From Rhetoric to Reality – NHS Wales in 10 years’ time
A discussion paper

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"The NHS must change or die by 2020." That is the message from Professor Sir Mansel Aylward, chair of the Bevan Commission.¹

Yet politicians, policy makers, the public and even health professionals seem not to understand the full scale of change required.

We cannot wait for the penny to drop - the NHS of 10 years’ time will be built on the back of the changes we make now. And decisive action is required. Many of these actions will cause controversy but their results will become a mainstay of the NHS in Wales. We can’t be defined by our rhetoric; integration, collaboration, radical change are not just the flavour of the moment. The people of Wales are relying on us to be better than our words and so we must make this rhetoric a reality.

Lord Darzi, the former Labour health minister argues that while extra spending in the NHS in the 2000s brought big benefits, “we missed the best opportunity in the history of the NHS to actually reform it... We just threw money at it.”

However, that was not our only opportunity to change, and not all changes are about money. In fact, if we’re not careful, the financial focus will be our undoing. The Francis report² highlighted that finance is not at the heart of quality care and warned that such a mindset is dangerous.

Instead, we must demonstrate our success in:
• Positive outcomes for patients
• Reducing health inequalities
• A passionate, highly-trained workforce
• Helping more people avoid hospital admission through improved community and social services

Only by making bold, wholesale changes can we match government ambitions for the NHS in Wales to be the best it possibly can.

We’ve become experts at saying it; now we need to become experts at doing it. We can only become the best in class when we are clear on how we can better meet the needs of the people of Wales with the resources we have available to us. This must be supported by an explicit understanding shaped and owned in partnership with the public.

Healthcare in Wales is on a ‘burning platform’ and it cannot stand still. We know that there are better solutions both for services and more importantly for the public. We must not lose focus of what drives us to change.

On average, between 2009-2010 and 2011-2012, almost a quarter of people in Wales (23%) were in low income households, higher than in both England and Scotland.\(^3\)

In serving the public we must consider our own success with regard not only to treating healthcare needs but more importantly in relation to the ability of others to impact on the quality of life for individuals.

Living in poverty continues to have profound implications for current households and future generations of children in Wales. The knock-on effect could impact on their educational performance, psychosocial development, ability to gain employment and to maintain their own health and wellbeing.

Public Health Wales, in its “Child Poverty Strategy 2012-2014”, notes the prime importance of breaking the cycle of poverty. Poor housing, for example, impacts on health. Therefore the existence of poor housing perpetuates and intensifies demand. When this is linked to a lack of employment opportunities and the inability of families to move home, the substantial impact poor housing has on other public services becomes clear.

But any other single factor – such as employment, education – has linkages that would lead to the continuation of poverty.\(^4\)

The Welsh Government’s “Tackling Poverty Action Plan 2012-2016” describes initiatives that place multidisciplinary teams around families to provide a holistic approach to addressing the various factors relating to poverty. The plan reflects the cross sector approach that is needed to tackle poverty effectively.\(^5\)

It is imperative that no part of provision, both in healthcare and beyond, should be considered “weak”. We must build on how we might improve our ability to work and support our partners and colleagues in other sectors, including social services, housing, education and transport, to reflect the multi-disciplinary demands required to run public services in a holistic way. This will in turn reduce overall demand on health and drive improvements across the board.

The way we consider health and healthcare must be premised on how we best support people to maintain their health, with the aim of eliminating or reducing their potential to require NHS services. However, some people will still reach that hospital bed when it might not be the most appropriate place for them, despite their and our best efforts.

We must invest time, money and services outside the hospital door; and shift effort from treatment based services to a wellbeing and public health centred approach.

When we hear about the change that is taking place, and is further needed in the health service, we often use the term “radical”. It is fair to say that many, if not most, people would agree that radical change is needed (meaning—especially of change or action—relating to or affecting the fundamental nature of something; far-reaching or thorough. Characterised by departure from tradition; innovative or progressive).⁶

During times of such change it is only right that Welsh Government legislation and policy sets out the required direction for the NHS in Wales. Of course, the NHS Finance (Wales) Bill and the Social Services and Well-being (Wales) Bill take necessary steps towards enacting change. This is through the creation of greater flexibility in Local Health Board accounting and planning periods, and though the push towards greater integration with social services respectively. But is this change radical enough? Is it radical at all?

When we consider the need for reconfiguration to deliver services closer to communities, and for less reliance on hospitals, is policy and legislation laying the way for such a shift to happen? The creation of an Intermediate Care Fund demonstrates a positive commitment from Welsh Government to backing the collaborative effort required across health, housing and social care. But is this just ‘dipping a toe in the water’?

Change brings with it a need to measure success and ensure patient safety, high quality services and overall accountability. Performance indicators will continue to be an important measurement of services. But they are often used in criticism of services with the NHS apparently falling short in a number of areas.

So it begs the question – why aren’t we hitting our targets? We are clearly looking at how we can best use our resources and this should be a key consideration in measuring the performance of the NHS. Improving measurement is a key focus for unscheduled care, for example. Yet limited resources coupled with increasingly harder to reach targets are in themselves creating a picture of a seemingly ‘failing’ system. That is not to paint over the cracks – we know that change is needed and performance can be better – but targets should support the drive in improvement. At present we do not believe this is the case.

In isolation, these measurements should not be used to define the ‘success’ or ‘failure’ of a service.⁷ It is time to re-focus performance indicators, and what meeting (or indeed not meeting) these targets actually mean. The setting of targets must be clinically-led, meaningful and based on outcomes. We must challenge any system whereby the NHS in Wales is known for what it doesn’t do.

The NHS will always need to treat people with high level, emergency, specialist and intensive care. We can’t get away from these high-cost, low-volume services. But a shift in emphasis now will mean that patients receive the care they need at the appropriate stage to prevent growing demands on costly hospital services in the future.

Our most powerful performance measurement tool is the view of each patient. Their expertise will be vital in ensuring services are accountable and that development is driven in the right direction.

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Service change acts as a catalyst to harness the expertise and insight of all staff to shape the way in which we provide healthcare. But is the service ready for change? Is the workforce prepared for a new culture?

With ongoing financial constraints, the previous growth in the workforce has ceased. Yet the future supply and availability of clinical staff is crucial to the quality, range, shape and organisation of health services as we seek to do more with fewer staff.

Delivering more of the same through traditional roles and ways of delivering care will not be an option. NHS Wales and its staff will simply have to work differently to meet increasing demands, and to be responsive to needs at the same time as ensuring high quality, compassionate, effective care.

NHS Wales has a strong tradition of workforce stability – many current employees will still be in the NHS in 10 years’ time, although a significant proportion of those will be aged over fifty. To avoid future skill shortages, the NHS must make the best possible use of all its people throughout all stages of their careers.

Many positive steps have already been taken to innovate and promote new ways of working. But are these both comprehensive and fast enough to respond to the increasing resource constraints? Flexible working, hitting the right mix of specialist and generalist staff and cross-boundary working all need to be addressed honestly. The Academy of Medical Royal Colleges in their report The Benefits of Consultant Delivered Care made an important recommendation: that more work should be done by clinicians and employers to map out the staffing requirements and service implications of a consultant-delivered service throughout the week. Does NHS Wales aspire to such a model? If so, are we prepared to make the necessary changes to achieve it?

Employment contract reform is being actively discussed. We need to ensure that the contracts for ALL staff adequately reflect what they are being asked to do to deliver 21st century healthcare, and reward them appropriately.

NHS Wales staff appear to exhibit a high level of dedication. In the recent NHS Wales Staff Survey more than four in five (86%) stated they are happy to go the ‘extra mile’ at work. Yet despite this dedication, only 60% suggest they are satisfied overall with their current job. Just over half (51%) of employees are proud to tell people they work for their organisation, with fewer still (48%) indicating they would recommend it as a place to work. So have we created the right dialogue with NHS staff about the need for change, which will often affect them personally?

The bottom line is that we cannot push for an NHS that is ‘best in class’ without staff who are themselves comparable with the very best. This involves significant investment in staff engagement, appraisal and health/wellbeing, to make the NHS an attractive prospect for existing staff, students and others aspiring to join the NHS as well as being able to pull in international skills and expertise.

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8 Academy of Medical Royal Colleges, 2012. The benefits of consultant-delivered care. London: Academy of Medical Royal Colleges
Public education and empowerment – both in respect of an individual’s own health and the services available to us when we require advice or experience ill health - are pivotal to the sustainability of the health service. The cost of poor health among the public is clear to see. For example, the estimated annual cost to the NHS in Wales as a result of inactivity is £1.0 - £1.8 billion.\textsuperscript{10} It is the hard-hitting nature of such figures that highlights the continued importance of public health initiatives and education about health across the life course.

We must continue to drive a mass shift in public thinking. The extent of success we are able to achieve in this area has much to do with the relationships developed through effective communication, ensuring that trust in the NHS is high. But how far should we go towards reducing the pressure on services? It is clear that some patients present at A&E who do not need to be there. So how do we ensure that people use services appropriately in primary and secondary care?

In terms of how services are used, the re-education of the public must put the writing on the wall – we must involve the public fully in deliberating what the NHS will and will not provide in future. We should be firm in discouraging people from using services inappropriately. We must make more of public health initiatives. Most people would acknowledge that this is complex and that there is no easy solution. Nonetheless, Public Health Wales is a big part of how we move forward.

There is more work we can do in harnessing the power of communities. England has recently called for a 100,000 strong army of good Samaritans to look in on elderly neighbours this winter. This co-production, in which health professionals and communities work together, can readily be built on in Wales – where we have a rich history of community life. We need to ensure that we nurture our relationship with communities to create the network of mutual support that the NHS does not have the capacity to provide formally.

Is it time to create an explicit ‘compact’ with the public? Originally driven through Welsh Government’s “Together for Health,”\textsuperscript{11} is it time to revisit this with renewed enthusiasm? The sustainability of the NHS is the responsibility of everyone in Wales – do we understand this? Over-reliance burdens our hospitals and online resources such as Choose Well and Stop Smoking Wales continue to be underused. We need to outline alternative health services that are available locally or remotely. Education is key and re-aligning expectations will go some way towards ensuring we all have a shared vision of what the NHS should provide and stand for.

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\textsuperscript{10} Public Health Wales, 2013. Transforming Health Improvement in Wales: Working together to build a healthier, happier future. Cardiff: Public Health Wales

An ageing population... it’s not all about numbers

It has been well reported that we face a substantial challenge as we come to serve increasing numbers of older people. This of course is an achievement we should celebrate and fully embrace. It reflects advancements in health care and an improvement in lifestyle and quality of life. The challenges that come with this should be welcomed.

In a report produced by a House of Lords Select Committee entitled “Ready for Ageing?”, the Committee concluded that public services as a whole are ill prepared for the challenges of serving an ageing population. The ways of addressing key challenges that relate to providing services to older people are the type of aims that could be extended across the population. These include practices such as providing care closer to home, self-management of conditions, and use of hospitals only when essential.\(^\text{12}\)

Hospitals are often not the right place for older people when they become unwell. We must use services offered by community pharmacies, housing associations and community groups to ensure the most appropriate use of services and empower older people, their families and carers to manage their own health care needs. The integration of Health and Social Services will make such key information more readily and consistently available, but we must ensure it is acted upon by all.

There are of course suggestions that the population projections are not as severe as has been suggested in many instances. But the extent of an ageing population should not be the key driver for change; it is the fact that there exists an ageing population, and that it is growing, that should drive our response.

While the above are all relevant challenges are we too ready to associate age with need? We should not overlook the substantial value older people offer society and understand that this is only set to increase.

Much of the dialogue relating to older people seeks to address how we deal with demand and need, focusing on statistics and population projections. But isn’t it also equally important to plan how we harness the skills, knowledge and experiences of older people to improve services, share learning and capture this expertise so better health outcomes for older people are, to some extent, a by-product of such an approach.

We are privileged in Wales to have the post of Older People’s Commissioner to provide “an independent voice and champion” for older people and to “stand up and speak out on their behalf.”\(^\text{13}\)

The experience and knowledge of many older people should also mean that we can trust many to make the right choices and know what they need from a service. Personal budgets could become one of the ways we empower people to access the care and support they require.

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\(^\text{13}\) Older People’s Commissioner for Wales, 2013. Stand Up, Speaking Out – Impact and Reach Report 2012-2013. Cardiff: Older People’s Commissioner for Wales
Let’s stop talking to ourselves!

The ‘new partnership with the public’ suggested within ‘Together for Health’ must be explored and developed to improve the Welsh NHS. Any new approach must be embedded now and continue beyond periods of reconfiguration and change. The public is the key indicator of successful services. Understandably, as the role of the NHS has grown, so too have the demands and expectations placed upon it.

Getting the message right, reconciling concerns and having an open dialogue with the public are central to change in the NHS. When we think of change those of us working in and with the NHS understand what this could mean for healthcare – and, of course, it’s something which has been on the radar for some time. To the public, however, change can mean something completely different – it may impact locality, personal health and that of family members and friends. All these highly potentially negative implications serve to produce a culture of resistance.

It is key that we work with the public to foster an understanding of what change will mean for the NHS and for all of us who need and use its services. We cannot allow ourselves to run the risk of people thinking that change means providing the same services with fewer resources. This in itself creates a dangerous and damaging perception of the NHS. We must ensure that we continue to spread the message far and wide that change is not a negative process. It is a chance to re-focus, to shift resources to where they are most needed and to improve further, even transform, the quality of the services we provide. We must be clear that this is not a transaction where financial savings are made at the cost of quality or patient safety.

The voices that resist are as important as the proponents of change. They remind us of the sensitive nature of our work and the importance of providing accountability and transparency in all that we do.

The NHS in Wales has moved away from telling the public how we plan to change services. Instead we are looking to seek more guidance from the public in how services should be changed. And during times of changing services, it is more important than ever that we support the public to be a partner in the NHS. As much information as possible should be made available to patients and the public about healthcare services. By having an open conversation we can better explain how the NHS works, where it could be improved and the reasons behind the need to transform services to shift the focus from hospitals to local communities and even people’s own homes.

We have a responsibility to give the public every opportunity to understand the tough choices that need to be made. We also need to explain the situation the NHS will find itself in if we all continue to do the same things, with diminishing resources and a changing world.

Involving the public is central to realising an NHS where patients and the public are key and valued partners, where they are seen as ‘assets’. Some people will not want to engage, but all have the right to be given the opportunity to do so. And the more informed they are in the process of changing a service, the more informed they should be further down the line as together we make the appropriate choices for our wellbeing and the care we require.

The role of technology, which already plays a massive role in most of our lives, will only grow over the next decade. Research by Ofcom suggests that by 2018 internet usage in the UK will be 300 times higher than in 2013. A health service fit for the future must embrace these technologies, while recognising the limitations that come with it.

Expectations of what technology health services can adopt, and what patients will embrace, vary wildly. A report by the Policy Innovation Research Unit considered scenarios for technology adoption in the NHS, with situations where ‘self-diagnosis and treatment have become as common as online shopping’, or technologies which have led health care professionals to ‘buy the latest toy’ regardless of evidence. While the clear thrust of these debates on technology is that the NHS cannot stand still, expectations of how much technology we can adopt must be realistic, and the policy debate must remain considered and evidence based.

Up-front investment costs can be high, and the evidence base for the savings and outcomes that telehealth can lead to is still in its early stages. Welsh Government’s support of £9.5m for the Health Technology and Telemedicine Fund is welcome, but can it provide the NHS with the transformation that we need? The NHS in England has encouraged a large rollout of telehealth through the use of devices at home, but one year after a target of 100,000 patients using the scheme was set, less than 2,500 were actively using the devices.

And the most important consideration in the debate around technology must be the patient, and their willingness to engage with any technology that is introduced. While we constantly consider the challenges of broadband and mobile coverage in facilitating new technologies, we must ask if everyone is able to engage with the new technologies we seek to adapt, or indeed ask whether they want to do so.

Relatively simple technologies, such as telephones and video conferencing, can have an enormous impact on the services the NHS offers to patients. While digital exclusion is undoubtedly an issue we must address in Wales, and one that ties in with other key determinants of health such as poverty and education, recent research by Deloitte found that 72% of people in the UK now own and use smart phones.

With the public adopting new technologies at such a rapid rate, the NHS in Wales must move beyond the 20th century, and make the most of technologies that are user friendly, and with which patients already have experience. There are already some examples of good practice in this area.

However, it is important we address the inconsistencies of provision, and roll out technology across Wales. Showcase the good work we’re doing, by all means, but where Wales finds itself behind the curve, we must demand more. With other countries much further down the line of technology adoption, more capital investment is required in Wales. Indications are that this is available, despite the austere times. Together with the right leadership and direction, this will facilitate the implementation of exciting and potentially transformational changes.

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15 Charlton, A., 2013. UK internet use to increase 300 times by 2018. International Business Times [online] 07/02/2013
18 Styles, K., 2013. 7 in 10 People in the UK now own a smartphone. Mobile Marketing magazine [online] 24/06/2013
Together for Mental Health?

In approaching this document, we considered whether it was appropriate to address mental health as a stand-alone issue. Indeed, Dr. Ed Mitchell, a clinical fellow to NHS England’s Director of Long Term Conditions, recently said:

“When the historians of the future write about healthcare in the twenty-first century, they will remark upon one of the more curious aspects of our healthcare system – the way we separate physical and mental health. Odd, they will think, that we should arbitrarily divorce these two aspects of our health and wellbeing.” 19

However, our research consistently found that mental health, and mental illness, were raised as areas of policy that required more development and discussion far beyond any other condition.

Mental health problems are amongst the most common health conditions, directly affecting about a quarter of the population in any one year. 20

Research published in 2010 by the Mental Health Foundation and King’s College estimated the economic impact of mental health on Wales at over £7 billion a year, with mental health disorders up to 25% more prevalent here than in England or Scotland. 21 With the economic downturn linked to increasing instances of mental ill health, 22 and impacting upon those suffering from mental health conditions, 23 the need to look at how we deal with mental health has never been so important.

It is estimated that only about a quarter of people in Britain with a mental health condition receive ongoing treatment, either because they have not gone to the doctor at all, have been misdiagnosed, or have refused treatment. In a 12 month period, only 3% of all people with mental illness saw a psychiatrist and 2% a psychologist. 24 Would we accept such a low treatment rate for physical health conditions with such potentially serious consequences?

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19 Mitchell, E., 2013. It is time to stop treating mental health as a “Cinderella” issue; NHS (England) News [online]
20 Public Health Wales, Together for Mental Health: Public Health Wales NHS Trust Annual Report 2012-13 Cardiff; Public Health Wales
22 Elizabeth Finn Care, 2010. New report highlights devastating effect recession has had on UK’s mental health. [online]
23 BBC News Mentally ill people ‘hit hard by recession’ [online] (27/07/2013)
Together for Mental Health?

However, evidence from health professionals and service users suggests that a medical model of addressing this challenge may not be the most appropriate. The Joseph Rowntree Foundation found that service users believe that a medical model based on ‘deficit and pathology’ still dominates public and professional understanding of mental health issues, and this model was ‘damaging’ and unhelpful.\(^\text{25}\)

As the evidence base moves away from the medical model, there will perhaps be less of an onus on the NHS to provide some services in this area. The NHS, though, must be a key cog in the system, providing the care at the correct stage of a patient’s mental illness, while working as part of a wider public service provision to reduce many of the socioeconomic problems that have led to increasing instances of mental illness.

Welsh Government has made positive steps in recognising that the challenges of mental health are not solely restricted to the health service, in introducing ‘Together for Mental Health’;\(^\text{26}\) a cross-government, all encompassing strategy for mental health and wellbeing. However, the implementation of this approach has been largely restricted to the NHS in Wales, and this needs to be branched out. The health service can, and should, work with colleagues in social care, housing and education to address many of these challenges.

We must consider not only how we treat mental health patients, but also how we tackle the stigma associated with these conditions. Nine out of ten people with mental health problems have experienced some form of stigma or discrimination regarding their condition, and we must welcome Welsh Government’s intentions in Together for Mental Health, and the work of voluntary campaigns such as Time to Change Cymru to tackle stigma. But in its position as Wales’ biggest employer, and with the role the NHS plays in promoting and communicating public health messages, can the NHS do more?

\(^{25}\) Beresford, P. et.al., 2010. Towards a Social Model of Madness and Distress? York: Joseph Rowntree Foundation

Money, money, money: reduce demand, or increase resources?

The Institute for Fiscal Studies’ report on future Welsh Government budget scenarios did not offer much hope for the future funding of public services, with a full recovery of budgets for public service provision unlikely until well into the next decade.

The report said: ‘The scale of the challenge implied by our more pessimistic – but not implausible – scenarios means advanced planning by the Welsh Government for the trade-offs that it would make between different public services over the next decade (and beyond) would be sensible. It will also be important to understand the demand and cost pressures facing public services, and to develop policies to try to reduce those pressures’.27

In the face of falling budgets, we must of course look to work differently, but is there room to develop policy that will reduce demand on the services, or even accrue or create further resource?

The ‘demand’ for NHS services will never go away, but the point at which the NHS intervenes has huge implications on both the cost and quality of care provided. Working with public health initiatives, and allowing the public to take more responsibility for their own health, we can reduce the complexity, and therefore the demand, of some of our highest need cases.

Figures published in 201228 estimated that healthcare costs for treating diabetes could ‘bankrupt’ the NHS over the next two decades, with the vast majority of the increase in costs linked to growing obesity in adults.

The Optimising Outcomes Policy of Cardiff and Vale University Health Board asks smokers and those with a BMI of over 40 to complete lifestyle courses ahead of any planned surgery, while a number of other schemes looking to tackle smoking and obesity have arisen across the UK. NHS Fife said it would no longer provide IVF treatment to couples if either of them smoked, or if doctors considered the woman to be overweight,29 while patients in Hertfordshire were told they could not have non-urgent hip or knee joint replacement surgery while their BMI remained above 30.30

Is it the role of the NHS, with our partners in Public Health, to guide people’s lifestyle choices? Would these approaches be welcomed nationwide?

28 Hex, N., Bartlett, C., Wright, D. & Varley, D. (2012) ‘Estimating the current and future costs of Type 1 and Type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs.’ Diabetic Medicine 29(7)
29 BBC News ‘Couples who smoke banned from IVF treatment by NHS Fife’ [online] (20/09/2012)
30 BBC News ‘Hertfordshire high BMI surgery patients told to lose weight’ [online] (08/04/2011)
BBC Wales polling showed strong support for this type of policy, but with lots of caution around how the NHS dictates lifestyle choices to people.31

- 82% agreed that all health authorities in Wales should require overweight individuals to lose weight before undergoing non-urgent surgical procedures
- 73% said the government should not be telling people what to eat
- 66% agreed with the statement that the “NHS spends too much money treating the conditions that result from poor diet and lack of exercise”
- 42% agreed that weight should impact on treatments received

And to the prospect of raising further funds; taxes aren’t always a popular policy area but what role does the NHS have to play in supporting taxes that could benefit the service and the long-term health and wellbeing of people living in Wales.

The much debated ‘Fizzy Drinks Tax’ – adding 20% in tax to the price of sugary drinks – has gained a wide range of political support in Wales, as well as support from the wider medical community, including the Academy of Medical Royal Colleges.

Are further taxes the answer to diminishing resources? Public health debates will always be controversial, but when the NHS and the public can benefit, let’s have the debate. From the fluoridation of water, to further action on smoking, and minimum alcohol unit pricing, let’s open the conversation. Many of these discussions may be highly charged and politically loaded, but when the public fully understand the scale of change required, they may be more receptive to policies which have the potential to secure their future health and health services.

Another area where much political capital has been gained is that of universal benefits. The support for universal free prescriptions goes to the very heart of the current Welsh Government policy agenda, but there are fears Wales does not have the budget to support this. While the number of prescribed medicines being dispensed is increasing, and still remains higher than provisions in other countries where prescription charges have been scrapped, the overall cost of the policy fell in 2012-2013 to £557.5m. This represents a £37m fall from its peak in 2010-2011 – and the lowest overall spend since 2003-2004, five years before prescription charges were abolished.

Meanwhile, in England, a report by The King’s Fund32 says that up to 90 per cent of prescriptions are dispensed free of charge. So we must ask ourselves if stopping the benefit of free prescriptions would in fact deter those whose earnings are just above the qualification level from getting treatment, for relatively little return?

32 Timmins, N., 2013. The four UK health systems. London: The King’s Fund
Productivity – we’ve put more in, so why aren’t we getting more out?

A report by The King’s Fund on the future financial sustainability of the NHS in Wales\(^{33}\) found that increased funding over the last decade has allowed the Welsh NHS to employ more staff, and in general to produce more activity. However, productivity – measured by hospital activity per head of staff – has fallen among medical staff. While activity among medical staff has also fallen in England over the same period, the decrease has not been as great, and nursing productivity, which has remained stable in Wales, has increased across the border.

With the increase in inputs into our health service, why has an increase in outputs not followed? And, with NHS funding in Wales per capita set to fall behind England for the first time over the coming years, can we afford for our productivity to follow the same trend?

Improvements in productivity could, through a combination of reducing costs and improving outputs per pound spent, in part help meet fiscal breakeven rules, and meet additional/ changing demands and improve quality (partly through reinvestment in higher-value services from cash releasing activities and partly through changes in service delivery/ organisation).

The difficult question is what scope exists in the system to deliver better health services through more efficient use of every health care pound. This would not just be over the next few years, but, even under the most optimistic future funding scenario, over the next decade at an average minimum rate of 5% per year.

Many of the most significant opportunities to improve productivity will come from focusing on clinical decision-making and reducing variations in clinical practice across the NHS, and shifting the focus away from hospital-led, acute services. Reducing variations in clinical service delivery and improving safety and quality should be key priorities for providers.\(^{34}\)

However, there is a danger that a necessary focus on improving productivity becomes an end in itself, or worse, a misunderstanding that the NHS needs to cut budgets dramatically, reduce services for patients and make more staff redundant. The NHS will need to select carefully the strategies which, together, produce different results from the same or similar resources – not the same for less.

In times of austerity and in economic boom, there is an obligation on public services to spend public money as efficiently and as productively as possible. However, as stated in The King’s Fund report on Welsh finances, there needs to be a realistic view about how close the system and individual organisations are to their maximum output given the inputs at their disposal.

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\(^{34}\) Appleby, J. et.al., 2010. *Improving NHS Productivity*. London: The King’s Fund
Conclusion

There are no easy solutions for the challenges we face in the NHS. But we know that, without change, the NHS will not be able to achieve the excellent standards, or offer many of the services, that the Welsh public needs and expects.

The stark choice between managed change in services now or potentially chaotic decline in services in the future must be made plain to the public. In implementing this change, we must be clear and bold about how the NHS will look in 10 years’ time and beyond.

The results of an independent survey commissioned by the Welsh NHS Confederation35 show that the level of debate is underdeveloped in Wales. Although the financial pressure the NHS is under seems to be widely understood by the Welsh public, there is much lower awareness of the quality and safety reasons that are driving the need for radical, transformational change.

We are yet to convince the public of the seriousness of the situation, and how the safety and quality of our services will be at risk if we do nothing.

The changes we make must not seek to address health as a stand-alone issue; in public services, we are ‘only as strong as our weakest link’. Engagement with all our public service colleagues is necessary to take us all from an ill health service that puts unnecessary pressure on hospital services, to one that promotes healthy lives.

Alongside this, we must improve our engagement with staff, ensuring they too understand the reasons for change, and how it can benefit the frontline services in which they work every day.

It is for these reasons that we are inviting as many people as possible – the public, politicians, staff and public service partners – to give us their thoughts on the issues, challenges and ideas we have set out in this paper.

Change is needed, and it is coming. We have been saying this for some time.

Huge progress has been made in many areas, particularly in shifting from an outdated model of care focused on buildings to a more modern, responsive, locally based model, focused on communities. Often without any fanfare, teams are continuing to develop new and innovative ways of providing services that are improving care for individuals and putting each person at the centre.

So although change is constantly taking place in the Welsh health service, the scale of the challenge means that much more radical change is yet to come. The support and understanding of our staff and public is crucial if we are to turn this rhetoric into reality.

Please let us know how you think we can turn our much talked-about NHS of the future into a much-needed reality for the people of Wales.

Join the debate by contacting our dedicated From Rhetoric to Reality email address: reality@welshconfed.org or writing to us at Rhetoric to Reality, Welsh NHS Confederation, Tŷ Phoenix, 8 Cathedral Road, Cardiff, CF11 9LJ.
