THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

Submission to the Parliamentary Review on Health and Social Care in Wales by the Welsh NHS Confederation

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1.0 Introduction and Strategic Context

1. The Welsh NHS Confederation, on behalf of its members, welcomes the opportunity to respond to the Parliamentary Review of health and social care in Wales. The Parliamentary Review is an opportunity to build political consensus around the long term challenges facing the health and care system. The demographic trajectory over the next 20 years is stark and the Parliamentary Review needs the type of long term focus envisaged in the Well-being of Future Generations (Wales) Act 2015 to meet the future needs of the Welsh population.

2. The Welsh NHS Confederation represents the seven Health Boards and three NHS Trusts in Wales. The Welsh NHS Confederation supports its members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work. Members' involvement underpins all our various activities and we are pleased to have all Health Boards and NHS Trusts in Wales as our members.

3. This response has been prepared in consultation with our members. As such it summarises the key areas and issues highlighted by Health Boards and Trusts. The response covers the four broad areas identified within the Review Terms of Reference and is structured to address systematically the key issues raised by members, rather than responding exclusively to the questions posed within the written evidence request.

4. Health and care systems across the world are under considerable pressure and face a number of significant challenges, including demand, workforce, finance, public health and integration. NHS leaders are seeking to tackle these immediate challenges in Wales. They are also committed to addressing the longer term challenge of improving the population's health and well-being, recognising the impact that this has on society, the economy and the demand for services. Their commitment is aligned to their obligations under the Well-being of Future Generations Act (Wales) 2015, which requires all public bodies to maximise their contribution to achieving the seven well-being goals.[i]

Demand management

5. Since the creation of the NHS almost 70 years ago, society has changed dramatically. Our average life expectancy has improved considerably, which is partly down to the success of the NHS and is something to celebrate. However, an ageing population also brings with it a series of fresh challenges for the health and social care sector, and as with all other UK health systems, the NHS in Wales faces these challenges as it works against a backdrop of increasing demand and under increasing financial pressure.

6. An ageing population, coupled with an increasing number of people having multiple and complex needs, means the demand for health and social care services is predicted to grow rapidly in the near future. The number of people aged 65 and over is projected to increase by 50% by 2037 while the number of young people aged 16-24 is set to decrease by 3% by the same year.[ii] More than a third of the population of Wales is expected to be

over the age of 60 by 2055 and by 2069, those aged over 75 will be the biggest proportion of all age groups.

7. While the Welsh population generally is living in good health for longer, this health gain is not distributed equally. Wales currently has the highest rates of long-term limiting illness in the UK, which is the most expensive aspect of NHS care. Between 2001-02 and 2010-11 the number of people with a chronic or long-term condition in Wales increased from 105,000 to 142,000.[iii] This figure is expected to rise for a number of conditions, including cancer, dementia and diabetes.

8. The number of people waiting for treatment is a reflection of this rising demand. Waiting times are a key priority for our members and there Integrated Medium Term Plans outline their considerable efforts to improve performance. While targets have a role to play, policy makers must also look at the bigger and longer term picture - instigating a whole system change in the way treatment is delivered and providing the best service we can within the resources that we have.

Workforce

9. The NHS is Wales' biggest employer, currently directly employing around 89,000 people[iv] (76,381 full time equivalent) and providing a significant contribution to the national and local economies. Across the UK, one in ten people in the working population are employed in the health and social care sector.[v] For the past six years, the total NHS pay bill has increased year on year, with an increase of 13% from 2010-11 to 2015-16. The cost of the workforce for 2015-16 was circa £3.3 billion – this represents a 4.5% increase on the previous year and the biggest jump in annual spending for six years.

10. With an ageing population and a rising number of people with complex and chronic conditions, the workforce must evolve and respond to the challenges ahead. As well as meeting the future needs of the population, the workforce must also develop new ways of working to address concerns about an expected shortfall in future NHS staff levels, particularly for certain types of jobs and in certain parts of Wales. We must also acknowledge that maintaining and developing the current workforce is just as important as growing and training a new one.

11. Depending on the settlement, the UK's exit from the European Union (EU) could have a profound impact on the NHS workforce. Across the UK, the NHS is heavily reliant on EU workers. In September 2016, there were 1,328 EU Nationals directly employed by the NHS in Wales. The current percentage of doctors who are recorded on the Electronic staff record as being from the EU is 8% (as at September 2016) and in 2016-15 the NHS in Wales recruited 377 nurses from overseas.

Integration

12. Integration is a means to an end – providing patients with a seamless service at the right time and in the right place. It is about getting all parts of the system to work together so that the patient receives quick, efficient and effective care with the right outcome. To achieve this, we need to get services working seamlessly together in health and social care, primary and secondary care, and physical and mental health services.

13. More broadly, improving population well-being and reducing demand on services also requires an integrated approach as it depends on good housing, education, social care, health, community support and an environment that actively promotes and encourages people to live healthy lives. To quote the Chief Medical Officer for Wales, "*Good health depends on much more than the provision of good health services. The way a society is organised; it's economic prosperity; a person's early life chances; their education and employment opportunities; community support and cohesion; the food we eat; the homes in which we live and many more factors make up the wider social determinants which impact on the health of both an individual and the nation*".[vi]

Population health and well-being

14. Wales faces a significant number of population health challenges, including high levels of obesity, drinking above the recommended guidelines, smoking and poor levels of physical activity. The most recent Welsh Health Survey results[vii] show that 19% of adults currently smoke, 40% report drinking above the guidelines on at least one day in the past week, 30% say they are physical inactive and 59% are overweight or obese. The impact of such behaviours on our health is resulting in significant demand being placed on our health services, as well as significant costs.

15. Smoking costs the NHS £386 million per year;[viii] alcohol misuse directly leads to over 1,500 deaths each year at a total cost of £100 million;[ix] physical inactivity costs the Welsh NHS £51 million per year and £314 million to the overall Welsh economy;[x] and the Journal of Public Health estimates that the 'largest economic burden' on the Welsh NHS is due to a majority of people (58%) being either overweight or obese.[xi] Bold decisions are now required to make industrial scale change in our services and shift the funding to support people to make healthier lifestyle choices.

Finance

16. Finance has long been a challenge for health and social services, but never more so than since the economic crash nearly a decade ago. Since then, all public services have struggled in the face of public finance austerity and while the NHS and social care have been relatively protected in Wales (compared to England and other Welsh public services), both sectors continue to struggle in the face of an ageing population with increasing chronic and complex health conditions.

17. Such a rise in demand, coupled with constrained financial resources, has made delivering health and care services in the current model increasingly difficult. The NHS is committed to working more efficiently to rise to the challenges it faces. However, it has become increasingly clear that traditional methods of savings are unlikely to deliver what is

needed. It is important that we are realistic about the current and future costs of health and care services and we need to work with stakeholders across the health and care sector to fully understand the future resources required to secure the system.

2.0 NHS Vision for Health and Social Care in 2027

Wind the clock forward to July 2027 and imagine the following. It's a cloudy Saturday morning. Things don't seem that different from 2017, but look a little closer and you will see a very different picture of health and care in Wales.

The first thing you notice is the number of people outside, making the most of the natural environment – walking, jogging and cycling. The town has a community services hub in its centre, which is open and bustling while its parks have become "green gyms". The hub has a range of services including a GP, a dentist, a pharmacy, a housing office, debt and benefits advice and a digital resources centre next door to a local leisure centre which is also busy with classes. Many years ago it changed its title to a sports and public health centre.

Preventative services have become the focus of the community, ranging from voluntary support groups to formal public services, all designed with citizens to help people stay connected, engaged, happy and healthy. Children are being taught about healthy living in schools and families are supported to give them the best start in life. The town is proud of its dementia-friendly status although breakthroughs in treatment mean that some forms of the disease are now preventable. The town has a wide network of volunteers and carers that provide invaluable support to vulnerable people in the community. People are calling in to see their neighbours, particularly those who live alone and those who are struggling with their well-being.

You will notice a number of extra care facilities and mixed housing developments in and around the town which have brought a renewed vibrancy to the town centre. The local market is in full flow and young and old alike are enjoying the environment and supporting the local economy. There is a real sense of community cohesion with teachers, charity workers and postal workers, all getting involved in supporting the local population.

One thing that isn't visible, but all take for granted, is the hyper fast broadband now available throughout the town and across the whole of Wales. The older people in the town can dimly recall the ponderous internet associated with the era of so called "high speed broadband". The new services operate at routine speeds achieving connections of 1 Gb or higher.

These advances in digital technology have transformed the town and its public services. There are new digitally-based businesses in the local community, many more people are working from home, and crucially, telehealth and telecare services are widely used to help maintain people's independence, health and well-being. The other fundamental change is the use of data. Individuals own their health and care records, and with health and care professionals, they are using their data more proficiently to design new services, to develop new treatments and to manage the whole system more efficiently.

Sadly, the cure for all ills has not yet been found and there are still people who need hospital care. But if you look into the nearest hospital you will not see queues of people waiting to be seen. The public are well informed about what medical support they need, as well as where and how they can receive care.

Prudent healthcare is embedded in the nation's psyche – the public are actively engaged in their health and well-being – and are supported to stay well. They are equal partners in their care, they take action to keep themselves well and the majority are living independently. People are able to confidently navigate the health and care system and are empowered to work with public servants and ensure they get the help they need. Crucially, the public understand and support the principle that services are organised to deliver the best clinical outcomes and therefore are prepared to travel to get the diagnosis or specific treatment they need at the quality they deserve.

Of equal importance is that preventive medicine has become increasingly prominent in healthcare and has brought about reductions in smoking levels and levels of obesity. They have also increased physical activity among the local population. The development of genome-based diagnoses and related technologies means people receive individually targeted information and treatment to live as healthy lives as possible. Moreover, chronic health issues are routinely monitored remotely via mobile apps and medical sensors. These technologies allow patients to spend less time in hospitals, thereby freeing up resources for those who need them urgently.

Finally, doctors, social workers, nurses, social care workers, teachers, pharmacists, paramedics, therapists, local housing officers, charity workers, volunteers and carers are all working together seamlessly. The public value and respect health and social care services because they deliver what they need efficiently and effectively. This has been made possible because the health and care workforce (public, private and third sector) works in multi-disciplinary teams and partnerships, each having the training, skills, support and capacity necessary to meet the needs of the population they serve. Each profession is valued and respected as highly as the next and while the governance of health and social care still resides with the NHS and local government, there is a "seamless" pathway of health and social care provision.

Since 2017, there has been a year on year reduction in health inequalities across the local population and the overall healthy life expectancy has increased by five years for both women and men. Over the same period, there has been a 10% reduction in obesity, smoking level have dropped to 10% of the population and mortality for diseases such as cancer have also fallen.

3.0 Improving Population Health and Well-being

18. As a nation we have made real strides in improving the health of the population over the past decade. We are living longer, fewer people are dying of cancer, strokes or smoking related deaths, we have fewer teenage pregnancies and better oral health. But we still have very high levels of obesity and wide variations in health equality within communities and across the country as a whole.

19. The population health context in Wales is characterised by persistent inequalities in health and a high prevalence of unhealthy behaviours that drives an increase in non-communicable diseases. We have an ageing population and an increasing number of people living with multiple health conditions. The 2016 OECD report[xii] recognised that Wales is the most economically deprived UK nation and that this has "likely impacts" on health and well-being, as well as the demand for NHS services.

20. Wales has led the way in many public health policies and legislation, such as the ban on smoking in public places, and we need to maintain this momentum. There is an explicit duty in the Well-being of Future Generations (Wales) Act 2015 to move to a health and social care model that is rooted in the community, focused on prevention and supports the well-being of the population. The NHS is seeking to improve the well-being of the population through the five ways of working that make up the sustainable development principle[xiii]:

    a. Looking to the long term so that we do not compromise the ability of future generations to meet their own needs;
    b. Taking an integrated approach so that public bodies look at all the well-being goals in deciding on their well-being objectives;
    c. Involving a diversity of the population in the decisions that affect them;
    d. Working with others in a collaborative way to find shared sustainable solutions;
    e. Understanding the root causes of issues to prevent them from occurring.

21. The NHS and local government are equal partners in this endeavour and leaders from both sectors accept that a preventative model which addresses the root causes of ill health and inequalities will lead to a healthier and happier population while at the same time reducing demand and financial pressure on secondary care services. This is supported by the legislative changes made through the Social Services and Well-being (Wales) Act 2014, which brings together health and social care as equal partners, along with other organisations and representatives in the form of Regional Partnership Boards to look at how integrated services can be delivered.

22. The NHS in Wales is already actively working to improve population and health and well-being, but there are few identifiable and defined programmes or interventions that are delivered in a systematic way that enable us to clearly capture and define the benefits and outcomes. Those which do exist, with the exception of tobacco initiatives, tend to be those more medically focused secondary prevention programmes such as assessment and risk factor management for heart disease in primary care. In addition, there is considerable variation in the uptake of existing programmes. We are continuously reviewing and learning from evidence from within and outside Wales, such as the case study below.

Case Study 1: Northern Health, British Columbia, Canada

Northern Health is a healthcare provider located in British Columbia, Canada, and serves a population of over 300,000. Northern Health recognised it was making limited inroads in care management because they lacked a unified definition of "care integration". The gap was discovered when the system medical executive raised this question before the executive team and found that little consensus existed around how to go about putting in place the necessary frameworks to deliver an exceptional standard of care centred around patients and their families.

In response, Northern Health established the Primary Care Home – where patients establish a long term relationship with a multi-disciplinary team that provides and directs their care. These Homes are usually established in a person-centred medical care setting such as a local GP surgery. The primary responsibility of these teams is to navigate patients to the most appropriate services, thereby preventing unnecessary hospital admissions and ensuring those with the greatest need are treated first. The system allows patients to receive seamless and co-ordinated services.

After developing a clearly defined population health management strategy, Northern Health created a proactive, multi-tiered communication plan. The provider also committed to radically changing their organisational structure, community by community, to better integrate care as well as developing and implementing a number of strategies aimed at improving service provider collaboration. The establishment of Primary Care Homes allows the multi-disciplinary teams to adopt a population health based approach tailored specifically to the needs of local people and allows them to be supported in managing their own health.

Inter-professional teams, who work in collaboration with primary care providers to provide a range of health care services, have also been established. This model of service delivery improves the quality of care by working with primary care physicians and nurse practitioners to design and achieve shared health goals with the patient and their family. The result is that patients feel valued by the system and feel involved in their own treatment. Additional benefits include less pressure on local emergency departments and a more sustainable model of care in the long term.

Finally, Northern Health have also established an Electronic Medical Record for each patient as opposed to multiple electronic and/or paper records. The Electronic Medical Record is used by the doctor or nurse practitioner and/or the inter-professional team providing care for patients, thereby allowing not only for improved delivery of care, but also for recommendations and progress reports to be noted and recorded.

23. The National Institute for Health and Care Excellence (NICE) has summarised a wide range of its work on the cost-effectiveness of prevention across 26 of its public health topics.[xiv] These range from behavioural interventions such as smoking cessation to walking programmes to improve adult mental health. Of 200 programmes assessed, 30 were cost saving (15%) and 148 (74%) cost less than £20,000 per quality-adjusted life year (QALY) – the threshold below which NICE usually considers interventions cost-effective: "*This*

analysis showed that the public health interventions considered by NICE are generally highly cost-effective according to the NICE threshold. As such they represent good value for money. Given that the cost per QALY for most interventions is extremely low, it seems likely that as a nation we are not investing sufficiently in public health interventions".[xv] The World Health Organisation, 'The Case for Investing in Public Health: A public health summary report for Essential Public Health Operations (EPHO 8) states that "*Prevention is cost-effective in both the short and longer term. In addition, investing in public health generates cost-effective health outcomes and can contribute to wider sustainability, with economic, social and environmental benefits".*

24. All public services have a role to play in creating a preventative model, as do the public. From the NHS and local government to the housing, the third and independent sectors, collectively we need to create the economic, social and natural environment in Wales that will support our own health and well-being and that of our children. Public Health Wales' report 'Making a Difference',[xvi] sets out three key priorities for preventative action:

    - Building resilience across the life course and settings;
    - Addressing harmful behaviours and protecting health; and
    - Addressing wider economic, social and environmental determinants of health.

25. Over the last eighteen months, a number of collaborative partnerships to improve health and well-being have been established either nationally or across particular parts of Wales including Cymru Well Wales, the Health and Housing Partnership, the Police and Health Partnership and HealthWise Wales. The latter is a study[xvii] that plans to recruit 260,000 people aged 16 and older in Wales over a five-year period.

26. There are many preventative services in local government, such as leisure centres, parks, adult education classes and community facilities, but these are provided at the discretion of local councils. Unfortunately, in recent years it is these services that have faced the brunt of cuts to local authority budgets while statutory services such as education and social services have been protected. At the same time in the NHS, available funds have been targeted at delivering improved performance in secondary care services, most notably to address referral to treatment waiting times. Pressure on hospital services has never been greater and NHS organisations have therefore struggled to redirect resources into preventative services based in primary and community settings.

27. It is imperative that we reverse the decline of preventative services and that we find a way to make some serious investment into new preventative services based in primary and community settings. There needs to be a shift of resources from treatment to prevention, but there is limited flexibility to shift significant investment away from traditional treatment services when the current demands on the health service are so great. This is an extremely difficult, yet vital, task and the health service will need support to achieve it. Against this background, the Welsh Government's investment in the Intermediate Care Fund and the Primary Care Fund have been welcomed by the NHS and local government and it has led to the introduction of a number of preventative services across Wales. Its success comes from providing dedicated resources, supported by focused leadership, joint decision-making and governance, to enable public servants

to concentrate and deliver transformational change. But in comparative terms it does not equate to the resource base of the £5.3 billion 'Better Care Fund' in England or at a city region level the £450 million transformation fund of the Greater Manchester Combined Authority[xviii].

28. The King's Fund report on transformation funding[xix] explains, the provision of funding is only partly the answer; successful transformation is also heavily dependent on ensuring public servants have the capacity (away from the day job) and skills to plan, drive and deliver change. Health and social care leaders need to recognise this and invest in their workforce to create the capacity and capability required.

29. Public accountability is also vital and the public, as individuals, need to recognise the role we all play in our own health and well-being. If the public and patients understand the impact their behaviours are having on their health, it will benefit not just themselves, but all those who will rely on the NHS in the future. Patients need to become partners in managing and improving their health, rather than passive recipients of services. The NHS should also manage expectations and help patients understand exactly which services the NHS can provide.

30. As well as preventative services in local government, it is important that we seek to ensure the population has good housing. It is well established that poor housing leads to poor health, but this only scratches the surface of understanding why housing, and the contact with housing associations, provides so many solutions to the dilemmas and challenges faced by the NHS. Housing associations are about far more than bricks and mortar. They represent a pillar of support for vulnerable people in difficulty, providers of not-for-profit care and enablers of community regeneration which reflects their ability to have a substantial impact on an individual's health and well-being.

Case Study 2: The 'In One Place' Programme

The 'In One Place' Programme is a formal collaboration between Aneurin Bevan University Health Board, five local authorities and nine housing associations. Underpinned by a legally binding collaboration agreement (endorsed through the scrutiny processes of each partner organisation) the programme is supported by the Welsh Government through the Regional Collaboration Fund and the Intermediate Care Fund. The agreement enables partners to:

- Establish a Special Purpose Vehicle that facilitates a collaborative approach to dealing with the accommodation requirements of people with complex health and social care needs in one place, thereby enabling partners to streamline procurement procedures where they are applicable;
- Agree to separate accommodation and care support requirements in the future, wherever possible; and
- Align health, social care and housing planning processes to ensure that current and future accommodation (and care and support) needs are addressed at the earliest opportunity.

In addition to better outcomes for service users and their support networks, the 'In One Place' model has the potential to realise considerable savings across agencies by minimising accommodation costs through the effective use of Housing Benefit, capital assets and grant funding. Working collaboratively, the model could also maintain efficiencies in care costs without any negative impact on the quality of care and support. It is the expectation of the 'In One Place' team that using a person's home as the basis for all care and support quality will be enhanced with better outcomes for all stakeholders.

Some early financial modelling has demonstrated potential savings in excess of £80k; continuing NHS Healthcare case shared across accommodation (£9k) and care and support (£71k). The 'In One Place' Programme team anticipate reviewing all current cases (78), including in particular 'Out of County Placements' (24) against the 'In One Place' model. In addition to existing cases, the 'In One Place' team are aware of 29 transition cases coming through from children's services over the next two to three years.

What would help the NHS improve population health and well-being?

- Ensuring the impacts on health, well-being and equity are known and harms are minimised and mitigated through adopting a 'Health in all Policies' approach across sectors. 'Health in all Policies' takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity.
- Implementation of the Public Health Wales Making a Difference report recommendations within a defined timetable.
- Supporting a culture of change among the public in terms of making healthier choices and reducing reliance on NHS services (See section 2.0).
- Strengthening primary care and the links with Public Health to focus on "wellness" as much as "illness".

4.0 Engaging the Public and Patients, and Co-production

31. There is an urgent need for a meaningful dialogue with the public about the future of public services, their expectations of these services and the different role they need to play. This is vital because evidence shows that public support is critical to delivering and securing policy and behaviour change. Programmes that are most successful in galvanising public support are those which place the public at the heart of the decision-making process, particularly when combined, if appropriate, with enabling legislation. This is borne out by successful national policies and programmes, such as seatbelt laws, the carrier bag levy, road safety campaigns, banning smoking in public places, and most recently in Wales, organ donation. In Wales we now have the legislative framework we need in the form of the Future Generations (Wales) Act 2015 and the Social Services and Wellbeing (Wales) Act 2014, but we still need to win the hearts and minds of the Welsh public.

32. Currently, the Welsh public is being bombarded with messages from public services, voluntary organisations, government, various media outlets and personal networks. Similarly, there are different requirements around public consultation in health and social care. There is an opportunity for effective communication and engagement with the public and patients to be more impactful across the whole public service by developing holistic messaging which would encourage public acceptance of the need for change. In addition, the language of public (and staff) engagement is often negatively framed around the need to save money, rather than the health benefits they strive to achieve and this too needs to change.

33. There is also a requirement for an open and honest conversation with the public about what the NHS can provide in future. While the NHS is free at the point of contact, it is not free of obligation, and the public will need to be supported in taking more responsibility for their own health. The NHS belongs to us all, and as individuals, we should do what we can to ensure it is sustainable, both now and in the future. In January 2017, the Welsh NHS Confederation conducted a survey[xx] which provided some encouraging results around the public's understanding of their role in taking responsibility for their health well-being and a willingness to take action. More than 90% said they have a great deal or a fair amount of responsibility for their own health and well-being, while 55% said they should be doing more to look after their own health and well-being.

34. Changing public attitudes and behaviour is critical to the achievement of our vision of health and social care. We believe there is much to gain from a national approach to public awareness and engagement which involves:
    - Reframing the conversations with the public (and the workforce);
    - Providing an easily accessible narrative on increasing public understanding of the case for change and the benefits of transforming services;
    - Building on existing engagement/communications relationships and channels at all levels, including Regional Partnership Boards and Public Service Boards;
    - Training and developing the workforce to use behavioural change tools and techniques such as motivational interviewing;

- Informing, educating and supporting the public to embrace the well-being benefits of self-care leading to changes in behaviour; and
- Proactively working with social movements to raise awareness, identify and deliver change.

35. We also need to harness the potential of informal groups or social movements focused on improving health and social care as effective means of civic engagement and behaviour change. Nesta defines a social movement as a "*persevering people powered effort to promote or resist change and the experience of health or the systems that shape it*".[xxi] We are seeing an increase in the proliferation and impact of social movements, facilitated by social media and access to information. The NHS and local government in Wales need to embrace this development and work with social movements to innovate, engage, mobilise community resources, raise awareness and change behaviour.

36. While Health Boards are continuously engaging with the public through the Public Service Boards, engagement boards and other means, it is vital to recognise that a major change in culture and approach is required to truly embrace the very different ways of working the NHS of the future demands. Although co-design and co-production are beginning to happen in some parts of the public sector, the prevailing mind-set in many areas is still one in which citizens and service users are passive recipients of services. In order to move towards the kind of engagement needed, we must embark on the significant task of upskilling public sector staff to work with people and communities in a way that recognises assets to build on, rather than problems to be solved. Similarly, a major cultural shift is required to move away from the view of public services as delivery agents to passive populations, to a greater focus on localities in which everyone contributes to maintain and improve services. Digital technology provides a great opportunity for public services to engage more closely with the public and patients, using social media and interactive technology to support self-care and management.

Case Study 3: The Esther Model, Sweden

Jonkoping County Council in Sweden developed the Esther Model in the late 1990s. Esther, an elderly woman living in the local community, experienced shortness of breath and was passed around the health system. She retold her story 36 times before receiving care. Her experience shone a light on the fragmentation of the system, particularly between primary and acute care. And it inspired action. The Council initiated an extensive series of interviews and workshops over two years to identify redundancies, gaps, and improvement areas in the medical and community care systems. A GP was tasked with leading the initiative, as they believed primary care should have a central role.

"Esther" came to represent all elderly persons with complex care needs that involve a variety of providers. The County Council built a system-wide vision around this image. Creating a persona helped to focus caregivers on the needs, preferences, hopes, and concerns of real people who need care – it made it less abstract.

Providers could then have concrete planning conversations: What does Esther need? What is important to her when she is not well? How can we collaborate to meet Esther's needs? What is best for Esther?

This mantra served as the foundation for a system-wide vision that brings together people from different levels at a variety of organisations. Every year a steering committee comes together to address challenges across organisations. Every quarter they hold "Esther cafés" for cross-organizational sharing and learning using actual patient stories as points of discussion. Cross-provider training sessions are held, and every year culminates in an annual "strategy day" where doctors, nurses, administrators, and patients come together to articulate priorities and ideas for addressing problems in care.

The Esther model has spread around the world. Some have kept the same elements, while others have adapted them according to their own communities and their health needs. In Singapore for example, SingHealth Regional Health System began partnering with community organisations and GPs in 2016 to develop an Esther network. They hold regional forums where people wanting to make changes come together and discuss ideas for collaboration. They now have 60 ambassadors from the hospital, community, and primary care leading the project and have trained a first wave of coaches.[xxii]

Esther also expanded to two systems in the UK in 2016. In South Somerset, the same Esthers attend cafés every other quarter to report on progress they have seen. In Kent, they are expanding on the model by offering cafés every two months instead of every quarter, and training care workers, social assistants, chefs, and maintenance workers to be a part of their vision. The key is that networks offer a variety of opportunities across the year for different kinds of stakeholders to get involved, both large and small groups, CEOs, patients and everyone in between.

37. In 2013, the Bevan Commission first articulated the concept of Prudent Healthcare[xxiii] which has been adopted by the NHS in Wales as a guiding framework to help improve services, make better use of resources and meet some of the significant challenges faced by the health service. Subsequent work around Prudent Healthcare, including the development of its principles and the support of its implementation has focused on securing the sustainability of the NHS, doing no harm, making best use of resources and working co-productively with the public as part of a new 'deal' in which citizens take a more active role in their treatment and responsibility for their health and well-being.

38. Over the last three years, much work has taken place with NHS staff and policy makers about what this means for the ways in which they work, and how they can go about successfully embedding it within their professional lives. Prudent Healthcare continues to be implemented across NHS Wales and there are many examples where progress is already being made, including the work being undertaken by Public Health Wales, 1000 Lives Improvement and the Bevan Commission Advocates.

39. In February 2016, the Welsh Government published a national Prudent Healthcare Action Plan which included a set of actions designed to focus the implementation of approach in a systematic way, focusing on: appropriate tests, treatments and medications; changing the models of outpatients; and working together to improve health. In addition, the plan identified a number of broader enabling actions including communication and

engagement with the public, professionals and public services leaders. However, the work with the public, though critical, has yet to take place in a systematic way.

40. There are examples where the benefits of a prudent approach are being realised, as evidenced by the Making Prudent Healthcare Happen website[xxiv], the Bevan Exemplars[xxv] and the annual NHS Wales Awards.[xxvi] The NHS has also signalled its commitment to the kind of culture change required to make Prudent Healthcare a reality through the roll out of its Core Principles[xxvii] to all 89,000 NHS staff.

41. For Prudent Healthcare to be successfully implemented, we need involvement from the public. This means engaging people to become active participants in their health and well-being who want to work with us to reduce demand for NHS services. This, for many, will mean fundamental changes to the ways in which they live their lives. If the public are unaware - or unsupportive - of the culture change we are seeking to co-produce, we are unlikely to be successful in encouraging sustainable behaviour change.

42. Behaviour change is a complex task for a range of reasons. Behaviour may be affected by the extent to which individuals are affected by the wider determinants of health, such as access to good housing, education and employment.

43. Most people feel passionately about the NHS and it is important to harness this as well as explain what role they can play in making sure it can continue to deliver effective services for people. A recent opinion poll conducted by Ipsos MORI found that 52% of the British population now see the NHS as one of the biggest issues facing Britain – this is the highest level of concern since 2002.[xxviii] We need to make a compelling offer to the public, demonstrating the benefits a prudent approach will have on their health and well-being.

Case Study 4: IMPACT DC, Washington and Project Dulce, San Diego

Research shows that patients remember significantly more information when presented with a printed aid and verbal instruction, rather than receiving verbal instruction only. Printed materials also alleviate the urge to teach every detail, instead focusing the conversation on the most salient points. Finally, patients can reference these documents at home when questions arise.

The best materials are short documents that patients can easily read and understand. For example, IMPACT DC, a programme of Children's National Medical Centre in Washington, designed a one-page guide to help providers more effectively educate patients and caregivers about living with asthma.

Using a familiar traffic light colour scheme, the document demonstrates how to recognise and treat symptoms they can safely manage themselves and those which require immediate medical care.

In San Diego, Scripps Health developed Project Dulce, a skills-based education programme for patients newly diagnosed with diabetes. The project provides practical guidance on daily activities such as testing blood sugar levels and making healthy lifestyle changes.

The programme also directly addresses issues of health literacy, teaching patients the meaning and application of the key terms necessary to manage diabetes.For example, one lesson focuses on nutrition and explains how to read food labels to make healthy decisions at home. Part of Project Dulce's success comes from its low cost, self-sustaining model: former patients receive in-depth training to become instructors, offering peer support in addition to subject matter expertise.

What would help the NHS engage with the public and patients, and co-production?

- Welsh Government funding and implementing a national public communication and engagement strategy for Prudent Healthcare.
- The development and implementation a national programme within an agreed timescale across government which identifies actions for all public services to take to engage public and patients in living healthier lives.

5.0 Integration: Designing Services around the Patient

44. There is much debate about what is meant by integration and this can be distracting as integration is no more than a means to an end. In the context of this submission, we are referring to the experience of the service user. From the moment a member of the public has need of care, primary or secondary health services, we want their experience to be seamless and this requires integrated service provision. Similarly, to achieve our vision for population health and well-being, the NHS needs to work collaboratively with all parts of the public, independent and third sectors to engage and work with individuals and communities to live happy and healthy lives.

45. The key for all of us involved in health and care services is putting patients at the heart of our vision and that requires integration. Integration of health and social care; integration of mental and physical health services; and integration of secondary and primary care. Integrated services lead to better user satisfaction, better outcomes and when implemented effectively, make better use of resources. On that point, the Welsh Government and NHS need to guard against overstating the economic benefits of shifting care into the community. As the Nuffield Trust point out "while out of hospital care may be better for patients, it is not likely to be cheaper for the NHS in the short to medium term.[xxix] The Welsh NHS Confederation believes that Wales, given its size, structure and strong working relationships, has a golden opportunity to achieve so much when it comes to designing and delivering integrated citizen (i.e. public and patient) centred services.

46. Across the world, the vision for sustainable health systems is based on moving care out of hospitals and into the community and to developing primary-led approach to healthcare. We believe that patient-centred care, which is measured in outcomes, should be driven further through the provision of more services in communities and closer to people's homes. Treatment should be provided in hospitals only when it is absolutely necessary to do so. Despite having integrated secondary and primary care organisations, the NHS in Wales is struggling to deliver truly integrated health services and to shift the system to one focused on primary and community care.

Case Study 5: Alzira, Valencia

Spain runs a public health system managed in 17 autonomous regions. In the 1990s, the city of Alzira in Valencia needed a hospital, but the government had no money to build one. So they contracted a private company (Ribera Salud[xxx]) to build it and to hold a contract to serve the population on a capitated basis. If the company could serve the population and save money, they would make a profit. If they couldn't, they wouldn't. Either way, the government budget would be protected. And they put an ingenious set of rules and incentives in place to ensure care quality.

The contract began and nearly ended quickly. After a few years it just wasn't working. By year five of the contract, Ribera was still unable to make ends meet because, as a hospital, they could not control what happened before and after the hospital visit, nor effectively move people into lower cost, more appropriate care.

Additionally, primary care providers had no incentive not to shift costs to acute settings. So Ribera made the case that they needed primary care to be integrated into the system for it to be viable.

Many credit the single budget as the source of success, but Ribera knew otherwise. Ribera knew it needed to create an active partnership with the primary care sector to ensure patients were connected to a provider that knew their conditions, managed their care and used secondary care services when only necessary.

They began to employ some primary care providers in the region, and could incentivize them differently, but the majority of GPs remain civil servants who receive their pay cheque from the government and can't be incentivised in the same way or degree as employees. So Ribera recognised that to develop an effective working relationship with primary care and make the model work, they had to invest in the partnership. One of the key investments Ribera made in this area was in sharing knowledge and expertise across providers to facilitate ongoing collaboration.

47. Only 1 in 5 people attending Accident and Emergency (A&E) Departments are admitted into hospital. The rest are either referred on to other services including their GP, given advice, or receive some treatment with no follow up required. Some people find it convenient to use A&E so they can be seen straight away (even if they have to wait a few hours). Others (e.g. homeless people) may not be registered with a GP. Many who end up in A&E are anxious and are unable to assess the severity of their condition. To understand the real crisis in A&E, we have to look at the groups of people who are waiting longest.

These are usually people with complex needs and multiple illnesses, often frail older people and people who need specialist assessment or to be admitted into hospital. For people with mental health problems, A&Es can be poorly equipped, often lacking the staff expertise, access to the patient's care plan, or even the space for people in distress. The real challenge in A&E is the flow of patients into, around and out of the hospital. More than two thirds of all hospital beds are occupied by people admitted in an emergency. When wards are full, and staff overstretched, people who need to be admitted to hospital end up waiting in A&E.

48. Once people are admitted, they can sometimes get stuck in hospital when they're fit to leave - two-thirds of patients waiting to go home are stuck because of delays within the hospital and between NHS services; the rest because the social care they need or want is not yet in place. If patients don't get the NHS and social care support they need in the community, they may have an avoidable health crisis and a cycle of emergency readmissions.

Case Study 6: Ambulatory Practice of the Future (APF) Massachusetts General Hospital

The Ambulatory Practice of the Future (APF) at Massachusetts General Hospital is an innovative new approach to primary care delivered by highly collaborative teams, with the patient as an active participant. This proactive partnership between patients and caregivers focuses on prevention and controlling the cost of care through prevention of chronic disease. The practice was first introduced in July 2010 and seeks to improve the work life of primary caregivers and support their professional development.

The concept for the APF began with discussions and interactions among clinical leaders and innovators at Massachusetts General Hospital who challenged a number of existing assumptions about patient experiences of the primary care treatment and called for a new model of care. APF is centred round the belief that a patient can only engage and understand their care sufficiently if it is delivered through collaborative teams that recognise the patient as a partner and a manager of their treatment. Thus effective communication between patients and multi-disciplinary teams is central to the APF project, particularly in relation to the management of a patient's illness post-treatment. APF recognise that it is by having frank and honest conversations with the patient about how they intend to manage their illness post-discharge, about how their lifestyles may need to change and about what they can do at home to maintain their independence and reduce their chances of readmission, that real progress can be made in terms of engaging people more closely with their care. Rather than treat the illness, APF treat the patient.

The APF model is heavily reliant on technology and allows for care to be provided through video platforms, telephone and email correspondence when appropriate. Moreover, the APF model also recognises the importance of effective patient education to promote increased self-management of chronic illness and shared decision making. Patients and care teams work together to develop a Health and Life Balance Plan, with a strong focus on personal wellness goals, around which their wellness and chronic illness conditions are managed collaboratively.

49. As The Kings Fund[xxxi] has highlighted, hospital is the default option for many patients because in the past we have failed to rethink how primary, community and social care currently operate. Primary care often operates on too small a scale, has inadequate access to specialist support and diagnostics, and has workflows and processes that are inappropriate for the types of patients it deals with (for example, the length of appointments are not sufficient for dealing with multiple morbidity and it is hard to provide continuity of care). The NHS in Wales is seeking to create a strong primary care platform to facilitate the changes needed. Wrapping community services, mental health services and social care around groups of practices, giving those practices access to specialists and diagnostics, creating more systematic approaches to working collaboratively would provide continuity or rapid access to treatment depending on patient needs. GP information systems are gradually helping to create the digital infrastructure required for this. New technology offers hope as well, although more evidence and lower cost solutions are needed to make this viable.

50. At the same time, all parts of the urgent and emergency care system, including A&E, Minor Injury Units, GPs, pharmacies, the ambulance service, the developing NHS 111 service and crisis response teams need to work as part of a single system, which is well understood by people when they need care and advice. People at home should be supported by community teams that include the social and voluntary sector, co-ordinated by GPs with access to hospital specialists.

Case Study 7: Falls Response Service, Welsh Ambulance Service NHS Trust and Aneurin Bevan University Health Board

The Falls Response Service (FRS) is an integrated service provided by Welsh Ambulance Service NHS Trust (WAST) and Aneurin Bevan University Health Board (ABUHB) in response to patients who have fallen in the community. Across Wales annually around 10% of the emergency calls received via the 999 system to WAST are classified as a fall. Throughout the ABUHB area in 2016, 71.4% of fall calls were for patients aged over 65. The Economic Model for Falls Prevention suggests that mild falls (those that don't require additional treatment on discharge from A&E) represent 47.2% of the total number of falls.

It was clear that often, patients who are categorised as Green 3 (not serious, non-life threatening) incidents, can experience longer waiting times for initial responses, unnecessary admission to A&E for complex care needs and delayed discharges of care from acute hospitals. During the period of October 2015-March 2016, around 64% of patients were transported to hospital following a fall. This highlighted the pressure being placed on the department as a result of patients who fall.

The FRS provides a timely response to 999 Falls Callers, followed by a full medical and social assessment at the point of need, from which patients are signposted to the most appropriate alternative care pathway to reduce unnecessary admissions to A&E. It appears that, since the project commenced, patients are receiving a quicker initial response to a fall. In addition, there has been:

An increase in the number of patients treated at scene/closer to home: 19% of patients were treated at home/at scene following a fall (excluding the RED Incidents) due to increased access, processes and skills to refer patients directly to community services;

A reduction in the number of patients requiring treatment within A&E: Based on comparison data for a six month period the previous year the trial has assisted in preventing 131 patients from attending the A&E unnecessarily; and

A reduction in inappropriate referrals or rejections of referrals to the Community Resource Team (CRT): only 13% of all patients attended were given onward referrals to the CRT. Without the trial operating, all patients who met the criteria of the WAST Falls Pathway, would have received a referral to the CRT and 22% of these would have been accepted due to the referral being inappropriate for falls, not meeting the falls criteria and/or a duplicate referral.

51. Funding provided by the Welsh Government in the form of the Primary Care Fund is facilitating their development. The additional funding is welcome not least because Health Boards are struggling to shift resources in primary care while seeking to address immediate resource pressures in secondary care. This is borne out by the figures - expenditure on Primary Healthcare Services (reported in the NHS Wales summarised accounts) as a proportion of all Health Board gross healthcare service expenditure has remained broadly the same between 2009-10 and 2015-16. Indeed, it decreased slightly from 22.3% to 22.1% over this period. It is difficult to track any changes in community services provided directly by the Health Boards (e.g. health visitors and community nurses) through the accounts.

Case Study 8: Primary Care Clusters, Hywel Dda University Health Board

In Hywel Dda University Health Board, the traditional model of General Practice is no longer seen as the only, or even the optimal, service delivery model. Clusters are up-skilling their workforce and employing other professionals to enhance the Multi-Disciplinary Team (MDT), including Occupational Therapists, Physiotherapists, Advanced Paramedic Practitioners, Pharmacists, Mental Health Support Workers, Third Sector Support Workers and telephone consultations commissioned remotely. The benefits to date include:

- Reducing demand on GPs by addressing and resolving underlying issues that are the root cause of multiple and regular contacts;
- Releasing GPs, practice and community nursing staff time;
- Proactively resolving health and social issues at an early stage, minimizing crisis situations that result in presentation/admission to the acute hospital;
- Sustaining people at home following discharge from hospital; and
- Releasing professional capacity by enabling people to maximise their own potential, promoting self-management, preventing ill health and dependency.

Carmarthenshire is unique within the Hywel Dda footprint in that all three clusters are integrated with the Community Resource Teams and have strong local authority representation. Discussions have commenced with further evolving local authority engagement in the other two counties within Hywel Dda.

Clusters are currently measuring their contribution against number of referrals into secondary care, admission rates, the number of GP appointments required in practices and staff and patient satisfaction surveys. The Health Board has committed funding to enable the wider primary care professionals to engage in the cluster decision making and project development and delivery. Lead pharmacy, optometry and dental roles have been developed and are being recruited to. It is believed that this will support broader integration and multi-disciplinary working.

52. The challenge is how to develop best practice for primary care clusters and to resource and roll this out across Wales with pace so that alternative services are available in the community consistently across Wales. The National Primary Care Programme and the Primary Care Cluster Hub hosted by Public Health Wales are both focused on driving this change. We believe the cluster development should be further invested in to ensure sufficient staff and ICT resources are available to support the coordination, planning and development of multi-disciplinary teams.

Case Study 9: Neath Primary Care Hub, Abertawe Bro Morgannwg UHB

There are eight GP practices within the Neath Primary Care Hub, all of which work together to see patients within community settings following an initial assessment by a doctor over the telephone. The Hub has a prescribing pharmacist, two part-time physiotherapists, and a Mental Health Support Worker who care directly for patients. The telephone call acts as a filter to determine whether a patient needs to see a GP or another member of the team.

The GP practices use special software which links their appointment systems, cuts paperwork and enables direct appointment booking while the patient is on the phone to the GP. This electronic communication also allows the clinician to write clinical entries onto the journal, back in the patient's surgery. This means no time is lost sending paper-based appointments and clinical outcomes.

53. Part 9 of the Social Services and Well-being (Wales) Act 2014 ('the Act') put onto a statutory footing seven regional partnership boards which bring together health boards, local authorities, the third sector and other partners to improve the efficiency and effectiveness of service delivery. The Boards oversee the Integrated Care Fund (ICF) for their region and their purpose is to improve the outcomes and well-being of people in response to the population assessment also required by the Act. As part of their role in making the best use of resources, boards are required to promote the use of pooled funds. Pooled funds must be established in relation to care home accommodation functions from April 2018. Boards must also consider the need for a pooled fund whenever they do things jointly in response to the population assessment. The NHS highly values the Regional Partnership Boards and across Wales senior joint posts are being created between health and social care. In Powys the Health Board and local authority are developing an integrated health and care service and have a joint long term health and social care strategy. They have also appointed the Health Board Chief Executive as the Interim Director of Social Services to drive integration agenda forward with pace.

54. The establishment of the £50 million ICF in 2014-15 has been a key driver for health and social care integration in Wales, focusing initially on enabling older people to maintain their independence at home, avoid unnecessary hospital admission and to prevent delayed discharges. The fund has supported collaboration and partnership working across social services, health, housing, the third sector and the independent sector and has been used to build on existing good practice and to roll this out more widely across regions. It has also provided pump-priming money for the development of innovative and new models of service delivery, care and support. We welcome the further investment through the rebranded Integrated Care Fund of £50 million revenue and £10 million capital for 2017-18 as well as widening scope to include older people with complex needs and long term conditions (including dementia), people with learning disabilities, children with complex needs due to disability or illness; and carers.

Case Study 10: Examples of how ICF Funding has been used across Wales in 2016-17

West Wales: nearly £235,000 was used by the Pembrokeshire Intermediate Voluntary Organisations Team (PIVOT) which aims to improve opportunities for independent living in the community and reduction in social isolation for individuals. The latest figures show 1090 bed days saved and 109 hospital admissions avoided. 100% of recipients surveyed said the service had made things better.

North Wales: nearly £57,000 was used for Occupational Therapy in Wrexham Maelor Hospital and Ysbyty Glan Clwyd to provide a point of contact for families and patients at weekends to expedite supported discharge. Latest figures show this service has supported 138 patients and saved an estimated 60 bed days.

Gwent: nearly £120,000 supported new Patient flow co-ordinators who work to reduce lengths of stay and delayed transfer of care. On average there are 103 patients who are medically fit for transfer and in an acute hospital at the end of each day. This funding aims to reduce this figure by 10%.

Western Bay: funding for a specialised nursing team that has consistently improved hospital admissions avoidance. Last year the service resulted in 70 admissions being avoided.

Powys: £30,000 for the Good Neighbour Scheme, which offers 1:1 befriending support for older people with the aim of providing practical support, reducing isolation and promoting independence. Latest figures show 143 people have used the service (37 new clients in the last quarter) with some 95 volunteers involved.

Cwm Taf: nearly £100,000 for the Complex Discharge Team which supports joined up services between primary care, secondary care, community care, social care and voluntary organisations. To date nearly 200 people have been supported by this scheme.

55. The Public Service Boards (PSBs), introduced as part of the Well-being of Future Generations (Wales) Act 2015, enable public services to commission and plan collaboratively, ensuring services are integrated and that care and support provided improves health and well-being outcomes for the local population. The Population Needs Assessments that have been undertaken will help PSBs to identify priorities and specific

actions they need to meet the health and well-being needs of their citizens and to help tackle health inequalities in their areas. Consideration should be given to involving other partners in the design of local preventative services, including non-devolved public services, local private companies and social movements. By leveraging innovative partnerships, the NHS could find cost-effective and scalable ways to monitor their rising-risk patients, engage more closely with patients and utilise the skills and qualities of local people wherever possible.

Case Study 11: Call and Check Programme, Jersey Postal Service

The number of Jersey residents aged over 65 is set to double between 2015 and 2040[xxxii]. Such a demographic change represents a significant public health challenge, particularly for a British Crown dependency with limited economic resource. In an apparently unrelated development, the postal service in Jersey carried out a questionnaire among its staff members to ask them what additional services they felt the Jersey postal service could provide – the result was the 'Call and Check' programme.

Staff identified the increasing number of frail and elderly people, particularly those living alone, as a gap in service monitoring. Under the Call and Check programme, postal workers visit these patients twice each week, for approximately five minutes each visit. They deliver prescriptions and provide appointment reminders, while also checking on patients to look for warning signs of deterioration.

Postal workers participating in the programme are required to undertake training before engaging with patients and are provided with an overview of how the programme is implemented and a checklist of 'things to look out for'. While no formal medical care is provided, these checklists allow postal workers to make recommendations to local primary care services should they feel that a patient requires medical attention.

An informal evaluation programme found that *all* elderly patients who had received home visits from local postal workers felt that they had benefited from the programme. It is important to note also that not only do patients who signed up to the scheme find the service valuable, but Call and Check also provides the families of patients living in Jersey, who may not be able to visit very often, with a sense of security. Postal workers who participated in the delivery of the programme reported greater job satisfaction and a feeling they were making a real difference to the local community.

In June 2014, the Call and Check programme took top spot in the Corporate Social Responsibility category at the World Mail Awards, beating two of the world's largest postal companies – the US postal service and Deutsche Post DHL.

Initially, the effectiveness of the programme was limited due to limited access to patient information, but plans are being drawn up to implement a cloud-based IT programme to allow postal workers to partial access to patients' medical records to check upcoming healthcare appointments.

56. There are a number of reasons why, despite legislation, Wales' relatively small size and the existing integrated health structure means that users do not already have a more truly integrated experience. It starts with different priorities and policies emanating from government for health and social care which are not always aligned to each other which can create confusion, tension and unintended consequences in the system, while

potential for other key service areas to support the system is often ignored (e.g. education, housing, leisure and transport). The development of cross cutting strategies within Welsh Government should help to address this issue and it is encouraging that we are now seeing a greater interest in the NHS from the wider Welsh Government cabinet.

57. Another obstacle to integration is human nature which leads individuals to focus on achieving their organisational objectives rather than acting holistically with a clear line of sight to outcomes for the user. We need to invest in and work with our workforce to understand and address these psychological barriers and to create a collaborative culture within our organisations. We need to work harder to improve employees' understanding of the whole health and care system as well as ensuring different professional groups accept and value the role everyone plays in the system.

58. The workforce is key to developing a truly integrated health and social care system. As such, long term workforce planning needs to take account of the system that we are aiming to create and should encompass the whole health and social care workforce across the public, independent and third sector. Importantly we need to ensure that unpaid carers are also included as part of workforce planning. There is a pressing and increasing need to develop a workforce in both primary and social care with the skill mix required to work effectively within multi-disciplinary teams and this therefore needs to be built into the education and training of health and social care professionals, including the provision of more integrated training opportunities.

59. Another aspect of the integration challenge for public servants is how to fully integrate a health and social care system when the financial and performance arrangements are different. This should involve consideration of revenue and capital funding and the public estate. There are different funding rules, accounting arrangements and accountability frameworks all of which have to navigated and complied with by different partners and this often leads to overly complex, bureaucratic and artificial arrangements being put in place to meet the requirements of regulators and auditors. The longstanding challenges presented by Continuing NHS Healthcare and their impact on patients highlight the importance of aligning health and social care funding rules.

60. There are also different performance measures and funding distribution mechanisms in place for discretionary funding and a wide range of specific grants which can complicate the landscape further and lead to unintended consequences. If we could take the best elements of both systems and develop more integrated arrangements, it could deliver real benefits in terms of driving true integration, efficiency and potentially medium term financial planning and management.

61. As well as integration between systems, it is also vital that there is closer integration between physical and mental health services. The economic and humanitarian case for giving proper priority to mental health services and parity of esteem with physical conditions is clear. In Wales, 13% of adults reported having a mental health condition in 2015 compared to 9% in 2003/4.[xxxiii] Mental ill health is associated with worse physical health, increased health risk behaviours, poor education and unemployment.[xxxiv]

62. The policy intention in Wales is clear. We have unique and pioneering mental health legislation in place in Wales – The Mental Health (Wales) Measure 2010, as well as a cross

Government strategy, 'Together for Mental Health – A Strategy for Mental Health and Well-being in Wales'. Mental health is a priority for the NHS with ring-fencing mental health expenditure and Health Boards Vice-Chairs have a specific mental health remit. Mental health is the largest of all the programme budgets in NHS Wales (just over 11%). One of the key challenges in comparing the provision of mental health services with traditional models of care designed to treat physical conditions is that mental health problems are not homogeneous. They can be any one of numerous conditions, ranging from eating disorders to dementia. It can mean having mild to moderate depression or can mean being diagnosed with paranoid schizophrenia. It is not a single condition and this makes establishing meaningful performance indicators problematic.

63. As well as the physical impact mental health problems have on individuals, people with a diagnosed psychiatric condition such as schizophrenia or bipolar die an estimated 15-25 years earlier on average. People with a mental health condition are also around three times more likely to be in debt and have financial problems, have the lowest employment rate for any main group of disabled people, have poorer housing, have fewer training and educational opportunities and experience greater social isolation.

64. At present, there is a lack of meaningful success indicators to highlight whether mental health services in Wales are getting better or worse. While we know how many people have a valid Care and Treatment Plan, how many are accessing services and being assessed and how many people are receiving treatment within 28 days of referral, it is difficult to access and provide data to show how many people are benefiting as a result of the treatment they receive. We must strive for a system where we are able to measure accurately whether people's needs are being met, whether successful outcomes are being achieved, and whether more people who use mental health services are getting back into education or training, volunteering or work.

65. As well as meaningful indicators and performance outcomes, services supporting people with mental health problems need to work closer together. People who have a severe and enduring mental illness often need support from a broad range of services such as health, social care, housing and employment, and so it is particularly important that all these services work together in a seamless and coordinated way. At present, service providers do not always work in a fully integrated way. There are many reasons for this - organisational interests and budget constraints, the lack of information sharing systems and technology to share information and organisational culture.

Case Study 12: Mid Wales Health Care Collaborative

The Mid Wales Health Care Collaborative, which comprises Powys Teaching Health Board, Hywel Dda University Health Board and Betsi Cadwaladr University Health Board, has initiated discussions with Shrewsbury and Telford Trust to scope the potential opportunities for regional working and clinical networking across the organisations to deliver more sustainable services for the population of Mid Wales.

The initial focus of these clinically-led discussions is regarding surgery, oncology, haematology and diagnostics. There is support to test a fully integrated model of a rural regional centre that would secure the triple integration aims in relation to integrating physical and mental health, health and social care, primary and secondary care including a diagnostics hub in Newtown. This work is exploring these opportunities in partnership to reduce demands on hospitals and to ensure more care is delivered closer to home whenever possible for the population of Mid Wales.

66. At the same time as investing in primary and community services the NHS in Wales needs to ensure it is providing integrated consistently high quality and safe secondary care services (i.e. services provided by medical specialists who generally do not have the first contact with a patient). The optimum configuration of secondary care services has been an issue for the NHS, here and across the UK, for many years as the demand for and nature of health services has changed over the last seventy years while the infrastructure has remained broadly the same.

67. Secondary and primary care services need to be designed in collaborative way to develop a network of hospitals, which together, and with the support of primary and community-based care, provide secondary and very specialist healthcare for the Welsh population. Case study 12 below illustrates the potential benefits where secondary and primary care services work effectively together.

68. In Wales we have a number of national programme boards that have been established in partnership by the Welsh Government and NHS organisations. Together they are seeking to reduce demand on secondary care services. These are the Unscheduled Care Board, the Planned Care Board and the Primary Care Board. The Welsh Ambulance Service Trust has a key role to play across all of the programmes and has made a significant contribution to reducing emergency admissions as evidenced in Case Study 7 above.

69. There a number of drivers for secondary care service reconfiguration, both positive (e.g. new technology makes care closer to home easier and a desire to) and negative (e.g. workforce pressures have made some rotas unsustainable, the need to improve patient safety, access and outcomes).

70. Following the publication of Together for Health[xxxv] in 2011, Health Boards in South Wales worked together to develop the South Wales Programme which set out a proposal for the reconfiguration of a number of specialties including consultant-led maternity care, neonatal services, inpatient children's care and emergency medicine (A&E). Despite extensive public consultation, progress on reconfiguring services has been slower than

desired. In part this is a consequence of the current governance arrangements under which Health Boards have a responsibility first and foremost to provide care for their local populations while reconfiguration of secondary care services usually involves planning, designing and delivering services on a supra-health board footprint. This issue is outlined in more detail in Section 8.0.

71. Over a number of years our members have developed a range of 'Clinical Networks' across Wales, combining staff from different units to enable people over a wide area to benefit from the best blend of skills and equipment. These are hosted by the All Wales NHS Collaborative which has been established by the 10 NHS organisations in Wales to facilitate national and regional service reconfiguration.

Case Study 13: All Wales NHS Collaborative

The All Wales NHS Collaborative (the Collaborative) is the current mechanism for progressing collaborative service change within NHS Wales. It is a partnership of all the NHS organisations in Wales and is hosted by Public Health Wales. Oversight of the Collaborative is provided through the Collaborative Leadership Forum comprising the 10 NHS Chairs and Chief Executives. The Collaborative has a clear work programme which includes the development of regional centres for ophthalmology, orthopaedics and diagnostics, the lead times for which are 1-3 years.

72. The challenge for the NHS and the Collaborative in the next period will be to make progress on a number of service reconfigurations including the establishment of Regional Treatment Centres for orthopaedic, ophthalmology and diagnostics together with the development of a Major Trauma Network in South Wales (including a Major Trauma Centre). Decision making aside, there is another major obstacle in terms of identifying the necessary capital and revenue resources to invest in these major programmes in a period of ongoing austerity.

73. Strategic financial planning of capital investment is urgently required with the NHS in Wales so that investment decisions are based on clear strategic national / regional priorities, underpinned by robust business cases that demonstrate the whole life costs of projects including critically, their implications (direct and indirect) on all health and care services.

74. At the same time it is important that both the Welsh Government and the NHS are realistic about the expected benefits (including the return on investment) of service re-configurations currently in the pipeline. That is not to say they shouldn't be pursued, but as The Kings Fund cautions "*a thin and ambiguous evidence base should not be a reason to maintain the status quo if real improvements could be achieved with a new service model. It simply means that innovators need to be realistic about the expected benefits, honest about what they can't predict, and committed to learning and evaluation so that we might one day have a better evidence base for the system to draw upon*".[xxxvi]

75. Perhaps the most difficult aspect of service reconfiguration is securing public and political support. In Section 4.0 we discussed the importance of public and patient engagement. Clinical engagement and leadership are also essential components of successful service reconfiguration and the NHS in Wales needs to invest considerable time and energy to securing support from all these stakeholders by engaging them co-productively in the design, planning and delivery phases through continuous and meaningful engagement. Over recent years the NHS has embraced the concept of continuous engagement with communities about all aspects of their health and wellbeing and good examples of community engagement do exist in Wales, such as that shown in Case Study 12 below.

Case Study 14: Prince Philip Hospital, Llanelli

In 2012, Hywel Dda University Health Board undertook a consultation exercise about A&E services in Prince Philip Hospital, Llanelli. The proposal centred on moving to a staffing model of GPs and nurses and was seen both within the hospital and the local community as 'downgrading'. The programme, led by hospital staff, changed the focus: putting the person at the centre. Its aim was simple - to deliver the best possible care.

This work was overseen by a multi-disciplinary Programme Board, chaired by a lead clinician from the hospital. It included a number of the hospital's clinical and non-clinical staff, Welsh Ambulance Services NHS Trust, Llanelli Rural Council, Hywel Dda Community Health Council, and the Chair of the Committee for Improving Hospital Services (CIHS). In 2015, CIHS' Chair cut the sod for the start of the work and joined the team in the official opening of the Units in 2016.

The Programme led to the development of a system of direct admission to the Acute Medical Assessment Unit (AMAU) and a separate Minor Injuries Unit, staffed by Emergency Nurse Practitioners (ENPs) and GPs; supported by strengthened alcohol liaison, mental health, frailty and ambulatory care services. This has meant that the Health Board's 4-hour A&E target changed overnight from 88.4% to 96.6%. Acute Medical Admission patients being discharged in less than 24 hours increased from 23.8% to 39.9%, despite a 39.6% increase in medical admissions over the last year and, importantly, patient satisfaction has improved.

What would help the NHS to further develop integrated patient centred services?

- Establishing governance arrangements that support regional / national decision making (See section 8).
- Welsh Government working with NHS to develop a strategic service reconfiguration programme to be implemented within an agreed timeframe.

- Welsh Government to work with NHS to develop a strategic investment programme to support the service reconfiguration plans (to include primary care estate).

- National Assembly for Wales and Local Government politicians supporting the NHS in engaging public and patients in case for change and specific reconfiguration proposals.

- Welsh Government working with the Welsh NHS Confederation and the Welsh Local Government Association to commission a comparative technical review of health and care funding and performance rules, accounting and accountability arrangements.

- Development of joint targets, accountability and performance management where appropriate and joint routes to capital for health and local government.

- Development of meaningful outcome measures for mental health and primary care services, including person centred outcomes for people in care homes and receiving domiciliary care.

- Developing an electronic patient record so that patients have a record of what services they have accessed and support received.

6.0 Reshaping the workforce

76. Health and social care organisations in Wales are facing major challenges in terms of the sustainability of their workforce. This includes the significant workforce challenges facing the independent providers of care home and domiciliary care services given their role in caring for some of the most vulnerable people in our communities. Recruitment and retention are the immediate challenges for the service and the NHS is pursuing a number of short, medium and longer term strategies to address current staff shortages which are set to continue.

77. The absence of an agreed long term vision for health and social care in Wales leads us to make short term planning and resourcing decisions, which poses significant problems for NHS organisations and local government in planning the workforce of the future. The fragility of the social care market impacts on care quality and is contributing to discharge delays in hospitals and years of public finance constraint have led to reductions in education and training placements, increasing our dependence on overseas recruitment. The implications of Brexit on our long term ability to recruit staff from overseas are still unclear, but it is likely to prove even more difficult to attract potential recruits from overseas in the short to medium term until the post-Brexit immigration regime settles down.

78. Policy makers and local leaders need to agree a joint long term workforce strategy for health and social care that will deliver a resilient, reshaped, well trained workforce with

the necessary skills and capacity to meet the changing needs of the Welsh population over the next fifteen years. With more than half of the NHS and local government budget being spent on staff costs, we also need to maximise the productivity of the workforce, address potential skill gaps and reduce our reliance on temporary staffing arrangements.

79. At present, the NHS Wales workforce is designed to deliver services to historic models and patterns of care. Previously, care has been modelled around treatment of single conditions but, with an ageing population, people often require long-term care from both health and social services. The skills and capacity of the workforce is a major determinant of the quality of care and outcomes. Successful delivery of the 2027 vision will be dependent on our ability to reshape the workforce to support new models of care. The changing nature of work means that in some situations current skills do not match what is needed now or in the future. Designing and delivering integrated patient centred services that span health and social care will require:

    - The development of pan public sector/multi agency workforce planning particularly with social care services and independent care providers;
    - Shifting the focus of the system towards prevention and well-being including concepts such as Patient Activation. This needs to be translated into training and development plans for the new and existing workforce; and
    - Delivering person-centred care within financial constraints must be supported by how multi agency/sector workforce redesign is approached.

80. Assuring patient safety and maintaining service quality is of paramount importance in planning the future delivery of healthcare services. The Welsh Government response to the Francis report around the failings in Mid Staffordshire hospital, Delivering Safe and Compassionate Care and the Andrews Report, Trusted to Care, has reinforced a strong focus on the importance of the NHS workforce and its critical role in ensuring high-quality patient-centred care, including a significant impact on nursing numbers. This has been reinforced through the Nurse Staffing Levels (Wales) Act 2016 which is welcomed by members, but also presents a number of workforce challenges. These include, but are not limited to:

    - Ensuring the system delivers high-quality services within financial constraints;
    - Developing effective measures for quality of care and productivity and ensuring high-quality data is collected;
    - Preparing for changes resulting from innovation and technology such as genomic medicine, genome sequencing, bioinformatics, cancer therapies, stem cell technology, robotic surgery, tissue regeneration, point of care testing and telemedicine; and
    - Ensuring the skill mix is appropriate to the requirements of the patients and clients, balancing the availability of specialist expertise and regulated healthcare professionals with the significant contribution of Healthcare Support Workers.

81. The future healthcare system needs to be redesigned around the individual – treating their needs but also helping them to self-manage their conditions and focussing on what matters to them. To be a success, planning for the workforce of the future must address the need to deliver care closer to patients' homes, support them to maintain their

independence and to stay as healthy as possible. Skills must be developed to support this in primary and community care and to make use of technologies that will aid this process.

82. This significant shift in care and treatment will only be successful with the participation of the entire health and social care workforce. As we move ahead, the skill set of the current workforce must be utilised to its maximum potential. There must be a greater focus on developing skills and competencies to allow a broader range of different services being provided by all members of the healthcare team. This will require radical thinking about what skills are needed and mapping what are already present in the system to ensure new roles add value.

83. We need to anticipate our future workforce needs and develop realistic plans that will enable us to develop sustainable numbers within the medical and non-medical workforce and recognising the length of time it takes to train doctors, nurses and other professional staff. A recent Nuffield Trust report[xxxvii] recognises that large scale workforce redesign is difficult and requires commitment from national policy makers and local leaders. For our part, the NHS needs to invest time and resources into developing a workforce with the right skills and a collaborative, prevention and patient focused culture. We need to engage our staff and trade unions in designing, planning and delivering the changes needed.

84. Starting with our school children, we want to enthuse and educate our young people to encourage them to pursue a health or social care career and widen access to health and social care careers from within our communities. Additionally, enabling and facilitating career development and flexible learning within the health and social care environment through a robust skills and career escalator will also provide for greater stability within our services and ensure robust connections with the populations we support.

85. Models of education and training will need to change to enable more flexible working across a range of settings to reflect changing patient needs and support future models of service provision. Consideration should be given to including multi-disciplinary opportunities during the education and training of all healthcare staff (e.g. doctors, nurses, social workers, Allied Health Professionals etc). The development of healthcare support workers across health and social care and the investment in their education and training is considered essential to the transformation of the workforce and support for the principles of prudent healthcare. The skills and career escalator approach is advocated to support the development of the workforce with new entry routes established, including flexible education pathways.

86. We need to develop the current workforce at all grades, by extending the skills of registered professionals, training advanced practitioners and developing non-medical health and care staff. Support workers provide vital patient-focused care to individuals at home, in the community and in secondary care and further investment in non-medical staff can reduce pressure on qualified staff and provide a valuable route to professional qualification to those without academic qualifications.

87. We also need to train and develop the current workforce to ensure they are comfortable and capable of making the most of new technologies in meeting outcomes for individuals and increasing efficiency.

Case Study 15: Primary Care Clusters, Abertawe Bro Morgannwg UHB

There are 11 cluster networks in ABMUHB, each with a central management team in place. The Health Board is redesigning the workforce, working with primary care and third sector providers to ensure that the right level of staff with the appropriate skills are delivering services in the most appropriate setting. The cluster workforce is being developed to support prudent healthcare principles, service developments and overcome recruitment difficulties for certain staff groups.

There have been opportunities to change the skill mix across the whole care spectrum both to address the core GMS work as well as addressing some of the demand factors, such as complexity, increasing number of frail older people, and the need to address the widening health inequalities gap. Investment in the wider primary care workforce has included clinical pharmacists, community pharmacists, counsellors, physiotherapists, occupational therapists and mental health link workers among others.

88. Designing, planning and providing seamless health and social care services in partnership with individuals and focused on their needs will require practitioners across secondary and primary care and health and social care to work together more closely. We believe this could be facilitated by the development of a joint workforce strategy, supported by a review of workforce policies, employment models and conditions across the two sectors to identify barriers to integrated working and opportunities to develop greater synergy and parity between health and social care workforces. New integrated models of care are being developed across Wales and the NHS and local government is committed to increasing the pace and scale of this work and as a system to learning from good practice as it develops.

Case Study 16: Ribera Salud, Spain

Ribera in Spain uses a two-way immersion program to create mutual understanding between secondary and primary care clinicians. It started on a volunteer basis, but has become an integral part of Ribera's culture of collaboration between GPs and specialists.

Every primary care doctor has one week a year during which they can choose specialties that they would like to work alongside in the hospital setting. They are encouraged to select specialties that they feel will be complementary to their professional development or where they have seen greater demand in their primary care clinic. They can participate in the exchange every year and are encouraged to choose at least two specialties to shadow during their immersion week. The exchange takes two forms—substitution and shadowing. GPs can substitute directly with emergency department doctors—they swap for the week and do each other's jobs. The other option is that GPs can shadow specialists in the hospital and then the specialists can choose immersion in the GP clinic or work on joint projects such as creating care pathways.[xxxviii] After the exchange, the doctors fill out an evaluation where they highlight how they would change or improve the care that was provided. The shadowed department evaluates the doctors, provides performance reviews and areas for individual improvement.

Like any project, it took a bit of time to get off the ground but now it's incredibly popular and has expanded to include nursing staff. Over a year they average 250 doctors participating, including mental health professionals, specialists, and primary care doctors and they see the same level of involvement from employees and civil servants. Since its introduction, staff report care plans are much more specific, save time and avoid waste, and patients referred from community clinics arrive in better condition.

89. Beyond the health and social care workforce there are opportunities to develop the skills of other occupations to help support the well-being of the Welsh population. Individuals who work in local communities; the postal worker, the teacher, the hairdresser, the charity volunteer and the shop assistant could all play an active role in supporting individuals and communities to stay healthy and connected. The Jersey Postal Service case study 9 in section 5.0 is a good example.

90. For NHS Wales the issue of the affordability/sustainability of the current workforce is critical. The Health Foundation report, The Path to Sustainability,[xxxix] assumed that pay inflation could be contained to 1% for the next three years, but with the Cost Price Index currently running at 2.3% and pressure from a number of staff groups (including nurses on a UK level), there is likely to be significant pressure on NHS employers to go beyond 1%. So the UK and Welsh Government need to be realistic about the extent to which the gap can be closed by pay bargaining and the potential contribution of redesign. The ongoing work on pay including medical contract negotiations and changes to Agenda for Change is important, but needs to be viewed in the context of the constraints on the ability to reduce and change workforce size and configuration without major service change and redesign.

91. The current focus on the workforce is predominantly through the numbers of registered professions (supply) rather than the needs of the patient (skills, values and behaviours a person needs to help them reach and maintain independence). Education and training of healthcare staff therefore needs to enable and facilitate the service being able to respond to the full spectrum of needs in society.

92. Some of the key risks and opportunities facing the NHS Wales workforce include:

- The ongoing growth of the medical consultants, the most expensive section of the workforce, whilst overall FTE has remained relatively stable;
- The focus on defining staffing ratios in the Nurse Staffing Levels (Wales) Act 2016 is welcomed in driving quality of care but could also act as a barrier to workforce redesign and the development of the healthcare support workforce. Increasing demand for qualified/registered nurses in acute care;
- A focus on prudent healthcare provides an opportunity to drive workforce redesign but there is also a need to recognise the danger of burn out in staff working continually at the top of their licence in addition to the need to ensure that experienced clinical decision makers are available at key points in patient pathways;

- Supply risks – shortages of doctors in emergency medicine, clinical radiology, psychiatry etc. These shortages are driving skill mix change and development of extended skills roles for other professions.

93. There is a need to align our workforce skill mix to case mix across patient pathways from primary / secondary / tertiary care and focus on those parts of the workforce where there is scope to develop and support new models of delivery and supporting them through policy drivers (e.g. investment in training and skills development support).

94. NHS Wales will need to ensure a more appropriate balance between generalists and specialists without losing sight of the importance of specialism. This will ensure that the future workforce is more adaptable, able to respond to and adopt the latest research and innovation that could benefit patients as well as promoting more rewarding careers for staff.

95. Modernisation of the workforce has often been ad-hoc and reactive to either local or national pressures with many changes not always reflecting service need or being sustainable. For example, new roles have been added without decommissioning old roles resulting in a net increase in costs and new categories of workers who often have very discrete roles, especially in relation to the roles of others and their contribution to the whole team.

96. The future is necessarily uncertain, and we should therefore plan for uncertainty by having a workforce that is capable of being more flexible and adaptable. The workforce is both a key enabler and a driver of change in health, and must be integral to all future planning and investment decisions if the opportunities to improve care are to be realised.

97. The NHS in Wales has developed six Core Principles (see Appendix 1) to help and support staff working in NHS Wales. Launched in February 2016, the Core Principles describe how we can work together to make sure that what we do and how we do it is underpinned by a strong common sense of purpose which we all share and understand. The NHS is continually under pressure to deliver more services, with better outcomes and maintain and increase quality against the backdrop of significant financial challenge, high levels of public expectation and with a population which is getting older and with increased levels of chronic conditions. The principles have been developed to help address some of the pressures felt by staff in responding to these demands. They will re-balance the way we work together so we are less reliant on process and are supported to do the right thing by being guided by these principles when applying policies and procedures to the workforce. Organisations have also undertaken a lot of work on a local level to develop their values and ensure that these are aligned to the NHS Wales Core Principles.

98. Across NHS Wales, Health Boards and NHS Trusts are working on approaches to staff engagement. The NHS Staff survey was repeated in 2016 and an assessment against the medical engagement scale (which measures the level of engagement between managers and medics) was undertaken across Health Boards to test levels of satisfaction amongst hospital doctors.

99. Ultimately, fully engaged staff will have higher job satisfaction and are more positive about where they work and what they do. They will become more committed to their

workplace and employer and act as ambassadors and advocates for their organisation. It is important for staff working across NHS Wales to have the best workplace experience possible to allow them to influence and shape services and deliver high quality, effective health care interventions for their communities.

100. There is a close association between high levels of workforce engagement and:

- Improved staff satisfaction;
- Improved staff well-being;
- Improved service outcomes including quality and productivity;
- Improved financial and performance efficiency; and
- Staff acting as advocates for the organisation.

101. The continued focus on staff engagement is essential to the development of the healthcare workforce and a strong emphasis on organisational development will be required to support the transformation[xl] of services. The Kings Fund noted in their 2015 report on Staff Engagement that there is an overwhelming body of evidence to show that engaged staff deliver better health care. Health organisations "*with more engaged staff tend to have lower levels of patient mortality, make better use of resources, and have stronger financial performance and higher patient satisfaction, with more patients reporting that they were treated with dignity and respect*".

102. There are many initiatives at local organisational level including the introduction of staff recognition awards within a number of organisations linked to local organisational values; the setting up of staff focus groups within NHS Wales Shared Services Partnership; and the development of Well-being Champions at Abertawe Bro Morgannwg University Health Board who help signpost staff to local health and well-being initiatives.

103. The Kings Fund paper encouraged Boards and other leaders to focus on staff engagement and suggested that there are six building blocks for ensuring a highly engaged workforce. These are to:

a. Develop a compelling, shared strategic direction;
b. Build collective and distributed leadership;
c. Adopt supportive and inclusive leadership styles;
d. Give staff the tools to lead service transformation;
e. Establish a culture based on integrity and trust; and
f. Place staff engagement firmly on the board agenda.

104. Such an approach should be comprehensively adopted for health and social care and not seen as an optional extras and this needs to be addressed through a long term commitment and investment.

Case Study 17: Physician Associate (PA), Abertawe Bro Morgannwg University Health Board (ABMUHB)

In 2016, ABMUHB worked in partnership with Worcester University to secure a cohort of PA Students to undertake their clinical placements across the Health Board. Seven PA students joined in September 2016 and are currently mid-way through their placement blocks. Placements include Primary Care and Community, General Medicine, Critical Care, General Surgery, Mental Health and Emergency Medicine. Students have also gained experience in specialist clinical areas including Trauma and Orthopaedics, Neonatology, Haematology, Burns and Plastics, Renal and Neurosurgery.

Student experience has been extremely positive in terms of variety and quality of clinical placement opportunities and the way clinical teams have welcomed and supported them. As the role of the PA is new to ABMUHB, there is still work to do to raise awareness of the role and how the skills of PAs complement and integrate into multi-disciplinary team working. This cohort of students have been very self-directed and well received throughout ABMUHB and have acted as ambassadors of the PA role, raising awareness. The students will continue to work on an internship basis post qualification to consolidate their skills and knowledge and act as mentors for incoming students.

In October 2016, Swansea University launched a new two year Post Graduate PA Programme. As an integral part of the ARCH Programme, ABMUHB and Hywel Dda University Health Boards are currently providing clinical placements opportunities for 15 students. Plans are also underway to recruit a further 20 students in October 2017 to provide an ongoing pipeline for PA students as core component of workforce development in South Wales.

The PA journey in ABMUHB is on-going. It has learned many lessons during the first year which will continue to shape the future of PA student placements and PA roles. As the appetite for the role of PA grows, consideration needs to be given to the additional pressure this places on clinicians job plans to release time for teaching and supervision due to elevated number of students on placements including nursing students, medical students and junior doctors. Students from Worcester and Swansea have networked well together and it is envisaged that internship posts in the autumn will lead the way for developing the role of the PA role in ABMUHB.

105. Workforce redesign needs to address short – medium term risks and priorities within the context of longer term direction of travel. This can be achieved by:

- Developing workforce planning and workforce redesign skills within organisations and supporting clinical leaders and managers to deliver this agenda;
- Developing clear strategies for training and development of the core workforce in addition to education commissioning of new staff and utilisation of flexible career pathways;

- Organisation development strategies to support redesign;
- Addressing the needs of the support workforce across both health and social care;
- Prioritising planning which addresses the need to deliver care closer to patients homes and maximising opportunities to develop skills to support this in primary care and community service and spreading the use of supporting technologies; and
- Developing roles around clinical teams with clear roles and accountabilities, identified career progression and reduced fragmentation.

What would help the NHS to reshape the workforce?

- Developing a joint long term workforce strategy for health and social care supported and underpinned by a meaningful approach to staff engagement and organisational development that will deliver a resilient, reshaped, well trained workforce with the necessary skills and capacity to meet the changing needs of the Welsh population over the next fifteen years.
- Support staff in the management of change.
- Ensure investment in mechanisms to enable resilience of the workforce, including effective line management skills.
- Development of a comprehensive skills escalator which supports flexible training and education pathways as well as widening access to healthcare careers.
- Flexible education commissioning to include part-time and apprenticeship-type models.
- National focus on the organisational development needs of NHS organisations and staff, recognising the requirement to develop the skills, competencies and capacity of individuals to take on new roles and relinquish tasks no longer required.
- National investment in a leadership development programme, including clinical engagement and a succession planning framework for senior leaders.

7.0 Finance, Technology, Efficiency and Value

106. Core NHS spending now accounts for more than 50% of the Welsh Government's revenue budget. However, in line with the rest of the UK funding growth has not kept pace with the overall growth in Gross Domestic Product – something which the Health Foundation suggests is key to ensuring a sustainable NHS in the future. At the same time social care spending on day to day adult social services has remained broadly flat, but the increasing over 65 population in Wales means that spending per older person has fallen by nearly 13% in real terms over that period.

107. The public finance outlook for the foreseeable future at least remains pessimistic and the indications are that the growth in funding which is badly needed in both health and social care will be very difficult to find and will require difficult choices to be made about public services in Wales. Wales Public Services 2025 has produced an analysis on the health and social care financial outlook to support our evidence to the Parliamentary Review Panel and this is attached at Appendix 2.

108. This is the financial context in which the NHS and social care is currently operating and both parts of the system are already feeling the strain. Despite the welcomed additional funding the Welsh Government has provided to the NHS and social care in 2017-18, a number of Health Boards are forecasting significant deficits and social care is forecasting a budget shortfall of around £82 million over the next year alone.

109. The Health Foundation report, The Path to Sustainability, referred to earlier, articulated the financial challenge facing the health and social care sector in Wales over the next fifteen years. The report suggests that a sustainable publicly financed healthcare system in Wales is achievable by 2031, but only with growth in funding in line with growth in GDP in respect of the NHS, plus a 4% uplift year on year in social care funding. The Institute for Public Policy Research[xli] estimates that across the UK there will be a funding gap to the tune of £13 billion for adult social care, equivalent to 62% of the total expected budget, by 2030-31 and they warn "*on current trends, adult social care is unsustainable*". Many other public services have been squeezed out as Councils essentially run social care and school provision.

110. A closer analysis of the Health Foundation report reveals an assumption that there will be no change in the current range or quality of service, year on year efficiency savings of at least 1% across the NHS and pay restraint for at least another three years. It took no account of the long term workforce requirements for the health and social care sector, nor could it reflect with any certainty the impact of Brexit or future political decisions.

111. Both the NHS and local government have delivered millions of pounds of recurrent efficiency savings over the past five years, as evidenced in various Wales Audit Office reports.[xlii] We now need to become more sophisticated in our search for further resource releasing efficiencies, going beyond the delivery of traditional technical efficiencies to consider the efficiency of our resource allocation, based on a better understanding of the outcomes of our spending decisions. There is further potential to

drive technical efficiencies from across the NHS. Our members are working to implement an efficiency programme using benchmark data, but we believe a greater pace could be achieved if Wales adopted a more systematic approach to efficiency, akin to the Carter work in England.[xliii] Similarly, we urge Welsh Government, Health Boards and Councils to consider the allocative efficiency of their budget processes to ensure they allocate resources to support a preventative model of health and social care.

112. Even then, the demographic trajectory combined with medical and pharmaceutical developments will lead the health and social care sector to continue to need substantial ongoing financial support, which is likely to involve further disinvestment in other public services. We recognise that the funding required is not within the Welsh Government's gift, even with the introduction of income tax raising powers. But we cannot simply ignore the reality of the problem. The Well-being of Future Generations (Wales) Act 2015, if not our collective conscience, precludes us from our desire to hope for the best and avoid the difficult question of how as a country (i.e. UK and Wales) we intend to meet the costs of a sustainable heath and care system that delivers the level and quality of care that our population deserves.

113. Many public sector leaders – politicians and policy makers – already recognise that the current funding model is no longer fit for purpose. It was designed in the post-war era when the birth rate was falling and the world was a very different place. While we would all champion a free health and social care system for all, those in positions of responsibility need to be honest with the public about what that could mean in the future. Especially if we don't succeed in securing the shared ownership and changed behaviours from the public.

114. We believe that it is not possible to consider the long term future of health and social care in Wales without considering the issue of how and to what level the system should be funded in the future as this will impact on decisions we make in the next five to ten years. Short term funding fixes will not suffice if we are to address the serious financial challenges we face. Neither will small scale amendments to the edges of service delivery. Indeed, the recent House of Lords Select Committee report into the long term sustainability of the NHS calls for radical service transformation, long-term funding solutions and immediate and sustained action on adult social care as the three key objectives that must be addressed if the NHS is to make real progress towards achieving long term sustainability.[xliv] We agree and believe that to realise the vision outlined at the start of this document governments need to consider alternative funding models for the health and social care sector. This includes options such as increasing taxes as well as paying for specific services or rationing others. As such, we would hope the Parliamentary Review will help to stimulate the debate and develop the public's understanding of the difficult choices ahead.

115. The old adage "failing to plan is planning to fail" is very relevant to this debate. If we fail to plan the resources now we will be left with failing services, longer waiting times, poorer patient outcomes and no funding available for discretionary services in future.

116. Some commentators are arguing that we now need a dedicated national health and care fund for integrated health and care. This would require some general taxation but could be gradually built up with more money from hypothecated taxes associated with health and consumption of care. This means using taxes on tobacco, alcohol, unhealthy foods, gambling and inheritance, and possibly a compulsory insurance tax at age 50, to pay for social care in old age. At its 2014 conference the Royal College of Nurses nationally debated whether a possible solution to current challenges would be to introduce patient charges for GP visits. Others have suggested that well-designed user charges would not only raise additional revenue, but would also limit unnecessary demand, encourage greater cost-effectiveness in the use of healthcare services, and promote the adoption of healthy lifestyles.

117. These ideas may be controversial, but shying away from difficult debates over these issues will not help the health service or social care an in the long run. As the crisis in England demonstrates, we are at a crossroads. To achieve the vision highlighted in our submission, the overwhelming weight of evidence points to the need to make radical changes now that will secure the health and social care system in the future.

118. We also believe that Health Boards should be given powers to borrow as this would:

- Give organisations much greater local flexibility of resource across revenue and capital;
- Enable the NHS to modernise and improve estate at a greater pace than is currently achievable;
- Allow Health Boards to invest in accelerating capital investments, where these demonstrate a clear revenue saving and payback;
- Instil a discipline of longer term planning and assessing business cases on a more commercial footing, securing an even greater focus on due diligence even in areas where borrowing is not required;
- Clarify current arrangements surrounding finance leases and PFI arrangements where Health Boards do, in effect, borrow to fund future developments; and
- Need to be balanced over revenue to pay back any borrowing and would require some form of underwriting to facilitate competitive borrowing rates.

Case Study 18: Rapid Access to Consultative Expertise, British Columbia, Canada

The rapid access to consultative expertise (RACE) initiative was introduced by Providence Health and Services in British Columbia. Specialists and family practitioners at Providence Health Care saw the increasing challenge of chronic disease management as an opportunity for creative, collaborative and innovative solutions. A partnership was formed between Providence Health Care and the Shared Care Committee (a joint committee of the British Columbia Ministry of Health and the British Columbia Medical Association) in collaboration with Vancouver Coastal Health to identify gaps in the care process for patients with chronic diseases and to develop and test prototypes for transferable and scalable improvement that brought about cost savings for the provider while delivering care closer to home for patients.

RACE acts as a direct line where family physicians call one number and are directed to the appropriate specialist in an acute setting for real-time advice. It enables physicians to seek urgent advice on potential treatment options and the opportunity to discuss these options with another professional. Calls are guaranteed to be returned within two hours, and commonly within one. In practice, this means that patients may be able to receive the care they require from their family physician within the community rather than having an appointment with a specialist at a later date in an acute hospital setting, thereby ensuring that those in greater need of seeing a specialist are treated first.

User satisfaction with RACE has been unanimous since its implementation - family physicians who have used the service said they would use RACE again and viewed it as an excellent resource, allowing for practical and specific advice in real time. 90% of calls were returned within one hour and 75% of calls were returned within 10 minutes. Providence Health Care also claim that RACE is also having a financial impact - family physicians using the service say RACE not only reduces the number of unnecessary referrals to specialists, but also prevents emergency department visits, with some figures suggesting that each call to RACE saves approximately $200 in acute setting costs alone.

RACE has received two awards since it was launched, including the IPAC/Deloitte Public Sector Leadership Award, the Health Employers Association of British Columbia Top Innovation Gold Apple Award and the BC Excellence in Quality award.

RACE serves to demonstrate the value of utilising professional skill sets to the maximum of their potential. Both patients and professionals benefit from having in place a system that allows for simultaneous sharing of information and best practice while further embedding the work of multi-disciplinary teams in the provision of care.

119. In the meantime delivering high quality, safe and prudent healthcare to optimise outcomes for patients will continue to be the NHS priority as recognised in the 2016 OECD report “Reviews of Health Care Quality: United Kingdom 2016”. We will continue to drive and embed prudent healthcare across the whole health system and would recommend that the prudent healthcare principles be extended to the social care sector and other public services.

120. There is a growing body of evidence on the prevalence of inappropriate clinical delivery efficiency. To tackle the issue we need to address the gaps in medical evidence and clinical resistance to standards of care. To be successful, the NHS in Wales needs to invest the resources required to support care standard development. International evidence suggests that the best in class standards are developed by creating multi-disciplinary teams led by doctors, collectively engaging the team in defining the right care. To embed the standards and derive the long term benefits will require a national performance management and accountability mechanism that promotes adoption, accountability and adherence. The NHS in Wales is developing a Reducing Unwarranted Clinical Variation Programme and this needs to be prioritised, resourced and driven over the next five years to systematically reduce variation. The case study below highlights the some of the work already underway.

Case Study 19: International Consortium for Health Outcomes Measurement (ICHOM)

ICHOM is a non-profit organisation founded in 2012 that has developed a globally agreed set of outcomes reflecting what matters most to most patients. In June 2015, ICHOM announced a new Strategic Alliance with Aneurin Bevan UHB (ABUHB) as part of their plans to embed value-based healthcare into their overarching strategy to support.

ICHOM has advised and supported ABUHB by providing a set of clearly defined and globally-agreed standards to draw upon. ABUHB now has a programme of eight projects in train, including Hips and Knees, Primary Care Mental Health, Cataracts and Heart Failure.

121. In addition to making best use of financial resources, the health and care system must maximise the strategic and operational potential of digital technology as an enabler of change. The digital revolution is upon us. In our domestic lives we understand and embrace it. The majority of us use digital devices and services daily, purchasing goods and services, networking with friends and colleagues and even interacting remotely with our heating systems. And yet, as a user of public services we are often disappointed, frustrated and surprised that we cannot engage digitally with the NHS or local government. The experience is similar as a public servant – we are exasperated that we cannot access or share data within or across organisations and that we are still operating antiquated paper based processes with the inherent waste and delay they create – and we know that our digital deficiencies are impacting on the quality of health and social care we are able to provide.

122. By 2027, the average aged public servant working today will be around retirement age and the average public servant will have a birth date of somewhere between 1980 and 1990. As such there will be no-one working within the health and social care system who did not grow up in the internet age. The wider population, even those who may be considered elderly, will have been living in the digital age for forty years. By then, experts predict “the Internet will be like electricity – less visible, yet more deeply embedded in people’s lives”.[xlv]

123. For this statement to be true in a future Wales, we need hyper fast broadband which is accessible in every home, business and public facility. Without it, rural communities in particular will continue to struggle to access modern health and social care services, demand on secondary care will not be reduced and health and care professionals will be disempowered to work in these areas.

124. Digital technology should be seen as the one of the most significant strategic tools available to us to shift to a new preventative model of health and social care – a model which will help to reduce demand on secondary care services. It is already being used to improve data quality and access, leading to higher quality, more accurate information and more tailored and individual service responses and improved self-care. There are many examples on a small scale where the NHS and local government is trying to embrace digital technology, such as the use of text messaging services to support individuals with chronic conditions[xlvi] or the establishment of online forums for unpaid carers. These developments are in line with Prudent Healthcare and are designed to promote self-care. In the main however, developments to date have tended to be local and ad hoc, despite the existence of a national Health and Social Care Digital Strategy.[xlvii] In the meantime, the independent sector has already developed over 165,000 health apps.[xlviii]

125. At an application level, we use digital technology to develop monitoring and wearable technology, on-line triage, information and advice services, appointment and transactional services and conduct remote consultations. But used as a strategic tool it can also help to transform the operating model of organisations. With a focus on the service user (and involving them in the process) and with an explicit aim of seeking to increase self-care and service outcomes, organisations can review their internal processes and redesign them, removing duplication and waste to create an operational model with digital technology embedded through and across whole organisations.

Case Study 20: Innovation Catalyst programme – Examples from across Wales

Thanks to the Small Business Research Initiative (SBRI) Innovation Catalyst programme nurses at Betsi Cadwaladr UHB are able to use tablets and other handheld devices to record patient information and complete paperwork at the patient's bedside (rather than at a desk), thereby allowing staff members to spend more time with patients.

At ABMUHB, the development of three state-of-the-art operating theatres fitted with high-definition cameras, a central control panel and a robotic arm to guide the endoscopic camera, means surgeons can treat more people through minimally invasive keyhole surgery than ever before. According to the Health Board, this means there is a much quicker recovery, less post-operative pain and a shorter stay in hospital.

At Velindre Cancer Centre, experts are now using stereotactic radiosurgery, a modern, more precise way of delivering radiotherapy which sends high doses of radiation to tumours and causes less damage to surrounding healthy tissue. The machine is one of the most advanced of its kind, targeting tumours with pinpoint accuracy, meaning therapy is delivered more efficiently to reduce side effects and shorten treatment time. The use of the radiosurgery also means patients who previously had to travel to Sheffield can now receive treatment in Wales.

In Hywel Dda University Health Board, oncology patients can access a new telemedicine service which allows them to take part in speech therapy video consultations within their own communities. Previously, patients with head and neck cancer living in Ceredigion or Pembrokeshire had to travel almost two hours each way to receive speech and language therapy at Swansea's Singleton Hospital. Macmillan Cancer Support invested in telemedicine equipment so patients can have a consultation closer to home from Bronglais, Glangwili or Withybush hospitals with the specialist therapist based and Singleton hospital.

Cardiff and Vale University Health Board has made the most of mobile technology to allow health staff to make thousands of extra visits to patients in the community. The roll out of hundreds of extra remote access devices, and the increased use of electronic records, has allowed the health board to increase the number of home visits by 16%. Staff can now access a single electronic file for community and mental health patient details at home or in hospital.

Public Health Wales and Alcohol Concern's 'One Drink One Click' app helps people to anonymously monitor how much they are drinking. Users can input the number of alcoholic drinks consumed, find out how many units this equates to and measure their data against healthy consumption guidelines.

126. The creation, ownership and access to user data is another critical aspect of successful digital transformation. This is an area where a national approach would seem sensible both in respect of identification and authentication models as well as the implementation of national data systems. We already have a number of national systems in place such as the Laboratory Information Management System (LIMS*)* and health and care software in the form of the Wales Community Care and Information System. According to The Kings Fund, by 2030 citizens should be able "to easily share their health data in a standardised format and in real time".[xlix] We have yet to establish a single identification model for the NHS or local government and the ownership of data remains an obstacle to further progress with issues around trust, independence and responsibility, despite some local developments such as Patient Knows Best and Dewis.

127. As the number of documents has increased, the quality of record-keeping has deteriorated. Poor documentation is a key theme which features in external health board inspection reports, including the Healthcare Inspectorate Wales, Trusted to Care (2014), internal organisations audits (for example, the Fundamentals of Care Audit 2015), disciplinary hearings and Public Ombudsman reports. Examples from these reports cite the fact that patient assessments are not completed properly, care plans are either not written at all or are not specific to the individual patient and are not updated. Across Wales, Health Boards are attempting to address these (national) problems locally, but this results in uncoordinated activity with duplication of effort and an increase in the volume of documentation. The ever-shifting footprint of health and social care organisations mean that a national approach to standardising the capture of care information needs to be the way forward.

128. A fundamental principle of a whole system approach to unscheduled care services is the ability to share patient and condition specific data across a number of service areas. We need to have much more easily accessible real time information about the performance of services to enable patients to make choices about their care and also how and when they access services. Transparency will be greatly enhanced by the provision of real time information as many of the current systems in healthcare take an extended period of time to produce meaningful data e.g. mortality data and other information can take three months or more to produce. To ensure transparency is the norm, performance and data systems need to be supported, however it is unclear how legislation in isolation would improve transparency as this would need to be underpinned by cultural change. The performance management framework for Wales could be used to drive improvement in terms of transparency and openness.

129. Performance is regularly monitored by Boards at public meetings and information is readily available on websites and this should be developed to be outcome focussed rather than process focused. National IT systems should be available to allow NHS organisations to make their performance information publicly available and reportable.

130. Organisations need to adopt a culture of sharing information where the benefit is to improve care for an individual. There are many perceived barriers to sharing patient information across the health and social care system. The Data Protection Act 1998 provides a legal framework for allowing organisations to share information appropriately, taking into consideration the privacy and confidentiality of individuals. However, it is often through a lack of understanding by an organisation or staff, or through a lack of training, that the legislation is used to prevent effective sharing. There is no doubt that the misunderstanding of how the legislation is to be implemented acts as a barrier as it is likely to prevent legitimate sharing when staff err on the side of caution.

131. As a result of the Information Commissioner's powers in extending fines for breaches in the Data Protection Act 1998, we now find ourselves in a position where the sharing of clinical data is restricted. Clinical information critical for prudent treatment and quality care for patients is sent in password protected formats that cannot be opened without considerable delays. We have defaulted to a system where now data protection risk trumps risk to the patient. The NHS in Wales needs to look closely at the way in which we transfer data and the limitations of our systems, rather than the law itself. If we want a joined up health and social care system, we need the infrastructure and the finances in place. An integrated IT infrastructure would make this possible but investment is needed as a priority.

132. Due to a lack of published national information governance standards in Wales, there is often a lack of trust between organisations to ensure that once their information has been shared, similar systems, processes and security measures will be applied to that information to help prevent damage to the organisation's reputation or application of a financial penalty. This is an area where the Welsh Government can take action to ensure that all policies requiring partnership working are supported by current or new legislative provisions enabling data sharing. The Social Services and Well-being (Wales) Act 2014 and related regulations set a good example of ensuring that organisations have the necessary

legal basis for sharing information across the new partnerships. Such legal gateways can obviate the need for the individual's consent when sharing their information.

133. Continued use of Wales Accord on the Sharing of Personal Information (WASPI) and the central arrangements would support the breakdown of perceived barriers. The introduction of published national standards around information governance, security and compliance with WASPI would lead to increased confidence between organisations and encourage more effective sharing, ultimately benefiting the patient and the care they receive.

134. Fundamental review and upgrading of IT systems and security is crucial. Investing in good quality and compatible IT systems that can 'speak to each other' across organisations would break down many barriers. Also, IT equipment and software systems of the highest standard can facilitate such sharing of information right across the patient/client pathway rather than acting as barriers.

135. The Welsh Government has recently moved to a position of presumed consent and an opt-out system for organ donations, following consultation and the adoption of a similar approach for personal information. This would create a positive shift in behaviours and approach. We consider that if patients feel their care will benefit they would be happy to have organisations share information. This will also avoid patients having to give the same information on numerous occasions to different professionals/ organisations. It would be beneficial if we follow the opt-out model being adopted by the Human Transplantation (Wales) Act 2013 because many citizens assume that their information is shared in order to plan and co-ordinate their care and would want the clinicians and professionals to have best access to the information about them.

136. The health and social care digital strategy presents an ambitious vision for the sector and the NHS alone has identified a funding gap of nearly £500 million over the next five years with the costs being associated with infrastructure, software and staff training and development. These figures do not include the costs for transforming social care so further work is needed to determine the minimum level of investment required. The workforce challenge of introducing digital systems should also not be underestimated.

137. In our view, we need to adopt a whole system approach to digital transformation and to be explicit about what should be done locally and what could be done nationally. We need to learn from our experience of the past decade to deliver digital transformation within a clear a national framework which does not stifle local innovation or progress. We also need to recognise that current public finance constraints mean that individually NHS organisations and local government do not have the scale of investment needed to transform and integrate the whole system, which is what we believe is needed.

What would help the NHS address the financial and technology challenge and drive greater efficiency and value?

- Welsh Government starting a debate with the National Assembly for Wales, UK Government and the public regarding future funding for health and social care.
- Being honest with the public about what the NHS can (and cannot) provide - work alongside the public to help them understand their role in supporting the health service and reduce demand and over-reliance.
- Welsh Government working with NHS to develop and implement a national efficiency programme within an agreed timeline.
- NHS to be given borrowing powers with a prudent framework akin to Local Government.
- Welsh Government to work with NHS to review existing digital strategy across health and care to agree clear national priorities and programmes to be implemented in a clear timeframe.
- Instilling a national focus on improving data quality across health and social care.

8.0 Governance and accountability

138. The Parliamentary Review is an opportunity to stimulate debate around whether legislation is needed to bring the current NHS governance structures up to date and ensure its functions are fit for purpose.

139. The complex and complicated governance and reporting arrangements within NHS Wales have developed over the eight years since the creation of integrated health organisations. The diagram in Appendix 2 highlights the complexity of a system and identifies a number of work around solutions that complicate the governance landscape further. There are a range of differing governance, accountability and reporting arrangements without an underpinning logic or structure. Legislation relating to hosting arrangements does not exist, despite a number of health organisations, including Velindre NHS Trust and Cwm Taf University Health Board, successfully 'hosting' services through varying governance models. Examples of current governance arrangements include:

    - Welsh Health Specialised Services Committee (WHSSC);
    - Emergency Ambulance Services Committee (EASC);
    - NHS Wales Shared Services Partnership (NWSSP); and
    - NHS Wales Informatics Service (NWIS).

140. Another issue relates to the role of Welsh Government in leading and managing the system. The 2016 OECD report suggested that the Welsh Government will need to become more prescriptive about what is expected from some bodies and organisations –

notably Health Boards – while encouraging and incentivising innovation[l]. In governance terms, the current system is already prescriptive and allows little freedom for health bodies to flex arrangements locally, e.g. in the composition of Boards. Health organisations are increasingly moving to systems that 'empower the front line' by increasing autonomy and accountability at a local level and the current arrangements at an all-Wales level are inconsistent with such a model. This, in turn, leads to the question of what are the underpinning principles on which the health and social care system should be developed and judged. In our view, they should be:

- Citizen-centred and easily understood;
- Based on prudent healthcare and co-production and allow decisions to be made at the nearest point to the citizen as possible;
- Designed to encourage and support service integration; and
- Developed to encourage consistent standards.

141. In respect of Welsh Government leadership of the NHS, NHS leaders require professional leadership from the Chief Executive of NHS Wales. At the same time, the Chief Executive is required to fulfil the Director General's accountabilities and sometimes these roles may be in conflict or tension. Our members believe that it would be beneficial to have the role and accountabilities of the Director General and the Chief Executive of NHS Wales separated to ensure there is professional leadership and support on behalf of the NHS and professional leadership providing direction from the Welsh Government. It would be useful to have someone independent who can provide the direction that Health Boards may require.

142. Moreover, it is important to consider the governance arrangements when service change is increasingly being considered on a pan-Wales basis. However, the statutory obligations of Boards are to their resident populations and not the overall population of Wales which has the potential to create conflicts of interest which are not easily overcome. In an attempt to address this issue, the NHS has created All Wales NHS Collaborative, overseen by the Collaborative Leadership Forum, but this arrangement has no executive function and so the potential for conflict remains. In our view, there needs to be a vehicle that enables an all-Wales planning and decision making process when necessary. There are potential opportunities to standardise and rationalise these arrangements e.g. through the establishment of a single all-Wales body to manage or host these arrangements. If an all-Wales body is established then it could be led by the Chief Executive for NHS Wales.

143. As highlighted in our response to the "Our Health, Our Health Service" (included in Appendix 3) an improved referral mechanism is needed for when Community Health Councils (CHCs) wish to challenge service change. It is important that the CHCs are maintained but we would recommend that their role is refocused to represent the patient voice and improving advocacy services. If they are given such a remit, consideration needs to be given to the appropriate "weighting" of the feedback received from CHCs and how this is played in any formal consultation mechanism the NHS is required to undertake. Our members also believe that the Cabinet Secretary's role should be reconsidered during resolution if the NHS Chief Executive is unable to reconcile the positions.

144. Beyond the NHS, as health and social care services increasingly work together to define and deliver against agreed aims and objectives through Public Service Boards, the current governance and management models operated by the NHS and local government in Wales may require further change. The role of Welsh Government (in its broadest sense) in leading and managing this transformational change is pivotal and clarifying this as part of any legislative change would be helpful. Any new legislation drafted should positively encourage the delivery of an integrated health and social care system across Wales.

145. Another area of governance that would benefit from further clarification is the relationship between the Regional Partnership Boards and the Public Service Boards. We would support the merging of Public Service Boards to a Health Board footprint where there is support from all partners, particularly for Health Boards that cover a number of local authority areas. We also believe consideration should be given to respective boards developing joint plans, based on shared aims and objectives to supplement Integrated Medium Term Plan (IMTP) arrangements within the NHS. Furthermore, it is important to consider and be clear about how NHS Trusts in Wales link in and report to Public Service Boards. This has clear implications for IMTPs and the current, direct accountability of NHS organisations to Welsh Government.

146. Consideration also needs to be given to decisions around integrated services, for example if Health Boards and Local Authorities cannot agree in relation to planning services, what process or person is there to support them to make the decision? There is already a significant amount of planning occurring on a Local Authority and Health Board level, but there needs to be other vehicles to support this on an all-Wales level if a decision cannot be made. In this context we also suggest that there could be stronger links between the CHCs, Town and Community Councils and the Local Authority Scrutiny Committees could be considered, thereby ensuring to a certain degree some democratically elected input. Such a move would address some of the current issues and criticisms in terms of lack of integration between health and social care at a grass roots level. In any restructuring, given the economic backdrop, care needs to be taken not to add further complexity and duplication to the system, but to use this as an opportunity to streamline.

147. Similarly, we believe the role of Health Inspectorate Wales needs to be reviewed in light of the move towards integrated health and social care provision. The opportunity to develop a single regulator or inspection body/framework for health and social care in Wales should be explored. We need one integrated regulatory body working within one framework. It's more than joint working, it requires legislative change with common standards and common framework. Merging the inspectorate bodies seems a logical step if we are really working towards integral health and social care. This would create a stronger, less complex system for patients, public and the service to understand and prevent issues falling between organisations.

148. The reduction of waiting times is a key priority for NHS Wales and there is much work underway to try to improve performance against waiting time targets. While targets have a role to play, we must also look at the bigger picture, instigating a whole system change in the way treatment is delivered to patients and providing the best service within the resources that we have. It is vital that we develop a performance management

framework that supports this, focusing more on clinical indicators and outcomes rather than processes and targets with limited, or no, clinical evidence to support them.

149. At the moment there are so many Tier 1 and Tier 2 targets that drive behaviour in certain ways. The targets are focused on acute and secondary care and the targets do not always help the system to grow and redesign, such as moving services into primary and community care. The future performance management framework needs to priorities patient experience and clinical outcomes.

150. When developing a performance management framework, the Welsh Government and other stakeholders should consider the key enablers that led to the implementation of the new Clinical Response Model (CRM) for the Welsh Ambulance Services NHS Trust (WAST). The CRM pilot has moved the focus from a specific time target, other than where clinical evidence supports such a target, to improving outcomes and experience for patients through introducing a clinically appropriate response.

Case Study 21: Clinical Response Model, Welsh Ambulance Services NHS Trust

Through the development of the CRM for WAST the following inter-related enablers were identified as important factors to consider when developing new performance frameworks for the NHS:

- Clinical evidence and leadership: Gaining support and advice from clinicians when developing a new performance management framework is critical to ensure that patient pathways and clinical outcomes are considered;
- Confidence: both public and political, in leadership and performance of NHS organisations is critical. Improvement in trajectory of performance builds political and Welsh Government confidence in the leadership of the organisation. Fronting difficult issues in media restores the connection with public and builds their confidence;
- Patient outcomes and pathways: When developing new targets, the whole patient pathway and the key milestones within the pathway must be considered (following NICE or other clinically recognised guidance);
- Independent review: An external review initially into performance targets could provide recommendations as to the reasons for developing new performance targets and provide further evidence in developing new targets;
- Staff support: As part of the review process staff engagement is critical to ensure that they are a partner in any changes and their feedback is taken forward as part of the process. Trade union and other professional organisation support is also critical in ensuring that there is a shared vision and commitment to change;
- Political Support: Engage Welsh Government and Cabinet Secretary to ensure their understanding of the clinical evidence in support of new performance targets and the difference it will make to patient outcomes;
- Policy direction: The new outcome based performance targets must consider the prudent healthcare principles and other key Welsh Government policies;
- External stakeholder support: To receive external stakeholder support it is vital to engage with unions, Royal Colleges and other stakeholders. It is key that their feedback is considered and they are informed of developments throughout the process;

- The operating environment: With rising demand, it is critical to evidence how the new performance targets will free up NHS staff time and bring efficiency to NHS pathways by doing what is clinically appropriate;
- External messages: NHS leaders need to engage with the media and provide consistent messages around why the changes are required and evidence the benefits to patients. As well as the media, it is important to keep Assembly Members informed about the process and highlight the evidence of how it will improve patient outcomes; and
- Audit and benchmarking: Once developed, it is critical that a clear audit of the process is developed and information released publicly. As part of the audit, it is important to consider all LHBs' performance so that we can benchmark to drive up consistency across Wales.

What would help the NHS address the financial challenge and drive greater efficiency and value?

- Welsh Government working with the NHS to develop performance management system that focuses on clinical indicators and outcomes, based on clinical evidence.
- Welsh Government to establish an appropriate governance mechanism to facilitate effective national / regional decision making where consensus cannot be achieved due to competing local priorities.
- The separation of the Chief Executive of the NHS and Director General for Health and Social Care roles.
- Simplification / streamlining of the current governance arrangements, terms of reference of hosted bodies.
- Simplification of governance associated with the Well-being of Future Generation (Wales) Act 2015 and the Social Services and Wellbeing (Wales) Act 2014 (i.e. regional partnership boards and public service boards).
- Simplify the current inspection and regulation arrangements including Community Health Councils, in line with our response to Welsh Government Green Paper (See appendix 3).

9.0 Innovation and the Economy

151. There is no doubt that the health and social care system in Wales, like many other systems across the world, is facing considerable challenges, but there are opportunities too. We need to see the challenges as the facilitator of innovation and transformation which can and will deliver better services and patient outcomes, based on the needs of the current and future population. At the same time innovation in health can stimulate economic growth in life sciences sector. The life science sector is a major contributor to the Welsh economy, employing around 11,000 with an average turnover of £2 billion per annum.[li]

152. One of the opportunities for the next that we need to harness is the potential to work with the university sector across Wales (and beyond) to develop our research, enterprise & innovation potential to drive an ecosystem of vibrant life sciences and health activity across Wales that will help us to deliver improved health, well-being and prosperity for current and future generations. We also need to engage the public and patients to participate in clinical research and trials and to create an infrastructure which identifies creativity and innovation in health and care and systematically support the expansion and commercialisation of good ideas.

153. In Wales around £40 million is spent each year on health research. We need to ensure that expenditure is delivering the greatest value possible for the health and care system and the Welsh economy as a whole. That requires us to place as much emphasis on development and on research so that we are investing in research which has the potential to deliver products and services that our current and future patients need, while at the same time enabling new home grown businesses to grow. We have taken tentative steps towards strategic partnerships with private sector business in the heath sector, as the case study below describes, and there is an opportunity for us to develop more of such partnerships. In doing so we need to develop and have confidence in our commercial capabilities, while also clearly defining boundaries and managing the relationship in line with public sector rules.

Case Study 22: Novartis Partnership, Welsh Government

In November 2015, the Welsh Government entered into a partnership with international pharmaceutical company Novartis to allow NHS Wales to access the drug everolimus. Everolimus treats certain types of advanced renal, pancreatic and breast cancers and non-cancerous brain and kidney tumours. The partnership brought together the Welsh Government, NHS officials and leading disease area experts, along with expertise from Novartis to plan this initiative. An individual patient funding request (IPFR) is not required to access the treatment, which can cost up to £36,000 per year. The drug would not be readily available to NHS Wales if it were not for the partnership.

As part of the deal, Novartis invested £1.3 million in Wales to set up a study on breast cancer in the main oncology centres, and a further £150,000 to support six programmes covering service re-design, healthcare professional education and development, improved patient support and a tuberous sclerosis complex clinic located in Cardiff.

154. We also need to invest in rolling out developments that have been proven to be effective and we have therefore welcomed the £25 million Health Technology Fund that was established in 2013 and which has supported a number of innovative projects (including PROMS/PREMS). Similarly, we welcome the creation of the Innovate to Save Fund that has recently been created by Welsh Government to support the development of innovative projects that will improve services and create savings, particularly in the areas of improving services for looked after children; using data and digital technology to drive change; social prescribing, and public sector procurement.

155. There are developments already in place in Wales to stimulate the life sciences sector in Wales, including the Welsh Life Sciences Hub which brings together academic, business, professional services and funding organisations. The case study below outlines the ambitious ARCH programme in South West Wales. Over the next five years we need to build on these developments and harness the wealth of expertise and experience that exists within the NHS, local government, industry and higher education for the benefit of the economy and the health and well-being of the population.

Case Study 23: A Regional Collaboration for Health (ARCH), South West Wales

A Regional Collaboration for Health (ARCH) is a collaboration between two university Health Boards, Abertawe Bro Morgannwg and Hywel Dda, and Swansea University. ARCH also works together with social care, voluntary and other public bodies – offering a truly whole systems approach. ARCH is developing and implementing new service models based on the principle of care being provided closer to home. They are promoting research, training and skills, to help deliver a vibrant economy through investment, innovation and sustainable employment, recognising that a healthy economy, with fewer people disadvantaged or living in poverty, in turn bolsters the wider health and well-being of the population.

156. Procurement and the development of Welsh supply chains is another key area of opportunity for the health and social care sector. The state of the social care provider market is of real concern as we see more providers leaving the market due to financial, regulatory and staffing challenges. There is a need and an opportunity to develop the social care market in Wales to address the exodus. The NHS in Wales needs to work in partnership with nursing, residential care providers for learning disabilities, and older people to understand and address their challenges so that we can collectively ensure that the social care supply will be in place to meet future demand.

157. The way in which we approach procurement in Wales could be enhanced to help develop local, regional and national economies, which in turn is good for the health and care system. By working in partnership, using community clauses in contracts, and developing independent and third sectors capability would all help to develop and strengthen the supply chains on which our services rely.

Case Study 24: Med Tech Centre of Research Excellence, New Zealand

The Med Tech Centre of Research Excellence in New Zealand is funded by the Tertiary Education Commission and hosted by the University of Auckland. The Centre seeks to develop new technologies to improve hospital, community and home-based healthcare for the New Zealand population, but also to nurture an enhanced Med Tech business sector that contributes to the growth of the wider New Zealand economy – New Zealand's medical devices and IT health industries are an emerging sector of around 150 companies and with an estimated value of $NZ 1 billion[lii]. The Med Tech CoRE was awarded a funding allocation of $NZ 23.6 million upon its introduction from the New Zealand government to develop technologies to address prevention, early diagnosis and self-management of disease.

This is supported by a partnership that includes the Callaghan Innovation (the New Zealand Government's innovation agency), as well as the Universities of Auckland, Canterbury and Otago, the Auckland University of Technology and Victoria University Wellington.

Med Tech works in partnership with the Consortium for Medical Device Technologies (CMDT) - a national resource linking research activities at New Zealand universities, Crown Research Institutes and agencies with companies, healthcare providers, regulatory and industry bodies, the Health Innovation Hub, and the Commercialisation Partner Networks. To date, the partnership has supported Med Tech in developing its research outputs around assistive technologies for the elderly, telehealth and health informatics and interventional technologies including a radical new method of controlling blood sugar levels for patients in intensive care.

New Zealand has taken these initiatives further through the establishment of the New Zealand Health Innovation Hub. The Hub represents a partnership between four of New Zealand's largest District Health Boards which encourages innovation through providing advice and support to new products and services that have commercial potential in bringing about improved health outcomes while also contributing to the wider New Zealand economy.

158. The health and care system, along with the rest of the public service has an important role to play in supporting people to stay healthy and in the NHS case to treat them when they are ill. The productivity rate in Wales is significantly below that of other countries and this is at least in part due to the level of sickness in the workforce. We envisage that the focus we are advocating on prevention and primary and community services will over time reduce sickness levels, but alongside this we need to recognise and respond to the significant levels of mental health illness within the population. With support from the Welsh Government and partners (e.g. through social prescribing schemes) to develop mental health services and integrate them with other services to ensure that we are meeting all of a patients' needs. This in turn will increase employability of those currently not in work and reduce sickness absence, thereby increasing productively and economic prosperity.

What would help the NHS encourage innovation and develop its economic potential?

- Welsh Government encouraging life science companies to invest and locate in Wales.
- The maintenance of research funding, with greater focus on short to medium term value adding activity for health and social care.
- Welsh Government working with NHS to explore new strategic partnerships with life science companies.

- National support for and promotion of further health and social care involvement in Welsh City Deals.
- Development and implementation of an ambitious procurement strategy across health and social care to develop markets.
- Welsh Government and Local Government working with NHS to identify and implement opportunities to reduce sickness absence in the NHS and social care workforce.

10.0 Conclusions

159. Everyone in Wales wants a sustainable and viable system of health and social care into the future. There is complete political consensus on this and public support is a given. Welsh Government has made impressive levels of investment in NHS since devolution and it has protected social care in comparison to what has happened in England. It is to the credit of all parties in the National Assembly that they have signed up to the Parliamentary Review investigating how the big challenges for the vital public services can be addressed in the future. This document has identified a number of actions that the NHS Leaders believe would help Wales to realise our vision for a sustainable health and care system. We agree with the conclusion of the 2016 OECD report that what is needed is "a menu of precise, measurable actions to be applied in a time bound way to create momentum"[liii] and hope the Parliamentary Review will assist the NHS, local government and the Welsh Government to write and deliver that menu.

160. Here are the key actions that NHS Leaders believe would help to deliver a sustainable health and care system in Wales in the next five to ten years.

Improving population health and well-being

- Ensuring the impacts on health, well-being and equity are known and harms are minimised and mitigated through adopting a 'Health in all Policies' approach across sectors. 'Health in all Policies' takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity.
- Implementation of the Public Health Wales Making a Difference report recommendations within a defined timetable.
- Supporting a culture of change among the public in terms of making healthier choices and reducing reliance on NHS services.
- Strengthening primary care and the links with Public Health to focus on "wellness" as much as "illness".

Engaging the public and patients, and co-production

- Welsh Government funding and implementing a national public communication and engagement strategy for Prudent Healthcare.
- The development and implementation a national programme within an agreed timescale across government which identifies actions for all public services to take to engage public and patients in living healthier lives.

Integrating patient centred services

- Establishing governance arrangements that support regional / national decision making.
- Welsh Government working with NHS to develop a strategic service reconfiguration programme to be implemented within an agreed timeframe.
- Welsh Government to work with NHS to develop a strategic investment programme to support the service reconfiguration plans (to include primary care estate).
- National Assembly for Wales and Local Government politicians supporting the NHS in engaging public and patients in case for change and specific reconfiguration proposals.
- Welsh Government working with the Welsh NHS Confederation and the Welsh Local Government Association to commission a comparative technical review of health and care funding and performance rules, accounting and accountability arrangements.
- Development of joint targets, accountability and performance management where appropriate and joint routes to capital for health and local government.
- Development of meaningful outcome measures for mental health and primary care services, including person centred outcomes for people in care homes and receiving domiciliary care.
- Developing an electronic patient record so that patients have a record of what services they have accessed and support received.

Reshaping the workforce

- Developing a joint long term workforce strategy for health and social care supported and underpinned by a meaningful approach to staff engagement and organisational development that will deliver a resilient, reshaped, well trained workforce with the necessary skills and capacity to meet the changing needs of the Welsh population over the next fifteen years.
- Support staff in the management of change.
- Ensure investment in mechanisms to enable resilience of the workforce, including effective line management skills.
- Developing of a comprehensive skills escalator which supports flexible training and

education pathways as well as widening access to healthcare careers.

- Flexible education commissioning to include part-time and apprenticeship-type models.
- National focus on the organisational development needs of NHS organisations and staff, recognising the requirement to develop the skills, competencies and capacity of individuals to take on new roles and relinquish tasks no longer required.
- National investment in a leadership development programme, including clinical engagement and a succession planning framework for senior leaders.

Addressing the financial and technology challenge and driving greater efficiency and value

- Welsh Government to start a debate with the National Assembly for Wales, UK Government and the public regarding future funding for health and social care.
- Being honest with the public about what the NHS can (and cannot) provide - working alongside the public to help them understand their role in supporting the health service and reduce demand and over-reliance.
- Welsh Government working with the NHS to develop and implement a national efficiency programme within an agreed timeline.
- NHS to be given borrowing powers with a prudent framework akin to Local Government.
- Welsh Government to work with the NHS to review existing digital strategy across health and care to agree clear national priorities and programmes to be implemented in a clear timeframe.
- Instilling a national focus on improving data quality across health and social care.

Encouraging innovation and developing economic potential

- Welsh Government encouraging life science companies to invest and locate in Wales.
- The maintenance of research funding, with greater focus on short to medium term value adding activity for health and social care.
- Welsh Government working with NHS to explore new strategic partnerships with life science companies.
- National support for and promotion of further health and social care involvement in Welsh City Deals.
- Development and implementation of three ambitious procurement strategy across health and social care to develop markets.
- Welsh Government and Local Government working with NHS to identify and implement

opportunities to reduce sickness absence in the NHS and social care workforce.

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Case Studies