made about transformational change and your ambitions in that area, I know that Abertawe Bro Morgannwg refer in the evidence that the lack of capital funding does affect your ability to create transformational change. What is your response as health boards to

ydy'ch ymateb chi fel byrddau iechyd i'r cyhoeddiad am £90 miliwn ychwanegol dros y tair blynedd o arian cyfalaf? A ydy hynny'n ddigon i ganiatáu i chi fwrw ymlaen â'r mathau o newidiadau trawsnewidiol rydych chi'n chwilio amdanyn nhw?

the announcement made by Welsh Government of the additional £90 million in capital funding over three years? Is that enough to enable you to crack on with the types of transformational changes you'd like to make?

[34] **Ms Howells:** I think that there's never probably enough capital to suit the needs of a service that wants to change and develop and improve. As you'll be aware, the health service is such a technology-based service, and we already would recognise that, from an information management and technology perspective, we are behind the curve really, in terms of what other sectors see. So, I suspect that you'll never satisfy the needs of the NHS for a capital point of view. However, the injection of funding is really welcome. I think that, as part of that, we will see some significant opportunities for primary care estate within that, which I think is really important, because we do recognise that a lot of our practices are still working in outdated facilities that don't meet the bare standards, let alone really provide them with the opportunity to develop new service models that the population needs for the future.

[35] **Rhun ap Iorwerth:** But, in a way, that lesson goes to the heart of what I'm asking, I suppose. If you're having to use that capital funding just to tread water by making sure your estate is just up to the job, that doesn't bode well for what we'd really like to be doing, setting us up for the future, which is to have that transformational change.

[36] **Ms Hamilton:** A significant proportion of our capital goes on maintaining the estate, but, of course, that's a safety and quality issue. We have to ensure that we provide settings for care that meet quality and safety standards, as well as prioritising investments for the future, particularly, as Alex says, the digital agenda, and also different kinds of settings where we can deploy multidisciplinary teams in a way that starts to innovate the nature of healthcare and services that we provide. It is a matter of prioritisation, but we have to acknowledge that, in the financial circumstances that the Welsh Government is operating in, any deployment of capital to that scale is clearly a welcome investment in the NHS, albeit we all have to make significant prioritisation decisions about business as usual and future investment.

[37] **Mr Williams:** We are seeing, in terms of the projects that we're moving

forward with Welsh Government support, that the investment that we are able to make is beyond what's needed to actually just do the basic maintenance, or the catch-up with the backlog maintenance. So, the projects, when we are looking at the projects, yes deal with the backlog maintenance issues, but also look forward in terms of the transformational work and changes we want to see in our services, and the investment is being provided for that at the same time. So, the investment that we are seeing in our projects deal both with the backlog maintenance, and also the changes that are needed. The projects we've got in Llandrindod, and expected to actually take place in Machynlleth hospital, actually do provide new models of services from those facilities. So, the capital support that we are getting actually allows us to move our thinking and services forward.

[38] **Rhun ap Iorwerth**: I'll invite your comments as well, but I wonder, do you hold a realistic list of what you'd like if the Government was able to give a little bit more? I'm not talking about a long list of all the things that you'd like to do to revolutionise the health service in your areas, but a realistic list, with a price tag to it, that you think, 'Actually, if Government could only reprioritise a little, with a few tens of millions of pounds more' you could really make a difference. Can you identify that shortfall, I wonder?

[39] **Ms Shillabeer**: Perhaps I can just offer a comment in relation to that. I think, from a Powys position, that list is emerging. We've agreed our long-term strategy—health and care strategy—between the council and the health board. And that's the point I'd really want to make, which is that we've often thought about NHS capital. I think we need to think much more broadly about how we have more innovative capital solutions, be it from local government, from housing, from other sectors, working together in that integrated way. More and more, our service delivery is on an integrated basis, and, therefore, we should be pooling our capital. We've one example of that so far in Powys, and that's Glan Irfon Health and Social Care Centre in Builth Wells, and that was developed some years ago, using a more innovative financing model, and I think that's where we will need to focus more in the future.

[40] **Ms Paget**: From an Aneurin Bevan perspective, similar to other colleagues, we have about £11 million discretionary capital allocation each year that we use to maintain our existing estate, and refresh and renew equipment et cetera. Clearly, we are also benefiting from a significant investment in our Clinical Futures strategy, and have had investment and support from Welsh Government over a number of years for that, which has

been incredibly welcome. I think, in terms of whether we have a list of things that we would want support for, our three-year plans provide us the opportunity to think through where capital would enable us to change and deliver services in a different way. We're in the process at the moment of reviewing our primary care estates strategy and there are a number of schemes that, clearly, we'd want to put forward for support at some point. But there is already a clear process for that to happen through our plans and through ongoing dialogue with Welsh Government, but clearly any additional capital that's available to be invested in services would be welcome and would be well spent, but recognising that there's enormous pressure across the system really.

[41] **Rhun ap Iorwerth**: But it's difficult to identify a capital expenditure shortfall.

[42] **Ms Hamilton**: If I may, again, it's a number and it's based on work from the teams in ABMU, but, looking at our investment in the maintenance of our existing asset base through our discretionary capital programme, simply to invest in our projected levels of operating equipment going forward over the next five years—and I'm looking at replacement of imaging, radiotherapy, informatics, cath labs—we could be looking at somewhere in the region of £140 million or £150 million over five years if we are simply to maintain the performance of that essential equipment, as an example.

[43] **Rhun ap Iorwerth**: That's useful. Our number crunchers can compare that with how much money there is in the pot.

[44] On savings, the Health Foundation calls additional NHS funding positive and points out that recent efficiencies of around 1 per cent a year would need to be maintained to allow for maximum funding for long-term transformation and sustainability. Are you confident in your ability to maintain those kinds of savings year-on-year?

[45] **Ms Paget**: I'll start. As a health board, we've achieved that level of savings over recent years, and our plan this year is to achieve that level of saving again. Our forward plan, demonstrated through our integrated medium-term plan, also identifies that. I think that what we are facing as health boards, and our plans demonstrate this, is, where we might have looked traditionally for efficiency savings to contribute to that 1.5 per cent or 2 per cent, those opportunities become less over time as services become more efficient. So, the need to think about how we redesign the way in which

we deliver care is becoming increasingly important and the conversations that we've just had about capital being an enabler to that and other pump-priming resource to do that is important. So, in terms of confidence levels, it becomes more difficult, but we have no reason—. Our current three-year plan suggests that that level of savings can be delivered. Clearly, it becomes more difficult each year and clearly we need to find new ways of doing that.

[46] **Ms Howells:** Clearly, from our point of view as a health board, we are focusing very much on efficiencies and we have nine or 10 work programmes that are linked with the National Efficiency and Value Board, picking up evidence from previous reviews like the Health Foundation's and Lord Carter's. So, things like medicines management and procurement, workforce, clinical variation—lots of different areas where we know we can improve efficiency, and because we've got benchmarking information that would demonstrate what the gap is perhaps between us and the best in class.

[47] I think the other aspect of this that we really try and work hard on as an organisation is the fact that we've got 16,000 people working in ABMU, and if we give them the skills and the empowerment to actually find those opportunities to improve efficiency at the front line as well, in addition to having a more strategic approach, then we've got a much better chance of having a sustainable approach to looking at waste, harm, duplication and improved efficiency, as we go forward. That's really what we're trying to focus on, as well as our savings plan, at the moment—how do we really galvanise our workforce to get on that continuous improvement journey to take us into the future?

[48] **Dai Lloyd:** Fe wnawn ni symud ymlaen nawr, yn nhermau amser, i edrych ar oblygiadau cyllidol iechyd meddwl. Angela.

Dai Lloyd: We'll move on, therefore, to look at the financial implications of mental health. Angela.

[49] **Angela Burns:** Diolch, Chair. Good morning. Thank you very much for your papers. I'd like to just ask you some questions around the provision of mental health services. Without exception, you all said that mental health services provision was under immense pressure, and some of you detailed quite extensively—and for that, I'm grateful—the overspend and the reason for the overspend that you have. I'm not going to ask the obvious question, because I'm sure I know what the answer is, which is: is there enough money in the budget for mental health?

[50] What I would like to try and understand is, a little bit more clearly, how you define what percentage of your budget should go into mental health services as opposed to medical services. Is it demand driven or do you lead with a transformation agenda in terms of delivery of mental health services? And will the money that you now have be enough to enable you to transform as well as deliver current levels?

10:00

[51] **Ms Shillabeer:** Thank you very much. So, you'll know that mental health's a really important priority for us in the NHS—increasingly so and rightly so. I think we're starting to see a move away from seeing mental health as one part of the service and physical health another part of the service. Through our plans and our developments, both in the health service and in other parts, in local government and in the third sector, we're seeing a much more integrated approach to mental health services as we move forward.

[52] So, I think we're starting not to say, 'How much are we dedicating to mental health?'—and I know you've had some discussions about the ring fence previously, and that was put in for a certain reason—but really seeing mental health as part of the whole and starting to understand that, actually, mental health and physical health services come together—people don't just have one or the other. And so, the service is really based on what it is the patients and the population need and how we might best arrange our services to respond to that.

[53] **Angela Burns:** I just ask you because my next question that I was going to ask, which you may all want to consider, is, then: do you think that the ring fence is now an artificial construct and that we should be looking at the person in the entirety and removing that ring fence? Or do you believe that mental health services still need that element of protection, because otherwise it would get subsumed by the hungry beasts of cancer or whatever it might be?

[54] **Ms Shillabeer:** Well, I think—. Certainly, I believe it was put there as a marker to ensure that people who were feeling mental health was often a cinderella service—that that was a very visible marker of, actually, 'This is the minimum.' It's the floor rather than the ceiling. I think there's evidence that we're moving way beyond that now and there is a real momentum around

mental health. Obviously, yesterday was World Mental Health Day and, just following some of the work that's been going on, it's starting to demonstrate that barriers are starting to come down, people's understanding is better.

[55] It may well be that the mental health community feel more assured with that ring fence and that floor, and it might be slightly early days to remove it completely, but I think there should be an expectation that we are beyond the floor and we are integrating our expenditure really around the needs of individuals and communities.

[56] **Angela Burns**: Does anybody else want to pick that up?

[57] **Ms Paget**: Yes, certainly. I think, from our perspective, mental health services experience the same sort of pressures as all our services. So, in our planning, when we set our plan, we take account of that in the way in which we look at service workforce and financial issues and reconcile those differences. Clearly, there are pressures around continuing healthcare. Clearly, there are pressures around the number of older adults with mental health that we're seeing presenting at our services. But, actually, from a planning point of view, and when we as an organisation set out our plan, we actually take account of that in setting budgets, which are then given to our services.

[58] So, the ring fence is there, as I see it now, as just a check to ensure that we are not falling below that level—and nor would we ever in Aneurin Bevan health board, because it is a clear priority for us and we spend well above that floor. But I think that making sure that mental health is seen as a policy as important—I think the ring fence provides an indicator of that in terms of its policy importance and its importance for not just us as organisations but the staff who work in the services, people who work in the third sector, and other people who might think, as you say, that some other services could swamp out the focus on mental health.

[59] **Angela Burns**: Before I come to you Alex, could I just ask, because continuing healthcare was a third point I wanted to raise, just for a moment of clarification? At least two of the papers refer to the increasing costs of continuing healthcare. I'm not sure, though—are there two continuing healthcare budgets? Do you have one that's predominantly mental health and one that is then for continuing healthcare in other sectors? The reason why I ask this very convoluted question is because it seems to me, from evidence we've taken on other inquiries, that

more and more of the people who will perhaps require continuing healthcare have an element of physical and mental health requirement. So, I'm wondering how those budgets are split. Or should those budgets actually just be one big continuing healthcare budget that covers anybody's need? I just don't know how the health board operates on that basis.

[60] **Ms Howells:** From our point of view in ABMU we do hold those budgets separately at the moment. I think you raise a really good point about that grey area, which is increasing as we're seeing the population needs shift. So, that is definitely something we should be considering as we go forward in the future. I think the pressures on continuing care come at both ends of the spectrum, really. One is, as colleagues have already said, an increasing elderly population and the mental health problems that are associated with ageing. But, also, we know that, within Wales at the moment, we do still rely on independent sector provision, perhaps outside of Wales, for some of the more specialist end of our services. So, those are still opportunities for us to explore together as NHS Wales, as to whether we can provide some of those services more locally and develop. Certainly, within ABMU, we already provide a number of specialist services and we're keen to really look at what else we can provide on a Wales basis, really, to reduce some of those costs but also keep patients closer to where their homes are as well.

[61] I would just reinforce what others have said about mental health. The ring fence is there. It almost doesn't need to be there, in one sense, because I think that the NHS fully supports how important mental health is, not just from a delivery perspective, but also from a population-health point of view. I think the thing with the ring fence is to make sure that that doesn't look as if it means the status quo, because mental health, as much as any other service, needs to change and adapt with the times and the service models now need to be much more recovery focused and much more preventative than perhaps the traditional, old services that the ring fence was associated with. So, it's really important that we continue the transformation effort in mental health as much as any other service.

[62] **Angela Burns:** Just two more very quick questions.

[63] **Dai Lloyd:** Quick ones, for you, Angela.

[64] **Angela Burns:** Thank you. While I've got—Alex, while I have you, because, thank you, your paper was very detailed, so I'm going to ask a detailed question, because you gave me the information. If you don't want

the questions to be asked, tell us nothing.

[65] **Ms Howells**: It's my first time. [*Laughter.*]

[66] **Angela Burns**: I love people like you, though. That's what we need, this information. You talk about the fact that there's £2.23 million for local primary mental health support, £77.8 million is secondary care, which is hospital and community services. Could you just explain to me two things—(1) is: is that balance right, or is it just driven because hospitals are so much more expensive? And (2) can you just clarify the difference between the community services and local primary mental health support? I'm assuming one is GP based, but, given that we're trying to get to people earlier, before they get to the point where they need really serious intervention—. I just wanted to understand that a bit clearer, those budget spends.

[67] **Ms Howells**: Fine. I think I can explain that but I'm sure my colleagues will help me out if I get this slightly not correct. The local primary mental health support service was something that was introduced about six, seven years ago as a dedicated service and it was an additional service that was introduced by legislation at the time. So, there was a focus on allocating money that was already in primary care, both from social care and the health sector, into that budget and it was to deal with, specifically, a primary-care focused approach as a front end to all the services we already had. So, it is separate to the community mental health teams, which are largely in the community budget. It was very much seen as a gatekeeper into those services but also extra support for GPs. So, it provides patients with access to lower-level interventions that mean they don't have to enter into the secondary care service.

[68] So, that's why it's recorded slightly separately. The question of whether it's enough—again, I think when we've been doing some work recently in ABMU on speaking to service users and carers and staff about the models of care for the future, they all feel that we should be investing more upstream in making sure that people don't then become ill enough to get into the secondary care service. So, I think, as we go forward, we will see those resources starting to flex through the patient pathway and focus on that more preventative low-level care, so that people don't get to the stage where they need that secondary care support. But I'm sure Carol or Judith might add to that answer.

[69] **Angela Burns**: My last question—and I can feel the eyes—is on prison

services, for those of you who have prisons. We listened to the Minister yesterday talk about the integrated care fund, about the regional boards, about pooling of resources and about trying to integrate across the piece. I would imagine that provision into prisons needs to involve a number of agencies. It's going to be multidisciplinary because of the complex nature of the services required. So, I just wondered if you could give us a bit of an overview on the cost that is involved in providing care into the prisons and whether there's just an indication of how much money you also get, or how much your money is pooled with, for example, local government, et cetera, in order to provide, say, social care, which I imagine will be part of that whole healthcare multidisciplinary team delivery. I hope that makes sense.

[70] **Ms Howells**: [*Inaudible*.]

[71] **Dai Lloyd**: You've got a prison, Alex.

[72] **Ms Howells**: Two. Yes, we've got two prisons in ABMU and I don't think we are being innovative or integrated enough in terms of how we're using our funding at the moment, and, certainly, the main issue that we deal with at the moment is there is definitely a pressure on the services that are going into some of our prisons where we've seen a significant increase in the prison population, and there doesn't seem to be a responsive formula to enable us to uplift our services in response to that. So, that is something that we are currently in discussion around, so it is an important point.

[73] **Ms Paget**: Yes, and we've got two much smaller prisons in our area, both in Usk. In relation to mental health inreach, that's a very small service, and we get that resourced through the National Offender Management Service. But, as a health board, we have our own team providing primary care support into the prisons as well. I can't tell you off the top of my head the level of investment we make, but we've got fairly substantial support going into both prisons, making sure that prisoners have access to all the things that they would need in terms of general practice, eye care, dental care, appointments and everything else as well. Clearly, one of the things that we're reviewing at the moment is that the prison population is ageing as well, in the same way as the population in our community is ageing, and we're doing a piece of work across the partnership to look at how the needs of prisoners are changing and how our services need to change in order to respond to that as well.

[74] **Angela Burns**: A tiny, tiny—. About the funding—. So, if you have a

prisoner that happens to end up in one of the prisons on your patch but comes from somewhere else, does any funding come with the prisoner that then comes to you, or are you expected to provide that service?

[75] **Ms Paget**: My understanding, unless my colleague is going to tell me something different, is that the funding is based on the fact that we've got 250 people in the prison and therefore the level of service we provide is consistent across that. It's not individually tailored to the individual needs of the prisoner.

[76] **Angela Burns**: No, I didn't think so. Thank you.

[77] **Dai Lloyd**: Ocê. Symud ymlaen i adran arall, sef gyrru newid trawsnewidiol, ac mae Jayne Bryant yn mynd i arwain ar hyn.

Dai Lloyd: Moving on, therefore, to another section, driving transformational change, and Jayne Bryant has questions.

[78] **Jayne Bryant**: Thank you, Chair. Good morning. Some health boards, including Aneurin Bevan and ABMU, have stated in your evidence that a small allocation of funds for specific purposes has a limited impact on driving forward transformational change. What do you think needs to be done to make significant headway towards the change process in financial terms? Everybody's trying to get in there now.

[79] **Mr Jones**: Shall I take that?

[80] **Ms Paget**: Yes, if you want to start, Hywel.

[81] **Mr Jones**: One of the things for me is around the difference in terms of scale. So, I think, by its very nature, when you're looking to introduce something new and innovative in a tight resource environment, there's a natural test around will you deliver the benefits through that change, and how you test that through that implementation process. So, through some of the innovative changes that we've brought in—and I'll use appointment reminder services as an example. So, we brought in a new patient reminder service that, basically, gave text reminders to patients about their appointments and it meant that we saw a reduction in patients who did not attend their appointments from 10 per cent to 5 per cent, which has meant that we can obviously see more patients through our clinics without incurring additional costs. Now, one of the key things for us within that was that it was an excellent idea. To what extent could that have a benefit and to what scale

was a little bit unsure to begin with, so we just needed to test it in quite a managed way, identify a funding stream for it and then introduce it at scale. So, I think one of the key issues for us is how we identify the benefits of a scheme and make sure that it's going to deliver in what is a tight resource environment.

10:15

[82] **Mr Williams:** It very often is the case as well that the investment that's available, which we actually initially make to actually do something, which is buying the kit or the software or the new way of working, that a lot of investment is needed to actually change the way that we work, over and above the investment that's needed to actually buy the piece of kit or the new technology, because we need to actually change the pathways and how we will work and use that technology. Sometimes, what's identified is just the cost of introducing the technology, rather than the change programme that needs to actually follow that, and it can well be that the cost of the technology might be 20 to 30 per cent of the whole cost. The big part of the cost is changing how staff work and how patients flow through the system, and sometimes we don't do enough of identifying the change programme cost to actually achieve the whole benefit of what that programme could actually achieve. So, if we were targeting somewhere, it is making sure we get the whole costing for the programmes of change that we implement.

[83] **Ms Howells:** If I can just add a point around timescales, because I think, sometimes, we have money for transformational purposes, but perhaps the expectation of what we can deliver in the timescales is perhaps overambitious, and sometimes we're our own worst enemies in that, because we're keen to get on with things, but the reality is, if you're really fundamentally changing something, you do need quite a period of time to make sure that you're delivering those benefits, and certainly that's been our experience, for example, of the integrated care fund. To make sure that we're really making sustainable change, you need that time to work with staff, to get those changes in practice embedded, changes in expectations for patients, and really see the benefits of those models coming through, and sometimes you can't do that on an annual basis—you need a bit more time than that.

[84] **Jayne Bryant:** Do you think those small amounts of money that come your way in terms of additional funding, and they're allocated in that sort of defined way, is that a real problem for you, or is flexibility—? You know, I

think everybody's always looking for that. Is that something you would identify with?

[85] **Ms Howells:** I think it is. I think where we're had investment over the last couple of years, some of the pots have been quite small and quite targeted, and I think that that doesn't always link back to what the key priorities are within a health board area, if we look at some of the wicked issues that we're trying to deal with. And whilst any funding is always useful, and there are so many priorities that you can always put that money to good effect, if you're really talking about getting a systematic approach to step changing a system, then it's much better to do something on a more strategic basis. So, it's been great, for example, that the primary care clusters have had their own money to deal with their own local priorities and needs, and that's been fantastic at getting people engaged in developing and delivering local projects. Equally, if you looked at how you would have used that money more strategically at a health board to, for example, get change in diabetes or respiratory right across the board, we may see more benefits at a system level as well as some of those local benefits. So, it's just, I think, maintaining that flexibility is going to be really important if there are other opportunities in the future, to link it with key priorities and plans.

[86] **Jayne Bryant:** Thank you.

[87] **Dai Lloyd:** Yes, we've got a report from this committee on primary care clusters, which is coming out—huge headlines—later this week, and millions await it with bated breath for the contents. Yes

[88] Yr adran olaf nawr ydy'r gweithlu. Dawn.	The final section, then: workforce pressures. Dawn.

[89] **Dawn Bowden:** Thank you; thank you, Chair. I mean, I think some of these points I was going to raise with you have been answered, actually as far back as when you answered Caroline's question right at the beginning, about some of the considerable pressures that you've identified that relate to workforce. I think we've all seen that in your evidence and we're well aware of that, particularly the rising locum and agency costs.

[90] I just wanted to pick up on a couple of things that both Alex and Judith raised, which were about difference service models and service redesign and workforce redesign. In a previous life, I used to sit on the workforce partnership council and the workforce partnership forum in the

NHS, and we were talking about this years ago. It's been talked about for as long as I can remember, as long as I've been involved, about the need to do things differently, the need for staff to be properly deployed, the need for staff at appropriate levels to be doing work that's appropriate to their grade et cetera, et cetera, et cetera. And yet here we are, still talking about it. When are we going to stop talking about it, and actually start doing it?

[91] **Dai Lloyd**: Carol.

[92] **Ms Shillabeer**: I'm very happy to respond to that challenge. Just to give you a sense—. Absolutely, workforce is enormously—. It's driving our costs, but it's also driving our opportunity to do things differently. So, if I just give you a couple of examples, certainly from our part of the world and I know others will share these, but the development of roles such as physicians' associates. We know that GPs in rural practices are pretty hard to come by, and changing the shape of the primary care workforce has been important. So, physicians' associates, advanced practitioners, not just in nursing—although very important—but also in therapies; you know, pharmacists in primary care and in the practices are reaping huge benefits; mental health practitioners from the voluntary sector working in that area. We've just done an exercise recently in Powys looking at all of our roles and understanding. We've got rehabilitation assistance that offers something different into our ward areas, and we've got nurse injectors who provide a service for people with wet macular degeneration, whereas that used to be done by consultants. So, I think, bit by bit, we're really trying to change the shape of the workforce. I think there are two challenges for us: we've got to make sure we've got enough supply coming through, we've really got to make sure we're exploiting the opportunities of health and social care and that whole workforce, and having a much more planned and integrated approach to that; and the second thing is that we've got to enable professionals to work together in a more flexible way to enable the clarity of cross-working that may not have been so evident in the past.

[93] **Dai Lloyd**: Alex.

[94] **Ms Howells**: I think, as well as the new roles, one of the things I think we have seen some real progress in is really applying the prudent healthcare principles of having existing staff working at the top of their licence. And, certainly, some of the work that the national planned care board has done in NHS Wales, looking at the role of optometrists in pathways for eye care, audiologists as alternatives to ear, nose and throat consultations in

secondary care, some of the therapy-based services that we've been able to put on the front of orthopaedic pathways, have really provided a better service for patients, a quicker service for patients, freed up secondary care resources for those who need them most, but also given more satisfying jobs for the people already in those roles. So, I think there's a range of things that we can now see happening, so I think we have gone past just talking about it and we can see lots of those examples. What we're in the process of doing is trying to make those more consistent across the board and make sure we've built that into our workforce planning, because that's going to be really critical in terms of how we commission training, et cetera, and recruitment in the future.

[95] **Dai Lloyd:** Judith.

[96] **Ms Paget:** Just absolutely the same, really. I don't want to repeat it and I know we're pressed for time, but just in my organisation, just looking back over the last five years: a real change now in the way in which we're focusing on the development of the workforce, new roles, seeing opportunities, whether they're inside the way in which our hospitals work, the way in which our community and primary care services work. So, yes, lots of examples out there of actually things starting to change now, which is really, really good, not just for us, but for our staff as well because it gives them so many opportunities to do things differently and use their skills, really.

[97] **Dawn Bowden:** And there has been some great innovation around the development of the healthcare support worker workforce, for instance.

[98] **Ms Paget:** Absolutely, yes.

[99] **Dawn Bowden:** I'm aware of that. Can I just briefly ask you to pick up Carol's point about workforce supply and how much of an impact—? Because we know that is a challenge, but how much of an impact do you think Brexit has had on that, or is going to have on that, particularly in terms of some of the professional nursing staff, for instance, and actually the non-registered lower graded staff that we have, say, working around social care and those areas. Is that an impact that you're noticing, or is it something you're expecting to potentially become a problem? And have you started to prepare and plan for it, really, I guess is my question.

[100] **Ms Paget:** So, in the 'Are we noticing it?', not as yet. Clearly, we are definitely keeping a very close eye on staff movement, but as yet not noticing

that, and really working collectively through the NHS confederation around what this means for not just NHS Wales, but for the NHS. So, I think my colleague from the confederation, when she gave evidence, made reference to the Cavendish Coalition and other meetings that were taking place, around really understanding the impact of that and planning for it.

[101] **Dawn Bowden:** Alright, that's fine. Just a final question, Chair, if I might. Again, in a number of your pieces of evidence, you highlight nursing shortages and we know what the reasons for some of those are. Coming on board next year, of course, we're going to have the nurse staffing levels requirements coming into place, what are your preparations for that and what kind of challenges do you think that's going to present to you, if any?

[102] **Ms Howells:** Well, Carol will be much more able to answer this question than me, but I'll just give an ABMU perspective, because we are starting off from a really significant problem in terms of nurse vacancies—we have 300 registered nurse vacancies across the organisation. So, that was already an issue for us and it's already an issue that's making us look really, really carefully at everything from rostering, from sickness levels, from recruitment and retention, but also that's what's really making us look at our service models and whether we're providing the right service models in the right way. Because, we can't continue to—. We've had 300 nurse vacancies for the last couple of years; that's in spite of considerable recruitment campaigns, not just in this country, but abroad. So, I think we've come to the realisation that we need to change the service models, because we can't now recruit the staff to work at the level that we need them to and to provide the right quality and safety of care, and that's when we start to look at particularly the frail older people service models and say, 'Is that the best place to be caring for these people in hospital, or can we work jointly with local authorities to do something completely different?' So, I think it triggers all sorts of responses, really, but certainly we are quite clear that if those are the nurse staffing levels, then we need to make sure that we've got plans in place to achieve them.

[103] **Ms Shillabeer:** So, if I might just pick up on that, clearly, the staffing Bill focuses on acute medical and surgical wards at this stage. I know that there is work taking place looking at a much broader range of clinical settings, and I think we've just got to try to remember why there was such a focus on staffing in terms of some of the difficulties in other places and our own places around the quality of care that registered nurses can bring. So, I think that remains a very important principle. I do think we need to challenge

ourselves on those service models, even in our wards in our big hospitals and our smaller hospitals, around the service and the workforce that we supply, that we do have. So, as I mentioned earlier, rehabilitation assistants who may be healthcare support workers with that broad training, the role of pharmacy technicians and others, in supporting a more multidisciplinary team. So, I think we must just make sure that we are able to modernise and change our perspective in terms of what the patients need and be able to staff it in that way.

[104] I think there are some very real challenges in meeting the requirements with the supply issues. I know that nurse directors as a peer group have been raising their own concerns and boards are very aware of it in terms of their legal obligations, and the sense that, as an NHS, we have worked with Government to try to increase the supply, particularly of registered nurses, coming through and that will take some time. But we also need to be quite flexible to think about apprenticeships and other different ways of supporting people and widening access to enable them to, over time, get to a level where they may be registered practitioners.

[105] It sort of ties to the Brexit question, which I'm very interested in, which is that we really do need to take the opportunity that Brexit brings to think much more broadly about our workforce and growing and supporting our own people in Wales to achieve all sorts of different roles. As you've been hearing, there is a plethora of interesting and satisfying roles that the NHS and social care can offer. So, I think it will require a very different approach as we go forward. We've just got to make sure that we've got the headroom and the ability to bring that forward.

[106] **Dai Lloyd**: Diolch yn fawr.

[107] **Dawn Bowden**: Yes, thank you.

[108] **Dai Lloyd**: A dyna ddiwedd y sesiwn dystiolaeth. Diolch yn fawr iawn i chi am y papurau y gwnaethoch chi gyflwyno ymlaen llaw, a hefyd am eich presenoldeb y bore yma ac am ateb y cwestiynau fel rydych chi wedi'i wneud, mewn modd mor arbennig. Felly, diolch yn fawr iawn i'r chwech ohonoch chi. Fe allaf

Dai Lloyd: That's the end of the evidence session. Thank you very much for the papers that you submitted in advance and also for being here this morning and answering the questions as you have done in such an excellent manner. Thank you very much to the six of you. Can I also say that you will

bellach gyhoeddi y byddwch yn derbyn trawsgrifiad o'r cyfarfod yma i gadarnhau ei fod yn ffeithiol gywir. Ni allwch newid eich meddyliau ynglŷn â dim byd, ond o leiaf fedrwch chi gadarnhau ei fod yn ffeithiol gywir. Gyda chymaint â hynny o ragymadrodd, diolch yn fawr iawn i chi.

receive a transcript of this meeting to confirm for accuracy? You can't change your minds about anything, of course, but at least you are able to confirm factual accuracy in the document. With that, thank you very much.

[109] Gallaf gyhoeddi i'm cyd-Aelodau cawn ni doriad, rŵan, am bum munud cyn i'r sesiwn dystiolaeth nesaf ddechrau. Felly, nôl yn fan hyn am 10:35. Diolch yn fawr.

Can I tell my fellow Members, please, that we're going to have a break now for five minutes before the next evidence session? So, back here at 10:35. Thank you very much.

Gohiriwyd y cyfarfod rhwng 10:29 a 10:37.
The meeting adjourned between 10:29 and 10:37.

Paratoi ar gyfer craffu ar gyllideb ddrafft Llywodraeth Cymru ar gyfer 2018-19—Sesiwn Dystiolaeth 4—Cymdeithas Llywodraeth Leol Cymru a Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru
Preparation for scrutiny of the Welsh Government draft budget 2018-19—Evidence Session 4—Welsh Local Government Association and Association of Directors and Social Services

[110] **Dai Lloyd:** Croeso nôl i bawb i adran ddiweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Rydym ni'n symud ymlaen rwan at eitem 3: paratoi ar gyfer craffu ar y gyllideb ddrafft 2018-19 Llywodraeth Cymru. Dyma sesiwn dystiolaeth rhif 4. O'n blaenau ni, mae Cymdeithas Llywodraeth Leol Cymru a Chymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru. Yn benodol, felly, rydw i'n falch iawn i groesawu i'r bwrdd Jon Rae,

Dai Lloyd: Welcome back to everyone to this latest section of the Health, Social Care and Sport Committee meeting here in the National Assembly for Wales. We are moving on now to item 3: preparation for scrutiny of the Welsh Government draft budget 2018-19. This is evidence session 4, and before us we have the Welsh Local Government Association and the Association of Directors of Social Services Cymru. Specifically, therefore, can I welcome to the table Jon Rae, director of

cyfarwyddwr adnoddau Cymdeithas Llywodraeth Leol Cymru; y Cynghorydd Huw David, y llefarydd dros wasanaethau cymdeithasol ac iechyd Cymdeithas Llywodraeth Leol Cymru, ac arweinydd cyngor Pen-y-bont ar Ogwr; a hefyd Dave Street, llywydd Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru, a chyfarwyddwr gwasanaethau cymdeithasol Caerffili. Croeso i'r tri ohonoch chi.

resources, Welsh Local Government Association; Councillor Huw David, spokesperson for social services and health, Welsh Local Government Association, and also leader of Bridgend council; and also Dave Street, president of the Association of Directors of Social Services, and director of social services in Caerphilly. Welcome to you all.

[111] Yn ôl ein harfer, rydym ni wedi derbyn y dystiolaeth ysgrifenedig gerbron, ac fel sydd yn draddodiadol, awn ni yn syth i mewn i gwestiynau. Mae'r amser yn gyfyngedig, felly a gaf i ofyn yn garedig i'r cwestiynau fod yn gyfyngedig, ac efallai hyd yn oed i'r atebion fod yn gyfyngedig hefyd. Rhun ap Iorwerth i ddechrau.

As is our usual practice, we have received the written evidence from you, and we'll go straight into questions, if we may. Time is limited, so can I please ask you to offer succinct questions, and maybe succinct answers also, if you'd be so kind. Rhun ap Iorwerth to begin then, please.

[112] **Rhun ap Iorwerth:** Bore da i chi. Rydym ni wedi darllen yn y dystiolaeth ysgrifenedig yr ydym ni wedi'i derbyn fod yr adnoddau ychwanegol a gafodd eu darparu gan Lywodraeth Cymru yn y flwyddyn ariannol bresennol yn annigonol i alluogi ateb y galw ychwanegol ar wasanaethau cymdeithasol. Mae hynny'n eithaf clir o'r dystiolaeth. Pa mor fawr ydy'r diffyg yn y flwyddyn bresennol, a beth ydy effaith y diffyg yna ar y gwasanaeth yr ydych chi'n gallu ei ddarparu?

Rhun ap Iorwerth: Good morning to you. We have read in the evidence that we have received in advance that the additional resources provided by Welsh Government to local authorities in the current financial year have been insufficient to enable you to meet additional demand for social services. That's quite clear in your evidence. But how big is this shortfall in the current year, and what will be the impact of that on the services that you're able to offer?

[113] **Mr David:** Shall I start? Thank you, Chair. So, we estimate this year there will be a shortfall of £100 million; accumulatively, £344 million. You will have seen in the evidence that there's been an independent report by the

Health Foundation that estimates that the cost of adult social care's going to double over the coming years. The impact of that is that we are going to struggle to maintain existing services because, obviously, we have fewer resources and we have rising demand for services, and the cost of those services is also rising as well.

[114] **Rhun ap Iorwerth:** I had to look twice at a couple of the graphs because of the sheer scale of increase in demand that you identified, just to check that it was all okay. If you look then at the draft budget just announced, where the Government says it will continue to invest in social care—equivalent to maintaining the Welsh Government share of core spending in 2017-18, 2018-19 and 2019-20—how do you square the maintaining of core spending with the 4.1 per cent increase year on year that has been identified?

[115] **Mr Rae:** Well, we just got the numbers yesterday, so I think there's still a lot of detail to be—well, there's a lot to be understood about how these numbers were calculated. You're quite right, the pressures here are running at £100 million every year, and that's not the WLGA shroud-waving, that's confirmed by the work that Councillor David referred to by the Health Foundation, where pressures are running around about 4 per cent in real terms. So, obviously, that's way above the £40 million—£43 million—that the Welsh Government—. Now, we're not convinced it's additional resource; it's a reallocation of resource within the current funding envelope. The funding envelope for 2018-19 reduces by 0.5 per cent. That's £20 million. What the Government is saying there, I think, and when the Cabinet Secretary last year referred to similar moneys within the settlement as a soft hypothecation—it's a nudge, it's saying, 'Prioritise these services'. The settlement last year for 2017-18 went up slightly; it went up by £10 million. It didn't address all the pressures in local government.

[116] **Rhun ap Iorwerth:** So you think there's a certain element of smoke and mirrors going on here, again. As you said, you point out very clearly, actually, in your evidence, in point 18 in the evidence, that, whilst £59 million was identified as additional measures, it only actually equated to £10 million in real terms. You fear that what we've seen now, the £42 million in 2018-19 and the £70-odd million the year after, isn't what it seems.

[117] **Mr Rae:** No, I think what—. We responded with a press release to the settlement yesterday, and what Councillor Hunt, who is the leader in Torfaen and our finance spokesperson said is we need more clarity about these

numbers. But he's pretty clear that we've got an overall envelope and it's reducing by 0.5 per cent, £20 million.

[118] **Mr David:** And I think we need to be clear about the scale of the challenge that local authorities are facing. In Bridgend, we have had a record number of contacts from headteachers, from police officers, from neighbours and from families, concerned about the welfare of children. They have been so concerned that they have got in touch with us. And we have record numbers of children that we have taken into care, because we have identified that those children are at risk or are being abused or neglected. Likewise, in terms of the adults we support, we are now supporting a record number of older people and people with learning disabilities, and that is a picture that is the same across Wales. It is a very serious position we are finding ourselves in in terms of that pressure.

[119] In addition to that, the complexity of needs of those people are more significant than they've ever been before, therefore the cost pressures are more significant. So, we're seeing that in terms of the level of support that those children or people are requiring. So, we have been successful in terms of keeping more people out of the system, where they've been on the edge of care or we've been able to support them at home, but that does mean that the people who are coming into the system have a greater level of need than would have been the case just a few years ago.

[120] **Mr Street:** If I could just add to that, Councillor David is absolutely right, we've been very successful at keeping people, certainly older people, in their own homes for longer. That doesn't come at no cost; there are demands in terms of those services. I think we all know about the demographic pressures, and we've known about those for some time. They don't come as a major shock. In fact, I think we've been very resilient in being able to deal with those adult care pressures. Perhaps what has crept up on us is the looked-after children pressures, because what we are seeing is not just an increase in numbers but the complexity in terms of children exhibiting behaviours at eight or nine years old now that previously would have associated with 14 and 15-year-olds. That means the interventions have to be slightly different. They're invariably more complex, more expensive and, of course, they have to be there for a longer period of time. So, all of those things together are of real concern. It's encouraging that those issues are being identified, and where children need support they are coming into the system but, obviously, that doesn't happen without any financial consequences.

10:45

[121] **Rhun ap Iorwerth:** Can I also ask you to comment on pressures caused by the need to spend on mental health services as well? Thankfully, it is becoming more of a priority now. That means additional pressure on you. How do you prioritise mental health within the constraints that you have?

[122] **Mr Street:** Well, you prioritise it to the best of your ability. I think that's one of the difficulties we have. It is very difficult to justify prioritising any one particular area. How do you prioritise mental health over looked-after children over those other things? We're acutely aware of that. It's an area where there are some very good examples of integrated working with health boards. Many of us, if not most of us, have community mental health teams. There is some good work going on there. There has been some investment in, particularly, mental health services for children and adolescents. That's been extremely important to us. There has been a void there in the past. But it's like the broader local government agenda. If indeed you do prioritise your resources towards mental health services, then there has to be another element of your business that you don't prioritise, and that is getting increasingly difficult to do.

[123] **Rhun ap Iorwerth:** With your permission, Chair, if I could just turn to the issue of the pooling of resources. Of course, the Social Services and Well-being (Wales) Act 2014 said that you can pool resources across regional partnerships. Some of us, perhaps, would like it to be slightly more statutory than that in terms of trying to drive integration. Considering the increasing pressure on you, should 2018-19, driven by Government, be a year when there is a beginning of much more pooling of resources in order to address those areas that are of common concern to local authorities and to health boards?

[124] **Mr David:** I think, first of all, there needs to be a recognition that there is already some significant level of pooling of resources, and we've given one example already of mental health where, in fact, it's commonplace across Wales for there to be a pooling of that resource, because there's a recognition that it's a joint responsibility in terms of improving people's mental health and well-being and focusing on the community side. I think we need to be realistic about what can be achieved by pooling, and also be clear that it's not an end in itself—it's a means to an end, and that end should be about integrated working and providing better outcomes for

citizens.

[125] We also need to be mindful of the fact that, quite often, there are different positions in different local authorities across Wales, and different needs. So, it's balancing the two in terms of getting that pooling of resources and not seeing that as a panacea, because if you do pool budgets, if the pools are still the same size, then it's not necessarily going to be a magic bullet. What we have to be mindful of is sometimes you will have small local providers that want to provide in their small local communities, but if you had a very large regional commissioning structure then it can become more difficult. I'm sure some of you—because I get correspondence off Assembly Members about the Welsh procurement service and the impact on supply teaching, because we've got a pooled system across Wales. And what that means is we've got one provider, and that makes it more difficult for some of the local providers. That's just a note of caution around that, but I do see there's some value in pooling budgets, but I don't think it's always the answer to every problem.

[126] **Dai Lloyd:** Okay. Dawn, do you want a supplementary?

[127] **Dawn Bowden:** Yes. I think what I would say is that, you know—I've got two local authorities that straddle my constituency, and I've spoken to both of them. In fact, Dave, we had a conversation not so long ago. I'm fully aware of the difficulties and the pressures. We get this every day in trying to have our relationships with our local authorities. We're looking at this, however, in the context of we're now moving into the eighth or ninth year of austerity. Welsh Government's budget has been cut by something like £1.5 billion during that period. The size of the cake gets smaller. The money available to Welsh Government to allocate to local authorities and everything else gets smaller and smaller. So, understanding all the pressures that you inevitably face, what is the solution within the context, from your point of view, of ongoing austerity? Because there ain't no more money.

[128] **Mr Street:** From a social care perspective—and I expect it's similar for some aspects of the NHS—it is about that wider community resilience. It's about people beginning to take some responsibility for their own needs moving forward, and understanding that the public sector often, moving forward, is going to be very different to what it's been historically. But the bottom line in this as well is that there are demographic pressures. If you read those figures in the submission, they are quite stark. You look at the number of people over 65 in the next 15 years, and, even more frighteningly,

the number of people over 85, and, unfortunately, there's going to have to be a public sector intervention for them unless another model can be developed. It is the perfect storm, isn't it? The demographic time bomb at a time of financial austerity is very difficult. You would hope that we can encourage and persuade people to take some aspects of their needs within their own families, within their own responsibility, but there is always going to be a cohort of people in an area like Wales, and in some of our more deprived communities in Wales, where the public sector will be the last resort.

[129] **Dai Lloyd**: On the same theme, Caroline's got some similar questions.

[130] **Caroline Jones**: It's unlikely that local authorities will receive additional funding, particularly for social services, and we note with social services that there are changes, such as the residential care capital threshold, which is not fully covered by the additional £4.5 million. So, could I ask please how you will give priority to certain areas, not to others? You have to have a list of where you can place your priorities without increased funding. I wonder if you could just answer that.

[131] **Mr David**: Basically, in terms of local authorities, what we have done is we have prioritised social care and education. So, for example, in Bridgend, the budget that we commit to leisure centres and swimming pools is half what it was six years ago. We've halved the spending on public protection, so environmental health, trading standards. We're looking at closing toilets. We've closed some toilets. We're looking at stopping subsidised bus services. We've cut the budget for libraries. We've cut the budget for highways. The list goes on. And, of course, I suppose—and this is partly answering Dawn's question, which is a good question—what we all know, and the evidence is very clear about a lot of those services, is that they keep people independent, in their own homes, and less reliant on expensive treatments later on down the road. In terms of your mental health and well-being, having parks and playing fields and somewhere like that stops you becoming isolated. So, basically, what councils have done is they've cut those other services quite significantly, so the evidence is there for that. But, of course, we're reaching the end of the road of cutting those services. So, when you've closed most of your public toilets and there's no budget left, then where do you go? So, you're left with those statutory services. And in trying to answer Dawn's question, I think it's about shifting—. What we're trying to do within local authorities, even with that happening, is shifting from treatment to early intervention and prevention. And in actual fact, I'm very proud of the fact

that, even though we've got more older people than we've ever had, in the last five years, there are fewer people in residential homes now than there were five years ago, and that number has fallen every year. Why is that, even though we've never had so many older people? It's because we're supporting more people at home. So, that costs significantly less, but the problem is that it still costs. So, if someone's getting a care package every day, that might be a couple of hundred pounds. It's not £400 or £500, which it would be in a residential home, but it's still a couple of hundred pounds.

[132] **Caroline Jones:** Yes, but it is a decreased cost. My question is: we're asking people to take responsibility for their own lives regarding obesity, and yet we're decreasing facilities. We're asking people not to be isolated and they may suffer from incontinence, so by closing the toilets, we've alienated a large area of the population—disabled people. I think that we have to look at other areas, because the toilet issue and the provision of toilets really angers me at that point, because we are alienating such a large amount of people who would otherwise be out in their community doing basic things such as shopping. So, if they get a carer to do the shopping for them because we have a lack of public toilets, then we're adding to that cost. So, I don't think that that has been looked at in the way that I would like it to be looked at in that area.

[133] **Mr David:** I suppose the problem is that our budgets are less. We have those statutory provisions. So, currently if the police contact us—. There will be a family in Bridgend today, and there'll be families across Wales, where they say, 'We walked into this house and mum's a heroin addict—she's out cold on the floor; you need to take those children into care'. Suddenly, the budget's gone up by £500. I would never not prioritise that. You take the action that you need to take, don't you?

[134] **Caroline Jones:** So, the budget is totally unrealistic—is what you're trying to say, really—to provide the services that we need—

[135] **Mr David:** If I'm being very frank—and it's not us saying this; it's the Health Foundation, it's Wales 25—the pressures that we face are more acute than the pressures in the health service. The health service will have their budgets increased this year. That's correct, isn't it? We will not have our budgets increased; our budgets will be reduced this year. I do recognise, though, that Welsh Government is in a very difficult position because of its finances not being increased as much as it would like them to be increased. That is a very difficult position that Welsh Government and you find

yourselves in, but we've got less money than we had last year and the number of people over 85 is going to double in the next 10 or 15 years. No-one is seriously suggesting that that is going to come without significant additional costs.

[136] **Dai Lloyd**: Jon, before we move on.

[137] **Mr Rae**: I maybe thought that part of the answer to that question was that, as the WLGA, we've set out our long-term priorities in our evidence to the parliamentary review. So, we've set out about five long-term priorities in there—amongst them, better engagement with the public et cetera in the demographic challenge and getting them to take more responsibility for their own health and well-being, digital transformation, health and social care integration and developing a sustainable approach to workforce and funding as well.

[138] I have to say, going back to the question from Dawn Bowden, that, as an association, we're awake to the challenges of austerity, even going back as far as 2007-08 and 2008-09, when my predecessor was warning of the impact of austerity. For us, it's been about trying to convince the Government that we need more funding flexibilities and that we need a more permissive arrangement around charging—not necessarily social care charging, because I know there are sensitivities around that—but just funding flexibilities. These are just tinkering at the margins at the end of the day. The bottom line is that cuts are having a big effect on local public services.

11:00

[139] **Dai Lloyd**: Caroline, are you sorted?

[140] **Caroline Jones**: Yes—well, I don't know about my next question, because it's to ask about further constraints in an already fragile market. As Huw has already said, to take—. Initially, you start off and you make changes and savings where there's an obvious target that you can, and then, as you go on, that target becomes less and less and less, so you reach a plateau where you can't go anywhere, really, and this is what's happened here. So, I'm happy, thank you, Chair.

[141] **Dai Lloyd**: Okay. Moving on, then, to workforce issues. Dawn.

[142] **Dawn Bowden**: Yes, here we go, workforce again. I mean, you're all going to be faced with current recruitment and retention issues. We know you've had to address that over a significant number of years, particularly in social care. What is the result of the prolonged budgetary constraints around the recruitment within social care particularly?

[143] **Mr David**: I suppose I'll ask Dave to come in. I think we've seen—. As you'd expect, you want local authorities to get best value in terms of commissioning. Because most adult social care will be commissioned from the third sector or the independent sector, it's always difficult to strike that balance. So, when you're commissioning, you want best value, to keep costs as low as possible. The problem, though, is that lots of those organisations are turning around to us and saying that we can't recruit and retain staff because we're not having enough money so we can't pay what we'd like to pay, and that is an issue.

[144] Some providers have turned around to us and said, 'Thank you very much but no thanks. This isn't profitable and we can't recruit and retain staff'. So, that is a scenario that we are seeing more of across Wales. I think unless that quantum of money in the system increases, then those providers and, indeed, the direct provision won't be able to increase the pay and terms and conditions that staff have in the social care sector, which is not—. I mean, it's not brilliant in the NHS, but certainly, compared to the NHS, the terms and conditions are not equivalent to that. We know that's the case because there are sometimes roles in nursing, for example, where they will move from the independent homes into the NHS where they can, because of the better terms and conditions.

[145] **Dawn Bowden**: Absolutely. And just in terms—sorry, Dave, did you want to come in on that?

[146] **Mr Street**: Just to support what Huw said. The principal difficulties we have at the moment are in that independent sector provision. That is an extremely fragile area in all kinds of ways at the moment. Despite the very welcome emphasis on making sure those roles attract at least the national living wage, with a cost, and the very welcome support via the social care workforce grant, many of those companies are struggling to recruit and retain. That's got all sorts of consequences in terms of additional capacity.

[147] We move into the winter period very shortly, if we're not there already. There will be spikes in terms of our demand. It is very, very difficult for

providers simply to go out and recruit and train and retain those people. Despite everyone's best efforts, the reality is that most of those carers can go and get a better paid job in the local supermarket, and that can't be right.

[148] We touched on complexity a little earlier. These are not home carers any more, they're not people going out to do a little bit of cleaning, a bit of dusting—these are people who are doing very intimate, personal tasks with people. If they're attracting national living wage, and quite frankly, at the supermarket down the road you can get a better paid job stacking shelves or whatever else you do, people will make an individual choice.

[149] It is a longer journey than that. It's about us as a public sector trying to encourage people who leave school and college that actually social care is somewhere you can make a career. There are too few of those people. We have university graduates going through and becoming qualified social workers, but social work is just one profession within a very diverse community of potential—. The advent of Social Care Wales will hopefully take us on that journey. The example I always give is both my daughters went through university, and, even as a director of social services, we never had a conversation with them about a possible career in social care. So, if I'm not having those conversations with my daughters, when I'm doing my job, then is it any wonder we're starting to struggle? We have a responsibility to help people to understand that, actually, coming into these roles may be step one, which will ultimately take them on a much longer career path.

[150] **Dawn Bowden**: And just in terms of that, because we heard in the previous evidence from the health boards that there's quite a lot of innovation around development for the healthcare support worker workforce in the NHS, which isn't apparent in local government. It just begs the question whether there is an argument for greater integration of that workforce, both in terms of its terms and conditions and everything else as well. It becomes more interchangeable. I know there are cost pressures attached to that as well. I won't necessarily ask you to comment on that now, that was just a thought. Are you struck with agency fees as well? Do you have to cover some of these services with agency staff?

[151] **Mr Street**: There are examples of that. I think that the position is variable across Wales. I think some authorities are more dependant than others, and geography can play a big part in that. If you're in those larger rural communities, you're probably more dependent on agency staff. It isn't a big factor, for example, in Caerphilly at the moment. So, that's very

welcome. Obviously, those staff come at a premium cost-wise, and, of course, your ability to retain them is even more challenging. So, there are issues there.

[152] The fragility of the market—Huw's right. Certainly, in my own authority, in the last financial year, we had one provider who turned round and gave us two months' notice and handed back 80 packages of care amounting to 1,000 hours a week. We have to respond to that. The way we were able to respond to that, interestingly, was by our dialogue with the small, local providers. It was those small, local providers that got us out of that position. The larger providers didn't want to know.

[153] **Dawn Bowden**: Just one further question, Chair. Have you had any thoughts or have you done any analysis on the potential impact on staffing social care of Brexit—what the potential impact of that might be?

[154] **Mr Street**: I'm not aware of any bespoke piece of work that's been done, if I'm honest. Certainly, within social care, I don't think it's a huge issue. I think—was the figure somewhere around 6 or 7 per cent, we estimated?

[155] **Mr Rae**: We haven't done any work ourselves. We've certainly relied on figures we've seen from the Local Government Association in England, putting the workforce from EU countries somewhere between 5 and 7 per cent.

[156] **Mr Street**: One of the things that might be an unexpected consequence, I suppose, is if indeed the NHS are more vulnerable. So, if there is a movement of staff from the NHS, then, if the NHS go to recruit, it's quite possible that some people from the social care sector will go and work in the NHS. That is a pattern we have seen in the past. Certainly, when the NHS has gone out and recruited support workers, a sizeable number of those posts have come from either local government or from the independent sector.

[157] **Mr David**: Because of the better terms and conditions.

[158] **Dawn Bowden**: Okay. All right, thank you.

[159] **Dai Lloyd**: Ocê, mae'r cwestiynau nesaf o dan ofal Lynne Neagle.
Dai Lloyd: The next questions are from Lynne Neagle.

[160] **Lynne Neagle:** Thanks, Chair. Can I ask about preventative work—how you are managing to fund it and what support you'd like to see from Welsh Government to enable you to continue to do that?

[161] **Mr David:** So, some of that preventative work has been funded, for example, through the intermediate care fund. I do welcome that. That has been a helpful catalyst in terms of that joint working with the health service that we're saying is so important and we need to do. We will do more of that in the future. On the face of it, we certainly welcome the flexibility of bringing some of those grants into the RSG so that we don't have to pay people to fill in forms. You, in the Welsh Government or National Assembly, have to pay people to check the forms and then write back to us and we write to you. You know, we don't need that bureaucracy, do we? We need to minimise that. But it is going to be difficult with those pressures, when you're firefighting, to do the preventative work. It has been successful in many regards. So, I talked about that shift around older people. So, it is happening but it becomes more difficult in that broader set of the—.

[162] There are probably two types of preventative work. There's that broader preventative activity that Caroline perhaps referred to and I referred to, and then there's the more targeted work that we do within social services where we work with families on the EduCare or targeted work like Flying Start or Families First, and I think every authority would try and prioritise those services where we're working with families that we know are, or adults that we know that are, vulnerable or at risk. If we get in there early, then we can stop their needs increasing.

[163] **Lynne Neagle:** Can I just pick up on Families First and Flying start, both of which I think are really fundamental preventative schemes? One of the things that I've seen in Torfaen is that families that would have been in the social care system are now having to be picked up by Families First because of issues with raising eligibility, pressure on resources, but, of course, that means that then the preventative end of that work is perhaps not so available. Is that a picture that you recognise?

[164] **Mr Street:** I think there are some pressures in the system alongside those. Certainly, within the world of childcare, we do all we can—if I use the word 'protect' very loosely—to protect those preventative services, because, quite frankly, that is the only avenue we have to stop some of the pressures that Councillor David alluded to earlier on. There is no other avenue you

have. Once your child has been identified with those needs, quite frankly, whether you've got the money or not, you have to react to that. So, you do all you can. Some families are more receptive in terms of how they engage with those preventative services. It's not what everyone wants. It's not always fit for purpose. I think sometimes we talk about prevention within social care as though it's a fairly new phenomenon; it clearly isn't. We've been doing some preventative work for many years. If you look at things like reablement services and adult care, we've been providing intensive periods of care to people coming out of hospital with a hope that, after that period, their care needs will reduce or even diminish completely.

[165] Certainly, from the work I've done locally, what it's shown us is that, actually, we buy ourselves some time. So, people may go away from the social care system, but tend to come back round 18 months later. So, sometimes it's just giving people a little more time being independent as older people before, ultimately, they come back within the social care system. And I think that is one of the things for me that we need to be a little better at. It's understanding the consequences of that preventative work. So, if indeed we are successful and people are signposted away from social care, what happens to those people? Do they simply maintain themselves in their communities without any interventions, or do they appear elsewhere within the public sector, creating a slightly different demand? So, they don't work with local authorities, but actually they're a big call on primary care services, for example.

[166] **Lynne Neagle**: Your paper picks up on the fact that the health service has had extra money and that a lot of that is going into secondary care, which, of course, isn't preventative, whereas we're seeing increasing pressure on local government to be more preventative. Do you think Welsh Government has got the balance right in the message that it's giving to the health service in terms of prevention, and do you feel that perhaps you are doing most of the heavy lifting on the preventative agenda?

[167] **Mr David**: I don't want to be unfair to colleagues in the NHS, because they face incredible pressures and I certainly wouldn't want to be in a health board in Wales at the moment, but I do think that perhaps there needs to be that conversation, dialogue, about—. That money is going to go into the NHS. It's how that money is spent, and with that focus on the—. So, even if it's within the NHS, then there are things that the NHS does that are preventative, aren't there, and early intervention. And I would like to see us working more with the NHS and the NHS working more with us on similar

lines to the intermediate care fund, which has been hugely successful. It's £50 million, but I don't know what the NHS budget is in Wales. Is it 6, 7—? Whatever it is—

[168] **Dai Lloyd:** Seven billion pounds.

[169] **Mr David:** Seven billion pounds. So, when you compare the two, then my view is that we need a significant increase in that joint funding. So, it might be about sitting down and saying, 'Well, do you identify or ring-fence or earmark some of that funding for the NHS to be invested jointly with local government and the third sector on those preventative services?' Otherwise, the risk is it will go into secondary care, and you're just going to be back to square one next year, aren't you? Because those pressures that we face from the ageing demographics in Wales are not going to go away, and those needs. So, we have got—

11:15

[170] **Dai Lloyd:** Well, hopefully not—some of us are ageing. [*Laughter.*]

[171] **Mr David:** Yes, that's right. [*Laughter.*] We welcome it. I should always add that caveat. It's wonderful that people are—. I hope to be part of that crowd in about 30 years' time, living in a nice extra care facility. But we would welcome that joint working with the NHS around how we invest that funding. We think that would be far more sensible.

[172] **Dai Lloyd:** Okay. Jon, before we move on.

[173] **Mr Rae:** Thank you, Chair. Councillor David raises a salient point, I think, about the size of the intermediate care fund. In England, they've got a Better Care Fund. It's about £5.3 billion. Obviously, it's England; it's bigger. I mean, on a like-for-like basis, I suppose, if our fund was relatively the same size as the Better Care Fund in England, there'd be maybe about £250 million in it, so—. Plus, there was some evidence—. We put evidence to the Finance Committee last year on the Welsh Government budget 2017-18. We looked at, actually, some of the programme spend within the NHS, and I think there was some evidence there. I'm not expert on NHS programmes, but, if you look at central returns there, actually some of the preventative programmes had received real-terms reductions over the past seven or eight years.

[174] **Dai Lloyd:** Okay. Well, seamlessly moving on to integrated care, as it's

now called, Angela.

[175] **Angela Burns:** Yes. Thank you very much indeed, and thank you for your paper. You were marginally gloomy, I thought, in your responses to Lynne about—

[176] **Mr David:** I take that as a compliment. [*Laughter.*]

[177] **Angela Burns:** —about the success of preventative measures, and yet you say in your paper that you feel that the new integrated care fund has actually been significantly successful in pooling resources and getting actions under way. Perhaps you could just talk about that a little bit more, about why you think that's been so successful. Is it literally just having the funding is place, which, as you say, is not £5.3 billion? And I'd also be very interested in understanding the rationale behind your very clear pitch to bring the oversight of the primary care fund under your purview—or the purview of the regional boards.

[178] **Mr David:** My view is that the intermediate care fund has worked, first of all, because there has been extra investment. That's happened, so that's been a catalyst. But also, it's been delivered through a partnership, so it hasn't just been local authorities, it hasn't just been health, it's been health, local authorities and the third sector, and I think that's been the key to success. Also, it's not just that. It's coming together with that shared vision around what we want to achieve, and it's been about keeping people out of hospital, stopping people going into hospital, and keeping them at home for as long as possible. When you've got that shared vision and you've got that extra funding, you're clear about what you want to do, then you can achieve that success, but it needs to be on that partnership basis, because agencies will quite often be working with the same group of people, the same individuals with often complex needs, and, if there isn't that join-up, I don't think you're going to get the success that you're looking for in terms of keeping them independent. I think, particularly, the success has been around older people, because that's where the focus has been in terms of the intermediate care fund. There has been some funding made available for children. That's latterly so, and that's now having some focus from the partnerships too.

[179] **Angela Burns:** Dave.

[180] **Mr Street:** If I could just add to that, one of the things it really has

allowed us to do is to try things. We've actually had funding where you could look at some initiatives and think, 'Oh, I wonder. I wonder, if we did A, B and C, whether that would have an impact,' and, actually, a mature dialogue and evaluation and an honesty in terms of 'Well, that didn't quite work out as we hoped, so we will divert those resources elsewhere'. Or, conversely, 'Yes, that was a great success. We need to put further resources into that.' That's quite a luxury in the current climate, where often, if you go down a particular road and you have to go off on a slightly different road, it's viewed as failure. And this isn't about failure; this is just trying to deal with a very complex situation and having a little bit of new money where you can pilot. That's had quite an impact.

[181] **Angela Burns**: Do you know, I couldn't agree with you more? I think one of the great disservices of public services is that you're not allowed to fail, and you've got to be able to be allowed to fail. Just slightly tangentially, I'd like to just ask you—I understand very clearly the weight of statutory services you have to provide versus the other services. What weight of your budget is hypothecated now? What percentage, do you know, roughly, of your overall budget?

[182] **Mr Rae**: I think, off the top of my head, there are 17 or 18 specific grants amounting to somewhere between £700 million and £800 million, and let's say net budgets are about £5.5 billion.

[183] **Angela Burns**: Okay. Do you think that if hypothecation were—? Because you again make a pitch somewhere in your paper—I can't remember where it is—about if you had funds, you'd like them unhypothecated. Do you think that—? You know, it's a tension there, isn't it? It gets hypothecated because we want to make sure it's spent in a particular area, but, obviously, if it's unhypothecated you've got far more wriggle room. Of that wriggle room, do you actually think that what it would give you would be the ability to use your funds more creatively to achieve the same objective? Do you see hypothecation as a stumbling block?

[184] **Mr Rae**: I think it is. It's obviously been a long-standing position of the WLGA. Every local government association in the UK, potentially across Europe and the world, I suppose, have ultimate freedom and flexibility—

[185] **Dai Lloyd**: So, you're the world spokesperson, Jon. Carry on. [*Laughter*.]

[186] **Mr Rae:** But it's not—. And, you know, for a long time it was just about the administrative burden of—Councillor David has already alluded to administering these things. More and more, it's about place-based approaches and trusting local government leaders to make the decisions about priorities in their area. I must say, for the first time in a long time—in the announcement yesterday we've seen £92 million coming into the settlement, and I think local government leaders have welcomed that. It's the first time we've seen such a large transfer into the settlement. I just hope the Welsh Government can keep up that kind of momentum.

[187] **Angela Burns:** We've talked a lot about preventative and the integrated care fund, my final question to you really is: is this now the time where local government will actually need to reassess its form and function in order to provide these services? By that, again, I see that there's quite a strong commentary in your paper overall about the fact that you think that well-being, and the responsibility for health and well-being et cetera, should be brought into local government—I hope I'm not pinching anybody else's bit on this, by the way—and should be brought far more into local government. There's of course a counter-argument that says that perhaps local government should end up being the overall managers of the system, and that we should use much more of the third sector to deliver it, rather than what's happening now, which is that third sector organisations are either handing back or, in fact, having stuff taken off them because county councils think, 'Actually, if we had that money back inside, we could flex it better than passing it out to a third sector organisation.' So, I just wonder if there is a thought process going on in terms of where you go from here and the pitch that you're going to be able to make, because, as Dawn said at the very beginning, there's just no money.

[188] **Mr Rae:** Public health is a local government function in England, and part of these things is having focused place-based approaches. It doesn't necessarily create any economy of scale because there are economies of scope as well. So, part of having a joined-up public health function with other functions in local government—in environmental protection, regulation, housing, transport, employment, other social interactions—is that it would make sense to have them joined up at a local level. That's where citizens, at the end of the day, interface with these services. Is it happening immediately? No, it will be a long-term thing. I think local government is slowly changing. We've got past the structural debate and now the debate, I think, is about local services and the regional strategic stuff as well.

[189] **Dai Lloyd**: That moves us seamlessly on to the last strand of questions from Jayne Bryant.

[190] **Jayne Bryant**: Thank you, Chair. You touched on some of the points in your response to Angela, actually, but I was looking to focus on how you think the Welsh Government could help in their approach to budgeting and resource allocation to help local authorities take a longer-term approach to social services delivery. I was thinking about your issues around flexibility that you mentioned in terms of budget allocation.

[191] **Mr David**: We do welcome—and I reiterate that—the fact that some of those specific grants have been brought into the revenue support grant. Obviously then, in terms of our financial planning, we'd much prefer, because we try and plan—I think every local authority in Wales plans—over the medium term, rather than just plan from one year to the next, so you try and project forward at least three years. So, to do that, I think it's helpful to have those forecasts. Mind you, you've got to be careful what you wish for, haven't you, because if it's a forecast of reductions, I'd be lying down in a dark room about now? [*Laugher.*] So, that's probably something that I think is important to local authorities—that stability in terms of forecasting. But, obviously, I'd want the forecast to be some growth, because I do feel that we're at the end of the road now in terms of trying to keep those services—the bedrock of a decent society—going.

[192] In my own authority, I'm just looking around and thinking, 'Well, we've done the efficiencies, we've brought this in—'. We've got this charity, this third sector—we do a lot of that in Bridgend. We've significantly reduced our management and administration. A lot of the services that we thought we could manage without have gone. I'm just at a loss now where to go if this carries on for the next four or five—. If we want to carry on in a decent, civilised way, really, and not end up that all we do is become that organisation—basically, a child protection service and schools. I'm not saying they aren't incredibly important, and they already take up about 80 per cent of our budget—social services and education—but I think Wales would be a much poorer place if that's what we're left with in terms of local authorities. So, over the next—.

[193] I know that, perhaps, that isn't a decision— well, I know that it isn't just for Welsh Government. Obviously that's about a decision for Welsh Government and UK Government, isn't it, about austerity? But I think that's what we need. We need to see that growth, because, as I said, the pressures

we face are more significant, and it's not me—there are about three independent reports, or any report you want to read. We are facing greater demographic pressures than the NHS. So, if there's more money going to the NHS—I'm not even saying I want the same, I'll just settle for more money coming into local government to deal with the pressures that we are facing on a daily basis and really struggling with at the moment. So, that's what I think—. Sorry, I've got on my soapbox now [*Laughter.*] I am a politician, I can't help it, but that's what I'd say. We need—

[194] **Dai Lloyd:** Well, we are looking for some take-home messages for the—

[195] **Mr David:** Yes, and it is going to be that we need to see—

[196] **Angela Burns:** You're at a tipping point.

[197] **Mr David:** Yes. We need to see an increase in resources.

[198] **Dai Lloyd:** Okay. Jon.

[199] **Mr Rae:** Yes, just quickly. One of the welcome things about the announcement yesterday was the Cabinet Secretary giving us an indication. Obviously, the insight's welcome, the cut isn't, for 2019-20. It's almost a—. We've argued for a long time that we need multi-year settlements. Even medium-term financial planning's not good enough anymore. We've got all these reports telling us that costs in social care are going to double. Councillor David's absolutely right: we're planning for the next three, four years. I've seen councils actually planning over a longer period than that, because they need to be, and what we need to look at is having a wider debate about the future funding of social care, which is why, in our paper, we talked about maybe some of the work that Gerry Holtham has been doing. We understand there may not be a public subsidy forever and a day, but how we address those vulnerable people in the future, in 10 or 20 years' time, is a serious worry for leaders at the minute.

11:30

[200] **Dai Lloyd:** Exactly. Jayne.

[201] **Jayne Bryant:** I was just going to go on to that point, actually, because, obviously, in the draft budget yesterday the Welsh Government suggested a

new approach may be needed to pay for social care, as you've suggested. Perhaps you could expand on your views on that, and just perhaps give a bit of an indication of how you see that going forward.

[202] **Mr Rae:** Yes, this is a proposal, isn't it, that I think was originally in an Institute of Welsh Affairs paper that was written by Gerry Holtham—an interesting idea? Both myself and the chief executive of the WLGA have had a discussion with Gerry Holtham just to explore some of the issues in his paper. Obviously, now it's become something with a little bit of traction. It's one of the proposals for an additional tax. I think these interesting proposals for additional tax have almost passed us by because of the budget announcement, the local government settlement, but we do welcome that the Cabinet Secretary is going to look at these things.

[203] So, in essence, Gerry's proposal is not so different to, essentially, a contributory pension fund. You build up a fund. It's not an individual or a private thing, though; it's a social insurance-type scheme. You create a fund of—I think the number is around about £4 billion—and it starts to address some of the pressures in future social care—those who are going to need social care in the future. Remember, we're still only talking about a small proportion of the population, so it's a contingent thing. So, it's apt to be a social insurance model.

[204] There are alternative things. You could have a private insurance model, which I think was part of the discussions way back in April, May in England, where you have a cap on fees that helps engender a private insurance market. But I think what's interesting about Gerry's proposal is that it's innovative, and, at the end of the day, it's not so difficult. You create a £4 billion fund for the potential needs of a couple of hundred thousand people—well, local government already administers pension funds. It administers, in total, £15 billion-worth of funds for the benefit of around about 330,000 potential and current pension fund members. So, it's not beyond the wit of the public sector in Wales to actually set something like this up.

[205] **Dai Lloyd:** Okay, Jayne? Yes. Good.

[206] Wel, dyna ni. Rydym ni wedi cyrraedd diwedd y sesiwn. Diolch yn fawr iawn i chi am eich tystiolaeth ysgrifenedig ymlaen llaw. Diolch yn	Well, there we go. We've come to the conclusion of that session. Thank you very much for your written evidence beforehand, for your attendance

fawr iawn i chi am eich presenoldeb y bore yma, a hefyd am ateb y cwestiynau mewn modd mor raenus. Diolch yn fawr iawn.

today and for answering questions in such a polished fashion. Thank you very much.

[207] A allaf i gyhoeddi mai dyna ddiwedd y sesiwn? Fe wnawn ni symud ymlaen, felly. Mi gewch chi drawsgrifiad o'r cyfarfod, jest i chi allu gwirio ei fod yn ffeithiol gywir. Ond dyna ni—diwedd yr eitem yna. Diolch yn fawr iawn i chi am eich presenoldeb.

Therefore, I can announce that that concludes our session and we will move on. You will receive a transcript of the meeting so that you can check for factual accuracy. But that's the conclusion of that item. Thank you for your attendance once again.

11:34

Papurau i'w nodi
Papers to note

[208] **Dai Lloyd**: Rydym ni'n symud ymlaen at eitem 4 nawr, gyd-Aelodau, a'r papurau i'w nodi. Fe welwch chi fod yna bedwar papur o lythyrau yn eich nodiadau, yn y *pack* yn fan hyn. Unrhyw beth yn codi? Nac oes. Diolch yn fawr.

Dai Lloyd: Moving on to item 4, colleagues, to the papers to note. You will see that there are four sets of letters in the pack there. Is there anything arising at all, please? No, nothing. Thank you very much.

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.

[209] **Dai Lloyd:** Gyda'ch caniatâd, felly, fe wnawn ni symud i mewn i sesiwn breifat. Pawb yn cytuno? Pawb yn cytuno. Diolch yn fawr iawn.

Dai Lloyd: With your permission, therefore, we'll move into a private session. All agreed? All agreed. Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:35.
The public part of the meeting ended at 11:35.