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

19/07/2017

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Yr Athro Syr/Professor Sir Mansel Aylward	Aelod o'r Panel Member of the Panel
Dr Jennifer Dixon	Aelod o'r Panel Member of the Panel
Eric Gregory	Aelod o'r Panel Member of the Panel
Dr Ruth Hussey	Cadeirydd y Panel Member of the Panel

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

Steve Boyce	Y Gwasanaeth Ymchwil Research Service
Sarah Sargent	Dirprwy Glerc Deputy Clerk
Sian Thomas	Clerc Clerk

Dechreuodd y cyfarfod am 09:31.
The meeting began at 09:31.

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

[1] **Dai Lloyd**: Bore da i chi gyd i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. A allaf i estyn croeso i'm cyd-Aelodau a hefyd datgan y bydd Rhun ap Iorwerth ychydig yn hwyr, ond mi fydd e'n ymddangos maes o law? A allaf i bellach egluro bod y cyfarfod yma'n ddwyieithog a 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? Yn bellach, a allaf i atgoffa pobl i naill ai ddiffodd eu ffonau symudol ac unrhyw gyfarpar electronig arall, neu eu rhoi nhw ar y dewis tawel, achos maen nhw'n amharu ar yr offer darlledu, a hefyd hysbysu pobl y dylid dilyn cyfarwyddiadau'r tywyswyr os bydd larwm tân yn canu?

Dai Lloyd: A very good morning to you all and welcome to this latest meeting of the Health, Social Care and Sport Committee here at the National Assembly for Wales. May I extend a warm welcome to my fellow Members and also just tell you that Rhun ap Iorwerth will be a little late, but he will be with us? May I explain further that this meeting is held bilingually and headphones can be used for simultaneous interpretation from Welsh to English on channel 1, or for amplification on channel 2? Could I remind everyone to either to turn off their mobiles and any other electronic equipment or to switch them to silent, because they can interfere with the broadcast system, and also tell you that, in the event of a fire alarm, we should follow the directions of the ushers?

09:32

Adolygiad Seneddol o Iechyd a Gofal Cymdeithasol yng Nghymru—Sesiwn Dystiolaeth gydag Aelodau'r Panel Adolygu
Parliamentary Review of Health and Social Care in Wales—Evidence Session with Review Panel Members

[2] **Dai Lloyd:** Gyda chymaint a hynny o ragymadrodd, gwnawn ni symud ymlaen i eitem 2, ac adolygiad seneddol o iechyd a gofal cymdeithasol yng Nghymru—sesiwn dystiolaeth gydag aelodau'r panel adolygu. Rydw i'n diolch yn fawr iawn i chi'ch pedwar am eich ymddangosiad y bore yma, yn naturiol, i fynd dros yr adroddiad interim. A gaf i estyn croeso, felly, i Dr Ruth Hussey, cadeirydd y panel adolygu; Jennifer Dixon, aelod o'r panel; Eric Gregory, aelod arall o'r panel; ac hefyd yr Athro Mansel Aylward? Croeso i chi'ch pedwar. Yn ôl ein trefn arferol, yn naturiol, rydym ni i gyd wedi darllen eich adroddiad mewn manylder dybryd, felly awn ni'n syth i mewn i gwestiynau. Mae'r cwestiynau cyntaf gan Caroline Jones.

Dai Lloyd: With those few words of introduction, we will move on to item 2, a parliamentary review of health and social care in Wales, and this is an evidence session with review panel members. I'm extremely grateful to all four of you for joining us this morning, when we will look at the interim report. So, may I extend a warm welcome to Dr Ruth Hussey, the chair of the review panel; Jennifer Dixon, a member; Eric Gregory, also a member of the panel; and Professor Mansel Aylward? So, a warm welcome to all four of you. As per usual, we've all read your report in great detail, so we will move immediately to questions. The first questions are from Caroline Jones.

[3] **Caroline Jones:** Good morning, everyone. Your interim report states that there's a compelling need for change regarding health and social care, and it also says that a bold vision is needed. Could you tell me, please, what action is needed to make this step change?

[4] **Dr Hussey:** Thank you very much indeed, and thank you for the opportunity to come and address the committee. I think it's fair to say, in the evidence that we've gathered and the strength of the case for change, both in terms of the changing patterns of need, the changing population distribution, the ongoing pressure on costs of health and care and, indeed,

the desire to improve outcomes, that the need to rethink how to offer care that better meets the needs of the population in Wales is urgent, and I think we say that very much in the report. We make 10 points, and the first one, clearly, is around the need to develop a vision and a concrete strategy to achieve that ambition. One of the areas that we found that was significant is that there was a strong consensus around the need for more services in the community, more locality working, care based around the home, more preventative care, and a strong focus on quality. That came through very strongly. There was a real consensus around all of that. However, what people also said is, 'So, what's the vision?' So, we proposed the idea of, in the next phase of our work, helping to make that vision more concrete by developing a range of ideas around the principles of models of care—what care might look like in the future—so that it becomes more tangible, and that would enable a vision and a strategy to be developed, based on a clearer understanding of what people were trying to achieve. I'll pause for a second in case colleagues from the panel want to add any points around that.

[5] **Mr Gregory**: I'll just add to that, if I may. There are a lot of quite impressive initiatives going on in Wales in a number of areas, and what we're looking to do by working together with the health and social care sector is to develop a framework for, in part, deciding which of those are the most important and should be taken forward and will meet long-term goals. The second part of our work over the next six months is very closely going to involve the professionals, the experts and citizens—the people of Wales. It's very much about the workforce and the people of Wales being involved in what I would call designing their own future, because you're not going to be able to deliver a refreshed vision and strategy without that kind of engagement. So, that's going to be a big focus of our work over the next few months.

[6] **Caroline Jones**: Okay, thank you.

[7] **Dr Dixon**: Thank you. Just to add: what we found was that there was quite a lot of consensus, as Ruth says, about the 'what', although that could be described more pithily and stronger, we think, at a national level. But, actually, the issue here is how to make change faster, and I think that's really a big area that we need to focus on.

[8] **Professor Sir Mansel Aylward:** Yes, and I think that what's different about this review is that lots of reviews in the past have paid lip service to involving the public, citizens and service users—or patients, as I still prefer

to call them—but actually, we're doing something that I've not seen in the past, and that is involving the people in making decisions about what they want for them and what sort of vision they want. And they want a vision whereby as a citizen of Wales, they have a health and care service of which they are proud, and which provides them with a satisfying service. And as a worker or as a healthcare worker, they also feel proud of the service that they deliver. Now, they may seem subjective words, but I think they are very important. We must have a vision that also reflects what the people think and what the people working in those organisations think, and indeed what Government thinks and what people around this table think. I'm sure that you will think, as members of this committee, that you've done your job well if we get a vision of that sort, and you are more likely to be re-elected next time. [*Laughter.*]

[9] **Caroline Jones**: Thanks for that.

[10] **Dai Lloyd**: A pithy consideration, if I may say so. Angela, you had a supplementary.

[11] **Angela Burns**: Yes. I just wanted to pick up, if I may, on a point made by Jennifer, which I've marginally rehearsed with Ruth already, but I'd like to have the opinion of the rest of the panel. You talk about the fact it's about how, the 'how' to do it, but have you also identified what have been the real barriers to the successful implementation of change? Because we've—. Change has tried to be promoted throughout the NHS for the last decade and more, and somehow there's just this gap, isn't there, between all the great policies and some of the great initiatives, and then there's space in the middle? So, you talked about the fact that you're going to concentrate on the 'how', but you can't really concentrate on the 'how', can you, unless you've identified what the current barriers are? I wondered if you'd done that, because that's the thing I didn't quite pick up from the report.

[12] **Dr Hussey**: Pretty much everyone's responded. I think Eric would also contribute.

[13] **Dr Dixon**: I think we were very struck by what people were telling us, and also the OECD analysis of the UK health system about the need for a stronger guiding hand, and there's a variety of tools that can be used in that guiding hand that need to be examined to see whether or not the blend in Wales is right, and whether or not there's more thinking that could be done about that.

[14] There are also some basic infrastructure issues, which I know that my colleagues have looked at: IT, workforce, some absolute must-dos that need to be—. We all know the workforce problems and shortages. How IT could be mobilised more effectively to serve and improve healthcare through, for example, making data more accessible, for greater data linkage and so on. There's also something to be said about the management structure across the NHS, across the UK—the management numbers, the skills and so on—so that's another aspect. And then, also, that's not to forget the clinical community that has often, sometimes, estranged from management must-dos—how to engage them in bottom-up change of the type we really want to encourage in their talent. And that's where we focus in the report: on quality improvement, and how to skill them up in quality improvement in a bigger way than, perhaps, from the useful start that's already been made in Wales. So, those are some ideas that we're going to be exploring.

[15] **Angela Burns**: So, the absence of those currently, are, in your view, the current barriers to the changes that we've all been seeking in the NHS.

[16] **Dr Dixon**: I think we believe that progress is being made on all of those as they are across the NHS, across the UK. And to be quite frank, nobody has got this blend right; everybody is trying to—

[17] **Angela Burns**: Sorry, I'm not trying—. Forgive me, but the answer is coming across quite defensive. I'm not trying to—. In business, if you're trying to reengineer business processes, you have to really identify what have been the barriers to being able to successfully do that to date. So, it's not that—. You know, we all accept, throughout the whole of the UK, Wales, England, everywhere, there are massive changes. What I'm trying to understand is, because we want this to work, and I think that this is a great start: we've got to really understand what those barriers are, and I still haven't been able to hear that, from the Minister or from any of us, you know, a clear identification. Because once we've got that taped, then we can move on to the next stage, I would have thought.

[18] **Dr Hussey**: I think Jennifer's highlighted—I'll bring Eric in—the sort of range of issues. I think the key thing is being clear what the future looks like. Are we clear on the outcome that's being aimed for? And then the methods for implementation: are they organised well? Have they been aligned effectively? Eric, do you want to come in on that implementation approach to transformation?

[19] **Mr Gregory:** Yes. Wales isn't lacking for initiatives, as you've said, Angela. But they have not been brigaded properly together, prioritised, et cetera. So, I think there's a lot around the framework here. We've already talked about vision and strategy, and from that, closed objectives, and from that flow change programmes, if I can call them that, and underneath those are metrics and success measures, whether they are improved patient outcomes or whatever they might be. And, in all of that, I think there is work to be done, which has certainly come across in all the evidence gathering, around prioritisation. So, are we doing too many things? Should we be focusing on the most important initiatives and really driving those through? What's the standard structure in place for business benefits cases around all of this? So, there's much greater clarity around that, which helps you decide on prioritisation.

[20] Are the governance arrangements appropriate and effective in terms of authority and responsibility for driving this? Is there proper engagement across the piece? So, if you look at digital, for example, there are a lot of very good things going on, and there are a lot of positives about the digital sphere in Wales, but there are some challenges around point-to-point relationships with health boards, for example, in terms of agreeing what's going to be driven forward. Is the public properly engaged? Going back to my point about designing your own future.

[21] And then there's a process of actually delivering change: how mature is that? How flexible is it in Wales? How are the outcomes of changes measured? What's being done in terms of learning from initiatives that have been successful or otherwise, and applying those lessons to changes in the future? There's a reasonable amount of work being done in all of these areas, but, I think, in order to deliver substantial, what I call, transformative change, all of that framework needs to be properly in place. I don't know if that helps.

[22] **Angela Burns:** Thank you. Yes, it does.

[23] **Professor Sir Mansel Aylward:** May I come in as well, please? You will recall that the OECD, in its last report, mentioned that, in Wales, we had innovation but we lacked capacity to actually exploit that innovation, and that something needed to be done about that. And we shall be looking at that in the next six months. But we do have quite large areas where innovation is evident, but they're not being gathered together, and people are not being

encouraged. I think one of the biggest barriers to change is not encouraging people with new ideas, with new practices.

09:45

[24] Now, there are a number of pieces of evidence that we've heard of where that can be done and that can be garnered. I think that, if we encourage that, we lessen the fear that people have that their ideas are not being heard, we promote a locus of control, which I think is one of the reasons—a major barrier to change—and we encourage self-confidence. Those are the issues that I think are imperative to be addressed—and we have been very well aware of that—if we are going to remove those barriers, because they're not structural barriers, they're people barriers, and that's where we've got to strike the most.

[25] **Angela Burns**: And perhaps we need to allow people to make mistakes—

[26] **Professor Sir Mansel Aylward**: Indeed.

[27] **Angela Burns**: —because then we can learn.

[28] **Professor Sir Mansel Aylward**: Indeed.

[29] **Dai Lloyd**: Ruth, briefly, before we move on to Caroline.

[30] **Dr Hussey**: And I'll just bring Eric in on a point as well. I just want to emphasise that we set out with the ambition that this report focused on health and social care as equal partners and what we've seen and heard, listening to people at the front line who are really trying to bring those services together in a holistic, integrated way, is the importance of, as Mansel was just saying, listening to people's concerns, fears, designing around the user—they use Mrs Jones in the example that we talk about in the report—and constantly putting the person they're trying to support in the middle of the conversation but also finding ways of really understanding what each member of the team brings to it. And they talk about how it helps them manage their concerns, because you're making choices that affect people's lives. So, there are some real lessons, I think, from the practical experience in Wales, and the report really focuses on 'don't start with the structures; start at the front line. Make it easy for the front line to do what they want to do with the people they serve.' Really: is everything else aligned

behind that through that integrated whole-system approach? And that's really what we're trying to get across. Did you want to come in with a point?

[31] **Mr Gregory:** Yes, I was just going to perhaps build on that. I think one of the ways of looking at this is to talk about what I call service change initiatives and not to talk about digital initiatives, for example, because digital shared services, et cetera, are really, really important what I call 'enablers' of an overall change and change needs to be viewed in that sort of integrated, collaborative way. There are a lot of good examples in Wales, and one would be something like the Efficiency Through Technology fund. We mustn't lose sight of the opportunity to encourage the involvement of third parties—academia, et cetera—to quickly develop initiatives that have possibly real potential and to drive those through as well. So, there are opportunities for really substantive changes that'll make a really positive difference but also what I'd call some quick wins as well. We need to get that balance right.

[32] **Simon Thomas:** Okay. Caroline, moving on to your question 4.

[33] **Caroline Jones:** Diolch, Chair. Do you envisage a need to develop new models of care that work differently in rural and urban areas?

[34] **Dr Hussey:** Yes, in the way that we're starting to think about this, we're very mindful that there'll be a different combination of things—different challenges, a different mix. We know that the populations are different, the availability of workforce is different, and we know that there are opportunities to blend services in a different way. So, we're very mindful that, when we go through our thinking around the models, what we really want to concentrate on is: what are the core principles, the design principles, that we're trying to get to? What can the person using services reasonably expect and understand these services will do, wherever they are? And, then, what are the differences in how to do them in different communities? We talk about services in the community, but it's actually quite hard for people to know what's available. So, these models are about telling people.

[35] The other thing that's really changed in recent years is, actually, some of the things that would have been unthinkable to do outside a hospital setting you can now do in people's homes. Now, does everybody understand that? Are we explicit that this—? Do we give people information that helps them make those choices? So, there's a whole set of issues about being clear on the design principles, clear on the types of services that can be possibly delivered, and then what's different about a rural community and how might

they need to be brought together in a different way because there are particular challenges.

[36] **Caroline Jones:** We communicate so differently now—in the last sort of 10 or 15 years—from what we did, but we have to encompass every person in the environment, so how do you envisage reaching everyone—in rural areas particularly?

[37] **Dr Hussey:** In rural areas? As you rightly say, the methods of communication have developed extensively, but what we mustn't also assume is that everybody's now using the internet and social media and everything else. So, public voice is a key area of our work. We've heard lots of different issues raised about public voice and public involvement. It's one of the six areas we've highlighted that we want to have a look at, because really seriously being able to involve people in the design of services, in their own health and well-being—. We've heard from people who use services saying, 'If I was able to have this—', you know, 'more information, access to my records—', various things, 'I could do a bit more myself'. So, that's the first level of engagement. That is mostly done through staff and the users of services working together.

[38] Then there's the second level, which is the design of services and how we engage the wider community in the design of those services, and, again, there are different ways of doing that. And then the third level is being clear on the respective roles and responsibilities—'What can I reasonably expect, as a citizen of Wales, and what's my contribution to that in the round?', if you like. So, the report tries to disaggregate the thinking around that, but it's an area we want to look at. I'm going to pause and see if the panel want to come in.

[39] **Dai Lloyd:** Sorry, we'll be drilling down on the details now as we go on. By the way, there's no need to feel that all four of you need to answer all the questions—

[40] **Dr Hussey:** I don't want to deprive them of the chance to contribute.

[41] **Dai Lloyd:** —otherwise we'll be here for days—and, frankly, some of us have to eat and sleep at times. [*Laughter.*] So, moving on, Dawn has got some issues.

[42] **Dawn Bowden:** Thank you, Chair, and good morning, everybody. It's

really interesting what you've been saying already, actually, but I just wanted to ask you a little bit more about—or a bit about—the role of the third sector and what you heard from the third sector in terms of what they feel that they can contribute, possibly, to service design—redesign—and prevention in particular, and actually whether they've got the capacity to do it. We had a session yesterday with the NHS Confederation on mental health services here, which I know we're going to come onto afterwards, and the third sector are saying they're really heavily involved in it, really want to do more, but capacity is a problem. So, just to get some views from you about the role of the third sector in all of this—.

[43] **Dr Hussey**: I'm going to make a comment, but I'm going to bring Mansel in fairly quickly, so I don't—. If I can have a chance to comment—. [*Laughter*.]

[44] **Angela Burns**: His bark is worse than his bite. [*Laughter*.]

[45] **Dr Hussey**: We have talked to a number of people in the third sector, mental health in particular, but also others. We're clear they are a part of that wider community of people who can support preventative approaches and support people in making a shift to be more independent and so on, and offer services in a more flexible and different way. But, Mansel, do you want to pick up the particular views that you've heard?

[46] **Professor Sir Mansel Aylward**: Yes. In fact, first of all, the value that the third sector brings, and can bring, and can be exploited in the best sense of the word, is—to use an unusual word—terrific, actually, because we've not exploited them in the past. However, what we gathered from several of them was that they felt that they were undervalued, they felt they were marginalised, they felt that, in their dealings with health boards, they were the nominal third sector, that they weren't, in any way, exploited to the extent that they'd like to be, and that part of the reason why they were unable to have the capacity to build capacity was because they weren't being used, and I think this is a message that we will need to get across to health boards. It's felt very strongly amongst several. The other aspect is that, particularly in rural areas, we find that the third sector plays a very important role, and that, again, is not exploited.

[47] **Dawn Bowden**: Is this both in health and social care?

[48] **Professor Sir Mansel Aylward**: This is in both, yes, but I was speaking

of the views that they expressed in regard to the health boards.

[49] **Dawn Bowden**: To the health side, yes.

[50] **Professor Sir Mansel Aylward**: In fact, the views they expressed in regard to social care were that they worked much more in harmony with social care and delivered social services in a much more effective way by being integrated. They are under-resourced, but I think their value can only be recognised, and therefore resources can flow to them, when their value is fully exploited by the health services, and they're not.

[51] **Dawn Bowden**: And they're not at the moment, no. Okay—

[52] **Dai Lloyd**: Before we go on, Lynne, did you want to come in at this point?

[53] **Lynne Neagle**: Yes. I mean, I know we're going to—

[54] **Dai Lloyd**: And then Julie.

[55] **Lynne Neagle**: —come on to mental health and look at young people as well, but the report does highlight the concerns that you heard about the emotional health of young people, and you specifically mentioned the youth service, which I was very interested in, and you highlighted the fact that a lot of the funding is short term, and that is not complying with our duty for prevention. I just wondered if that was going to be developed further as you complete your work on this.

[56] **Dr Hussey**: I think what we've tried to do is set out what we've heard people raise with us. So, the key message we've tried to convey is the importance of having a long-term view of what's being aimed for, and to do that looking at what gets in the way, stopping people being able to be part of that long-term view. So, if people are worrying about annual contracts, or short-term contracts, and so on, it isn't conductive to building the sort of relationships that Mansel was alluding to, which are necessary if you want to have a range of people, different providers, as part of that long-term landscape. We've had similar conversations with social care providers. They see themselves as part of the conversation going forward, so it's about what you need to have in place to build those long-term relationships.

[57] Now, clearly, if they're new services, then there's a need to evaluate

them properly, and also to be brave and say, 'Actually, those services haven't done what they were hoping to do', and they either need to adapt and reform or something else is needed. So, just being clear whether these are things that you want for the long term, and therefore building that long-term relationship, and which services are the ones that you want to try and test and evaluate in a constructive way to make sure you're actually getting the best impact on the things that really matter, which are the outcomes and the value for the population.

[58] **Dai Lloyd:** Okay. Julie, did you want to come in on this one? We'll go back to Dawn, then.

[59] **Julie Morgan:** Yes, it was just this issue about the relationship between the third sector and I think, Mansel, you said the health boards. You identified this as a particular issue, the actual relationship between the third sector and the health boards. Were you able to establish exactly what that was? What was the problem with the health boards?

[60] **Professor Sir Mansel Aylward:** I was able to establish that there was this feeling by the third sector that the full value of what they could bring was not being used to its greatest extent. I also obtained a feeling from them that they could contribute more fully, and were not being used. So, I've really said the same thing twice now. That's something that we're going to be looking at. This is the evidence that we've gathered, and we're going to be talking more in our future events and stakeholder events, and with the third sector, to elaborate on that and find out what possible recommendations we may make in that regard.

[61] **Julie Morgan:** Because that does seem a crucial area, doesn't it?

[62] **Professor Sir Mansel Aylward:** It is and—

[63] **Julie Morgan:** Because particularly the voluntary sector and charities bring their own money to begin with into the equation, and also they're able to reach people that statutory services can't reach. So, it just seems to me it's a crucial area for you to look at—to take forward.

[64] **Professor Sir Mansel Aylward:** We recognise that, and we've picked up that. The other thing is, with regard to local government relationships, although they're better, and I gathered that social services interaction was better, nonetheless there was a problem with payment—I think Ruth has

alluded to that already—whereby they may have put up some money in the first instance out of their own pockets, and that money may sometimes not even be paid, or be delayed so much that it compromises the actual intervention—a successful intervention can't be completed because the money doesn't turn up, and they may wait six months, 12 months, or 18 months for that money. We've picked up that, and that's another thing that we'll be looking at.

[65] **Julie Morgan:** Thank you.

[66] **Dai Lloyd:** Dawn.

[67] **Dawn Bowden:** Thank you. Just in terms of good practice, I suppose, and what Welsh Government could do now, because obviously this is an interim report, you've got a final report to come, and there could be a little bit of time yet before we get all your proposals rolled out, shall we say—you did identify already some areas of good practice, and I'm just wondering whether you think that there is evidence from the good practice that you've already found that Welsh Government could start to roll some of these things out immediately, rather than waiting.

[68] **Dr Hussey:** Perhaps I'll pick that up and colleagues might want to comment. I think one of the things that we're mindful of is clarity about what success actually is in practice. Some of the models that we've seen look very promising, and they have some of the measurement that you'd want—maybe better outcomes, or better processes of care—but you actually need a rounded picture: 'Is it better value?'

10:00

[69] Because coming back to the big picture here, people have got to be mindful of the pressure on the costs of health and social care and seeking to be more efficient and more productive. That's why one of the areas we're very interested in is, 'What are the high-level success measures that you can then test these models against?' So, there's a clear understanding that it isn't enough to have a bit of the picture, and I think often the frustration of the third sector is that they've got some of the evaluation, but they haven't got the whole picture. Jennifer, do you want to talk a bit about evaluation and what's needed?

[70] **Dr Dixon:** Yes. In my day job, I've been evaluating these things for

some years—these new models of care. And the first thing to say about them is that they are often adapting, growing things—they're not something that is hermetically sealed you can roll out. So, that's the first thing. And no-one knows how far they can develop, but it's an iterative thing. So, the second thing you need is an ongoing kind of assessment as to what impact they're having. In other parts of the UK and, indeed, abroad, there seem to be two main ways of doing that. One is to develop with these new models themselves, including the public, a set of dials, metrics and measures that they all find are valid and monitor those. But, importantly, a sort of central assessment of evaluation of their impact is crucial, because otherwise what happens is that the models can draw the wrong conclusions about whether they're being successful or not, because they're not comparing themselves rigorously with others.

[71] So, it's just a small suggestion, but what we could help with is that we at the foundation where I work have set up with NHS England exactly this kind of support, which is, again, in turn, modelled on what CMS have done in the United States of America with accountable care organisations, to have the most rigorous central analysis of impact, and then not just for the nationals to monitor, but for the local sites to know, and then they can course correct as to how they're developing. So, there are some practical suggestions for you, and this definitely links to the third sector, because a lot of third sector organisations have enormous burdens of proof put on them by potential commissioners, and they can't do that. So, how to lift the weight off them is important.

[72] **Dr Hussey:** Eric wants to come in.

[73] **Mr Gregory:** I'll just pick up on the vision and the new models. I don't think we should lose sight of the opportunity to improve what's already in place and to learn from best practice from what's already in place as well. So, there are highlights from the NHS Wales efficiency, healthcare value and improvement group, which is chaired by the chief executive, I think. I would expect that to have quite a lot of muscle and influence in being able to examine unwarranted variations, waste across health boards—whether it's to do with estates cost or staff or medical costs—and to be able to help drive improvements in that area as well. That's kind of an immediate thing that should be going on now, and it's all set up to actually do that as well. So, that just needs to be leveraged.

[74] **Dai Lloyd:** Great. Dawn, are you—?

[75] **Dawn Bowden:** Yes, just a couple of final quick points. I was very pleased to hear you talking about the involvement of staff in the discussions that you've been having. In my previous life, I spent an awful lot of time telling NHS managers that if they wanted to get things right, talk to the staff on the front line and they'll tell them how to get things right. So, I'm really pleased that you're doing that. Are you confident from what you've seen so far and heard so far that the final report is going to be able to deliver the kind of change that we think we need? And just a throwaway remark, really: have you really found anything so far that you didn't already know, or has this just confirmed what you had thought?

[76] **Dr Hussey:** On the first point—'Will the report lead to change?'—I have to say the panel have put hours of work so far into thinking about the issues, bringing external challenge into the thinking, but also listening carefully to a wide range of people. We've had patients, we've had staff and all sorts of different people involved in telling us how it is for them. Obviously, some of us have worked in Wales, but for the panel, really getting to understand—and I'll bring colleagues in as to comments on whether they've heard things they didn't already know. I think it's brought into sharp relief the things that matter to people who are trying to deliver the services, and helped to clarify, for me, some of the possible barriers that need attention. But maybe colleagues who are not so familiar, and Mansel as well—what are your reflections?

[77] **Professor Sir Mansel Aylward:** I know Wales quite well. I learned nothing new in the sense of a completely novel issue, but what I did find that was new was how important it was for staff themselves to feel involved, and how many of them, again, felt marginalised, that they weren't being listened to. And when I'm speaking of staff and the workforce, I'm speaking about everyone. I'm not talking about any particular level. That is something that I didn't realise before—how readily staff are willing to talk, how readily they are being very frank and open, and how readily they would like us to have them involved and help them perhaps to relate better to their managers, or better to other staff, or better to service users. And that is something that was new for me. It was a new area, a new resource, which we hadn't exploited to the full.

[78] And, similarly, we intend to engage with the public in a much more meaningful way in the next few months, but already, although there hasn't been the reception by the public as yet of our interim report—and I don't

think it will be something like a major item—nonetheless, people have been talking to me in my social life about it, and saying 'This is interesting. What's going to make this report different?' And I said, 'The difference is we're going to involve you.' So, that's something where I think, 'Those are the new things', but otherwise, what we're doing is: we know there's a case for change, everybody's talked about it, but what are we going to do about it?

[79] **Dai Lloyd:** Okay. Can we move on? Because most of these will be covered anyway. Lynne, did you want to come back on integration?

[80] **Lynne Neagle:** Thank you, Chair. You've suggested that, despite legislation, existing health and social care structures are not well integrated. To what extent is that due to the different policies and priorities that are emanating from Welsh Government, and whether they are sufficiently aligned? And do you think that the legislation that we've got in place is providing us with the right tools and levers to secure integration?

[81] **Dr Hussey:** Okay. I think that one might fall to me, but I hope colleagues will join in. We're very clear that we talk about whole-system services. So, I think we've seen the strength of opportunity, if you like, from a holistic alignment of services, and not just health and social care, but the importance of housing as well. If home is where care is going to be in the future, you need to think about integration in a broad sense. That's the first point.

[82] The second issue, on your question around the legislation—I'll come back to the policies and direction—on the legislation, I think the panel, generally, has been impressed with the framework of legislation—not putting words—about future generations. People in other countries are thinking 'This is very powerful stuff.' It sets that public sector expectation. In the social services and well-being legislation, one of the things—. First of all, it does push towards preventative approaches, citizen engagement and user engagement very clearly, which I think is very powerful, and we've heard examples of people talking about how they're starting to use this. One area that I would flag up is that I'm not sure the NHS is fully engaged in understanding that it applies across both sectors. There are key parts of the legislation that are actually for both sectors to work together. So, there's something about thinking through the legislation.

[83] There are opportunities through the way the agencies come together. So, when we talk to the front-line people who are trying to do this

integration, they want—what they're telling us is: co-location has been important for them to build teamwork; shared IT systems, so they're not using two computers; and infrastructure that helps them do the things they need to do together as a team. So, what that opens up for us is, if you work back up the chain: what are the things that sit behind all of that that get in the way—the barriers that we were talking about before? So, you could look at management arrangements, or you could look at use of capital to create opportunity for co-location. You can look at the regulatory framework, and colleagues may want to comment on that. So, you go up the chain, if you like. What we didn't want to do was come in at the structural conversation, but really try to see if you can start from the front line and then work backwards in terms of what things need to be in place more and more to help overcome the barriers. So, they can describe to you the things that they uncover: policies, practices, cultural things, as well as systemic things that need to be adapted and changed, and they work through it. So, those are some of the areas we found. Colleagues, I don't know if Jennifer or—

[84] **Professor Sir Mansel Aylward:** I think, like all Governments everywhere, there are some silos. There are some disruptions in thinking and in policy making across groups in the Welsh Government, as elsewhere. But that's been addressed to a significant extent by the health-in-all-policies approach that we are now seeing. That has made a big difference. The other thing is: is the legislation appropriate? Yes, it is. I think that the well-being of future generations Act, like the NHS, is another jewel in the crown of Wales, because wherever I go in my perambulations, there is always one thing that they bring up: they bring up the NHS, and how good it is in the UK, but they also talk about Wales being the only country in the world that has put well-being at the centre of its policy making and its objectives. I think if we adhere to that Act and if we look at achieving those goals, which encompass health and encompass well-being, obviously, and look at transport and education and whatever, we're on the right road. So, the legislation is there, it's just that we've got to exploit it to the maximum extent.

[85] **Mr Gregory:** I think the principles set out in the various items of legislation are really good and they're excellent for a framework. I think some of the challenge around this area is cultural. There's not been a shared working experience between the health and social care sectors in the past and one of the things that we want to do in the second half of this, via the stakeholder group that we're talking about setting up, is to encourage that. We've also already encouraged it via some of the workshops that we've held in the first part. So, we've got some goodwill and traction there, which we

really want to leverage going forward in the second part. When there's a collective understanding that there are shared benefits, particularly for patients and citizens, then I think you can get that kind of traction working together and an understanding that things can be done about organisational barriers and financial barriers and that sort of thing.

[86] **Dr Dixon:** Just to add, most of my working life is steeped in English policy, and Scottish, to an extent, as well. The stories told in England, are, of course, that if you have, as on the health side here, integrated boards, effectively—you don't have a provider split—then it follows that there will be greater integration. I think one of the surprises that I've had here is that that doesn't necessarily follow. So, it's not a structural issue, going back to what people have said, or indeed a legislative issue; it's about behaviours and goes back to the people, as you have said. So, the question is: what would unlock change there? For example, at the moment, there are a lot of resources continuing to grow in the hospital sector and not enough in primary care, for example, given the shifts we want to see. So what could affect that simple change of relative growth? That's something that we will want to do some more work on.

[87] **Lynne Neagle:** My second question was going to be whether the two separate structures are fit for purpose. It sounds as though you're saying that it's a work in progress and that you're trying this bottom-up approach to get that better integration. So, I think my question would be: how long is that going to take and have we got the time to do that?

[88] **Dr Hussey:** I think, for most of us, the experience is that if we think having two structures coming together will change that cultural practice on the front line, history would tell us probably not, and it will take a lot of leadership energy to do the organisational change bit, but it would carry on leaving people trying to deliver the services and trying to make sense of some of that. There are some views that say, 'Yes, but if you signal very clearly that the organisations are coming together, then that'll help the front-line transformation.'

10:15

[89] I think our starting point is: be clear what the front-line transformation is about and what are you trying to achieve, and then the rest becomes a question of getting rid of barriers that are getting in the way. So, that's why we've really focused on—if you don't really pay attention to the

culture, the practices, the organisation of services, what matters to staff and the users, then you could get very busy doing some of this structural change.

[90] Your question was: how long do you wait to do that? Well, the urgency that we try to get across is that the case for change now is not something that's coming in the future. People are feeling it now. We're living in the case for change now. You only have to talk to the staff in each sector, each bit of the system. They can tell you how hard things are. There are services that people can tell you that they may not get full access to.

[91] So, I think the issue is creating the urgency about that transformational change. Now, as I say, assuming that there's some backstop that's structural, I think, is an area we'll probably explore a bit more.

[92] **Dr Dixon:** There are other nudges that can help nudge the behaviour in the way that you want, if you want integration, and you have to think of a range of tools here. One is the regulatory tool, for example, another is using a different range of financial incentives on budgetary arrangements without the structural—. So, there's a range of tools that I think we're interested in looking at.

[93] **Lynne Neagle:** Ruth, you mentioned housing as being important. We're all familiar with the budget around here, where health is the big winner and we often have to fight for things like Supporting People. How key is it that we do protect investment in those housing programmes that underpin all this, then?

[94] **Dr Hussey:** I think I said earlier on in the session, if 'home first' is the building block of the new health and social care system for Wales, then home has to be part of the understanding of the new capacity, if you like. So, being clear in terms of the settings that health and care estate conversations are surrounded by—it's got to be, 'What is possible to support people living at home?'

[95] There are also, if you like, conversations to be had about what sort of housing is needed to keep people independent so they don't need to come into the health and care sector, because they're able to manage with adaptations and services in a different way—a different home setting. So, I don't have an easy answer about how to think about that, but I think the first thing is openly recognising that that's got to be part of the equation. In some parts of Wales, it's pretty urgent, isn't it, to have choices, so that people can

actually choose to be independent and stay at home, and the way services wrap around those choices is absolutely key.

[96] Now, I know there's been a report from Judith Phillips and colleagues earlier this year that does set out—I mean it's not for us to go into the whole housing debate, but I think we did want to signal that there's a key relationship there that needs to be tested and worked through.

[97] **Professor Sir Mansel Aylward:** Could I just say, quickly, declaring a conflict of interest, I did a review of Supporting People some years ago—

[98] **Lynne Neagle:** Yes, you did; I forgot about that, Mansel, to be honest. I had forgotten, but when I asked the question, I did—I should have credited you. [*Laughter.*]

[99] **Professor Sir Mansel Aylward:** No, no. I staunchly defended—

[100] **Lynne Neagle:** I know you did.

[101] **Professor Sir Mansel Aylward:** —funding. The reason for that was the huge effect that Supporting People has, the programme, on improving the health of the most vulnerable in our societies. So, we're not going to neglect thinking about things like that.

[102] **Lynne Neagle:** Brilliant, thank you.

[103] **Dai Lloyd:** Angela, you're making overtures there; I take it you want to ask a question.

[104] **Angela Burns:** Yes, please. [*Laughter.*] Definitely. Within your report, one of the things that really struck me as an enormous wake-up call to all of us was when you were talking about intrinsic levers, and you've mentioned culture quite a lot, and quality improvement. I thought that your chapter on quality improvement actually was quite a slap in the face, because I think it's very stark and I think we probably needed it, all of us, because it's across the political spectrum. But, to get that quality improvement, it's got to be about the staff well-being, and what I wanted to know was what kind of—. Going forward in the next bit of the interim—to finalise the report, what discussions will you be having or how will you look at how we can change the culture within the NHS? Because everyone starts out as wanting to do their best, et cetera, but when you're under pressure, when you're absolutely exhausted,

when you're the only guy or girl on duty and it's the dead of night, you know, quality starts slipping, that ability to repeat good practice consistently and coherently starts to slip. So, I wonder what you might be able to do to—or what emphasis you're going to be putting on how we change the culture within the NHS, because that will make all these other things that we've talked about flow really importantly. And will you be talking to people like clinical psychologists? Also, there are some outstanding heads of employee well-being within some of our health boards, who I'd like to give a shout out to, because I think that they really understand what the problem is, even if they haven't been able to drive that change through. Staff mustn't ever be frightened to criticise or make a comment or say, 'This has got to improve'. But the culture does not allow that and stifles that, and then we have people off with stress and all the rest of it.

[105] **Professor Sir Mansel Aylward**: I think the single focus in both the workforce strategy and, indeed, one of the major messages that we want to get out, I'm sure, because of what we've heard already, is how important the culture is in all areas, not just in the one of quality improvement. But the main way of getting to that is valuing the staff.

[106] There are a set of values that the health service has. Each health board has also got a second set of values that they apply, but they're not being applied in the sense of being lived by, and I think that's a message that we've got to get out. They don't just have a set of values and they're in a book and we've got them and that's it. They've got to plan their integrated medium-term plan, they have to use the way in which they work with their staff with each set of values underpinning everything they do and so that the staff know they are being valued in that sort of way.

[107] Also, I think instilling a belief in the system—. Because many staff are disillusioned. They've lost morale, and they've lost that because of the pressures that all of them have had on them. I think there has to be a more sympathetic and empathetic look at that, both by middle managers and by senior managers and, really, at all levels, to know the pressures that staff are under. Unless you approach it in that 'people' way, in looking at beliefs, attitudes and ways of working, we won't proceed. It's soft stuff. It's nothing where I can say, 'Do this and this will happen'. But it's valuing staff, caring for the workforce. It's something that everybody has lip service for but they don't actually practice to the extent that they should, and I understand why: because of the pressures. But it's got to be No. 1 in ensuring that we have a better delivered health and care service.

[108] **Dr Hussey:** Jennifer and Eric would like to add to that.

[109] **Dr Dixon:** Just to say we had a wonderful meeting with about 50 junior doctors in Wales and also some nurses as well. They brought tears to your eyes because they were so talented and so motivated, wanted to make change—could see changes every day they wanted to make. What they felt was they didn't have the skills to make those changes. They wanted to be skilled up in quality improvement skills. They also felt as if, if they tried to make changes, they didn't get support from the managerial layer and, therefore, some kind of support nucleus, if you like, inside some of these organisations would have helped them. And then the leadership didn't really—the leadership was very busy, targeted and focused on the must-dos, the financial balance, the waiting times, and wasn't really in the same space as them and helping them think through more everyday items that absolutely needed to change. So, skilling up and support from management were two big, practical things.

[110] But the third thing they said, which was rather chilling, was that they all felt like transient workers. Here were they, fresh, enthusiastic, talented, but they felt that they were here and there, gone in a few months, no-one invested in them. And they are the future, really, they are the ones who will shoulder this health system. So, there's quite a lot to be done about the junior ranks and about how they can be supported—skilled up in QI, but actually skilled as valued members. That's something we have got to tackle, because, really, the talent is all there. That's the issue.

[111] **Dai Lloyd:** Or loved by management, I would say, as opposed to mistrusted by management.

[112] **Dr Hussey:** They also are very good eyes and ears because they actually move into different settings, so they actually can compare as well. Eric, do you want to add?

[113] **Mr Gregory:** Well, I know from my working experience in the private and the public sectors what difference to an organisation's health having an engaged and motivated workforce makes. I've seen that in the public sector, absolutely, not just the private sector as well. There's no doubting the commitment and professionalism of the individuals working in health and social care in Wales. I think there are some immediate things that could be done, some quite simple things, to gain a bit more traction around this.

There should be a full annual staff survey. At the moment, it's not regularised and it's not across the board, but, more than doing that, that is a platform for staff's views to be listened to by management and leaders. What should come from that is a very clear set of actions, not all necessarily delivered by managers—quite often, the staff should be enabled to do that—and a very clear improvement programme that's associated with that. That will give that whole process credibility and a belief from staff that their managers and leaders are actually listening to them and delivering on the key challenges that they've exposed in that. I've seen that work very effectively in the public sector, and that's something that could be actioned now.

[114] **Dai Lloyd**: Okay. Time is marching on now, so from now on, short questions, short answers, really. Lynne—mental health.

[115] **Lynne Neagle**: The report states that the road map for improvement across the whole mental health system is not clear. Would you agree that there is a lack of meaningful success indicators to highlight whether things are getting better or worse in mental health services?

[116] **Dr Hussey**: I think—in the interest of short answers—we heard people suggesting that, whilst the mental health Measure had helped draw attention to certain things, it, in some places, was a process, and that there was a need to think through what success looks like, in mental health as much as any of the other areas that we've talked about, as well. Do you want to comment?

[117] **Dai Lloyd**: We'll move on. My main attack dog is Jayne. [*Laughter.*]

[118] **Jayne Bryant**: Just as it's getting to short questions and short answers. [*Laughter.*] You say in the report that there's a mismatch between the needs of the population and delivery of services. Do you think the Welsh Government, health boards, should push forward with the service reconfiguration that they've got in the pipeline?

[119] **Dr Hussey**: Again, I'll draw colleagues in. The thing that really struck us was this need to make the aspiration of this new out-of-hospital model of care explicit and clear as to what people would expect in the future. Having done that, and it seems there's a strong consensus that's what's needed, there is also then a need to think through what are the supporting services that are needed to help enable that sort of model of care to work. We also make it very clear that models of care on their own won't be enough, that

there's a need to look at efficiency and productivity as well. So, every bit of the system needs to think through how it fits into a different way of working. So, I'm not sure what plans you're referring to in terms of what's in the pipeline, but does this mean transformational change across all services? I think it does. If you really seriously want to bring integration, if you seriously want to build a primary care infrastructure and out-of-hospital services, it's going to have consequences.

[120] In our report, we talk about hospitals being about assessment and treatment. We also highlight where there is strong evidence that some services need to be working at an aggregate higher level, and there are a couple of examples in the report where the evidence is really quite strong, now. Do you want to comment, Jennifer, Eric, on service change, generally?

[121] **Professor Sir Mansel Aylward:** No, I think that the whole thrust of the interim report—that part about what's going to happen—is addressing that. I think that is what it's all about: the mismatch of needs and delivery of appropriate services. What we hope to do in the next six months is to go into that in much greater depth with the public, the stakeholders, et cetera, and the recommendations that will fall from that will be addressing those very issues.

[122] **Jayne Bryant:** Okay, thank you. Just quickly, the interim report states that the governance, finance and accountability arrangements need to be better aligned with health and social care. Can you expand a bit on this as well?

[123] **Dr Hussey:** I don't know if colleagues want to have a go at this, but I'll start off. It comes back to the point that Lynne Neagle was saying about the organisational issues around integration, and Jennifer made the comment about—we have integrated health boards, but actually the systems are still working quite differently. So, it's an area we want to tease out. The complexity of governance is quite striking. In fact, we've seen, I think, probably a couple of different maps.

10:30

[124] I don't think we've seen the full picture yet of exactly all the different arrangements that exist, and people have raised things that perhaps are counter to each other, or a lack of clarity about where the decision levels are made. Staff talk to us about how, 'It's not clear where you get decisions

made; we go from one committee to another', so we do think there's something around thinking through who has to do what where. People have talked to us about the national level and a need for some decisions to be made at a 'once for Wales' level, and colleagues may want to come in on that. People have talked quite a bit about the regional level and the coherence around the health board footprint, and then there's a real issue about local planning. We were energised by what we heard from the GP clusters, and I know we look forward to your report on what you've heard from them, but, again, what is that local input into shaping the local pattern of services and what needs to happen at those different levels? There's that element of it. I could carry on, on the accountability in the financial systems and everything else, but colleagues can join me on this—

[125] **Mr Gregory**: It's a really complicated governance structure, but then it's a really complicated set of systems. I think it is appropriate and it has been raised with us to ask the question: how effective is it actually in practice, and is decision making and authority lying in the correct positions? I think Ruth highlighted one key area of consideration for this: the judgments around 'once for Wales' versus greater autonomy. What are the principles around that? What's the decision-making process for that? There are real opportunities for Wales in getting that balance right. So, from what we've heard there are opportunities to streamline and make the whole governance arrangements more effective.

[126] **Professor Sir Mansel Aylward**: I think some of the governance, accountability and hierarchical maps that I've seen are like snakes and ladders—without the ladders. It's really very complex and it needs to be addressed.

[127] **Jayne Bryant**: Okay, thank you. That's very helpful. Just moving on quickly to engagement, you said you've been hearing views of people who work in and deliver health and social care services, and those who use them. Have the messages from those different groups been quite consistent, would you say?

[128] **Dr Hussey**: Actually, in the stakeholder events where we brought staff and users and managers together, it's remarkable, actually. There isn't a lot of disagreement about the direction of travel generally. The disagreement comes about how to organise it differently, and clarity about what matters to the different groups. So, clarity of purpose, and the organisation of the delivery of services I think are probably the key areas, but the actual general

direction, I was struck by—we couldn't find much disagreement.

[129] **Dr Dixon**: The general direction of travel is actually very similar across western Europe and North America, in many respects: the shift from hospital to out-of-hospital care joining up with social services to support people. On the one hand, that's a sort of centrifugal force. The centripetal force is to concentrate on more specialised services—back to your question—and how to get that balance right is a critical issue.

[130] **Professor Sir Mansel Aylward**: I think it's remarkable how many people come to that conclusion without having been told. It's not top-down. They see in their everyday life that's just the way it's got to go.

[131] **Dr Hussey**: And that is a fantastic starting point: (a) that most health systems are trying to think this through, but I think the point we tried to get across in the report is that this is a real opportunity for Wales to grab this now. With that level of consensus and understanding of the issues, this is not only an opportunity—it's an absolute necessity. As I said before, this case for change is happening now. It's not about thinking about it for another few years. This is about really saying, 'We know people are behind this general direction; we've got to try and work together now to push this forward quickly.'

[132] **Dr Dixon**: We want a single-payer unified system so all the levers, potentially, are in your hands.

[133] **Dai Lloyd**: If we move on—Julie, some workforce issues. Some of them have been covered, but feel free to go for whatever you want.

[134] **Julie Morgan**: Yes. Have we covered the records—the same records to be held by all health and care organisations in Wales? Do you think we can get to that position?

[135] **Mr Gregory**: In terms of an infrastructure sense, Wales is actually very well placed for that. It has a national architecture. It has increasing sharing, both within the same sector, so across NHS boards, and from GPs, for example, to the secondary care arrangements so that the GP record can be shared there. I think, obviously, you have to be extremely careful that you have the appropriate standards in place, that security is incredibly robust around all of this, but there is potential and there is a lot of work going on there to drive this consistency and make sure that health records are shared

across the piece. There are also longer-term, bearing in mind consent and personal privacy issues—. The framework is there for the opportunity for individuals, for patients, to see their own records via My Health Online as well. So, that needs some thinking about what are the values and merits of doing that and the security side of things.

[136] So, I think the infrastructure's there; there's been some really good progress. I think this is an area where it would be worth highlighting with NHS Wales Informatics Services and others in the health boards in particular, and asking whether there can be a more rapid drive on some of the initiatives here to complete the whole consolidation and sharing of the patient record. It's a huge initiative. I think, you know, there's like 1 million of these created on a, sort of, weekly basis or whatever it is, so—. But I think Wales is well placed from that point of view; it's not got a lot of disparate infrastructures that are not interfacing properly. So, yes, we're going with the focus—

[137] **Julie Morgan:** So, you think we will reach that?

[138] **Mr Gregory:** I think we will reach that. I think there needs to be—. In the whole digital area—it's a complex area. I mean, NWIS supports 77 systems already. So, I think you'll have seen in the report that quite a high proportion of their staff is actually dedicated to supporting those systems, and that is incredibly important: that they're secure, that they're available, that they're flexible, that they're extendable, and all the other good things that you need around that. But I think there is a dialogue to be had around 'What are the opportunities to dedicate more resource to driving forward the key initiatives?' Going back to the discussion we had before about deciding what the really key things we want to do are—what could hang off this in terms of improved productivity for the workforce, for example, in having sought digital access to the records in a hospital setting, and then maybe reprioritising and refocusing resources to drive this forward.

[139] **Dr Hussey:** Just to add on the health and social care side: there are some really promising developments around the shared record.

[140] **Mr Gregory:** Yes, I was going pick up on that. We highlighted the community care information system in our report, and I think that's an excellent example of the health and social care sectors working together and delivering a shared initiative. So, that's got mobile access for professionals; they don't have to go back to the office, it's doing away with paper, it's getting very positive feedback, as I understand it, from patients. So, this is

the kind of initiative that appears to be delivering benefits across the piece, which should be encouraged. It's a good example of how the two sectors can work well together as well.

[141] **Julie Morgan:** Thank you. And just on the workforce: what do you see that the health and social care worker of the future will be? How do you see it? What do you think they'd look like?

[142] **Dr Hussey:** I think the themes that come out in the report are that whilst many of the roles that we have now are going to be needed into the long term—so, you know, the value of a generalist general practitioner is absolutely recognised—there's a growing sense that there's a need to wrap around multiprofessional teams. So, we'll continue to see a range of health and social care workers who fulfil particular professional roles, but, actually, there is also a pressure, I think, to be more generalist, being able to work flexibly across the different roles, fully understanding when a particular skill is needed to be bought into. So, we try to set out that the balance of specialism and generalism needs to be reconsidered a little bit. We also think, and we've heard from some of the evidence, that there is a need for some types of new roles, whether they're specific technical support roles—. But one thing I really want to emphasise is what we've heard about caring roles: that the social care sector, in particular, have been very clear about the importance that needs to be attached to valuing the care role.

[143] We haven't, perhaps, talked so much this morning about the pressure on the turnover of staff in that sector, and the importance of valuing those people, and really promoting caring as a real career choice. Now, there are some barriers and issues that are in that mix. We've heard concerns about pay rates and competition from sectors outside health and social care. We've heard about career progression. I could spend a long time on this, and I'm remembering that this is a short-answer session, so, generally, there's a point about specialism and generalism, multiprofessional working, and valuing particular roles, because if you look at where the major gaps are going to be going forward, those generalist support roles will be very, very key. Do colleagues want to add anything?

[144] **Dr Dixon:** Just one quick thing. Some integrated care models have been using personal coaches for high-risk patients who route people through to—whether it's housing need, benefits needs, or further routing through a complex healthcare system, and that's proving very valuable. So, there may be these routers, and they may not be medical professionals, or

NHS professionals, they may be somebody quite different in the community, indeed. So, I think that's another pivotal person, particularly for the most vulnerable.

[145] **Julie Morgan:** Thank you.

[146] **Dai Lloyd:** Are you okay with that?

[147] **Julie Morgan:** Yes.

[148] **Dai Lloyd:** Good.

[149] Symudwn ni ymlaen nawr at faterion cyllidol, neu faterion efallai sydd ddim yn yr adolygiad yma. Rhun.

We'll move on to funding issues, or perhaps issues that aren't covered in the review. Rhun.

[150] **Rhun ap Iorwerth:** Ie, ac rwy'n ymddiheuro am fod yn hwyr yn cyrraedd; roeddwn yn teithio i lawr o'r etholaeth y bore yma. Nid oedd cylch gorchwyl yr adolygiad yma yn cynnwys dadansoddi dulliau eraill o ariannu'r system iechyd.

Rhun ap Iorwerth: Yes, and I apologise for my late arrival; I was travelling down from the constituency this morning. The terms of reference for this review did not include analysis of alternative methods of financing the health and social care system.

[151] I think we may have some problems there; I'll continue in English for now. The terms of reference for the review did not include an analysis of alternative methods of financing health and social care, but we know that there are plenty of people who say, 'Well, this is something that needs to be addressed.' Several stakeholders have said, 'Well, this needs to be looked at in future.' What are your thoughts on that?

[152] **Dr Hussey:** Chairing this review, the terms of reference were broad from the outset, so we were very clear to try and establish from the starting point what was in scope and out of scope. And we were very clear that the future way of funding health and social care was not in scope for us. Our focus was very much about how to use the resources. The case for continued pressure on funding for health and social care is actually well laid out in the Health Foundation report, so we didn't need to repeat the cost pressures that were coming in through health and social care. That work's been done. So,

our focus is very much about how best to deploy the resources, to ensure that these issues that have been with us a long time, about waste, variation, productivity, better outcomes, all the things that we've been talking about, and are set out in the report—. The question about getting to a point when you want to change the fundamental basis of how to raise the resources for health and social care was not in our remit.

[153] **Rhun ap Iorwerth:** Having said that, though, it goes without saying, I assume, that as you were working through the review, all the time you were aware that everything that you were proposing or considering was more deliverable were there to be an alternative model that provided more money. That's a given, I assume.

[154] **Dr Dixon:** I think the first thing to say is that the UK spend on healthcare is at the EU-14 average. That was the latest definition from a few months ago. We kind of go around thinking it's a miserly amount that we spend on health and social care, but, actually, it isn't. Could the system do with more? Yes. But other polls show that 50 per cent of the public report seeing waste in the system. So, we're quite clear that the new models themselves, even if they are floridly implemented, are not the full story here if one wants to improve productivity. We have to consider labour and total factor productivity, and that's going to be a feature of the next part of our analysis. If productivity levels could increase by 1 per cent, then we'd be nearly home and dry. Another 1 per cent. And this is a very unusual industry. It's service based, and we know that productivity levels are lower than the general economy, but the rate of increase in the health sector is actually slightly higher than that in the general economy, where it's limp.

10:45

[155] So, nevertheless, there's a lot to do and some of the things we've been looking at in terms of infrastructure are the sort of things—innovation and IT, which Eric's mentioned, are critical here. But not just that; it's also behaviours and culture and valuing staff and getting the best out of them.

[156] **Rhys ap Iorwerth:** How much work has been done, though, on evaluating the potential gains that can be made through efficiency, increased productivity—putting it in pounds and pence terms, if you like? You emphasised the need to invest in and improve the use of digital techniques within medicine. There are plenty of IT-based savings that can be made. How eager are you that work is done—more than has been done already—to

quantify what can be achieved through those kinds of moves?

[157] **Dr Dixon**: A lot more could be done to measure that. At the moment, we don't even have hospital-level productivity measures in Wales. We're making an attempt at that for the Health Foundation, actually publishing later this year. We just have crude national measures, which do not allow those who are responsible for the resources at board level to even compare themselves to know whether they are productive or not. So, there's a lot of work to be done across the NHS, UK-wide, on this particular issue, before you then get into questions of nutting out what might be productivity gains for investment in IT or other things that you mention. But it's exactly the right question to be asking.

[158] **Mr Gregory**: We did talk earlier on about there are some mechanisms in place. There's the NHS Wales efficiency, healthcare value and improvement group, which is scrutinising and trying to understand where there are unwarranted variances and opportunities to improve those, learn from best practice, and reduce waste. So, that kind of initiative should be robust and continuing and have a sharp focus. On the digital side—we talk a lot about digital—the other points I'd make about digital and that whole area are that it has to support business change initiatives. It's not just digitising things, and we know what can happen—. We've seen elsewhere in the UK and in Europe some of the issues that can emerge if you take the wrong approach there.

[159] There are opportunities for different and new partnerships, either with the third sector or with innovators or via the Life Sciences Hub and that sort of thing to harness some of the initiatives there, whether they're associated with apps or sensors and that sort of thing. We did talk about the Efficiency Through Technology fund and the opportunities that might offer. Then, the final point I'd make here is that there are opportunities to actually deliver these things differently through a more iterative, agile way. So, provided there's—. You have to be very clear about the risk appetite around change in the health and social care sector, obviously, but, provided there are opportunities to develop prototypes, to test them out, to iteratively refine them, incubate them, and then look at the opportunity to roll them out more widely, I think that's a real area of focus that we could have in the future as well.

[160] **Rhun ap Iorwerth**: And that's likely to be something you will focus on in the latter part of your work, as a—.

[161] **Mr Gregory:** We'll definitely—. We would like to work closely with the NHS Wales Informatics Service in the context of the digital ecosystem, the Life Sciences Hub, innovators, and explore that whole area. The other area that's important here is the NHS Wales Shared Services Partnership. That's driven some really valuable benefits, some of which we've highlighted in our report, and we'd like to look at what other opportunities there are there as well. So, that's the general support infrastructure.

[162] **Professor Sir Mansel Aylward:** Also, may I just briefly mention that there's a report shortly to be issued by the Bevan Commission on innovators where selected projects that showed innovation according to certain criteria were demonstrating a return on investment of between three and tenfold in cash terms? This just demonstrates that, if one actually provides just a small amount of money in the first instance and carefully chooses the innovation that will prove effective and could be transferred across boundaries—. There is a need to do that and exploit your resources to a maximal extent.

[163] **Mr Gregory:** But then you need have real leverage around—. Once you've identified those that are going to deliver real value and service improvements and better outcomes for patients, whatever your measurements might be, there needs to be a real focus and drive on implementing them across the board as far as possible, regionally or even nationally.

[164] **Dai Lloyd:** Okay. Angela.

[165] **Angela Burns:** Yes. I think my question bounces off of the innovation/productivity discussions you've been having with Rhun. The other side of the coin is: when you go forward in the next few months, will you be suggesting new or alternative performance management metrics? If I give an example, for example, we constantly look at what are the waiting times for orthopaedic surgery. So, rather than saying we're going to judge you on the waiting times for orthopaedic surgery, what we're going to say is, actually, the performance management metric might be that you have mobility aids, that you have physiotherapy, that you have dietetic help, you have—. So, it's not all about the nuclear option—being operated on—but, actually, it's that whole journey. So, it's irrelevant, then, whether you are waiting two years or five years, because, if you're well as can be and you're supported during that, then that's not the end goal. I hope that's made sense.

[166] **Dr Hussey**: There's no doubt there's a growing awareness and interest in measuring outcomes—outcomes as determined by people who have a health need, and clinical outcomes in terms of the quality of care. We also know, from history, that if you focus on a few small measures then all the energy goes into those issues, which may be counter-productive to the long-term direction that you want to go in, but important nevertheless. Timely care is important. Colleagues may want to talk about it, but we've certainly flagged up that there's a need to think in the round about the measures you use to make sure that you're actually making the difference people wanted. The work that Aneurin Bevan's doing around value and outcome starts to point to, actually, some of the things that are offered didn't actually make the difference people were hoping for. Some of the treatments—in hindsight, they perhaps wouldn't have had those treatments. It gets us into a real conversation about shared decision making, what are people hoping for from the treatments that are being offered, particularly with chronic illnesses, where there are choices to be made—not necessarily in the acute trauma area. So, there's a need for the measurements of the system to start thinking through how you can measure things that matter to people that demonstrate good-quality care and a good value at the same time. I think we've got to sort of think through it. Do colleagues want to comment on—?

[167] **Dr Dixon**: Yes, on the dials of the new models that we talked about earlier, which were co-produced with people at the front line and the patients, avoidable admissions is another obvious one, and that's not an outcome. Well, it sort of is an outcome, but it's a process. So, that type of thing. But it could be co-produced, particularly if we're going to have a big exercise involving people and patients in developing these models: what would be compelling outcomes for you? Independent living is another one. But, whatever set of metrics you have, they'll always be limited, considering the enormous number of things that the health service does. So, the question is to make sure there isn't undue attention to those—significant but not undue—to ignore this other lot. So, that's the other thing to factor in here.

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

[169] **Dai Lloyd**: Okay. Mansel, were you chomping at the bit there now?

[170] **Professor Sir Mansel Aylward**: No, no, I'm in entire agreement, as always, with my panel. [*Laughter*.]

[171] **Dai Lloyd**: Right. Okay. Are you done, Angela?

[172] **Angela Burns:** Yes. Thank you.

[173] **Dai Lloyd:** Can I just finish off with a general question about prevention and the prevention agenda? Obviously, we all talk a lot about it, and you've mentioned it a bit. We were in the cross-party group on cancer earlier on, ably chaired by Julie Morgan. If we got rid of obesity, basically, roughly about half of bowel cancers, for instance, would be prevented just by physical fitness and not being overweight. Is there a need for a new impetus in the prevention agenda?

[174] **Dr Hussey:** A couple of things—and Jennifer might want to come in. On the terms of reference we had, it was clear that (a) we were being asked to look at health inequalities, but (b) it was very much about the whole health and social care sector and services. So, I think, as a panel, we've been sort of treading a careful line between trying to review everything that's done, because we all know the importance of the social determinants of poor health that drive that pattern of health inequality and some of the lifestyle challenges that we see. So, we were mindful that we could really look at all of those issues and end up doing almost a cross-Government review of all of the things that would help change people's health outcomes. So, we've tried to focus on the role of the health and social care sector, and in the report we talk about preventative models of services. And there are promising things in that area, both in terms of individual, tailored support, as Jennifer described earlier around the workforce question—different types of workers to help people with particular issues. There are other areas where—I know in Wales there's an emerging interest in social prescribing, so connecting people to alternatives that have a more preventative slant. And, going back to the third sector conversation, we know they have a role in more of those preventative services, and there are good examples in social care, too.

[175] So, we absolutely recognise that the systems need to be preventative. The legislation, actually—the social services and well-being Act—says the focus should be more preventative. I guess the challenge, again, is the 'How?' question. Do you want to comment, because you've been looking at health inequalities at the Health Foundation, haven't you?

[176] **Dr Dixon:** Yes. There's a wider health inequalities agenda, which is a big societal—you know, local authorities, business, all the rest of it; the health sector as well. But 90 per cent of health is affected by that. But I think with our focus—we've got to focus on this report, haven't we—the new

models of care, actually, could be far more proactive in going upstream to prevent ill health. And we know from examples abroad that there's some very—. If you construct the new models properly and have data linkage of the type we mentioned earlier then you can get much more analysis about who's high risk, who might be high risk in future, how to target and support such patients better, whether it's through psychological support, whether it's through other—telehealth, or whatever. So, you can get into the prevention agenda that way, and I think that's what we think could be more manageable in this report than a big review of social determinants of health, which, actually, Michael Marmot has done a grand job of in the past, hasn't he, on that, and there's an agenda of six points to be tackled. Public Health Wales have done some brilliant work, too.

[177] **Dr Hussey**: Not scripted.

[178] **Professor Sir Mansel Aylward**: Not scripted. [*Laughter*.] The other thing is let's not forget the inverse care law, because that's where health and social care, if properly integrated in delivering in a quality way, will have a major effect. And we still have the inverse care law in Wales, and we all know what that is—the services received by the least well-off are far less and inverse to those that are well-off, and it's still happening. It's not happening because we haven't put the resources in place, as in Merthyr Tydfil with its Keir Hardie centre—a centre of excellence—but the fact that the people are not accessing those services, and they're not aware of the services that they can access. And I think, by having health and social services working together and with local government and Public Health Wales, that's an excellent angle that one can use—well, not angle, an excellent way in which one can make sure that that inverse care law and the access part of it is improved, and therefore prevention is addressed.

[179] **Dr Dixon**: And inverse care law, particularly as applied to late diagnosis of cancer, is a big, big issue, which if your data linkage was better then you could pinpoint the areas and the populations that were coming late and therefore try and do some—which practices they belong to, what their needs are, et cetera.

[180] **Professor Sir Mansel Aylward**: Precisely. You see, we work together so well. [*Laughter*.]

[181] **Dai Lloyd**: Great. That's an opportune moment to wrap up. Just for information, obviously, this committee is in the process of undertaking and

will shortly be undertaking reviews into things like ICT infrastructure and rural models of care and, obviously, also the primary care clusters that you outlined earlier. We'll be reporting on that over the next couple of months, so doubtless we'll be in touch as regards—

[182] **Dr Hussey:** That'll be very helpful. Chair, can we just say thank you very much indeed, both to the committee for the contributions today—we'll certainly take on board the ideas and the areas that we've explored—but also to the political reference group? The one thing that is absolutely clear is that there's an appetite here that we've heard that people want to see change happen, and it's really important that—. We feel we can try and help to create that sense of everybody's got a role to play in this in trying to meet the challenges ahead, and I really appreciate the conversations we've had so far in helping to shape our work. And we really hope that you continue to do that as we get towards our final recommendations. So, thank you very much.

[183] Dai Lloyd: Great.

[184] Wel, diolch yn fawr. Fe ddown ni â'r sesiwn yma i ben, felly. A allaf ddiolch i'r tystion i gyd am eu tystiolaeth, a hefyd gyhoeddi y byddwch chi yn derbyn trawsgrifiad o'r trafodaethau y bore yma er mwyn i chi gadarnhau eu bod nhw yn ffeithiol gywir? Felly, diolch yn fawr iawn i chi.

Well, thank you very much. We'll draw this session to a close. May I thank all of the witnesses for their evidence, and just tell you that you will receive a transcript of this morning's proceedings so you can check them for factual accuracy? So, thank you very much once again.

10:59

Papurau i'w Nodi
Papers to Note

[185] **Dai Lloyd:** Symudwn ni ymlaen yn awr, fy nghyd-Aelodau, i eitem 3 a phapurau i'w nodi. Fe fyddwch chi wedi ymdrin â nhw eisoes. Mae yna lythyr yn fanna oddi wrth Dr Arfon Williams ynglŷn â'n hymchwiliad ni i fewn i ofal sylfaenol. Mae yna hefyd lythyr yn fanna oddi wrth yr

Dai Lloyd: We'll move on now to item 3, papers to note. I'm sure you will have seen these. There's a letter from Dr Arfon Williams in relation to our inquiry into primary care. There's also a letter from the Cabinet Secretary for Health, Well-being and Sport on services fit for the future.

Ysgrifennydd Cabinet dros Iechyd, Llesiant a Chwaraeon ynglŷn â gwasanaethau sy'n addas i'r dyfodol. Mae yna wybodaeth ychwanegol gan y comisiynydd pobl hŷn ynglŷn â'r ymchwiliad i unigrwydd ac unigedd—gwybodaeth arbennig o dda, mae'n rhaid imi ddweud—a hefyd lythyr gan y Llywydd ynghylch gweithredu Deddf Cymru 2017, a hefyd lythyr oddi wrth Gadeirydd y Pwyllgor Cyfrifon Cyhoeddus am y trefniadau llywodraethu ym mwrdd iechyd prifysgol Betsi Cadwaladr. A oes unrhyw Aelod eisiau dweud rhywbeth, neu a oes unrhyw sylw ynglŷn ag unrhyw un o'r materion yna? A yw pawb yn hapus jest i'w nodi nhw?

There is additional information from the older people's commissioner in relation to the inquiry into loneliness and isolation—it's wonderful information, if I may say so—and also a letter from the Llywydd regarding the implementation of the Wales Act 2017, and a letter from the Chair of the Public Accounts Committee about governance arrangements at Betsi Cadwaladr university health board. Does any Member have any comment on any one of those papers? Is everyone content to note them?

[186] **Dawn Bowden**: Hapus.

Dawn Bowden: Content.

[187] **Dai Lloyd**: Diolch yn fawr, Gwawr.

Dai Lloyd: Thank you very much, Gwawr—

[188] 'Dawn' in Welsh, for the uninitiated.

11:00

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.

[189] **Dai Lloyd:** Felly, rŷm ni'n symud ymlaen i eitem 4 a chynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod. A ydy Aelodau yn gytûn i wneud hynny? Diolch yn fawr.

Dai Lloyd: We'll move on, therefore, to item 4, the motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting. Are Members content? Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:00.
The public part of the meeting ended at 11:00.