



# **The Review of Health and Social Care in Wales**

**The Report of the Project Team  
advised by Derek Wanless**

**June 2003**

Report commissioned by the Welsh Assembly Government

This report may also be viewed at:

**[www.wales.gov.uk/subieconomics/hsc-review-e.htm](http://www.wales.gov.uk/subieconomics/hsc-review-e.htm)**

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# FOREWORD BY DEREK WANLESS

My letter to the Chancellor of the Exchequer in April 2002 accompanying my report *Securing our Future Health: Taking a Long-Term View* was, I hope, very clear in its analysis and conclusions. The UK has fallen behind other countries and faces a long, difficult and expensive task to catch up with the best. And we must do that while the challenge is intensified by shifts in medical technologies, in demographics, in the rising expectations of the public and in the growing importance which people are likely to give to choice in the future.

We begin from a position of inadequate capacity in our workforces, premises and information technologies. These cannot be corrected in the short-term; it needs a long-term view.

The UK report concluded that both additional resources and radical reform are vital; neither will succeed without the other. Nor is the level of success we all wish to see likely unless the full engagement of both the public and the services is achieved; the public through a better understanding of health promotion and action on disease prevention; the health and social care services through integrating their thinking about enhancing productivity and learning what a holistic patient-centred service really means.

Against that background, I was delighted to accept the invitation to advise the project team set up to review health and social care in Wales and to help them understand where the additional resources now available should be directed. Not only to alleviate short-term issues, of which there are many, but also to seek the major shifts needed to balance demand and supply in the long-term.

Generally, the current position in Wales is worse than in the UK as a whole, reflecting trends evident over decades. Wales does not get as much out of its spending as it should; in health, for example, it now places unsustainable pressure on its acute sector. The impact extends into social care. Long hospital waiting lists and assessments without subsequent social service provision are the unacceptable consequences and are symptoms of the deep underlying problems needing to be faced.

Capacity problems intensify and, particularly in the case of the workforce, the danger is that present gaps will widen. Capacity planning needs realistic long-term thinking and a recognition of the need that every pound spent must be as productive as possible. Currently, people working in health and social care try hard to keep up with demand but the system in which they operate does not make success easier. It lets them down.

This report has picked up the messages from the UK report, has drawn on the available evidence for Wales and has made well thought through comments and sound proposals about both short- and long-term areas for attention. Often the information base on which to formulate recommendations is poor and there is more subjectivity than the team would like. But the consultation process has suggested that there is widespread support for the principles and practical steps which the report proposes.

What is important now is the response from the Welsh health and social care services. It needs to be positive. The opportunity given by extra resources and by the greater certainty about likely future resources must be taken by the services as they seek to capitalise on the new structures within which they are now operating and as they seek to integrate their thinking. Tough decisions to remove waste and the unsustainable aspects of current provision must be implemented. Financial discipline will need to be strong and evidence-based recommendations should be followed through rigorously and seen in a broad national context.

Advising the project team has been a pleasure. They have worked hard and long, often with limited information, and have produced both a fair assessment of the current position and sensible recommendations designed to tackle both the immediate problems and the longer-term opportunities. I hope this report leads to action and also helps stimulate productive debate throughout Wales, particularly amongst the general public whose full engagement is vital.

**Derek Wanless**

**June 2003**

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# CONCLUSIONS AND RECOMMENDATIONS

## Background

The task of the Review of Health and Social Care in Wales has been to examine how resources should be translated into reform and improved performance. The background to our work was the policy direction and structural changes to the NHS in Wales heralded in *Improving Health in Wales*<sup>1</sup>.

The starting point was the then Finance Minister's announcement in October 2002 of a substantial increase in the future resources to be allocated to health<sup>2</sup> in Wales. Chapter 1 gives more details, and describes how we went about our task. The context for our review was Derek Wanless's report for the Chancellor of the Exchequer *Securing our Future Health: Taking a Long-Term View*, which appeared in April 2002. Chapter 2 describes the relationship between that report and its findings, and our work.

## Conclusions

The provision of health and social care is a complex and multi-faceted issue which cannot be summarised in a sentence. While we hope the summary below is useful, we caution that it is no more than the broad features of the detailed and varied picture which we describe in our report.

### Health and Social Care in Wales today (Chapter 3)

- The health of people in Wales is relatively poor. Many lead unhealthy lifestyles, and although rising resources and improving productivity are increasing the supply of health and care services, this is being outstripped by more rapidly growing demand. Large and increasing numbers are not receiving social services after assessment, and hospital waiting lists and times are unacceptably long.
- The current configuration\* of health services places an insupportable burden on the acute sector and its workforce. This is the most expensive part of the system. More acute beds are not a viable or effective long-term response. Actions to reconfigure provision, release acute capacity and raise productivity are needed alongside a rebalancing of the system to meet need earlier in the 'care pathway' and improvements in the way in which the parts of the system work together.

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\* "Configuration" in this report refers to where and how care services are provided

Supply is involuntarily rationed by long hospital waiting lists and times and assessments without subsequent social services.

- Wales does not get as much out of its health spending as it should. Health spending has risen substantially in absolute terms, and consumes a larger share of Assembly spending than in 1998-99. Even so, in every year but one since 1994-95, NHS organisations have reported deficits over £10m. In social care cost pressures are increasing. There is significant variation in the level of spending on social services between local authorities (as one would expect) and in its cost-effectiveness.
- Wales has significant capacity shortcomings in workforce planning, Information and Communication Technology (ICT), and estates and is unlikely to achieve the fully engaged scenario for health without (among other things) a sea-change in the quality and nature of its planning and capital and revenue investment.
- There is some good and some excellent performance in health and social care. But there is also widespread under-performance associated with systemic defects – we do not have the performance management and incentive systems to drive properly creation or imitation of best practice. Different areas of national policy-making need to be better integrated. The quality of information, and so of the decisions based on it, is unsatisfactory at every level.
- Health and social care organisations frequently find change difficult, particularly where working across boundaries is required. There are some, but too few, examples of successfully engaging the public in a change agenda.

#### **Health and Social Care in Wales in future (Chapter 4)**

- A step-change in individuals' and communities' acceptance of responsibility for their health is needed. No amount of effort by the health and care services can be a substitute for this. We recommend policy action to raise public awareness, and more research to produce an evidence base into the gains which different sorts of action may yield.
- There should be a strategic adjustment of services to focus them on prevention and early intervention. Potentially this offers significant long-term cost and quality of life gains. It entails service reconfiguration, and adjusted roles for social, primary and secondary care. In the short term immediate steps are needed to relieve pressure on the acute sector by making bed equivalents<sup>⊕</sup> available, and addressing as a priority delayed transfers of care. A redoubled

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⊕ "bed equivalent" means provision to meet patient need in a way which does not require a hospital bed

effort to secure seamless service provision should be made which could entail changes to policy-making, financial, and accountability mechanisms.

- Reshaping services and making seamless provision a reality will not be enough on their own. Mutually consistent, evidence based and costed policies supported by a clear financial strategy are also necessary. Attention should be given to developing a mechanism whereby the flow of money round the system both reflects need and rewards greater productivity.
- The Assembly should stop funding deficits in NHS Wales. We recommend stronger incentives and sanctions, which reward success, give greater freedom to good performers, and are supported by the way in which resources flow. Improved performance management, founded on reliable and rounded performance information, is essential to raise standards across the board. The scope to focus on those activities which make the greatest difference, and to drive out variable performance, should be exploited.
- Workforce planning needs to be altogether more sophisticated, robust, and long-term, and based on future models of service provision. Training and retention of current staff also need attention. There should be an overhaul of information systems, to improve quality, timeliness and coverage. ICT is in urgent need of investment within a national strategy which embraces both health and social care. Major investment in estates will be necessary, and decision-taking processes which will govern it should be strengthened. Clear and shared understanding of national and local roles, and the relationship between national and local health, social care and well being strategies, are needed to make the new organisational structures effective. We should clarify and strengthen accountability of NHS chairs and chief executives, and of those delivering services which cross organisational boundaries.
- It will be important to chart, and adhere to, a programme of change which is realistic. An implementation plan identifying short, medium and long-term steps and strategy is a way forward. Investment in ICT and estates are priorities, as are immediate steps to reduce delayed transfers of care and accelerate alternatives to acute hospital admission. In some cases it may be necessary to make ring-fenced funding available to meet reconfiguration costs. Successful change will depend on leadership, energy and commitment from politicians, professionals, managers, and staff alike.

## **Recommendations**

A number of our recommendations in Chapter 4 specify options which should be considered, or elaborate on actions which are implied. While it is not practicable to reproduce these further details here, any consideration of how to respond to our recommendations must include consideration of them as well.

### **The role of individuals and communities**

We recommend a much greater emphasis on preventing ill health and early intervention in order to raise public awareness of its importance to the ability of health and social care services in Wales to meet future demand. [4.6]

We recommend a programme to develop further the research base to enable an evidence-based approach to indicate what gains can be expected for different types of public health/prevention expenditure in Wales, to inform future policy making and resource allocation decisions. [4.7]

### **Reshaping services**

There should be a long-term strategic adjustment of services to focus them on prevention and early intervention. [Box before 4.8]

There is a pressing need for a review of the pattern of health and social care services – a radical redesign is imperative. [4.8 and 4.15]

We recommend the development of clear principles to drive evidence-based commissioning and delivery of health and social care services. [4.11]

We support, and stress the need to accelerate, the work being undertaken to implement *A Question of Balance*<sup>3</sup> which is attempting to deliver new ways of working which equate to the ‘479 bed-equivalents’ recommended by the report. The short-term actions need to be supportive of, and lay the foundations for, the long-term strategic solution. [4.14]

Experience of health and social care in Wales has shown we are best able to achieve major change and realise new service models where there is a clear strategic direction, linked to dedicated resources. [4.19]

There is a need to develop capacity – workforce, skills, infrastructure – within non-acute settings to deliver new service models. In particular, we are concerned that the primary care sector as currently configured requires considerable development to take on its enhanced role. [4.20]

The range of services provided in our major acute hospitals will need to change. [4.22]

It is clear to us that the rebalancing of the acute hospital sector must involve better utilisation wherever practicable and cost-effective of the smaller, community, facilities for a wider range of activity. [4.22]

For solutions to be sustainable, patients and the public should have the opportunity for full involvement in meaningful decision-making about the future shape of service provision, and the complex choices required. This should include publication and open informed discussion of the performance outcomes of services provided by different professionals and in different settings. [4.23]

### **Seamless service provision**

We need to be resolute in breaking down barriers between health and social care. We believe that the Assembly needs to look again at what might be done to bring it about. By this we do not mean structural change. What is needed is integrated thinking, across social care and health services, about achieving the best possible local outcomes together. [4.25]

We believe that national standards for health and social care provision are needed, so that both health and social care become national services, delivered locally. Organisations delivering health and social care need to operate in a whole systems way. We recommend a redoubled effort to secure seamless provision including consideration of options for finance, accountability, performance, policy and audit and local service delivery. [4.27 and 4.28]

### **The operational framework**

The Assembly should bring forward policies only alongside a published evidence base, including costings and evaluation criteria. [4.31]

We recommend an overall policy framework for prevention, health services and social care. [4.32]

Looking further ahead, we recommend that the Assembly give thought to, and stimulate public debate about, the role of the state in providing care. [4.33]

There is a case for viewing the prevention, health services and social care budget in the round at the Assembly level. We need to focus investment on delivering health gain in the most resource-effective way. [4.35]

We encourage local organisations, having considered the total health and social care budget available to them, to make greater use of pooled budget powers to overcome difficulties in managing the interfaces between the health and social care budgets. [4.37]

We believe there is a need to examine further how resources flow in the health and social care systems. More work is needed to examine how we can develop a system in which money follows activity through a commissioning mechanism that both reflects need and rewards greater productivity. [4.38 and 4.39]

There needs to be a greater commitment to public debate and published information locally on where, and why, local organisations spend public money, and the outcomes expected and achieved for that investment. [4.40]

### **Improving performance**

A clear message from this Review is that the Assembly must stop shoring up the present funding arrangements by effectively underwriting NHS deficits each year. [4.41]

The need for improved incentives is one of the most striking Review findings. We suggest principles to inform the system of incentives, and a systematic approach of piloting incentive systems. [4.44 and 4.45]

We also recommend stronger sanctions. As a principle, the new performance management system in health should identify potential failure and intervene much sooner. We suggest that sanctions should be the reverse of incentives – a loss of autonomy and a removal of opportunities to access additional funding for service developments. [4.46 and 4.47]

We recommend the balanced scorecard should be implemented as quickly as possible to establish it within the new organisational arrangements. [4.48]

We recommend an approach which benchmarks and scrutinises performance against agreed good practice as one element of the balanced scorecard. [4.50]

To maximise the value of our investment, there needs to be a concerted effort to analyse and improve the results of current activity and focus on elements of high value. [4.51]

We need a robust approach to ensuring that good and modern practice is implemented in Wales. There are numerous areas where we could improve system performance by universalising best practice. [4.52]

## Delivery

The Welsh Assembly Government should review the current workforce planning mechanisms and put in place alternative methodologies which will ensure that the NHS and social care is able to deliver the ambitious service strategy.

In social care, we need to accelerate, as a priority, the action already in train to reduce the skills and qualifications gaps in the sector. [4.58]

Piloting new ways of working will be important. We recommend examining the results of the European Working Time Directive Pilots in England, and early piloting of new workforce models in Wales to deliver flexible high quality care in new settings. [4.59]

We recommend a review of the managerial and professional leaders' skills portfolio in health and social care. [4.61]

We recommend that employers work together to improve management and organisational practices that contribute to retention difficulties. In social care, employers should consider collectively what action could be taken across the sector to bring an end to the destabilising practice whereby staff move from one employer to another in return for short-term rewards. [4.62]

We recommend an urgent overhaul of information systems, to improve quality, timeliness and coverage. [4.63]

We regard it as very important that the goals outlined in *Informing Healthcare* should be attained as soon as is practicable. [4.67]

We recommend that the Assembly should give a lead in social care ICT and build on the work of the consortium, to ensure common standards. [4.69]

We recommend development of a common health and social care ICT strategy which ensures that these exchanges of information are as easy as is practicable. We stress, though, the need to be clear about, and to evaluate, the benefits to patients and service users of investment in ICT. Ring-fenced funding and regular auditing linked to common standards and an integrated system are vital. We believe ICT should be a priority for investment. [4.70 and 4.71]

It is more important than ever that processes for taking capital spending decisions are robust. It is important that those in health and social care who take capital investment decisions should consider carefully the longer term affordability of investments so that running costs do not become unaffordable. [4.75 and 4.76]

There should be an end to the practice of transferring money intended for capital investment to running costs. [4.77]

We recommend that local estate strategies are integrated with the health, social care and well-being strategies. They should be whole system, covering all health and social facilities, irrespective of ownership. [4.78]

We emphasise the need to develop a "collaborative accountability" model with all partners signing up to key principles and identifying a mechanism to bring all partners together to take decisions and resolve conflict. [4.80]

It will be important within the new structures to have clarity about the national role and responsibility, so that local organisations have a clear understanding about the extent, and degree of, local freedoms. [4.81]

We believe there is a need to clarify, strengthen and enforce the formal accountability arrangements whereby the chairs and chief executives of NHS bodies are held to account. [4.84]

### **Pace of change**

We recommend that any implementation plan developed by the Welsh Assembly Government to take forward our recommendations should address systematically the short, medium and long-term strategy, implementation plan and resources – capital, revenue and capacity – required to achieve the fully engaged scenario in Wales. [4.88]

Any additional temporary funding to meet one-off reconfiguration costs and to enable the benefits of new provision to be seen before arrangements which are coming to an end have finished, should be linked to clear and explicit criteria. [4.90]

# CHAPTER 1

## INTRODUCTION

- 1.1 In October 2002, the then Finance Minister for the Welsh Assembly Government Mrs Edwina Hart announced a substantial increase in the future resources to be allocated to health<sup>4</sup> in Wales. She also made clear that the use of these resources needed to be allied to improved performance and modernisation of health and social care services. At the same time she announced that the Welsh Assembly Government had asked Derek Wanless, the author of the report for the Chancellor of the Exchequer *Securing our Future Health: Taking a Long-Term View*, to act as advisor to a team set up to review health and social care in Wales and to examine how resources should be translated into reform and improved performance.
- 1.2 The Review Team comprised officials from the National Assembly, the NHS, the National Audit Office and a former Director of Social Services. We took as our starting point the UK Review, and were asked to consider and make recommendations in the following areas:
- issues which are currently impairing the efficient and effective use of resources;
  - the use of resources (capital, revenue and human) to bring about a significant improvement in the quality of services in the NHS and relevant sectors of social care services in Wales;
  - ways in which health and social care systems can work in an integrated way to maximise performance and use of resources;
  - the effectiveness of the decision-making and accountability processes in health and social care in Wales;
  - factors that contribute to success and the need for long-term investment.
- 1.3 We have worked to a project management methodology and have drawn on the expertise of many parts of the Assembly, local authorities, and those working directly in health and social care. We examined a range of issues in the NHS and social care and have spoken to a wide number of stakeholders. A Project Board was established to provide a high level steer to the work of the project and give advice on priorities, standards and principal requirements. The full

terms of reference and the approach adopted are set out in Appendix 1. A Reference Group of practitioners and others was also established to act as a sounding board for the Team. The membership of the Group is at Appendix 2.

- 1.4 We also undertook a widespread consultation exercise with health, social care, professional, voluntary and independent sector interests to gauge their views on the state of health and social care in Wales and the future direction for which we should aim. We are deeply indebted for the time and effort expended in completing consultation responses. These were an invaluable source of evidence to the Review in helping us understand how the system operates currently and in drawing conclusions and recommendations for the future. Details of those who responded are at Appendix 3.
- 1.5 We would like to express our gratitude to everyone who helped us in our work through meetings, discussions, consultation responses or in the preparation of papers. Above all, we would like to express our thanks to Derek Wanless for his wise counsel, patience, advice and involvement throughout the process.
- 1.6 We are conscious that there are many issues which we have not been able to address within the time and resources available to us. This is by no means a comprehensive blueprint for the future. We hope that we have succeeded in highlighting the major issues, and making recommendations which will help the Welsh Assembly Government and those delivering health and social care services; and that the report will encourage a wide debate around Wales on the crucial, and sometimes difficult, decisions which lie ahead in fashioning a system of care for the twenty-first century which lives up to the aspirations of us all.

# CHAPTER 2

## SECURING OUR FUTURE HEALTH: TAKING A LONG-TERM VIEW OF HEALTH AND SOCIAL CARE IN WALES

### *Securing our Future Health - Starting Point for the Review of Health and Social Care*

- 2.1 The starting point for the Review of Health and Social Care in Wales was *Securing our Future Health: Taking a Long-Term View*, Derek Wanless's report for the Chancellor of the Exchequer on the future of health services in the UK. We used the modelling work, analysis and conclusions of *Securing our Future Health* as the basis for our investigation of health and social care in Wales. We also took account of the greater certainty about likely future resources for the health service which has resulted from the UK Review, and the new opportunity that this affords.
- 2.2 In addition, particularly important to our work was the recommendation in *Securing our Future Health* that projections for social care demand needed to be thought through in the same level of detail as those for healthcare and that thinking about the resourcing of health and social care should be integrated.

### **Influences on demand**

- 2.3 *Securing our Future Health* and the Review of Health and Social Care in Wales need to be seen in the context of the rapidly changing world in which health and social care systems operate. *Securing our Future Health* considered in some detail the main influences on the resources required to deliver services over the next 20 years. The main influences on resources required are:
- commitments already made to improve the quality of health service and its consistency;
  - changing patient and public expectations and the need to integrate services;
  - advances in medical technologies;

- changing health needs of the population, including demographic shifts as well as the impact of public health initiatives;
- prices for health service resources;
- the level of productivity improvement, taking account of the capital (especially premises and Information and Communication Technology (ICT)) implications.

2.4 The interaction of these influences impacts to varying degrees on need and demand<sup>5</sup> for health and social care services. For example, whilst improvements to public health may lessen the need for health services, demand, especially from older people, will increase. *Securing our Future Health* found that technological developments have been, and are likely to continue to be, one of the most important drivers of medical spending. Although often reducing the unit cost of treatments, they have enabled many more people to be treated and have opened up new areas of treatment. The UK's record lags behind many other countries and the introduction of proven techniques has been patchy. Medical technologies (including new drugs) were assumed to continue to drive cost growth. More rapid and uniform diffusion of existing and new technologies was assumed along with benefits which should arise from the movement of some care away from hospitals and the better management of chronic conditions.

2.5 Of particular interest to the Review of Health and Social Care in Wales was the finding that demographic shifts towards increasing numbers of old people could impose greater proportionate growth on social care needs than healthcare needs. Evidence suggested that proximity to death had a larger impact on healthcare costs than age although the report also noted evidence that, while severe disability might decline, the number of minor health problems might well increase and that there could be increasing demands from older people for elective medical interventions, for example cataract operations and hip or knee replacements. The impact of new technologies on self-care, the better management of chronic diseases and changes in the variety of styles of accommodation available are examples of areas needing thought.

2.6 The Review of Health and Social Care was also able to take account of the modelling work on demand for social care in Wales commissioned by the Welsh Assembly Government from the Personal Social Services Research Unit (PSSRU) of the London School of Economics<sup>6</sup> to inform the work of the Wales Care Strategy Group. This found that in Wales, the number of people at or

above retirement age is projected to increase by 11% (compared with a 3% increase for the overall population) over the next 20 years.

- 2.7 This work modelled the demand for different types of social care services for older people in 2020, based on different assumptions of dependency\* – a base case<sup>7</sup>, moderately optimistic (age specific dependency decreases by 0.25 per cent per year), more optimistic (dependency rates fall by 1 per cent per year), pessimistic (dependency increases by 1 per cent per year) and the so-called Brookings Scenario<sup>8</sup> which hypothesises that the age of onset of dependency increases at the same rate as life expectancy increases. The modelling work found that if no action is taken to change the pattern of social care provision, then social care services will have to increase by some 24% – an additional 5,000 care home places, and support for a further 15,000 at home – to provide the same service by 2020. However, if we succeed in reducing dependency, or if people remain healthier for longer, the need for care home places will remain constant, but there will be a need for expansion of domiciliary services.

### ***Securing our Future Health – The vision for health services in 2022***

- 2.8 *Securing our Future Health* examined how well the outcomes from health services in the UK compared with other countries and with patients' increasing expectations. The conclusion was that the UK had not kept up. Life expectancy, premature mortality and key survival rates were all worse than average. With improving information, the differences were becoming increasingly visible to patients. Cumulative under-investment over decades and organisational and delivery arrangements not designed to meet the changing challenges were held responsible. Spending growth for health services had been erratic for decades and had helped to create a short-term focus whereas the sector needs a longer-term focus, particularly in thinking through capacity issues. UK health services have serious capacity shortfalls which inhibit their ability to develop services adequately responsive to patients' needs. There are not enough skilled people, up-to-date premises or appropriate information systems.
- 2.9 Looking forward, pressures were assumed to intensify. The report assumed that the patient of the future will:
- be better informed;
  - be more educated;
  - not have enough time to get things done;

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\* Dependency is the extent to which people require assistance with daily living tasks, and increases and decreases in dependency refer to the proportion of those in the population reliant on services to provide assistance

- be more affluent;
- be less deferential to authority and professionals;
- have more to compare the health service against; and
- will want more control and more choice.

2.10 The vision proposed for patients in twenty years time was:

- safe, high quality treatment
- waiting within reason;
- an integrated, joined up system;
- comfortable accommodation services; and
- a patient-centred service.

Each of these elements was specified in some detail.

2.11 The basis of the interim UK report was that UK standards would catch up with comparator countries and then keep up. The health services would "universalise the best". The process assumed was the development of a comprehensive range of National Service Frameworks (NSFs), which were kept up-to-date and delivered, along with improved clinical governance. Waiting times were significantly reduced, the estate of property modernised and information systems developed enabling a holistic service to be provided.

2.12 The UK consultation process added two further issues. Firstly, the impact of health promotion on the demand for healthcare needed assessment and opportunities for evidence-based spending on the prevention of illness should be taken. This was particularly important; although much of the return would occur in the longer-term, that should be very beneficial because in the 2020s/30s the number of old people was projected to rise sharply as post-World War II baby-boomers reach old age. Secondly, sustained investment in social care was vital. There were short-term difficulties to overcome but also the need to integrate thinking about healthcare and social care was stressed. A "whole systems" approach to health and social care was seen as highly desirable and the final report began to address this issue. It concluded that much more needed to be done.

## Capacity to deliver

- 2.13 Two-thirds of UK health spending is on staff costs. The workforce is a major driver of total spending as well as a vital ingredient in any assessment of productivity of spending. The UK does not have enough health professionals and the existing plans were not considered adequate to fill the likely gaps as demand increases. *Securing Our Future Health* therefore stressed the need to improve efficiency and effectiveness by changing significantly the roles of healthcare professionals. The areas identified with most potential for improvements in productivity were more self-care by patients, better ICT, radical changes in the skill mix and the redirection of resources towards treatments which are proven to be cost-effective and away from relatively unproductive treatments.
- 2.14 The expectation in *Securing our Future Health* was for more self-care, with most primary care provided by nurses and other healthcare professionals, and GPs focusing on patients with more complex needs and providing a wider range of diagnostic and treatment services. GP services would often be provided by teams including more specialists where volume permitted; more older people would be supported at home or in intermediate care and major acute hospitals would focus on intensive and high dependency care. To be fully effective, changes in skill mix would need to be accompanied by flexibility in the management of resources created by the pay modernisation deals with GPs, nurses and consultants.
- 2.15 The final UK report made detailed assumptions about all these issues. A high quality vision of the NHS, to be achieved within 20 years, was described. Estimates of the investment required to achieve that vision were produced, based on three differing scenarios of how the drivers that affect cost might interact to determine the demand for healthcare. These scenarios are summarised in Box 2.1.

**Box 2.1: Summary of the three scenarios which will drive the costs required to deliver high quality health service within 20 years**

- *Solid progress* – people become more engaged in relation to their health: life expectancy rises considerably, health status improves and people have confidence in the primary care system and use it more appropriately. The health service is responsive with high rates of technology uptake and a more efficient use of resources;
- *Slow uptake* – there is no change in the level of public engagement: life expectancy rises by the lowest amount in all three scenarios and the health status of the population is constant or deteriorates. The health service is relatively unresponsive with low rates of technology uptake and low productivity; and
- *Fully engaged* – levels of public engagement in relation to their health status are high: life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the health system and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. Use of resources is more efficient.

*Source: Securing our Future Health – Taking a Long-Term View*

2.16 All the spending assessments were very sensitive to changes in the assumptions, particularly productivity. The report concluded that both additional resources and radical reform were vital; neither would succeed without the other. The report was not a detailed organisational review but it set out some observations about issues of standard-setting, delivery and processes. These included:

- older technologies and practices being examined in addition to new technologies;
- commitments made should include estimates of resource requirements;
- a key priority is to invest effectively in ICT;
- public health expenditure decisions should be evidence-based;
- greater local freedom should be developed much further, with potentially powerful benefits from innovation and experimentation in resource management;

- rigorous and regular audit is necessary and preferable to a small number of targets because of the danger of misallocation of resources;
- the balance of health and social care is skewed too much towards the use of acute hospital beds;
- better public engagement could play a major role in the future stability of the NHS and clear signs of progress are necessary if the services are to command continuing public confidence and support;
- much necessary data is not available and much primary research has not been done;
- throughout the UK, each country should have a single source of validated health and social care related information based on common definitions. Data difficulties prevented exploration of different parts of the UK in detail.

## **Review of Health and Social Care in Wales**

2.17 The Review of Health and Social Care in Wales was asked to consider how we should use the resources available to optimal effect. The recommendations of *Securing our Future Health* on capacity, standard setting and productivity formed the base for our work together with a detailed review of:

- decision-making processes;
- the capacity and effectiveness of existing resources;
- the capability of management;
- the processes governing standard setting, management information, money flow, incentives and sanctions;
- how to achieve deepening public engagement;
- the priority which should be given to public health.

2.18 In some areas we found that the position in Wales was better than the UK-wide one described in *Securing our Future Health*. The attention given to addressing health inequalities through action in other policy areas is an example. But, generally the Welsh situation was behind the UK-wide one, for example in

spending on ICT and workforce modernisation. As with the UK report, this reflects deep-seated and long-standing issues that go back over many years.

- 2.19 These are among the topics examined in Chapter 3, in which we ask how near Wales is to achieving the fully engaged scenario set out in *Securing Our Future Health* in order to assess the state of health and social care in Wales today. In Chapter 4 we make recommendations for improvement, having as our goal that within 20 years health outcomes and independence levels in Wales should match the best in the developed world.
- 2.20 We do not recommend structural changes. The new NHS Wales structures were a starting point for our work, and in any case we are clear that more structural change is not the answer to the issues we have encountered. Our recommendations have however considered the action needed to ensure the effectiveness of these structures, particularly how local government and health services work together, in achieving the vision for health and social care in Wales.

# CHAPTER 3

## HEALTH AND SOCIAL CARE IN WALES TODAY

- 3.1 The previous chapter described the trends affecting the health and care system, and the scenarios for the future developed in *Securing Our Future Health*. This chapter examines how well placed Wales is to achieve the fully engaged scenario, which combines the best outcomes with the lowest cost.

### Summary

- The health of people in Wales is relatively poor. Many lead unhealthy lifestyles, and although rising resources and improving productivity are increasing the supply of health and care services, this is being outstripped by more rapidly growing demand. Large and increasing numbers are not receiving social services after assessment, and hospital waiting lists and times are unacceptably long.
- The current configuration of health services places an insupportable burden on the acute sector and its workforce. This is the most expensive part of the system. More acute beds are not a viable or effective long-term response. Actions to reconfigure provision, release acute capacity and raise productivity are needed alongside a rebalancing of the system to meet need earlier in the ‘care pathway’ and improvements in the way in which the parts of the system work together. Supply is involuntarily rationed by long hospital waiting lists and times and assessments without subsequent social services.
- Wales does not get as much out of its health spending as it should. Health spending has risen substantially in absolute terms, and consumes a larger share of Assembly spending than in 1998-99. Even so, in every year but one since 1994-95 NHS organisations have reported deficits over £10m. In social care cost pressures are increasing. There is significant variation in the level of spending on social services between local authorities (as one would expect) and in its cost-effectiveness.
- Wales has significant capacity shortcomings in workforce planning, ICT and estates and is unlikely to achieve the fully engaged scenario for health without (among other things) a sea-change in the quality and nature of its planning and capital and revenue investment.

- There is some good and some excellent performance in health and social care. But there is also widespread under-performance associated with systemic defects – we do not have the performance management and incentive systems to drive properly creation or imitation of best practice. Different areas of national policy-making need to be better integrated. The quality of information, and so of the decisions based on it, is unsatisfactory at every level.
- Health and social care organisations frequently find change difficult, particularly where working across boundaries is required. There are some, but too few, examples of successfully engaging the public in a change agenda.

## Welsh health and provision of care

The health of people in Wales is relatively poor. Many lead unhealthy lifestyles, and although rising resources and improving productivity are increasing the supply of health and care services, this is being outstripped by more rapidly growing demand. Large and increasing numbers are not receiving social services after assessment, and hospital waiting lists and times are unacceptably long.

- 3.2 People in Wales have, and perceive themselves to have, poorer health than those in England<sup>9</sup>. Life expectancy is on average two or three years less than the best in Europe and rates of coronary heart disease, cancer and respiratory disease are all relatively high. There are continuing and substantial inequalities in health within Wales<sup>10</sup>, and some people live in social and economic circumstances which are not conducive to good health.

### Caring for ourselves

- 3.3 The fully engaged scenario assumes a dramatic improvement in public health, as people actively take ownership of their own health<sup>11</sup>. This relies on, amongst other things, individuals doing as much as they can to maintain or improve their own and their children's health, and effective action to help them to do it.
- 3.4 Work for the Review suggests that while Wales is making progress, the pace of change is insufficient and current prospects for better health lie somewhere between the 'slow uptake' and 'solid progress' scenarios described in *Securing Our Future Health*. This highlighted the risks associated with not achieving full engagement, and in particular the "possibly unsustainable" costs if we do not

exceed the slow uptake scenario. The incidence of risk factors such as obesity and overweight are increasing, and only around a quarter of adults undertake sufficient physical activity<sup>12</sup>.

### **Social care services**

- 3.5 The number of older people receiving social care services following assessment rose by 44 per cent between 1994 and 2001<sup>13</sup>, but this was against a background of the number of older people who were assessed increasing by 115 per cent. This means that the number who did not receive services following assessment grew from around 11,000 in 1994 to over 40,000 in 2001<sup>14</sup>. In other words demand increased faster than social services could increase supply<sup>15</sup>. This trend in demand is likely to continue: *Securing Our Future Health* and the emerging findings of the Wales Care Strategy Group both foresee growing demand for social care over the next 20 years as the population ages.

### **Healthcare services**

- 3.6 In health, as in social care, more services are being provided. Acute and geriatric inpatient activity in Welsh hospitals grew from 313,000 cases in 1981 to 439,000 in 2001-02<sup>16</sup>. But, again, this has not been enough to keep pace with rising demand.
- 3.7 The most visible symptom is unacceptably long hospital waiting times in parts of Wales. At the end of March 2003 almost 8,400 people had been waiting more than 18 months for a first outpatient appointment<sup>17</sup>. Almost one person in every hundred in Wales had been on a waiting list for admission to hospital for over six months, and one person in every forty had been waiting to see a consultant for over six months<sup>18</sup>.
- 3.8 In summary, the services are delivering more care, but the system is still not meeting the demands placed upon it. Moreover, *Securing our Future Health* makes clear that these demands will increase over the next 20 years.

### **Imbalance in the system**

The current configuration of health services places an insupportable burden on the acute sector and its workforce. This is the most expensive part of the system. More acute beds are not a viable or effective long-term response. Actions to reconfigure provision, release acute capacity and raise productivity are needed alongside a rebalancing of the system to meet need earlier in the 'care pathway' and improvements in the way in which the parts of the system work together. Supply is rationed by long hospital waiting lists and times and assessments without subsequent social services.

## Pressure on the acute hospital sector

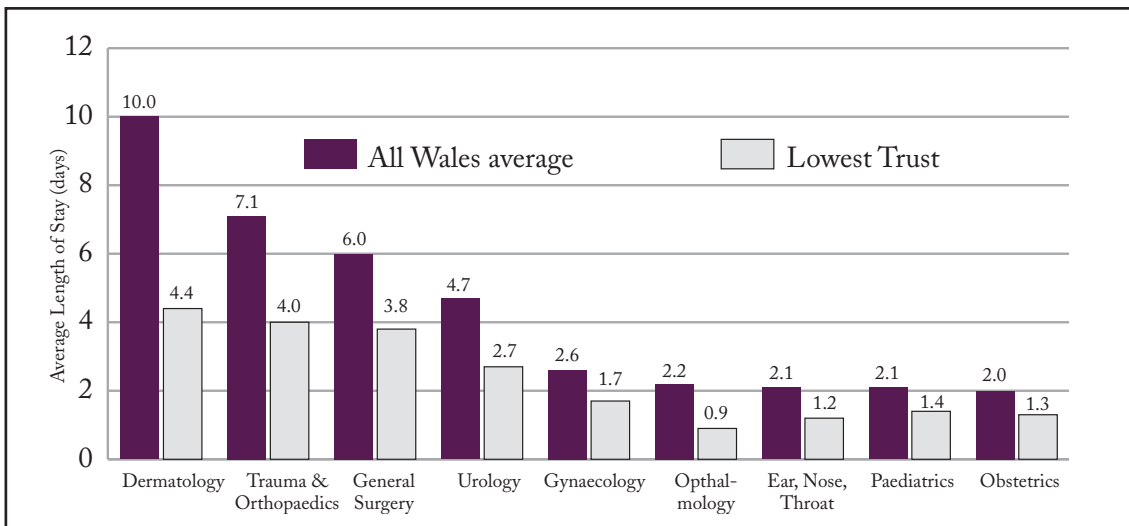
- 3.9 *Securing Our Future Health* found that the balance of the health and care system is skewed too much towards the use of acute hospital beds. We found that this is especially true in Wales.
- 3.10 We have just over 11,000 general and acute hospital beds in Wales. This is 37 per cent more per head of population than England<sup>19</sup>. But we do not have anywhere near the optimal mix of beds: over 3,000 of these are in community hospitals and are less effectively used than they might be (see below), while acute general hospitals are struggling to meet demand. In March 2003 over 5,000 Welsh residents had been waiting more than 18 months for inpatient or day-case hospital treatment<sup>20</sup>, whereas in England nobody had been waiting that long.<sup>21</sup>
- 3.11 This places enormous pressure on those working in acute hospitals. Occupancy levels of around 98 per cent are reported rather than the 82-85 per cent maximum stable level<sup>22</sup>. These hospitals are ever-nearer to supplying an emergency service only as elective activity is crowded out by emergency admissions (which accounted for 73 per cent of admissions and 77 per cent of inpatient bed days in 2001-02)<sup>23</sup>.
- 3.12 The Assembly has commissioned work to estimate the number of additional acute beds which appear to be needed. The conclusion of a thorough analysis in the 2002 report *A Question of Balance* was that, at 85 per cent bed occupancy rates, a further 479 beds or bed-equivalents would be needed, with current levels of activity and length of stay remaining constant<sup>24</sup>.
- 3.13 But we agree with *A Question of Balance* that it would be a mistake to suppose that – if more beds were provided – all else would or should remain constant. The productivity of hospitals contains such variations that there is clearly hidden capacity waiting to be released by improvements in efficiency and innovation (Boxes 3.1 and 3.2, and Figure 3.1). Delayed transfers to other care settings alone impose an enormous burden (see below). The Audit Commission in Wales told us that it believes that "...inefficiency at each stage of the care pathway exerts increasing pressure on the ability of care services to meet their fundamental objectives....the evidence indicates that there is not a bed shortage but rather a chronic pressure on those beds. There is increasing evidence to suggest that more "assertive" bed management could free up sufficient capacity." In addition, research has noted that communities with a relatively greater supply of hospital beds tend to use hospital services at a greater rate: "hospital beds that are built tend to be used."<sup>25</sup>

### Box 3.1: Variable performance in hospitals in Wales

- Emergency admission rates – range from 7–8 per cent to 36 per cent of A&E attendances and from 90 to 139 per 1,000 of the local population
- Day case rates – rates for excision of breast lump range from 19 per cent to 100 per cent
- Community hospital utilisation – the average number of patients using each bed during a specified review period ranged from 14 in one Trust to 7 in another
- Average Length of Stay – the average length of stay in acute hospitals in general medicine/ elderly medicine ranges from 5.9 to 11.3 days

Source: *A Question of Balance, Williams, 2002*

**Figure 3.1: Average length of stay – lowest in Wales, main surgical specialties – acute general hospitals**



Source: *A Question of Balance, Williams, 2002*

### Box 3.2: Release of acute capacity through innovation

Significant numbers of patients with chronic disease continue to be admitted to the acute hospital sector, despite the fact that there are many good examples of services across the UK in which patients are more effectively and appropriately managed in the community. In particular, there is scope for the introduction of chronic obstructive pulmonary disease teams, which might avoid 30 per cent of admissions for acute episodes of this disease, saving perhaps 14,000 bed-days across Wales.

Source: *A Question of Balance, Williams, 2002*

3.14 Furthermore, before we consider increasing bed numbers we should make sure that the acute sector we already have is optimally configured to deliver safe, high-quality services to patients within a reasonable timescale. We doubt that it is. The efforts of acute sector staff to deliver services are hampered by a configuration of hospitals which faces a number of ever-increasing pressures. A safe service for patients requires:

- **adequate medical staffing**, but there are high consultant vacancy rates in a number of specialities, and junior doctors' hours are reducing as a result of the New Deal contract and the European Working Time Directive. Moreover, a Wales-wide workforce planning review concluded that, given the existing consultant vacancy level, the predicted workforce needs and the people in training, most of the changes required can only be fully implemented in relation to service reconfiguration, managed networks and long term reform. It further stated that without action along these lines, the shortage of medical staffing of the NHS Wales is likely to deteriorate further, affecting the quality and quantity of services available<sup>26</sup>;
- **24 hour critical care support services**. This issue was the subject of a report by the Royal College of Physicians in 2002 on the potential risk to patients posed by what it termed the UK's 'isolated hospitals', unable to provide adequate 24 hour critical care and support services<sup>27</sup>. In Wales there will be several units which will be only able to provide limited critical care facilities, mainly because of restrictions on working hours, under Health and Safety legislation - the Working Time Directive. There is also evidence that more critical care beds are needed;
- **recognised medical training standards**. Services in some hospitals do not allow the level of specialisation required by the medical Royal Colleges, leading to potential loss of recognition as training hospitals and a consequent reduction in the care available for patients. For example, there are a number of hospitals in Wales where, because of a declining birth-rate, the number of babies being born falls below levels the Royal College of Obstetricians and Gynaecologists advise are needed to support training standards.

3.15 As well as these pressures acute hospitals face:

- growing difficulties in replacing clinical generalists because of the trend to increased clinical specialisation and sub-specialisation;

- advances in medical technology which allow more sophisticated diagnosis and testing but which require specially trained staff to operate it and interpret results.

**Box 3.3: Pressures on acute services elsewhere in the UK**

Pressures on the configuration of acute services are not unique to Wales. The Department of Health estimated in 2002 that 75 per cent of English hospitals were involved in some sort of reconfiguration debate, about the provision of secondary and tertiary care services<sup>28</sup>. In Northern Ireland, the follow up to the 2001 report of the Acute Hospitals' Review Group has led to a reconfiguration in which the 15 existing acute hospitals will be reduced to 9 or 10 as part of a £1.2 billion modernisation programme<sup>29</sup>. In Scotland, the NHS in Glasgow is investing £700 million in transforming five existing acute hospitals into three adult in-patient hospitals and two ambulatory care hospitals<sup>30</sup>. This indicates the scale of the capital investment (and the timescale – 10-12 years in Northern Ireland and Scotland) that could be involved in any large-scale reconfiguration

3.16 The demand for emergency services is driving out the ability of the NHS in Wales to meet the demand for elective activity. However, the need for elective activity is also increasing, and must continue to do so if the Assembly's waiting time targets are to be met. Advances in medical technologies will also increase these demands. This is illustrated at Table 3.1.

**Table 3.1: Waiting lists for in-patient and outpatient appointments in Wales 1997 to 2002**

	Total patients awaiting first outpatient appointment	Patients waiting six months for first outpatient appointment	Total patients waiting for in-patient treatment
31 March 1997	101,308	5,956	37,095
31 March 1998	112,758	10,340	40,574
31 March 1999	134,364	21,828	35,851
31 March 2000	160,844	37,991	43,105
31 March 2001	177,647	45,757	36,156
31 March 2002	212,352	68,560	38,717

*Source: National Assembly for Wales*

- 3.17 Reconfiguration is necessary to deliver a safe service for patients in a timely way. The NHS in Wales has a good record of meeting its emergency access targets, but a weaker record on its waiting times. The way ahead must involve maintaining the good performance alongside improving the weaker and doing so in a way which maintains safe clinical standards.
- 3.18 Providing additional beds is one, short-term, solution. More attractive, because more likely to deliver enduring benefit, is early action to solve the problem of delayed transfers and, in the longer term, reconfiguration of existing capacity. This could include dedication of existing or new facilities to elective work, including diagnostics. Such Diagnostic and Treatment Centres are being introduced in England, which has much lower waiting time figures. This is also the approach being followed in Glasgow.

#### *Smaller hospitals*

- 3.19 There are 3,100 or so beds in community hospitals, mostly in Wales' 78 non-psychiatric hospitals with 100 beds or fewer.
- 3.20 Community hospitals provide inpatient care which does not require the highly technical specialist support of an acute hospital. GPs, specialist doctors or nurses supervise inpatient care, which may include a minor injury service and elderly mentally ill beds. Where consultants provide care this is usually for elderly patients. Other services such as outpatient clinics, diagnostic and therapy services and day care may also be provided, but not emergency acute admissions or inpatient general surgery requiring general anaesthesia.
- 3.21 These smaller hospitals may fail to achieve economies of scale and can be under-utilised hospitals. In 2001-02 beds in community hospitals had an average gap between patients of over seven days, as opposed to less than one day for most acute beds<sup>31</sup>. Variations in average length of stay in community hospitals are so large (from over 40 days in Ceredigion to 13 days in Powys)<sup>32</sup> that questions arise as to how far some of these hospitals are really providing medical care (ie characterised by medical interventions) at all.

#### *Demand management*

- 3.22 Even where the configuration is optimal, increasing acute capacity is not only of questionable efficacy; it is also a very costly response to the problem. Acute beds are the most expensive part of the system<sup>33</sup>, costing around £120,000 a year each<sup>34</sup>. It is wasteful of resources to provide acute care for conditions which could be more cheaply treated elsewhere with, often, (and more importantly)

better outcomes for patients. For example, there is considerable demand for acute care as a result of diabetes, which can lead to blindness, amputation and even death, and is a risk factor for Coronary Heart Disease, stroke and kidney failure. But, as *Securing Our Future Health* notes about diabetes, there is scope for significant cost-savings through prevention, earlier diagnosis, and better management and secondary prevention after diagnosis.

#### *Earlier intervention*

- 3.23 What is needed, as the diabetes example above suggests, is to reduce the burden on the acute sector in the first place by providing care earlier in the 'care pathway', or preventing ill-health altogether. As the Association of Directors of Social Services, in its comments to the Review, observed: *"Expectations of, and demand for hospital services are constantly increasing and insufficient attention is paid to alternatives to hospital care."*

#### *Social Care*

- 3.24 Poor public health (see paragraphs 3.2-3.4) makes for avoidable ill-health. As the social care system struggles to contend with demand it has responded to resource pressures by concentrating on those requiring the most intensive care packages, with too little space in the system for preventative and early intervention to promote effective and sustainable independence. (Influences include a perceived need to target resources on those most in need, which implies those who may need residential care, and the fact that it can be cheaper to provide residential rather than domiciliary care for the very needy.)

#### *Primary Care*

- 3.25 The primary care sector in turn is not sufficiently resourced or incentivised to keep patients out of hospital (though it is hoped that the new General Medical Services Contract (under discussion at the time of this report) will create such incentives). GPs are the main source of Wales' particularly high demand for acute emergency services. There are 19 per cent more attendances at A&E departments per head of population than England,<sup>36</sup> and around 40 per cent more emergency admissions<sup>37</sup>, which suggests an absence of, or absence of awareness of, more appropriate alternatives. The Assembly has recognised the need to *"enable primary care, in partnership with others, to play a full part in the protection and promotion of the health and well being"*<sup>38</sup> and its *Inequalities in Health Fund* demonstrates clearly the enthusiasm of some GPs for new local action to prevent ill health in order to avoid unnecessary hospitalisation. Under the Fund a number of early treatment and risk reduction programmes for conditions including CHD and diabetes have been established by GPs in different parts of Wales.

- 3.26 The Audit Commission suggested to the Review that what we have is a vicious circle of a failure to meet elective demand and rising emergency admission rates – *"admissions through A&E are often high.... In many cases, this is because primary care practitioners often feel that admission is the only way to access trust services"*.
- 3.27 We lack sufficient relevant information at the national level on the exact service being delivered in primary and community settings. This is unsatisfactory given primary care's fundamental importance to the successful functioning of the health and social care system<sup>39</sup>. We do know that although at present GP list sizes are lower than in England, statistics show that the highest list sizes, the lowest numbers of female GPs, the highest numbers of single-handed GPs and the highest numbers of GPs due to retire soon are found in the most deprived areas which have the highest health need according to the Welsh Health Survey<sup>40</sup>. In short, the configuration of primary care is poorest where it is most needed and this has inevitable consequences for the quality of service provision for patients, and for additional pressures on hospitals in these areas.

#### *Unsustainable configuration*

- 3.28 In summary, the preceding section and this one have described a pattern of healthcare provision in Wales which, often because of changes which are outside its control, is not optimally configured to:
- sustain safe, recognised specialist and acute services;
  - meet elective demands;
  - support critical care services;
  - achieve sustainable bed occupancy rates;
  - replicate achievable high levels of productivity across all sites;
  - supply predicted consultant numbers;
  - utilise available capacity to the full;
  - provide treatment in the most cost-effective setting;
  - provide sustainable primary care services where they are most needed;
  - distinguish discrete capacity for elective and emergency secondary care.

- 3.29 In Chapter 4 we make recommendations for short-term action to make bed equivalents available, and to bring about longer term adjustments, to address this unsustainable situation.

*Which demand is met*

- 3.30 None of what has been said above removes the question as to which demand should and should not be met. In Wales, as elsewhere, waiting lists have rationed demand for health, while in social care assessments have often not been followed, or followed promptly, by services. Many local authorities have tightened their eligibility criteria<sup>41</sup> in the light of growing demand so that more people are faced with finding their own solutions to problems.
- 3.31 There are no studies or information that give a reliable picture on the requirements of those 40,000-plus older people who do not receive services following assessment. It seems likely that some will find other ways of meeting needs, for example family and other sources of private or informal help. A proportion will cope as best they can, and for these there is almost certainly a greater risk than there otherwise would be that sooner or later they will be unable to cope and will be routed into more costly or inappropriate care.
- 3.32 This state of affairs, which includes differences in eligibility criteria from one local authority to another, can create pressures elsewhere and does not support a properly balanced approach. The Assembly has started to address this through a requirement for revised eligibility criteria in order to help achieve greater consistency in meeting people's needs<sup>42</sup>.
- 3.33 *Securing our Future Health* recommended that the attempt to define which new services should be available via the NHS through the work of the National Institute of Clinical Excellence should be extended to examine older technologies and practices which may no longer be appropriate or cost effective. Addressing these questions of demand management, including through explicit priority-setting, is, we believe, likely to be necessary to achieve an optimally balanced system.

**Working together**

- 3.34 The imbalances described above are also due in part to the need for the different parts to work together more effectively. Delayed transfers from acute to social care settings are one example (which the Assembly has sought to address through measures such as grants to help local authorities work with the NHS and independent care home owners). The acute sector is caring for a

significant number of patients whose transfer to another care setting has been delayed. In 2001-02 there were an average of 806 delayed transfers of care at any one time, and fifty-seven per cent of patients were delayed for social care reasons arising from difficulty in arranging funding for care packages. By early 2003 the delayed transfer figure exceeded 1,000 – or more than twice the number of acute beds or bed equivalents which *A Question of Balance* found were needed (see above).

- 3.35 Different structures make it harder to work together. We have a national health service and 22 local authority social service departments. Information exchange is impeded by practical obstacles such as differing systems, and understandable concerns about client or patient confidentiality. Planning, performance management, accountabilities and resource allocation systems for the NHS and social care are quite different. We understand the overall public sector context for the differences, but the differing accountabilities create the danger that members of the public with health and social care needs find that nobody seems to be responsible for meeting them because everybody involved can refer the matter to someone else. In addition both health and social care to varying degrees have important relationships with the voluntary and private sectors: in both health and social care a major contribution is made by family and other carers.
- 3.36 Progress has been made in improving joint working through the creation of incentives<sup>43</sup>, and we found numerous examples of good practice in areas as diverse as reablement, elderly care assessment, children's services, learning disabilities, etc. But we did not find that integrated thinking systematically rolled out across the core health and social care services was the norm. For example, we found no evidence that emergency medical services or services for older people were being planned and provided in an integrated way, by bringing together budgets and workforce to deliver services.

## Financial position

Wales does not get as much out of its health spending as it should. Health spending has risen substantially in absolute terms, and consumes a larger share of Assembly spending than in 1998-99. Even so, in every year but one since 1994-95 NHS organisations have reported deficits over £10m. In social care cost pressures are increasing. There is significant variation in the level of spending on social services between local authorities (as one would expect) and in its cost-effectiveness.

## Comparison with the North East of England

3.37 Because our health is worse than England's we need to spend more on health and social services, and over the five years to 2001-02 we spent on average 16 per cent more per head<sup>44</sup>. But it is not necessarily the case that all of this additional spending is justified by additional health need. While there are some differences, the North East of England is very similar to Wales across a range of socio-economic indicators and expenditure on private healthcare, but over the four years to 2001-02 we spent on average over 5 per cent more per head on health and social services. Compared to the Northern and Yorkshire region<sup>45</sup>, in Wales:

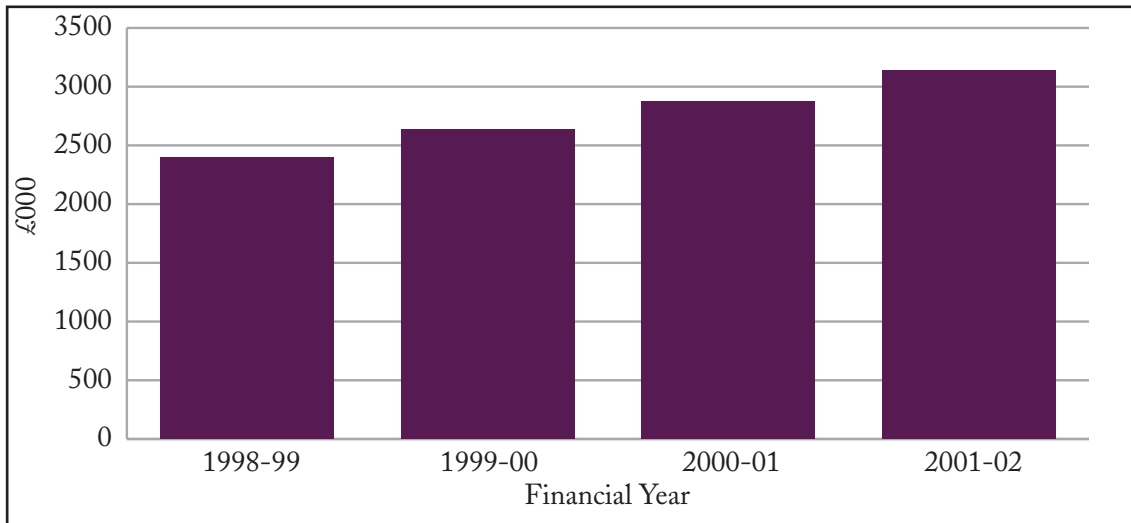
- there are 8 per cent more nursing, midwifery and health visiting staff per head of population;
- there are 17 per cent more hospital beds per head of population;
- the average length of stay is 15 per cent longer;
- 9 per cent more per head is spent on prescribing, and 12 per cent more items are prescribed per head.

3.38 We did not get as much for our additional spending as we might have expected: at the end of March 2002 almost a quarter more people per head of population were on the inpatient and day-case waiting list in Wales than in Northern and Yorkshire, and 14.3 per cent of them had waited over a year compared with only 0.3 per cent in Northern and Yorkshire<sup>46</sup>. In social care, the North East and Wales appear to enjoy similar provision: the Review compared five performance indicators on services for adults which included numbers of people aged 18-64 and aged 65+ supported to live at home and numbers of assessments<sup>47</sup>. On all these indicators Wales and the North East were close and mostly within 1 per cent of each other.

## Financial position in health

3.39 Since the Assembly came into being, spending on health has risen significantly (see Figure 3.2, which charts expenditure by health Authorities – the vast majority of Assembly health spending). In absolute terms it rose over 30 per cent between 1998-99 and 2001-02. In every year since 1998-99 it has represented a higher proportion of the Assembly's spending than it did then.

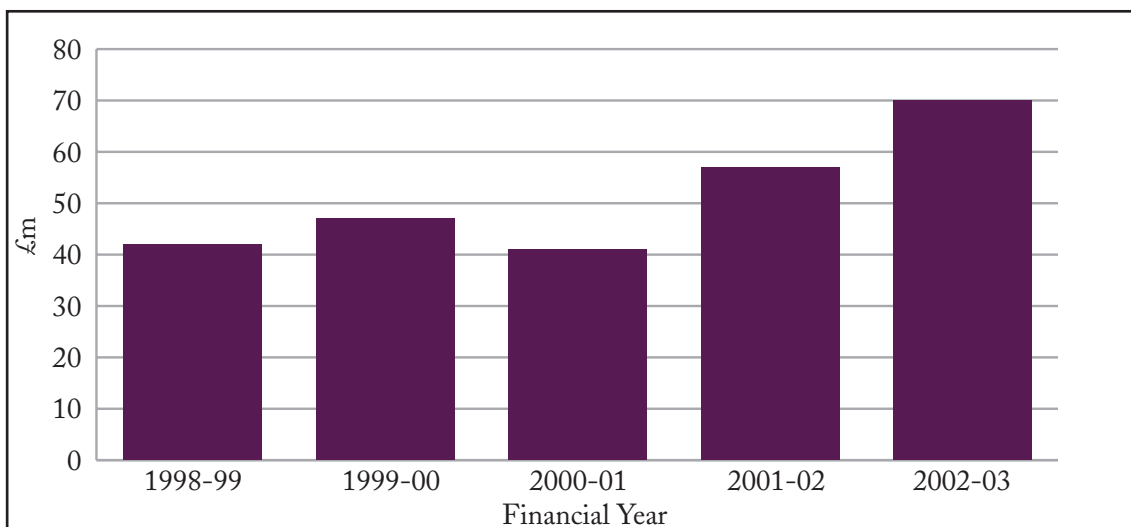
**Figure 3.2: Health Authority audited expenditure 1998-99 to 2001-02**



Source: NHS Wales Summarised Accounts

3.40 Even so, health expenditure is running beyond what is made available at the start of each year by the Assembly Government. The overall NHS Wales deficit had reached £56m in 2001-02<sup>48</sup>. Deficit is not a new phenomenon – in every year but one since 1994-95 NHS organisations have reported deficits over £10m. As one would expect in circumstances where annual deficits are being incurred almost every year, the accumulated deficit is climbing (Figure 3.3).

**Figure 3.3: NHS Wales accumulated deficit 1998-2003**



\* forecast figure given for 2002-03

Source: NHS Finance Directorate, National Assembly for Wales

- 3.41 The Assembly has responded to these deficits in several ways. Before 1 April 2000 organisations in deficit received repayable loans in the context of an agreed plan for restoration of financial balance and repayment of the loan. In January 2002 it was decided to write off the outstanding loans (which totalled around £40m – of which £16m is held by Trusts and has yet to be written off<sup>49</sup>). In 2001-02 health organisations in deficit received ‘strategic assistance’ from the Assembly<sup>50</sup>, ie one-off payments totalling £9m which did not have to be repaid, again in the context of agreed plans for restoration of financial balance. However, in 2002-03 a number of health organisations which had previously agreed Recovery Plans to bring them back into financial balance in 2002-03 in fact remained in deficit. In addition, the NHS required repayable loans of approximately £20m to finance this operating deficit. The accumulated deficit does not take account of the strategic assistance and the initial write-off of debt announced in January 2002, and therefore would be greater had this assistance not been provided to the NHS.

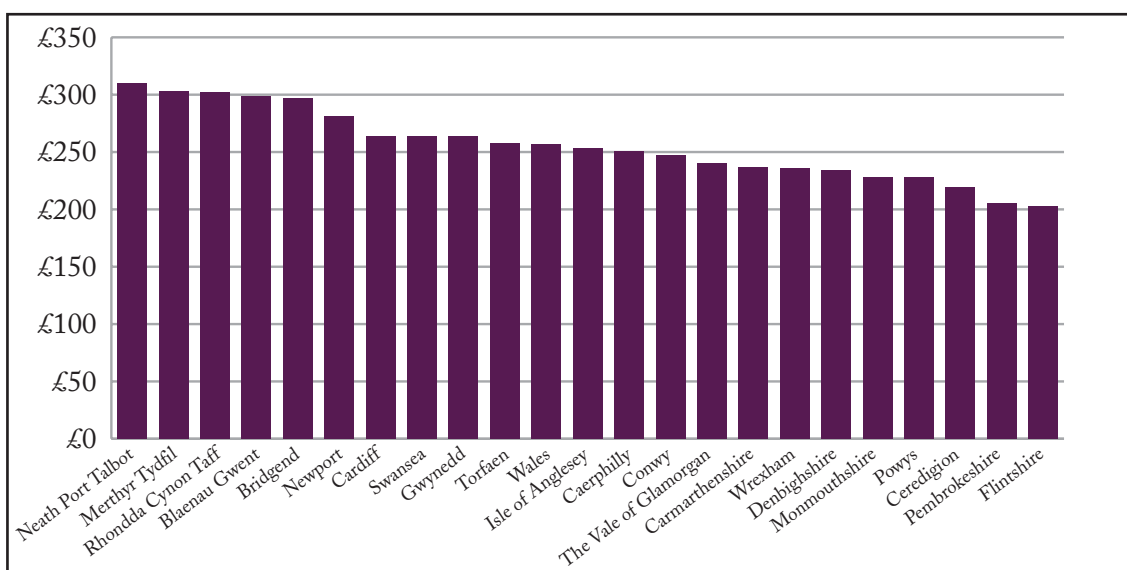
### **Financial position in social care**

- 3.42 In assessing the financial position of the social care sector in Wales a different approach is required. Deficits can perhaps be better termed as cost pressures building up in local authorities that need to be met in order to allow authorities to provide a quality service in the future. These can lead to overspends in specific areas, such as specialist residential care placements.
- 3.43 The local authority revenue settlement is not hypothecated and there is not therefore an identifiable global sum which can be regarded as being for social services. The average share of Welsh local authorities’ net current expenditure spent on personal social services rose from 16.6 per cent in 1996-7, when £526m was spent on personal social services in Wales, to 18.3 per cent in 2001-02, when £747m was spent in total.
- 3.44 The growing numbers who are assessed but do not receive services (see paragraphs 3.24 and 3.30-3.32 above), the submission of the Association of Directors of Social Services to the Welsh Local Government Association in the context of the 2002 Budget Planning Round, and the longer term projections prepared for the *Wales Care Strategy Group* all point to significant cost pressures developing. If resources are in fact diverted elsewhere then these become even more severe.
- 3.45 This means the proportion of the budget allocated to personal social services by each local authority is also important. As one would expect, given the variation in need in different parts of Wales (which is reflected in the varying support

provided by the Assembly Government), there is significant variation in what authorities spend, with the highest spending 53 per cent more per head than the lowest in 2001-02 (see Figure 3.4).

3.46 We found no obvious relationships between spending and outcomes and performance in social care. For example, there seems to be little overall direct correlation between the cost of residential care for older people and the extent to which it is used, or between the cost of residential care, the extent of delayed transfers and individual authorities' expenditure per capita on services for older people. Higher as well as lower spending authorities have been the subject of unfavourable Joint Review reports and vice versa. This raises issues of effective use of resources and good systems of performance management, which we discuss later in this chapter.

**Figure 3.4: Personal social services expenditure per head, 2001-02**



Source: National Assembly for Wales

## Infrastructure

Wales has significant capacity shortcomings in workforce planning, ICT, and estates and is unlikely to achieve the fully engaged scenario for health without (among other things) a sea-change in the quality and nature of its planning and capital and revenue investment.

## Workforce

3.47 *Securing Our Future Health* noted that "the size and composition of the workforce is one of the most important determinants of the capacity of the health service".<sup>51</sup> We

consider this is equally the case for social care. But our conclusion is that we do not have, and have not properly planned, the health or social care workforce necessary to deliver modern services in the future.

### Workforce - health

- 3.48 The health workforce is large and complex. The NHS is the largest employer in Wales, having over 81,000 staff<sup>52</sup>. A further 10,000 are employed in the primary care sector. A very large range of health, health-related and management skills are required. Many of them take years to acquire. More than two-thirds of the total health budget is spent on pay.
- 3.49 We found that in important respects we do not have the health workforce we need. Despite significant investment in the workforce in recent years, vacancy levels are high<sup>53</sup>. According to the NHS Vacancy Survey 1,515 NHS posts, or 2.5 per cent of all NHS posts, had been vacant for three months or more at 30 September 2002. There are a large number of medical specialities which are particularly vulnerable to shortages in the future. Shortages in support specialities have also been identified. Wales' small size compared to England means that if shortages occur, for example of consultants in a particular field, they have the potential more quickly to raise questions of service sustainability.
- 3.50 The NHS spent £24m on bank and agency nurses in 2000-01, and expects to have spent £38m in 2002-03. Table 3.2 below shows the vacancies in different staff groups, and compares with the position in England.

**Table 3.2: NHS vacancies by staff group as at 31 March 2002**

Category	Wales	England
Nursing, Midwifery and Health Visiting	3.6%	3.1%
Medical and Dental (including consultants)	7.4%	3.7%
Consultant posts	8.8%	3.8%
Allied Health Professions	7.5%	5%
Scientific and Technical	2.2%	3.2%
Other Staff	1.2%	1.2%

- 3.51 The high levels of vacancies across the service bring into question the ability of the NHS to meet the current service plans and targets through current workforce models. Moreover, the problem is worsened by high turnover rates. Examples of turnover rates for some staff groups are shown in table 3.3<sup>55</sup>.

**Table 3.3: turnover rates for selected staff groups**

	1996-97	1997-98	1998-99	1999-00	2000-01
Adult Branch Nursing	8.4%	10.3%	7.1%	10.1%	9.8%
Physiotherapy	12.4%	14.1%	13.9%	13.1%	13.3%
Speech & Language Therapy	6.5%	10.9%	29.6%	20.0%	14.2%

- 3.52 In addition there are large numbers who leave (or qualify but do not join) the service. A recent study of non-practising nurses and midwives in Wales<sup>56</sup> found that there were 8,087 nurses and midwives under 65 years who had allowed their registration to lapse and were therefore not practising (compared to 37,378 employed by the NHS at 30 September 2002<sup>57</sup>). More than half were under 55 years of age, and this proportion was mirrored in each health authority in Wales.
- 3.53 In primary care GP list sizes in Wales are smaller than those in England, but the areas of greatest health need<sup>58</sup> are also those with highest list sizes, fewest female GPs, most single-handed GPs and highest numbers of GPs due to retire soon. Wales has the fewest dentists per 10,000 population in the UK.
- 3.54 Measures being taken to tackle the vacancies problem include those which make jobs more attractive such as flexible working arrangements and childcare support, and recruitment overseas.
- 3.55 The longer term aim of the Assembly is to train sufficient staff to enable the NHS to recruit mostly from Wales and the rest of the UK. Developing more innovative and flexible training is vital and some progress is being made in this area. It is essential that the capacity of education providers, and of the NHS in providing additional training placements to support additional training places, should match what is required. Skill mix changes will be crucial. More broadly, the need to train, and enhance the skills of, the health service workforce of tomorrow highlights the important role of education providers and academic medicine in Wales.
- 3.56 High quality workforce planning is critically important, and the Assembly's NHS Directorate has work in hand which is intended to identify improvements which are needed. A number of weaknesses were brought to our attention:
- until 2001 trust projections of requirements for nurses and allied health professionals (AHPs) were based on affordability rather than need, which led to under-training of NHS professionals, the consequences of which

have been described. Table 3.4 shows that subsequent upward revision of targets still falls short of numbers needed according to workforce planning data for 2002.

**Table 3.4: Workforce targets and identified need**

2010 Target	2008 Identified Need
+ 525 consultants	+ 876
+ 6,000 nurses	+ 8,046
+ 2,000 other healthcare professionals	+ 4,114
+ 175 GPs	Not identified

- even these numbers for identified need are unreliable because they are based on meeting future need through today's, not an expected future, pattern of provision. This is a critical weakness given the conclusion in *Securing Our Future Health* that the workforce implications of increased activity will present a significant challenge, demonstrating the need for skill mix changes<sup>59</sup>;
- data currently collected from workforce plans is inconsistent across Wales and there are concerns about its accuracy and validity. There is a paucity of workforce planning capacity and skills which limits accuracy. Not all Trusts and LHBs have dedicated workforce planners;
- workforce planning is undertaken in isolation from strategic and operational planning, and setting of service and financial targets. For example, Trust workforce plans are not routinely discussed and agreed with commissioners. This seriously weakens the credibility and usefulness of the data;
- workforce planning and service planning often operate under very different timescales. New initiatives such as the National Service Frameworks (NSFs) often have short to medium targets. Workforce planning is medium to long term because of the length of time it takes to plan for, educate and train staff. The workforce plans now show large increases in staffing requirements over the next 2-3 years that probably cannot be met;
- the data collected from the workforce plans is used as the sole determinant of the numbers of training places commissioned for nurses

and AHPs. No account is taken of wastage rates throughout the system. The effect has been an under provision of training places.

- 3.57 This discussion of health workforce issues has centred on professionals. This is not because the third of the workforce who are not professionals are unimportant, but because we found that little information is held centrally on this group. This seems to us a serious weakness: an understanding of the skill levels, productivity and future resource requirements of these staff is a prerequisite both to effective resource allocation and to improving the performance of the NHS in the future.

*Workforce – social care*

- 3.58 Approximately 70,000 people are employed in social care (of whom about 3,000 are qualified social workers), but it is a much more heterogeneous picture than health<sup>60</sup>. Over 50 per cent are employed by private employers, and there are 22 different local authority public employers. Women make up 80 per cent of those working in the sector, whereas they make up 45 per cent of the overall workforce in Wales.

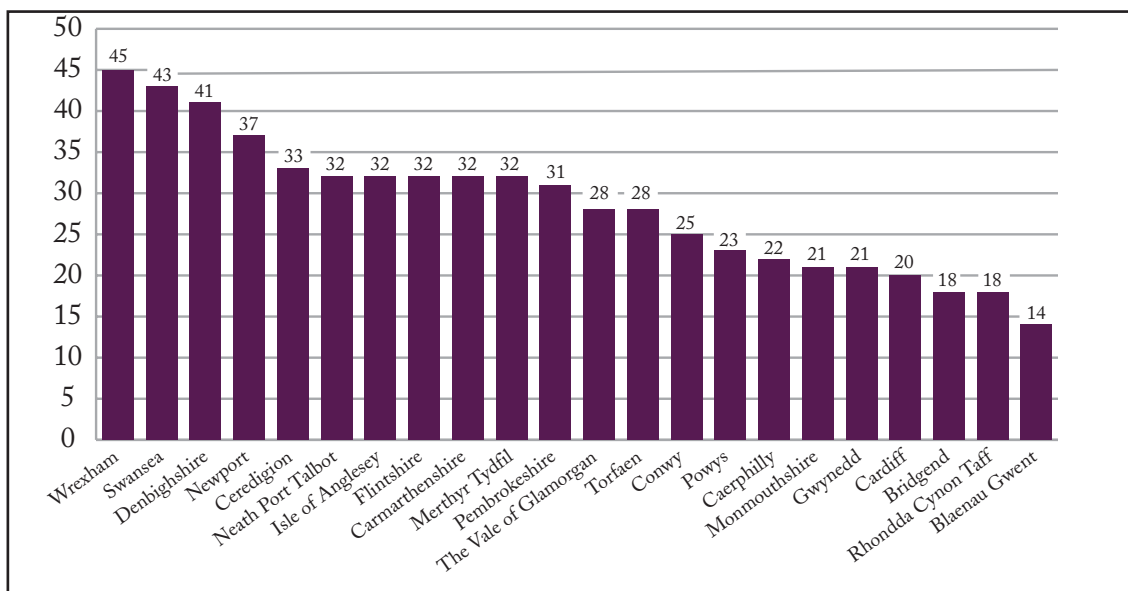
- 3.59 Notwithstanding the differences, we found key similarities to health:

- vacancies at levels likely materially to affect the quality of care which can be provided;
- weaknesses in workforce planning;
- shortcomings in the availability and quality of data;
- wide variations in skill levels across Wales.

- 3.60 Data on vacancy and turnover rates is fragmented, and varies by user group and type of work. A survey of Welsh social services in the spring of 2002 indicated a vacancy rate among qualified social workers of 13 per cent<sup>61</sup>, which is similar to the position in England. Some authorities faced a particular problem in recruiting and retaining Welsh speakers. In addition, lack of front-line domiciliary services staff is closing off some home-based care options.

- 3.61 The same survey revealed significant rotation of social workers between authorities, perhaps because of "golden hello" schemes in response to high vacancy rates. The overall effect is to intensify the problem caused by vacancies. The Audit Commission have estimated that the average direct cost of recruiting

a member of staff is £3,456 and that on average a new recruit performs at only 60 per cent of their productive potential for at least a year before reaching 100 per cent<sup>62</sup>.



3.62 Moreover, there are wide variations in qualification levels across local authorities. This suggests that, at least in some parts of Wales, there is a significant shortage of skills. (See Figure 3.5 below.)

**Figure 3.5: Percentage of local authority personal social services staff holding a listed qualification as at 30 September 2001**

3.63 As in health there have been efforts to improve workforce planning, and the Care Council for Wales is developing a Skills Foresight Plan which will document numbers in the sector and their skills, qualifications, and development needs. There is consensus that the workforce, and demand for qualified social workers, will increase in the short to medium term (although in recent years applications to social work courses have been falling<sup>63</sup>).

3.64 The structure and complexity of the sector, and the important part played by private employers, presents particular difficulties for information-gathering to support workforce planning. The Assembly is leading work to improve workforce planning and creating regional partnerships of employers to address recruitment, retention and training issues. However, there is some way to go before we have consistent data from all employers to inform workforce planning at local regional and national levels.

3.65 The vacancy levels in health and social care are imposing important constraints on service provision. Some of these have been outlined above in the discussion of the pressure on the acute sector. As was explained there, the difficulties will be exacerbated as the European Working Time Directive, which limits hours which individuals may work, takes effect. Unfortunately, at the same time that workforce constraints in the acute sector are helping to make other kinds of response to need imperative, shortages elsewhere are increasing the burden on the acute sector. As the Welsh Local Government Association put it in their comments to the Review, "*shortages of occupational therapists in both local government and the NHS, physiotherapists, social workers and care workers in all sectors are contributing to pressures on NHS acute services, delaying assessments and reducing the availability of community based solutions which seek to maximise independence.*"

## **Information and Communication Technology (ICT)**

### *ICT in health*

3.66 *Securing Our Future Health* found that ICT offers scope for significant productivity improvements in the longer term, but that the UK health service has had a particularly poor ICT investment record<sup>64</sup>. The picture in health in Wales is if anything worse:

- expenditure on ICT accounts for less than 1 per cent of total NHS expenditure in Wales<sup>65</sup>, around half the proportion spent in England;
- ICT development in NHS Trusts has taken place in piecemeal fashion, without any overall strategy;
- Trusts manage their ICT in different ways. For example, approximately 50 different clinical systems are in use<sup>66</sup>, and different systems are not necessarily integrated within Trusts<sup>67</sup>;
- there is no commonality of Patient Administration Systems between Trusts, and in some cases, for example where a merger has occurred, there may be more than one system in a single Trust.

3.67 *Informing Healthcare* (Welsh Assembly Government, 2002) describes the difficulties that professionals and patients experience. For professionals it means:

- delays in getting results because they are paper based;
- poor access to evidence in the workplace;

- time consuming recording by hand in patient notes;
- frustration at the unavailability of notes produced by others; and
- errors caused by poor access to timely information.

3.68 For patients it means:

- wasted journeys because records are mislaid;
- frustration as the same information is requested again and again;
- inconvenience and discomfort through repeat tests when results are lost;
- anxiety through lack of continuity and clear explanation; and
- incorrect treatment due to mis-identification or mis-diagnosis.

3.69 This is a deeply frustrating state of affairs for patients and for all those trying to provide high quality care, because the potential benefits of ICT are widely understood. *"We believe that [this] investment in ICT is an investment in improving the efficiency and effectiveness of resource management within NHS Wales and should therefore not be seen as a cost that brings no tangible benefit."* (Welsh NHS Confederation, comments to the Review.)

3.70 *Informing Healthcare* sets out how the Assembly intends to tackle these shortcomings. The intention is to develop compatible ICT across the Welsh health system, and to exploit the opportunities to enhance productivity, not least through the introduction of an electronic patient record.

3.71 The situation is better in primary care. An ICT Foundation Programme will have equipped all general medical practices with information and communication systems by the end of this year. The critical success factors for the programme have been ringfenced funding and the support of the GPs. But it is difficult to quantify the value achieved for the investment because – although the need for a benefits realisation programme was identified at the outset – evaluation of benefits has only recently received attention.

#### *ICT in social care*

3.72 A very provisional estimate, drawing on work done by KPMG, is that the figure spent on ICT in 2001-2 was around 1 per cent of the total Personal Social Services budget<sup>68</sup>. ICT is not yet realising its potential to improve the

productivity of social care in Wales. Operational staff and managers often lack IT skills and find that IT systems do not significantly assist them. Local authorities frequently lack skilled ICT support staff and training to alter this.

- 3.73 Work is being undertaken to improve the position through the Performance Management project for social care. The KPMG report itself was a product of consortium working between 11 local authorities to assess their ICT capability. There has been other consortium work and work on an all-Wales basis in recognition of the lack of capacity in individual local authorities. However, this work is in early stages and it is not surprising, against this background, that coordination of ICT systems between health and social care, to enable exchange of information, individuals' records etc has not yet taken place in Wales.
- 3.74 The infrastructure to support any increase in reliance on ICT is presently inadequate. To solve these problems and to provide the NHS and social care with modern, integrated ICT systems would inevitably require considerable investment. The benefits to patients/ service users and practitioners are clear but at this stage it is not possible to estimate the cost benefits.

## **Estates**

- 3.75 *Securing our Future Health* described the urgent need to modernise the NHS estate to avoid detriment to the comfort and care of patients. Whilst there are examples of modern hospitals using state of the art building technology and equipment, there remain too many examples of the NHS attempting to deliver 21st century healthcare in buildings which are outdated or inaccessible. More than three-quarters of the built estate is over twenty years old, with one in ten properties built before 1900. In 2001 only half of the estate held by Trusts was assessed as fully or reasonably fit for purpose<sup>70</sup>. The backlog maintenance figure is estimated to be over £400 million<sup>71</sup>.
- 3.76 There are around 750 GP premises in Wales. A recent survey found that while £12.6m would be required to ensure statutory compliance of premises, extrapolation from a pilot in Rhondda Cynon Taff suggests that £150-£250m would be needed to provide the premises across Wales from which to deliver modern health services as part of an integrated health and social care system<sup>72</sup>.
- 3.77 There are also estate issues in other parts of the health and social care sectors. It is becoming increasingly evident that:
- there is uneven availability of care homes across Wales to meet the growing demand for this type of accommodation. In more and more

parts of Wales this is putting pressure on the availability of beds in hospitals;

- a few people with learning difficulties are still housed in inappropriate institutions rather than in smaller community settings;
- home adaptations and home help that would allow elderly and disabled people to live safely in the community require a major boost in investment;
- there is a need to develop more effective links with housing services to provide a wider range of options to help people maintain independence and community living – new technology offers further opportunities that could be exploited.

3.78 It is clear that in health significant investment in the estate is required to bring it up to acceptable modern standards. This is acknowledged in the recently developed NHS National Estates Strategic Framework<sup>73</sup> which sets out the foundation for improvement. In social care much of the estate is provided by the private and voluntary sectors. Capital costs will be reflected in the fees paid. There are likely to be cost pressures in bringing premises across the sector up to the standards required by the Care Standards Inspectorate.

## Raising Standards

There is some good and some excellent performance in health and social care. But there is also widespread under-performance associated with systemic defects – we do not have the performance management and incentive systems to drive properly creation or imitation of best practice. Different areas of national policy-making need to be better integrated. The quality of information, and so of the decisions based on it, is unsatisfactory at every level.

3.79 *Securing Our Future Health* envisages raising the standard of care by universalising best practice. This is to be achieved through the development of a comprehensive set of costed NSFs and through centrally set non-clinical standards in areas such as ICT. Processes which enable organisations to deliver and encourage them to raise performance are also necessary.

## Raising organisational performance

- 3.80 There is good and innovative performance in Wales, and there are a number of NHS organisations which consistently achieve external and internal measures of good practice and service and financial targets<sup>74</sup>. There is evidence that waits in Accident and Emergency in Wales are shorter than elsewhere<sup>75</sup>. In local government, joint reviews of Social Service performance have found that nine authorities were judged to be ‘serving some people well’ and in some Authorities where poor reviews were reported this has acted as a catalyst to change and improvement<sup>76</sup>.
- 3.81 But it is also clear that there is considerable room for performance improvement within NHS and social care organisations. No social services authority inspected in Wales through the joint review process has been rated as ‘serving most people well’<sup>77</sup>. During the Review seven of Wales’ 15 hospital trusts were in financial Recovery following failure to meet their financial targets, and the ambulance service had just emerged from Recovery<sup>78</sup>.
- 3.82 We stress that the evidence we found was of people in health and social care working very hard. But they are working within systems which militate against good performance, and where there is excellence in our view it is despite rather than because of the system.
- 3.83 We did not find evidence of sophisticated performance management systems, of the kind needed to drive continuous organisational improvement. *"Performance management tools.... measure what is easy to count rather than what counts towards service improvement."* (Comments to the Review from Monmouthshire Local Health Board.) *"There is a risk that the [health] service collects too much data and not enough information"* (Audit Commission in Wales.) *"Although information around performance indicators is being gathered around individual services, we do not focus on whole process outcomes."* (Conwy County Borough Council Social Services.) *"The concentration on achievement of absolute targets has been a particularly perverse pressure as it makes it impossible for organisations to reflect how far they have moved towards improvement."* (North West Wales NHS Trust.)
- 3.84 In both health and social care the Assembly Government is taking action to address this. The want of robust information described above is a central issue:
- it inhibits reliable performance *measurement*, which is a prerequisite for effective performance *management*;

- what is measured varies – as North Wales Public Health Service put it *"there are no current national NHS value measurement systems"*<sup>79</sup>;
- we have not developed measures of the outcomes we want, and tend to measure failure (eg hospital waiting times) instead.

3.85 Assembly initiatives include introduction of a balanced scorecard in health, which has the potential to deliver the sophisticated performance information to underpin continuing performance improvement, and an initiative to improve performance management in social care which also recognises the central importance of reliable and comprehensive information.

3.86 We are not good at imitating best practice elsewhere. For example the 2002 Overview Report on the Audit Commission/Social Services Inspectorate Joint Reviews of Social Services commented that: *"Despite the energy shown in tackling issues following a joint review, it is disappointing that we have only seen limited evidence of councils learning from the experience of others, prior to their own Joint Review."*<sup>80</sup> Variations between performance in NHS organisations have been highlighted above (see 'Pressure on the acute sector') while in primary care the proportion of practices retaining payments following validation in 2002-03 under the Sustained Quality Payments scheme varied from 86 per cent in the former North Wales Health Authority area to 21 per cent in the Bro Taf area<sup>81</sup>. We noted that the Assembly is taking steps intended to address this, for example by enhancing the role of its Innovations in Care team which is charged with spreading awareness of good practice in health.

### **Incentives to improve performance**

3.87 Incentives to improve performance are of critical importance, both to stimulate imitation of best practice elsewhere and to encourage development of new best practice in the first place. Incentives are central to both the invention and the diffusion processes.

3.88 We did not find evidence that there are sufficient incentives to organisations to improve performance. In health, funding is not connected at all closely to performance or level of activity. GPs' remuneration is largely related to their list sizes, although there are relatively small payments such as those under the Quality Payments System scheme (see above) intended to encourage better performance.

3.89 Trusts receive specified payments from the Local Health Boards (previously from Health Authorities) in return for a specified quantity and quality of

secondary and community treatments. Specialist and tertiary services are commissioned by Health Commission Wales from a top-sliced allocation. However, the payments are not closely tied to treatments of individuals, and Trusts which outperform the specification do not receive additional payments (although in 2002 the Assembly did pilot payments for Trusts who achieved their service and financial targets, making small payments to four Trusts in recognition of their performance in 2001-02<sup>82</sup>). On the other hand Trusts which are not able to deliver the treatments and balance their books have frequently received substantial additional funding (see the "Financial Position" section above).

- 3.90 In other words failure has attracted more rewards than success – financial incentives to outperform targets are weak, while in most of recent years tens of millions have been directed to health organisations who failed to meet financial targets. It is very unsatisfactory that organisations have gone into Recovery and then had one Recovery Plan (containing milestones, personal accountabilities, etc) give way to another when they did not adhere to the first one. The events described in 'Financial position' above are demoralising for staff who want to help their organisations operate as effectively and efficiently as possible because they signal that there is little to be gained by taking the trouble to introduce difficult or uncomfortable changes. The events also suggest insufficient clarity about where accountability lies for the delivery of service and financial targets.
- 3.91 In social care the system of audit and review has led to action to try to improve matters where there have been shortcomings, but problems remain (see above). We remain to be convinced that, as presently constituted, the introduction of policy agreements between the Assembly and each local authority will act as a significant incentive since few consequences attach to meeting or missing the targets in them.

## **Policy**

- 3.92 Indicating what the services are expected to do, and designing the processes which enable them to do it, is the function of health and social care policy. If national policy is defective then, far from universalising the best, we programme the system to perform sub-optimally. It is therefore critical that:
- policy-making processes should be robust and evidence-based;
  - there should be arrangements to make sure different policies do not conflict, and to inform resource allocation between competing priorities.

- 3.93 There are examples of good practice. The all-Wales strategy for people with learning disabilities integrated health, social care and financial considerations (through guaranteed long-term provision and ring-fenced transition funding). Parts of Wales have seen health and social care systems working together to transform services for these citizens. Community care services and supported housing mean that for every eight residents in NHS learning disability units 20 years ago there is now one.
- 3.94 But we have also found important shortcomings. In particular:
- there is no single overall policy framework for prevention, health and social care to give a sense of how individual decisions may impinge on one another. For example, we have in the past given the NHS, local government and social services departments different targets at the same time for reducing delayed transfers of care;
  - we have not managed the policy portfolio as a whole – a review of health policy-making in 2002-03 found that one of its single biggest tasks was simply arriving at a complete list of all the policies in place;
  - policies have been advanced without being costed, which makes it impossible to know their cost-benefit, or whether their implementation is affordable. The Coronary Heart Disease NSF is an example.
- 3.95 We have also found disconnection between policy and implementation. The share of social services expenditure for older people spent on support at home fell from 46 per cent in 1996-7 to 42 per cent in 2000-01 despite a national policy of increasing independence<sup>83</sup>. Strategic reconfiguration of health services has not happened, although a number of policy documents have highlighted the need for it<sup>84</sup>. From 1996-97 to 2001-02 primary care's share of primary and secondary funding barely changed, despite several policy documents stating a commitment to a preventative, primary care led NHS.

### **Information to support decision-taking**

- 3.96 Underlying many of these shortcomings is a paucity of information to support decision-taking, which exists at all levels of the health and social care systems. *"Unfortunately current health information systems cannot tell us whether the increased expenditure in Wales represents an effective response to poor health or inefficiency in service provision."* (Response to the Review by the NHS Trusts in Wales in association with Institute of Medical & Social Care Research, University of Wales Bangor.)

- 3.97 We are not the first to find this: from decisions about allocating resources in health to commissioning social care it is a depressingly familiar theme. The Audit Commission told the Review that *"Information is essential to underpin rational decision-making by clinicians and managers, and the poor quality of information within health systems in Wales is a routine finding from our reviews at both a national and local level."*<sup>85</sup> Here, as we have done elsewhere, we note the frustration which those charged with making decisions and delivering services must feel at the inadequacy of the information on which they have to rely.
- 3.98 It applies to both the tracking of the impact of past decisions (see Box 3.4 below), and making decisions on future action such as capital expenditure proposals in health, which have not been assessed against common criteria, or their outputs given monetary values so as to rank different projects investments (weaknesses which it is intended a new Capital Investment Board will address).

**Box 3.4: Tracking impacts: how were increases in the NHS pay bill spent?**

In the two years from 1999-00 to 2001-02, health spending rose by £557m (21 per cent) to £3,168m. Over half of the increase went to NHS Trusts, who in turn spent over half of it on pay. The Review has examined how this money (£254m) was spent.

We have been able to estimate the relative costs of the annual pay awards, the growth in staff numbers and other issues influencing staff costs such as the Working Time Directive, the increase from 2000-01 in superannuation costs etc.

We note that the £68m (27 per cent) spent on growing the workforce was a relatively small proportion of the total increase. Increases to other pay costs included national pay and policy requirements such as the costs of pay awards (36 per cent), implementation of the European Working Time Directive (8 per cent), Junior Doctors' contract (7 per cent) and the Employers' Superannuation contribution (9 per cent).

The £15.7m increase (6 per cent of the total) in the use of non-NHS staff, typically more expensive than those on the payroll, may not have represented best value, even if necessary because of a lack of availability of NHS staff.

Much of this increased spending does not appear to have had a direct link to outputs. To the extent that there was a link we did not find it easy to quantify the impact. It seems to us unsatisfactory that it is not possible to be more precise about the impact of this large expenditure on outputs.

### Box 3.5: Prescribing

Prescribing behaviour illustrates many of the points discussed in this part of Chapter 3:

- there is significant variation within Wales. Underlying the mean Local Health Group GP prescription cost per head of £153.86 in 2001-2 was a difference of £41.45, or 31.5 per cent, between the highest and lowest spending Local Health Groups<sup>86</sup>;
- Welsh residents are prescribed 15.9 items per annum compared to 11.8 in England. Prescribing in Wales costs 20 per cent per annum more than England<sup>87 88</sup>. Since we lack information about what the optimal level of prescribing would be we do not know whether this is a good thing or not;
- There are few incentives to avoid inappropriate prescribing. Eighty per cent of prescriptions are repeat prescriptions possibly indicating a lack of active medicines management.

## Managing change

Health and social care organisations frequently find change difficult, particularly where working across boundaries is required. There are some, but too few, examples of successfully engaging the public in a change agenda.

- 3.99 *Securing Our Future Health* stressed that radical reform was vital. We draw the same conclusion from our examination of health and social care in Wales. We have therefore considered how readily health and social care organisations in Wales adapt themselves to change.
- 3.100 A number of responses to our consultation stressed the cultural obstacles to the changes which effective joint working of health and social care services would entail. Community Pharmacy Wales said that *"there are often strong cultural differences between health and social care which act as a barrier to communication."* The Audit Commission in Wales commented that *"often barriers... reflect issues of control and culture within individual agencies, and demand strong political leadership to provide the intent and the cultural change needed at times."* Denbighshire County Council stressed the need to deal with cultural issues because of the strong professional cultures which exist.

- 3.101 We have also found that where changes have been needed in order to deliver more effective and efficient services there is good practice (see Box 3.6), but there has not always been the attention given to presenting the issues to, and consensus-building with, the public which they should be able to expect. This is evident in the fact that it is not widely appreciated that the objectives of minimal waiting times, free personal care, NSF implementation are not all achievable in the short term. Many attempts to reconfigure health services have met with fierce resistance from the public across Wales – proposals for Powys community hospitals and Cardiff Royal Infirmary are examples.
- 3.102 We found that as with other areas of good practice not all organisations had invested with partners in the time, effort and resource required to build local consensus where change is needed. As the Office of Public Management reported in 2001 *"the analyse-decide-consult-implement"* model has had little success<sup>89</sup>. This, however, remains the statutory guidance<sup>90</sup> to the NHS on consulting on changes to health services.

**Box 3.6: Service changes - good practice in engaging the public**

There are examples of good practice in involving members of the public in planning decisions which result in the closure of long established and well-loved health facilities, and their replacement with modern service models. In the Cynon Valley the NHS locally has been working with partners and consulting with a 'people's panel' of almost 100 local people for the past two years (the Cynon Valley Forum). Their objective, which they have delivered, has been to consider what is wrong with services as they are and to agree how they should be improved.

- 3.103 During the Review we have met many people working in health and social care, including many in leadership positions. We have been impressed by the widespread appreciation that fundamental change is needed. Indeed, most expressed concern that we might understate what is required. We regard this as a very encouraging sign that there is a readiness to change, and we appreciate that the Welsh Assembly Government has already embarked on the change agenda. We do believe far-reaching changes should be made, and they are the subject of Chapter 4.

# CHAPTER 4

## HEALTH AND SOCIAL CARE IN WALES IN FUTURE

- 4.1 The starting point for this Review was the substantial increase to the health budget announced by the Welsh Assembly Government Finance Minister on 15 October 2002, the use of which is to be allied to improved performance and modernisation. The context was the report *Securing our Future Health* which articulated the vision of health services in 20 years time, and created an environment in the UK of greater certainty about likely future resources than before. Taken together these represent a new opportunity, and it is one we must grasp.
- 4.2 The Review has shown us the present position is unsustainable. The NHS and social care workforces are trying to keep up with ever-increasing demands upon them, but the system within which they operate is letting them down. Their efforts will not succeed, unless there is a break with the patterns of the past (and the problems are deep-rooted and long-standing, going back well before the start of the Assembly). The prospect, if we do not change, is of acceleration towards a service which is reactive rather than proactive, does not meet the expectations of patients and the wider public, and remains insufficiently accountable. This is even on the assumption that future resourcing will compare favourably to that for other services in Wales.

### Summary

- A step-change in individuals' and communities' acceptance of responsibility for their health is needed. No amount of effort by the health and care services can be a substitute for this. We recommend policy action to raise public awareness, and more research to produce an evidence base on the gains which different sorts of action may yield.
- There should be a strategic adjustment of services to focus them on prevention and early intervention. Potentially this offers significant long-term cost and quality of life gains. It entails adjusted roles for social, primary and secondary care. In the short-term immediate steps are needed to relieve pressure on the acute sector by making bed equivalents available, and addressing as a priority delayed transfers of care. A redoubled effort to secure seamless service provision should be made which could entail changes to policy-making, financial, and accountability mechanisms.

- Reshaping services and making seamless provision a reality will not be enough on their own. Mutually consistent, evidence based and costed policies supported by a clear financial strategy are also necessary. Attention should be given to developing a mechanism whereby the flow of money round the system both reflects need and rewards greater productivity.
- The Assembly should stop funding deficits in NHS Wales. We recommend stronger incentives and sanctions, which reward success, give greater freedom to good performers, and are supported by the way in which resources flow. Improved performance management, founded on reliable and rounded performance information, is essential to raise standards across the board. The scope to focus on those activities which make the greatest difference, and to drive out variable performance, should be exploited.
- Workforce planning needs to be altogether more sophisticated, robust, long-term and based on future models of service provision. Training and retention of current staff also need attention. There should be an overhaul of information systems to improve quality, timeliness and coverage. ICT is in urgent need of investment within a national strategy which embraces both health and social care. Major investment in estates will be necessary, and decision-taking processes which will govern it should be strengthened. Clear and shared understanding of national and local roles, and the relationship between national and local health, social care and well being strategies are needed to make the new organisational structures effective. We should clarify and strengthen accountability of NHS chairs and chief executives, and of all those delivering services which cross organisational boundaries.
- It will be important to chart, and adhere to, a programme of change which is realistic. An implementation plan identifying short, medium and long-term steps and strategy is a way forward. Investment in ICT and estates are priorities, as are immediate steps to reduce delayed transfers of care and accelerate alternatives to acute hospital admission. In some cases it may be necessary to make ring-fenced funding available to meet reconfiguration costs. Successful change will depend on leadership, energy and commitment from politicians, professionals, managers, and staff alike.

## The role of individuals and communities

A step-change in individuals' and communities' acceptance of responsibility for their health is needed. No amount of effort by the health and care services can be a substitute for this. We recommend policy action to raise public awareness, and more research to produce an evidence base on the gains which different sorts of action may yield.

- 4.3 As we understand better the range of factors which affect health (such as diet, exercise, and lifestyle, including smoking habits, housing, employment and economic circumstances, education, and environment as well as healthcare and social care) it becomes ever clearer that securing better health cannot be accomplished by the state, or by the health service, acting alone.
- 4.4 Individuals are responsible for doing what they can to maintain and improve their own health and, as parents, for that of their children as they grow up. Organisations share this responsibility for health and well being in Wales with individuals in terms of the roles they can play in creating the right conditions for people to protect and improve their health. This message needs to be driven home, along with greater acceptance of the shared responsibility. Individuals are personally responsible for using services appropriately.
- 4.5 Some people's personal circumstances can be barriers to healthy living and override concerns about ill health that may catch up with them some years later. No amount of effort by health and care services can substitute for people taking more responsibility for their own health but, unfortunately, in Wales too many individuals and communities accept ill health and risk taking behaviours as the social norm. We are a long way from where we need to be to achieve the fully engaged scenario.

### Raising public awareness

- 4.6 We recommend a much greater emphasis on preventing ill health and early intervention in order to raise public awareness of its importance for the ability of health and social care services in Wales to meet future demand. We need a step change in our attitudes to our own health. Consideration should be given to:
- focusing services on reducing the risks of disease, with action concentrated on addressing the risk factors for major diseases such as coronary heart

disease, lung cancer and diabetes for which there is evidence of effectiveness;

- better use of the media and other means of communication to inform and motivate people to look after and to improve their health;
- capacity building to increase individual and communities' recognition and acceptance of the responsibility they have for their own health and that of their children;
- action across all the Assembly Government's policy areas (and we recognise that it has made a start) to create the social, economic and environmental conditions that lead to better health and well being;
- a much greater focus on children and young people's health and greater partnership with the education system in Wales to help improve it;
- focusing services for older people on improving their physical and mental health to prevent ill health and risk of accidents and injuries and increase their chances of living independently for as long as possible;
- more effective secondary and tertiary prevention, that is to say, management of diagnosed conditions to minimise their adverse impacts.

## Research

- 4.7 We do not know as much as we should like to about the benefits that could be expected for a given expenditure on any given initiative to support prevention. We recommend a programme to develop further the research base to enable an evidence-based approach to indicate the gains that can be expected for different types of public health/ prevention expenditure in Wales. The criteria for assessing the long-term effectiveness of particular actions and for fixing priorities for expenditure should be made explicit and could be used as a trigger for public engagement.

## Reshaping Services

There should be a strategic adjustment of services to focus them on prevention and early intervention. Potentially this offers significant long-term cost and quality of life gains. It entails adjusted roles for social, primary and secondary care. In the short-term immediate steps are needed to relieve pressure on the acute sector by making bed equivalents available, and addressing as a priority delayed transfer of care. A redoubled effort to secure seamless service provision should be made which could entail changes to policy-making, financial, and accountability mechanisms.

4.8 There is a pressing need for a review of the pattern of health and social care services, where these have been overtaken by advances in patterns and techniques of care. At present we have a system which:

- is unable to deliver the outputs or outcomes we aspire to;
- in important respects does not give value for money;
- is unsustainable with current and planned workforce capacity;
- is overly focused on institutional settings.

### **Strategic adjustment**

4.9 Modelling<sup>91</sup> has shown that remedies to the current pressures in the system will often lie in better management of conditions outside the acute sector. As we explained in Chapter 3, we do not believe that more acute bed capacity is a strategic long-term answer to the pressure currently being experienced by the acute sector: that would be to treat the symptom rather than the problem. Nor would it serve the aims of full engagement and maximising independence, both of which imply minimising the role of institutional care settings.

4.10 As well as reducing ill-health, a commitment to early intervention has the potential to drive down costs by delaying or avoiding the need for more expensive care later. By decreasing avoidable emergency admissions, the acute hospital sector will be freed to focus its attention on providing timely and effective elective interventions, reducing the unacceptably long and painful waits which many patients experience. There is widespread support for this approach. In its response to the Review the Welsh Local Government Association advised that a *"whole systems approach designed to tackle current pressures on acute NHS services and deliver improved health must have a much stronger focus on 'before the event' intervention."*

### **Configuration of services**

4.11 The service redesign necessary to orientate our health and social care towards health and well being will require difficult choices. It is not the role of this Review to provide a blueprint for future service provision. However, we do recommend the development of clear principles to drive evidence based commissioning and delivery of health and social care services. We suggest that these might be to:

- maximise independence;
- provide safe and effective health services;
- manage risk proactively, and agree with individual service users of the risk level acceptable to them;
- reach a new compact with patients and the public, featuring explicit minimum service levels including maximum travel times to access services;
- recognise and take account of the growing importance which patient/client choice is likely to play in the future;
- provide care pathways which are centred on users' and patients' needs and outcomes, unrestricted by boundaries between professions, organisations or other systems or structures;
- achieve a sustainable balance between centralisation and local access;
- devise solutions which take account of the contrasting physical and social geography in Wales.

### **Immediate steps**

- 4.12 The immediate need is to address the unsustainable pressure on the acute sector. If bed levels continue to be run at occupancy levels exceeding 85% then the system is inherently unstable and inefficient.
- 4.13 We stress below the need to redouble efforts to secure seamless health and social care provision, not least in order quickly to reduce significantly the number of delayed transfers and release acute capacity.
- 4.14 We support the work being undertaken to implement *A Question of Balance*<sup>92</sup> which is attempting to deliver new ways of working which equate to the '479 bed-equivalents' recommended by the report. The short-term actions need to be supportive of, and lay the foundations for, the long-term strategic solution. They include:
- efficient bed management and discharge processes which free acute capacity for elective work and support patients in the most cost appropriate and cost effective settings;

- tighter management practice to increase efficiency, including ring-fencing of acute elective beds, and universal implementation of agreed good practice;
- much more effective use of community hospitals:
  - as step down facilities from acute care;
  - for invigorated intermediate care incorporating active rehabilitation;
  - as resource centres for primary care;
- development of robust disease management services in primary care settings and more GPs with special interests;
- redesignation of existing minor acute facilities as Diagnostic and Treatment Centres;
- enhanced partnership with the independent sector for a range of treatments including diagnostics and therapies;
- exploration, and commissioning, of out-of-Wales options to reduce unacceptably long waiting times;
- putting in hand evaluation of the contribution which separate, dedicated elective facilities might make.

4.15 This work is necessarily short-term in its focus. Its aim is not only to deal with the immediate issue but to lay the foundation for the health and social care system of the future. In the medium and long-term, a radical redesign of services is imperative if the NHS and social care sectors are to have the headroom to provide first-class services.

### **Longer-term measures**

4.16 In the long-term we would expect the new integrated framework for service delivery also to include the following features:

- cost-effective prevention and public health measures;
- social care support which enables people to stay in their own homes, and facilitates discharge from hospital;

- new models of primary care which obviate the need to go into hospital;
- development of new service models, which will see specialist, currently secondary care, services also being delivered in primary and community settings where they are a clinically and cost effective solution;
- optimal use of resources, in particular of acute capacity through an appropriate use of increased specialisation;
- a joined up hospital sector in which different kinds of hospital provide integrated care on a local and regional basis as part of the whole health and social care system;
- greater productivity and innovation in all sectors;
- closer working with the independent and not-for-profit sectors and promotion of a 'mixed economy of provision' for long-term care;
- the integration of service strategy with plans for capacity – revenue, workforce, ICT, medical technologies, and buildings.

4.17 Box 4.1 summarises a case study which appeared in *Securing our Future Health*, and offers an illustration of the impact this sort of system might have on diabetes. It shows how incidence and management could be affected by a rebalancing towards prevention and early intervention, with potentially dramatic implications for improved quality of life and value for money. The prize is considerable: there should be no need for any patient to suffer blindness, amputation or death as a result of diabetes.

**Box 4.1: The care of diabetes in 2022 – a case study (adapted from *Securing our Future Health*)**

Diabetes provides a good example of how a 'whole systems' approach could work in future. A Welsh National Service Framework (NSF) has been issued to set standards and monitor quality of care. As it is a risk factor for CHD, stroke and kidney failure, diabetes links across disease areas: tackling it at root would help to prevent these diseases as well. It exemplifies how all the aspects of health promotion and health care interact and demonstrates the importance of looking, in a whole systems way, at all points of the 'patient journey.' Over the next 20 years, there appears to be scope for significant cost savings as well as – more importantly – avoiding the human costs of the disease including sometimes fatal complications. Generating such benefits will, however, require action across many fronts:

- **public health:** better diet and increased physical activity should help to reduce the prevalence of obesity, a key risk factor for diabetes. Reductions in socioeconomic inequalities will also be important;
- **public expectations:** greater awareness of diabetes will increase demands for top-quality treatment. People with diabetes are ‘expert patients’ due to the chronic nature of their condition, proactively seeking information and making frequent contact with the health service. It will need to live up to their high expectations, providing them with good information and responding to well informed questions about treatment and care;
- **primary care:** enhanced awareness of diabetes in primary care could lead to earlier diagnosis and improved diabetes management to prevent complications;
- **self-care:** new technology will allow better testing by remote monitoring or telemedicine. Call centres will phone to remind people to test their glucose levels. Improved access to health education would also help people to maintain the right blood glucose and blood pressure levels;
- **information and communication technology:** in particular, an accessible Electronic Health Record could transform diabetes care, preventing treatment errors and improving patient safety, through improved service co-ordination across the whole system; and
- **workforce:** practice nurses and community pharmacists could use their skills in diabetic care, saving GPs’ time and giving a more specialised educational role for secondary care.

4.18 We have noted the controversy which has arisen from attempts to compare NHS performance with the integrated healthcare system of Kaiser Permanente<sup>93</sup> in California. We do not comment on the feasibility of benchmarking such different systems, but we do think there are a number of important lessons to be learned from the success factors cited for their apparently superior performance:

- integration, through partnerships between physicians and administrators, which allows Kaiser to:
  - exercise control and accountability across all components of the healthcare system;
  - manage patients in the most appropriate setting;

- implement disease management programmes for chronic conditions;
- make trade-offs in expenditures based on appropriateness and cost effectiveness rather than budget categories;
- treating patients at the most cost effective level of care – Kaiser Permanente members spend one third of the time in hospital compared with NHS patients;
- optimal use of information technology to reduce administrative time, particularly clinician's time spent taking medical histories, dictating letters, and locating patient records.

4.19 There are obviously resource implications in these recommendations: a central question is how to support the right balance of health and social care, primary and secondary, treatment and prevention/promotion. Experience of health and social care in Wales has shown we are best able to achieve major change and realise new service models where there is a clear strategic direction, linked to dedicated resources<sup>94</sup>.

### **Primary care**

4.20 There is a need to develop capacity – workforce, skills, infrastructure – within non-acute settings to deliver new service models. As Chapter 3 has pointed out and studies have shown<sup>95</sup>, at present there is often no perceived option other than the District General Hospital available to GPs in seeking help with medical emergencies. In particular, we are concerned that the primary care sector as currently configured requires considerable development to take on its enhanced role. Some of the issues, such as more effective medicines management, relate to performance of the role it already has. In Chapter 3 we noted the shortage of information, and the relative weakness of the primary sector in the very areas where it is needed most.

4.21 We envisage development of capacity – including increasing numbers of specialist GPs and nurse practitioners, and development of resource centres – within primary care services which actively manage chronic disease, provide an effective first contact service, undertake a greater range of diagnostic and therapeutic services, and undertake more elective services e.g. minor surgery. To be effective there is also a need for NHS Trusts proactively to develop and relocate their own services in, albeit very different, primary and community care settings.

## Secondary care

4.22 The framework set out above implies that the range of services provided in our major acute hospitals will need to change. Some services will need to be provided more centrally; others may be provided more locally. It is also clear to us that the rebalancing of the acute hospital sector must involve better utilisation wherever practicable and cost-effective of the smaller, community, facilities for a wider range of activity. The introduction of new diagnostic and ambulatory care services in these facilities to relieve pressures of acute hospitals must be part of the way ahead. We envisage that some community hospitals will redevelop as Primary Care Resource Centres or active intermediate care facilities. NHS hospitals should not any longer solely provide nursing or respite care without the need for other specialist interventions and support. Any which are providing nursing home, residential or respite care, without medical interventions should, we suggest, transfer to an alternative provider as part of the commissioning arrangements, provided they can be shown to be cost-effective. Where they cannot, they should close.

## Choices

4.23 For solutions to be sustainable, patients and the public should have the opportunity for full involvement in decision-making about the future shape of service provision and the complex choices required. This should include publication and open informed discussion of the performance outcomes of services provided by different professionals and in different settings. The challenge for those proposing change will be to show clearly how and why it will deliver better outcomes overall. Public engagement should not be an add-on – local and national organisations will need to prioritise the strategic and systematic capacity building required for effective collective influence.

4.24 As well as involvement in choices about future service arrangements, the public should enjoy choices about the treatment available to them – we must move on from a ‘one size fits all’ philosophy. Shared decision making protocols should be key elements of patient/user pathways. We need to recognise that as people become fully engaged they will want choice in their health and social care services as in every other aspect of their life. Expansion of choice implies a clearer recognition that there are some choices, particularly in social care service provision, which will not be paid for by the state, and this is discussed further later in this chapter.

## Seamless Service Provision

4.25 The importance of integrating thinking about health and social care was a fundamental recommendation of *Securing our Future Health*. Seamless provision is an objective that enjoys near universal support. But our work for this Review has shown that we are a long way from achieving it in Wales. We need to be resolute in breaking down barriers between health and social care. We believe that the Assembly needs to look again at what might be done to bring it about. By this we do not mean structural change. What is needed is integrated thinking, across social care and health services, about achieving the best possible local outcomes together.

### *Health and social care interfaces*

4.26 We recognise that, when either health or social care services do not meet demand, the result is currently an insupportable burden on the partner service. Delayed transfers are a particular issue in the system that leads not only to ineffective use of resources, but sub-optimal care for people placed in an inappropriate setting. A pressure point is formed at the place where the acute health system, with its need for quick turnaround, and the longer term care system, with its need to consider carefully options for people's futures, come together. Management of this interface is critical to the effective use of resources.

### *Options for achieving seamless provision*

4.27 We need to work hard to realise the benefits inherent in Local Health Boards' coterminosity with Local Authorities, and their duty to develop a health and well being strategy. It is an opportunity to solve the problem, and not the solution in itself. Organisational boundaries and differing accountabilities could continue to work against an integrated approach. We believe that national standards for health and social care provision are needed, so that both health and social care become national services, delivered locally. Organisations delivering health and social care need to operate in a whole systems way.

4.28 There is therefore a need for the Assembly Government and Welsh Local Government to meet the challenge of ensuring that there is an approach to managing and funding the continuum of health and social care in new ways which ensure that there can be planned and predictable responses to people's needs. Possible responses to this challenge have been put to the Review, including:

- hypothecating the element of Revenue Support Grant to be spent on social care;
- a single integrated budget for older people’s services held by LHBs
- joint consideration of health and social care budgets, locally and nationally;
- placing a responsibility on local authorities to pay the NHS the costs of delayed transfers of care.

We are convinced that change is necessary and therefore recommend that the Assembly Government and Welsh Local Government consider the options and come to an agreed conclusion which provides the necessary framework for funding health and social care. Other areas which should be considered include:

- accountability and performance:
  - recognition of the inter-dependencies within the system and the need to balance formal, hierarchical accountability with new forms of network governance and multiple accountabilities (discussed further below);
  - a common performance measurement and management framework across health and social care, focused on common outcomes, so that objectives and answerability need not be limited by organisational boundaries;
- policy and audit:
  - integration of health and social policy development at the Assembly level;
  - alignment of audit and regulation as well as action to ensure compliance with recommendations in line with statutory requirements;
- local steps:
  - design of services in a patient-centred way;

- work on capacity mapping and monitoring to ensure there is an appropriate balance of resources in each locality. This includes prioritising the development of alternative options and resources and further work to create incentives to maximise independence and rehabilitation and prevent re-admission or inappropriate use of health or social care;
- reinforcing collaborative infrastructure for service delivery through joint assessment and the unified assessment system;
- greater use of the statutory ‘flexibilities’, which enable different budgetary arrangements etc to be overcome, for core services.

## The Operational Framework

Reshaping services and making seamless provision a reality will not be enough on their own. Mutually consistent, evidence based and costed policies supported by a clear financial strategy are also necessary. Attention should be given to developing a mechanism whereby the flow of money round the system both reflects need and rewards greater productivity.

### Policy

#### *Evidence based and costed policies*

4.29 There is a case for saying that the Assembly is trying to do too much at once and that the connections with what is happening on the ground are sometimes too tenuous. There is a multitude of initiatives and action plans but they are not being properly seized upon and followed through in all cases. We found that there is sometimes a worrying disconnection between policy and implementation. Much of this section is a case for ‘making haste by going more slowly’.

4.30 Two prerequisites of good policy-making are:

- a basis in robust evidence. We have found that this is too rarely available. For example, we recommend research above to find out what gains may be expected from different preventative activities. *Securing Our Future Health* recommended that the National Institute for Clinical Excellence should investigate the cost-effectiveness of existing treatments because too little is known about which treatments are acceptably effective;

- that policies should be costed (and shown to be affordable over their expected life), and subject to rigorous evaluation criteria to inform subsequent policy development. Without this rigour there can be no certainty that a policy will be effective, or affordable within the budgets of the organisations asked to deliver it. We comment below on the need to end the funding of deficits in health: one prerequisite is that organisations must not be expected to supply standards of service which it is not possible to achieve within their financial allocations.

4.31 The Assembly should bring forward policies only alongside a published evidence base, including costings and evaluation criteria.

*Mutually consistent policies*

4.32 Different policies should be mutually reinforcing where possible, and always avoid inconsistencies between them. This requires an overall policy framework for prevention, health services and social care. Importantly, such a framework would also enable decisions between priorities to be made on a common basis, using a technique such as Quality-Adjusted Life Years (QALYs) gained to inform choices (see Box 4.2).

**Box 4.2: comparing impacts of different policies**

*Securing Our Future Health* contrasts the cost of gaining a QALY through smoking cessation programmes (put at £212-£873) with gaining one by using statins to prevent or manage CHD (put at £4,000-£8,000)<sup>6</sup>. It quotes Professor Sir George Alberti, who was at that time President of the Royal College of Physicians ‘*smoking cessation is extraordinarily cost effective compared to anything else the NHS does.*’ In Wales, local smoking cessation services have been in place since 1999. As with other services, smoking cessation outcomes have been variable across Wales. The best outcomes have been reported in Gwent where 71% of participants had successfully quit at four weeks (all Wales average 52%) at a cost per quitter of £585.

**The role of the State**

4.33 Looking further ahead, we recommend that the Assembly give thought to, and stimulate public debate about, the role of the state in providing care. This is a profound issue which should not hold up progress on our other recommendations. But it is also a strategic question which we suggest needs to

be settled to flesh out a long-term vision of service provision. It is not for the Review to give the answers but we suggest they will need to take into account:

- that the State can neither do everything nor nothing;
- the financial resources likely to be available and the need to match services to them;
- that the State's resources should be used where they will have best effect;
- alternatives which are or could be available;
- that if choices are not provided as part of the publicly funded system, then some will opt out and public provision will be residualised by default;
- that as well as direct provision an important role of the State is likely to be influencing others (eg private sector house-builders who could supply homes suitable for elderly people);
- the essential role appropriate incentives in the system play in shaping behaviours and resource allocation decisions;
- the part charging might play in contributing to overall capacity, balanced alongside considerations of access and equity.

### **Financial strategy**

4.34 The work concerned with the formula to determine how funding is allocated to Local Health Boards, and the information and processes needed to support it, is being led by Professor Peter Townsend and the Standing Committee on Implementing *'Targeting Poor Health'* rather than by this Review. We support the approach being taken to tracking, monitoring and evaluating the impact of targeted funding. There is a need for greater clarity about the speed with which we are to move to allocation using the direct needs formula. However our main focus, in both health and social care, is on how funding decisions are made between competing priorities, and the ways in which investments are made.

4.35 There is a case for viewing the prevention, health services and social care budget in the round at the Assembly level. We need to focus investment on delivering health gain in the most resource-effective way. We recommend a financial strategy which:

- is linked to a clear investment strategy for health or social gain;

- sets out very clear objectives, confronts the difficult choices which these may imply, and aligns revenue and capital expenditure;
- includes a process for disinvestment in ineffective procedures and outmoded care settings or delivery mechanisms without destabilising the system;
- ensures that resource allocation will reflect priorities so that, for example, a policy of enhancing the role of primary care is accompanied by a greater share of health spending on primary care;
- provides guidance as to the right balance of investment as between short and long-term, and capital and revenue, spending;
- requires objectivity and rigour in major spending decisions, so that competitors for funding can be assessed and ranked against common criteria, and the recognition that policy aspirations cannot be created outside of the resources which they can make available. Publication of decisions, and supporting reasoning (including decisions not to spend) would be likely to encourage good practice.

4.36 Part of the value of a financial strategy lies in the stability it creates. It follows that, once a strategy has been settled, it is important to stick to it. We do not underestimate the pressures upon the Assembly to attempt to accommodate all the myriad demands upon the NHS and social care systems. If the Assembly is to roll out its vision of universal public services in health and social care then it has to decide to which services this will apply, and avoid suggesting that every expectation can be met.

4.37 The underlying principles here apply also in social care, though the national role is obviously different, and the focus will be on ensuring that financial strategies are in place in local authorities to deliver national policy objectives. As discussed above, we encourage local organisations, having considered the total health and social care budget available to them, to make greater use of pooled budget powers to overcome difficulties in managing the interfaces between the health and social care budgets.

### **Money flows**

4.38 We believe there is a need to examine further how resources flow in the health and social care systems. Getting this process right locally is essential if standards are to be met. Chapter 3 has described how Local Authorities and

NHS organisations receive their budgets from the Welsh Assembly (and local taxation). We suggest there is a need to develop coherent resource flow principles to determine how money flows through system locally, between commissioners and providers of service.

- 4.39 The challenge is to move us away from processes that can seem monolithic and a barrier to change, with a high proportion of the total resource tied up in long term agreements for current patterns of service provision and with current, sometimes inefficient, service providers. Resource flow principles need to facilitate change and reflect the resource requirements of prevention, promotion and primary care. There is a need for a rigorous and comprehensive performance management framework to allow the Assembly and commissioners to determine what activity is required for a given financial framework. More work is needed on how this could be achieved and to examine how we can develop a system in which money follows activity through a commissioning mechanism that both reflects need and rewards greater productivity.

### **Informing the public**

- 4.40 We also suggest that to reach the fully engaged scenario there needs to be a greater commitment to public debate and published information locally on where, and why, local organisations spend public money, and the outcomes expected and achieved for that investment. This approach should reinforce accountability arrangements and help to develop public understanding of the services provided. LHBs in Wales seem ideally placed to develop this enhanced dialogue.

### **Improving Performance**

The Assembly should stop funding deficits in NHS Wales. We recommend stronger incentives and sanctions, which reward success, give greater freedom to good performers, and are supported by the way in which resources flow. Improved performance management, founded on reliable and rounded performance information, is essential to raise standards across the board. The scope to focus on those activities which make the greatest difference, and to drive out variable performance, should be exploited.

### **Deficits**

- 4.41 A clear message from this Review is that the Assembly must stop shoring up the present funding arrangements by effectively underwriting deficits each year. Whilst we appreciate the practical pressures that have led to these funding

decisions, this is not a long-term way to run the NHS (or anything else). All parts of the NHS should be subject to the discipline of having to live within the allocations they can generate. Otherwise the Assembly is perceived as having rewarded failure and penalised success. This sends all the wrong signals and does not encourage efforts to increase efficiency.

### **Incentives and Sanctions**

- 4.42 To break down the barriers within health and social care we have suggested that we need to align the performance management and measurement systems for health and social care, so partners are held accountable jointly for agreed and shared output/outcome targets. There will also be a need to align incentives and sanctions: in particular to build "positive drivers" and incentives into the system, to reinforce "network-promoting" behaviours.
- 4.43 Current incentives for the NHS and social care to perform well are too weak. Without appropriate incentives – signals which help individuals and their organisations focus their efforts where they can do most good – outcomes will not be as good as they could be. Organisations which are eagerly monitoring and imitating good practice elsewhere are the exception.

#### *Strengthening incentives*

- 4.44 The need for improved incentives is one of the most striking Review findings. Many different methods have been recommended, and some implemented, in the last 30 years. The challenge is to give maximum local discretion and support within a tight overall policy framework of national standards. The Assembly should not seek to micro-manage the local organisations, nor should it feel the need to account itself for every local decision; that should lie at the local level. But the Assembly should set priorities and the overall strategy. And it should expect NHS and social care partners to translate this properly into action at the local level – and to be accountable for their performance. At the level of individual organisations, those which are performing well should be given as much freedom as possible to get on with the job. We suggest the following principles should inform the system of incentives:
- the emphasis should be on rewarding success rather than punishing failure;
  - greater freedoms in the form of devolved authority responsibility resources to those organisations who consistently perform well;

- recognition that improved behaviour, reinforced by aligned financial incentives and specific accountabilities is needed to improve the system;
- as has been discussed above, exploration of ways to enable resources to flow to the most successful parts of the system should be sought, for example through linking organisational funding closely to cost-effective activity;
- alignment of incentives to help realise a different balance between acute health services and community primary and social care, e.g. rewarding organisations which succeed in keeping people out of hospital;
- a move away from targets which focus overwhelmingly on performance of the acute sector – for example, incentivising independence and rehabilitation to prevent readmission or inappropriate use of health or social care.

#### *Role of pilot schemes*

4.45 We recommend a systematic approach of piloting incentive systems in the three regions of Wales. Possible pilots might include:

- giving patients with chronic diseases the option of managing their own care within a pre-determined budget. We understand that in Holland this successfully shifted care away from the acute sector, and patients stayed within their budgets;
- giving selected Trusts, LHBs and Local Authorities working as part of a whole system health and social care economy the objective of achieving the fully engaged scenario. Part of their task would be to assist in rolling out knowledge and experience to the rest of Wales;
- using the ‘Director’s Fund’ (ie money top-sliced from the NHS funding allocation to be distributed according to the instructions of the Director of NHS Wales) in NHS Wales to reward good organisational performance against transparent and objective criteria set out in advance.

#### *Sanctions*

4.46 We also need stronger sanctions. As a principle, the new performance management system in health should identify potential failure and permit intervention much sooner. Whilst changing senior management is sometimes necessary it may distract from other causes of failure and may cause more

problems than it solves, including creating an incentive to conceal, and ultimately worsen, problems.

- 4.47 We suggest that sanctions should be the reverse of incentives – a loss of autonomy and a removal of opportunities to access additional funding for service developments. Approaches which might be considered include guaranteed minimum performance outcomes for the public. So an organisation which failed to meet a minimum standard, for example relating to waiting times, could be obliged to purchase the service for the member of the public from elsewhere (in the UK or EU, or the private sector).

### **Performance Management**

- 4.48 Incentives and sanctions are only one aspect of a performance management system. We highlighted, in the section on seamless service provision, the need for whole system performance management across health and social care, to measure inputs, outcomes and assessment of performance. We welcome the introduction of a balanced scorecard to underpin continuous improvement in health organisations. We believe it should be implemented as quickly as possible to establish it within the new organisational arrangements. We also recommend that this approach is developed to improve the performance of local health and social care systems, linked to achievement of the outcomes set out in health, social care and well being strategies.

### *Performance Information*

- 4.49 In Chapter 3 we described the lack of sophisticated performance management systems, and of robust performance information, as a central issue. Reliable, timely and appropriate performance information is the cornerstone of performance management. For example, improving NHS Wales' financial performance – and an end to the Assembly shoring up deficits – depends in part on a clear and detailed understanding of the causes of the financial difficulties of individual health organisations.
- 4.50 In considering how we improve performance, targets clearly have a role to play in focusing day-to-day operational management. They are not, however, a substitute for a rounded assessment of performance (for example through the balanced scorecard, appropriately constructed and used) underpinned by regular and rigorous audit and inspection, linked to continuous improvement. Over-reliance on targets, if there are too few, leads to distorted incentives and, if there are too many, to mutual inconsistencies and distraction from other important goals. Moreover targets should measure success – what organisations are there

to do – not failure. We recommend an approach which benchmarks and scrutinises performance against agreed good practice as one element of the balanced scorecard.

### **Maximising value for money**

4.51 Most of what the health and social care system in Wales will achieve over the next five years will be achieved from budgets already anticipated. To maximise the value of our investment there needs to be a concerted effort to analyse and improve the results of current activity and focus on elements of high value. Possible ways of doing this include:

- marginal analysis of expenditure – reallocation of funding while not damaging core services;
- focused evaluation of current practices – with a view to maximising health improvement through managed change;
- a targeted efficiency programme – we believe there are potentially considerable savings to be made by collaboration and economies of scale in provision of support services. This could focus in the short term on ensuring that opportunities for collaboration in health and social services are explored fully, and would be followed by exploration of opportunities to share services e.g. common finance and IT systems, across health and social care.

### *Driving out variable practice*

4.52 We also need a robust approach to ensuring good and modern practice is implemented in Wales. There are numerous areas where we could improve system performance by universalising best practice. For example, Trusts in Wales typically carry out lower levels of day surgery than those in England. We need to work with auditors and best practice units systematically to benchmark and scrutinise elements of service to ensure they are in line with good practice. The existing health and social care ‘change agent team’ could be used to make sure that best practice in working together with health services for common goals is universalised.

## Delivery

Workforce planning needs to be altogether more sophisticated, robust, long-term and based on future models of service provision. Training and retention of current staff also need attention. There should be an overhaul of information systems to improve quality, timeliness and coverage. ICT is in urgent need of investment within a national strategy which embraces both health and social care. Major investment in estates will be necessary, and decision-taking processes which will govern it should be strengthened. Clear and shared understanding of national and local roles, and the relationship between national and local health, social care and well being strategies are needed to make the new organisational structures effective. We should clarify and strengthen accountability of NHS chairs and chief executives, and of all those delivering services which cross organisational boundaries.

## Workforce

### *Workforce planning*

- 4.53 Chapter 3 noted that workforce planning has not been based on expected future patterns of service provision, and information and resource limitations have raised doubts about the reliability of the projections made. As the Association of the Directors of Social Services have pointed out in their consultation response *"The absence of robust and sophisticated workforce strategies in health and social care has encouraged the need for short term and costly remedies to staffing shortages and unhelpful competition between different elements of the whole system for the same pool of staff."*
- 4.54 Getting the right workforce in place to deliver an agreed service model is a long term task. Workforce planning needs to look 20 years ahead as part of an integrated health and social care strategy, which also embraces revenue and capital. Clear objectives and milestones for the workforce plan are needed.
- 4.55 Workforce planning is an area where there is a powerful case for a strong central lead, because of the overarching strategic nature of the issues and to establish economies of scale. The resource involved in workforce planning is currently dissipated. It is important that it is concentrated and that sufficient human and financial resources are devoted to the task. Local health and social care organisations will also need to increase the resources allocated to workforce planning to make sure that their conclusions are robust.

- 4.56 The Welsh Assembly Government should review the current workforce planning mechanisms and put in place alternative methodologies which will ensure that the services are able to deliver the ambitious service strategy. There is also a need to build on and improve relationships with education and training institutions so that the required number of training places are commissioned, and the changing skills and competencies that health professionals will need into the future are developed. The work should be related closely to the development of UK-wide Skills Councils.

*New ways of working*

- 4.57 Workforce plans must be grounded in service strategy and redesign, and reflect the fundamental point that conventional ways of working and delivering healthcare are in need of radical change. We must not plan for more of the same – attention needs to be given to changing significantly the skill mix of those working in health and social care.
- 4.58 Traditional ways of working need to be challenged as a matter of urgency, and efforts made to remodel the workforce so that it can deliver modern flexible high quality care. Services should be provided by the professional or support worker best able to deliver the service, not necessarily those who have traditionally done so. Specifically, Wales needs to be more innovative in developing some of the new professional roles being planned elsewhere in the UK and beyond, e.g. physicians assistants, practitioners in emergency care, extended role nursing, therapy practitioners, as well as improving the range of skills of care-workers. In social care, we need to accelerate, as a priority, the action already in train to reduce the skills and qualifications gaps in the sector.
- 4.59 Piloting new ways of working will be important. We recommend examining the results of the European Working Time Directive Pilots in England, and early piloting of new workforce models in Wales to deliver flexible high quality care in new settings. This will require a modernisation of the education and training processes and programmes, and education providers will need to be involved at an early stage in developing and rolling out innovative new approaches.

*Training existing staff*

- 4.60 As well as ensuring appropriate numbers are receiving the right sorts of training, there will be a need to train, and use to full effect, those already in the services. We cannot satisfactorily quantify the value of our increasing investment in the health workforce and there are considerable inefficiencies in

the way in which the social care workforce moves from employer to employer. We need a concerted effort to realise the innovation possible as a result of *Agenda for Change* pay modernisation and the new GMS contract (under discussion at the time of this report). Similar issues apply in social care.

- 4.61 *Securing our Future Health* stressed the need to ensure that skilled professionals are able to spend as much of their time as possible with patients and service users. We also recommend a review of the managerial and professional leaders' skills portfolio in both services, to ensure we have in place skills such as change management, formal monitoring and evaluation, and decision-appraisal techniques such as health economics.

### *Retention*

- 4.62 The Review has shown that there is significant scope to improve retention rates in both health and social care. We recommend that employers work together to improve management and organisational practices that contribute to retention difficulties. Mechanisms by which employees can move more easily between sectors should be developed. In social care, employers should consider collectively what action could be taken across the sector to bring an end to the destabilising practice whereby staff move from one employer to another in return for short-term rewards.

### **Information Systems**

- 4.63 It is taken as axiomatic that decisions will only be as good as the knowledge and information on which they are based. But important decisions in health and social care are too often taken with incomplete or unreliable information. There is a general need for better information at all decision-taking levels. We recommend an urgent overhaul of information systems, to improve quality, timeliness and coverage, including development of:

- common and shared information systems between health and social care. Whilst we appreciate the practical difficulties to be overcome, information obtained at each stage of an individual's journey through the system should be shared with appropriate professionals, providing consent is obtained;
- systems which can track expenditure on programmes and by category;
- systems which connect expenditure to outputs;

- means of measuring health and social care outputs, which capture positive as well as negative features and show how we are performing against standards;
- comparative cost information to enable commissioners to balance the real cost choices of home care, residential care, or intermediate care, for example;
- meaningful comparisons and benchmarking until all services are covered.

4.64 This has important implications for ICT (see below). One is that a programme to achieve these objectives which lasts a number of years is likely to be needed, in view of existing systems and contracts. Protocols will also need to be firmly established for the exchange of information between professionals and organisations. These factors make it more, rather than less, important to signal clearly the outcome which is to be sought.

## ICT

### *ICT in health*

4.65 *Securing Our Future Health* identified a particularly strong case for setting common national standards in ICT<sup>98</sup>. We found widespread support amongst consultees for the approach recommended in *Securing Our Future Health* to increasing ICT investment, and linking this to tangible service benefits. The Welsh NHS Confederation in their submission to the Review commented "*We believe that [this] investment in ICT is an investment in improving the efficiency and effectiveness of resource management within NHS Wales and should therefore not be seen as a cost that brings no tangible benefit.*"

4.66 Chapter 3 noted the very low level of ICT spend in health and social care in Wales, and the absence of common standards. The need for the Assembly to give a lead here is, if anything, even stronger than in England. This is because spending to date has been lower, and because the financial position in Wales makes it vital that the productivity gains which effective use of ICT offers are realised as quickly as possible. The Assembly is developing a strategy to address the ICT issue in health<sup>99</sup>, which we believe contains the right elements – in particular recognition of the importance of centrally set standards, developed with users involved and defining needs.

### *ICT support for service delivery*

- 4.67 It is also important to implement ICT strategies that are supportive of the service delivery framework. Increased use of telemedicine, shared electronic records and electronic links can facilitate integrated working between the different elements of the health and social care system. Technology to monitor patients with chronic conditions in their own homes can be used to detect early exacerbations, initiate treatment and prevent avoidable admissions<sup>100</sup>. These are important gains, and we regard it as very important that the goals outlined in *Informing Healthcare* should be attained as soon as is practicable.

### *ICT in social care*

- 4.68 In social care the Assembly has sought to facilitate the work of the consortium of 10 local authorities who have appointed KPMG to help them identify and meet their future ICT needs.
- 4.69 There is a need to go further. We recommend that the Assembly should give a lead in social care ICT and build on the work of the consortium, to ensure common standards.

### *Health and social care interface*

- 4.70 Easy exchange of information between health and social care is essential to the seamless provision we have discussed in this report. This depends in part on compatible ICT systems. We therefore recommend development of a common ICT strategy which ensures that these exchanges of information are as easy as is practicable.
- 4.71 We recognise that there are other ICT issues, including the need for social care systems to interface with other local authority corporate systems. These should be taken into account, but are not reasons to forego a common approach. To focus on each sector separately would be to miss a golden opportunity to break down barriers between health and social care. We stress, though, the need to be clear about, and to evaluate, the benefits to patients and service users of investment in ICT. Ring-fenced funding and regular auditing linked to common standards and an integrated system are vital. We believe ICT should be a priority for investment.

## **Estates**

- 4.72 It is important that the issue of how we configure our health service should not be based predominantly on considerations of buildings. As Black<sup>101</sup> has pointed out "*buildings are necessary, but they do not themselves contribute to health gain.*"

### *Modernisation and reconfiguration*

- 4.73 However, Chapter 3 has described a health and social care estate which needs both modernisation and reconfiguration, linked to service strategy. Chapter 3 also highlighted the major capital investment required to achieve extensive reconfigurations of health service provision.
- 4.74 Some buildings will need change of usage (eg community hospital to primary care resource centre) and others change of ownership. There are effective examples of innovative developments where the ownership of, and services provided in, community hospitals have changed. For example, the former Ledbury Community Hospital, a 13-bed cottage hospital, is now a Hospital and Community Centre, owned by a not-for-profit Registered Social Landlord.

### *Process for taking capital spending decisions*

- 4.75 Our recommendations earlier in this chapter imply significant capital expenditure. This will make it more important than ever that processes for taking capital spending decisions are robust.
- 4.76 There has been work to improve the process of approving capital investment for the NHS through the establishment of a capital investment board with a longer term programme for investment. This is a welcome step which should allow clear prioritisation based on explicit values and strategic aims, more in-depth and rigorous option appraisal and benchmarking of projects to give a more consistent idea of what outcomes could be expected. It is important that the board, and others in health and social care who take capital investment decisions, should consider carefully the longer term affordability of investments so that running costs do not become unaffordable.
- 4.77 Greater certainty over resources which will be available for future capital spending is also needed. A corollary should be an end to the practice of transferring money intended for capital investment to running costs.
- 4.78 We recommend that local estate strategies are integrated with the health, social care and well being strategies. They should be whole system, covering all health and social facilities, irrespective of ownership.

## **Organisational structures**

- 4.79 A starting point for the Review was the new NHS Wales structures, implemented from 1st April 2003.
- 4.80 To work effectively, there needs to be clarity of role and responsibilities between the different elements of the system. As delivery in so many areas crosses organisational boundaries, we emphasise the need to develop a "collaborative accountability" model with all partners signing up to key principles and identifying a mechanism to bring all partners together to take decisions and resolve conflict.
- 4.81 There is an emphasis on the local nature of the new arrangements and the need for local solutions to the health and social care issues facing communities. It will be important, therefore, within the new structures to have clarity about the national role and responsibility, so that local organisations have a clear understanding about the extent, and degree of, local freedoms.
- 4.82 *Securing our Future Health* emphasised the national role in standard setting, regulation and establishing the processes which determine the flow of information and resources works. In our view a key element of the national role will be the development of a resourced, five year strategic framework, incorporating service strategy, workforce estate, ICT, and capital investment plans, from which annual operational plans for health and social care will flow (we envisage remodelling of the existing Service and Financial Framework agreements here). Local organisations should interpret the central framework in their health, social care and well being strategies.
- 4.83 We suggest that there should be a dynamic relationship between national and local strategies; when the health, social care and well being plans are complete they should be reflected in the national strategy which would in effect be a summation of them.

## **Accountability**

### *NHS accountability*

- 4.84 We believe there is a need to clarify, strengthen and enforce the formal accountability arrangements whereby the chairs and chief executives of NHS bodies are held to account by the Assembly for achievement of service and financial objectives. For financial issues one mechanism would be, as a matter of course, for chief executives of all NHS organisations reporting a financial

deficit to be called to appear before the Assembly's Audit Committee to account for their stewardship of resources. For service issues, including corporate responsibility for clinical governance, the Health and Social Services Committee may be called on to exercise its scrutiny role. Individual health professionals continue to be accountable to these regulatory bodies, but they also have responsibilities to organisations which are normally contractual. There should be a commitment to learning and sharing the lessons of rigorous and independent audit.

*Accountability for multi-organisation services*

4.85 The "cross-cutting" nature of the health and social care agenda in Wales presents a dilemma for government. We need to create new mechanisms of accountability, and to ensure that the Assembly has the leverage to ensure that effective, co-ordinated services are delivered by the network partners. Government therefore needs *"to devise strategies to assess and manage for outcomes as well as outputs"*<sup>102</sup> and to hold networks to account for those outcomes. This new "collaborative accountability" model could involve the following steps:

- identifying the participants in the network who share responsibility in achieving the outcomes;
- requiring all partners signing up to key principles;
- apportioning responsibility through the outputs each partner needs to achieve;
- identifying a mechanism to bring all partners together to take decisions, resolve conflict, etc;
- holding each partner responsible for achieving those outputs;
- assessing whether the combined outputs produce the desired outcome;
- applying appropriate performance management incentives and sanctions;
- promoting the concept of "network management", aligned with collective accountability, to ensure the connection between policy "outcome" expectations and delivery on the ground.

## Pace of Change

It will be important to chart, and adhere to, a programme of change which is realistic. An implementation plan identifying short, medium and long-term steps and strategy is a way forward. Investment in ICT and estates are priorities, as are immediate steps to reduce delayed transfers of care and accelerate alternatives to acute hospital admission. In some cases it may be necessary to make ring-fenced funding available to meet reconfiguration costs. Successful change will depend on leadership, energy and commitment from politicians, professionals, managers, and staff alike.

- 4.86 An agreed pace of change will be important. This should be challenging but achievable and means:
- deciding what will be done when, and then refusing to be deflected from the programme;
  - recognising that this timetable will itself be influenced by the capacity to change. This capacity can be increased by training people, and by making resources available.

### An implementation plan

- 4.87 We have an unprecedented new opportunity to plan for the long term with greater certainty about future resources following the UK Wanless Review. An overarching recommendation of this Review is the need for a long-term approach to the issues affecting, and changes needed in, health and social care in Wales. We found widespread support for this view amongst health and social care colleagues and consultees, who cited the lack of long-term strategic planning with short term funding, one-off initiatives and changing priorities as a block in the current system.
- 4.88 Developing a detailed road-map to take us from where we are now to the vision for 20 years' time was neither our remit, nor achievable within our time and resource constraints. We do however believe that we have identified both pressing short-term problems of capacity, and wider medium and long term issues. We recommend that any implementation plan developed by the Welsh Assembly Government to take forward our recommendations should address systematically the short, medium and long-term steps and strategy – capital, revenue and capacity – required to achieve the fully engaged scenario in Wales.

4.89 Among our findings which this plan should take into account are a clear need for accelerated investment in ICT and premises to realise improvements in productivity and new service models. It is also clear that if we are to deliver new models of service provision which focus on prevention, promotion, primary and non-institutional care, resources are needed to develop capacity in these sectors. The lead times for attainment of the benefits of investment in infrastructure and new service models are medium to long term. In the short-term an immediate priority should be action to reduce delayed transfers of care, and accelerate development of alternatives to acute hospital admission.

### **Funding reconfiguration costs**

4.90 A specific question we have considered is whether to recommend additional temporary funding to meet one-off reconfiguration costs and enable the benefits of new provision to be seen before arrangements which are coming to an end have finished. We are clear that criteria should be developed which:

- do not make additional funding automatic, since where it is not necessary this would waste resources;
- are objective and transparent, so as to avoid diverting energies into lobbying for discretionary funds;
- preserve incentives to make difficult changes, by ring-fencing funds and releasing them only on the condition that their purpose is actually achieved.

### **Leadership**

4.91 The most important attribute which successful change will require is leadership. The national leadership of the Assembly will be essential, but not sufficient. Clinical leaders, NHS Trusts, Local Health Boards and Local Authorities all have a vital part to play. The Centre for Health Leadership should also have a pivotal role in taking forward the leadership development agenda.

4.92 As well as this, there is an important role for the individuals and communities in Wales – and, of course, for the people who work in health and social care, whose dedication and professionalism will be critical. We have witnessed this dedication and professionalism at first hand during the Review. It is the presence of so many people with a powerful sense of public service and a desire to provide a high standard of care that makes us believe that the services can be transformed – to release their talent and energy in order to deliver the care which Wales deserves.

# TERMS OF REFERENCE

A1.1 The Finance Minister for the Welsh Assembly Government announced a substantial increase to the health budget on 15 October 2002. She made clear at the same time that the use of these resources needed to be allied to improved performance and modernisation for health and social care in Wales.

A1.2 Mr Derek Wanless, the author of a comprehensive report to the Chancellor on the future of the NHS, has been invited by the Welsh Assembly Government to act as an adviser to a review of health and social care in Wales. The review will look at how resources for health and social care can be translated into reform and improved performance, taking the Wanless review as its starting point and taking into account the additional resources of health and the new NHS Wales structure.

## Project Brief

A1.3 The overarching aim of the review is to look at how resources for health and social care in Wales can be translated into reform and improved performance. The review will need to consider and make recommendations in the following areas:

- issues which are currently impairing the efficient and effective use of resources;
- the use of resources (capital, revenue and human) to bring about a significant improvement in the quality of services in the NHS and relevant sectors of social care services in Wales;
- ways in which health and social care systems can work in an integrated way to maximise performance and use of resources;
- the effectiveness of the decision-making and accountability processes in health and social care in Wales;
- factors that contribute to success and the need for long-term investment.

## **Product of the Review**

A1.4 The product of the review will be a report to the Finance Minister advising on the optimal use of financial resources to deliver and sustain whole system health and social care services for the people of Wales over the next 10 years. The report will also highlight the performance indicators and information requirements needed for successfully monitoring delivery of health and social care services.

## **Methods of working**

A1.5 The project will not undertake primary research or data collection, but will review available information and research.

A1.6 The review will need to consider the present distribution of resources and the value achieved for the level of spend. Performance measures and indicators will be an important part of the issues to be taken into consideration, and the establishment of incentives to encourage best practice. The review will be advised by Derek Wanless in considering these issues and drawing conclusions and recommendations on them. The review will take evidence from key stakeholders with a focus on gathering evidence of best practice and what works.

## **Consultation**

A1.7 The review will take written evidence from the key stakeholders in health and social care in Wales including:

- The NHS;
- Local government;
- Patients' groups;
- Voluntary sector;
- Independent sector;
- Staff and professional bodies;
- Academics.

## **Timescale**

A1.8 The review will report in the late spring of 2003.

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## **Project Team**

### *Editorial*

David Richards, Principal Finance Officer, National Assembly for Wales (Chair)

Jan Williams, Project Manager, Chief Executive, Bro Taf Health Authority

Sally Attwood, Bro Taf Health Authority

Claire Jones, Bro Taf Health Authority

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### *Advisory*

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Ceri Breeze, Welsh Assembly Government

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Sian Harrop-Griffiths, Bro Taf Health Authority

Alun Lloyd, Bro Taf Health Authority

Ashley McDougall, National Audit Office

Steven Phillips, Welsh Assembly Government

Nigel Towns, Dyfed Powys Health Authority

Bob Woodward, Welsh Assembly Government

Vanessa Young, Welsh Assembly Government

## **The Project Board**

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Jan Williams, Project Manager, Chief Executive, Bro Taf Health Authority

Sandy Blair, Welsh Local Government Association

Mike Chown, Head of Local Government Finance Division, Welsh Assembly Government

Dr Mark Drakeford, Special Adviser, Welsh Assembly Government

Hugh Gardener, City and County of Swansea

Paul Griffiths, Special Adviser, Welsh Assembly Government

Dr Ruth Hall, Chief Medical Officer, Welsh Assembly Government

Ann Lloyd, Director NHS Wales, Welsh Assembly Government

Steven Phillips, Head of Financial Planning Division, Welsh Assembly Government

Helen Thomas, Head of Social Policy Department, Welsh Assembly Government

(The role of the Project Board was to provide advice and feedback to the Project Team on the management of the Review process, and on the analysis of the emerging conclusions. However it is Project Team, rather than the Project Board, which is responsible for the drafting of the final report.)

# THE REFERENCE GROUP

The aim of the Reference Group was to provide a mechanism for engaging with, and encouraging ownership amongst, key individuals and groups affected by the project and who have a stake in its outcome. The Reference Group structure allowed a forum for two-way communication between the project team and project board and stakeholders.

## Membership

Paul Williams, Chief Executive, Bro Morgannwg NHS Trust

Geoff Lang, Chief Executive, Wrexham Local Health Board

Ellis Williams, Director of Social Services, Newport CBC

Jane Jeffs, Welsh Association of CHCs

Ros Williams, Carers National Association in Wales

Professor Julian Hopkin, Director Swansea Clinical School

David Jenkins, Wales TUC

Philip James, Lloyds TSB Bank

Professor Ken Woodhouse, University of Wales College of Medicine

Phil Davies, Alzheimer's Society

Tony Beddow, Principal Lecturer, Welsh Institute of Health and Social Care,  
University of Glamorgan



# RESPONDENTS TO CONSULTATION

We are very grateful to those individuals and organisations who took the time to offer their views on the key issues facing health and social care services in Wales both now and in the future. They were extremely helpful to our work and may be viewed at [www.wales.gov.uk/subieconomics/hsc-review-e.htm](http://www.wales.gov.uk/subieconomics/hsc-review-e.htm)

## Respondents

1. North Wales Public Health Service
2. Care Council for Wales
3. Carmarthenshire NHS Trust
4. The All Wales Committee for Healthcare Professions
5. College of Occupational Therapists
6. Gwent NHS Trust
7. General Practitioner Committee Wales
8. Merthyr Tydfil Local Health Board/Merthyr Tydfil County Borough Council (multi-agency)
9. Dr Gillian Richardson, Consultant in Public Health Medicine, Temple of Peace and Health
10. Royal Pharmaceutical Society of Great Britain Welsh Executive
11. The Association of Welsh Community Health Councils
12. The Resources Group of the Welsh Branch of the Association of Directors of Social Services (ADSS)
13. Swansea NHS Trust
14. Mr Keith Tayton, Consultant Orthopaedic Surgeon, St. Joseph's Private Hospital
15. Gwent Community Health Council
16. Gwent Health Authority
17. Dyfed Powys Health Authority
18. Neath and Port Talbot Community Health Council
19. Rhonda Cynon Taf County Borough Council
20. Monmouthshire Local Health Board
21. Denbighshire County Council
22. North East Wales NHS Trust
23. NHS Trusts in Wales in association with the Institute of Medical and Social Care Research, University of Wales, Bangor

24. North Wales Health Authority
25. Welsh Food Alliance
26. Community Pharmacy Wales
27. Iechyd Morgannwg Health
28. North West Wales NHS Trust
29. Vale of Glamorgan LHG
30. Dr PE Williams, Consultant Clinical Immunologist, University Hospital of Wales
31. Cardiff LHG
32. The All Wales Public Health Service Network
33. Caerphilly LHG
34. School of Postgraduate Medical and Dental Education, UWCM
35. Diabetes UK
36. The Chartered Society of Physiotherapy
37. Brecknock and Radnor Community Health Council
38. Directorate of Public Health and Policy, Bro Taf HA
39. Cardiff and Vale NHS Trust Board
40. Welsh NHS Confederation
41. Bro Taf HA, Gof Cockell, Chief Statistician, ' An analysis of the pressure on acute hospital beds in NHS Wales'.
42. Newport Local Authority/Newport Local Health Group & Gwent Healthcare NHS Trust - multi-agency response
43. Welsh Institute of Health and Social Care
44. Dyfed Powys Health Authority Public Health Department
45. WLGA
46. Pembrokeshire County Council
47. Carmarthenshire Health & Social Care Partnership Board
48. Professor Geraint Williams, Assembly's Welsh Scientific Advisory Committee
49. Pembrokeshire and Derwent NHS Trust
50. Blaenau Gwent LHG
51. Various Geriatric Departments, UHWC
52. Conwy Social Services
53. UKHCA
54. Audit Commission Wales
55. Barry Latham, Care Forum Wales
56. Yvonne Hern, All Wales Forum of Parents & Carers

# NOTES

- 1 *Improving Health in Wales: A Plan for the NHS in Wales with its Partners*, Welsh Assembly Government, 2001
- 2 *Official Record of the Welsh Assembly, 15.10.02*
- 3 *A Question of Balance: A review of capacity in the Health Service in Wales*, Williams, 2000
- 4 *Official Record of the Welsh Assembly, 15.10.02*
- 5 In Wales as in all health and social care systems, in theory it is possible to distinguish between demand (what people want) and need (capacity to benefit, usually defined by professionals), and to plan and provide for the latter. In reality both need and demand are affected by supply of services which can be reflected in increased referrals for treatment, by GPs for example, or reduced treatment threshold (*Creating the Climate - Health Futures for Wales*, Office for Public Management – 2001).
- 6 *Projections of Demand for Long-Term Care for Older People in Wales to 2020*, Adelina Comas-Herrera, Raphael Wittenberg, Linda Pickard, PSSRU Discussion paper 1989.
- 7 The base case takes account of demographic projections, trends in dependence and housing tenure. It holds as constant present patterns of care and funding systems, that supply adjusts to meet demand and that demand remains as in 2001
- 8 The ‘Brookings Scenario’ was developed by Wiener *et al* (Wiener *et al.*, 1994) at the Brookings Institute. It assumes that as life expectancy rises years without dependency increase by a similar amount, i.e. if life expectancy rose by 2 years between 2001 and 2020 a person aged 70 in 2020 would have the same chance of being dependent as a 68 year old in 2001
- 9 According to the 2001 census 12.4 per cent of respondents in Wales reported health which was ‘not good’ compared to 9.2 per cent for England and Wales as a whole. Wales is disadvantaged relative to England on a range of socio-economic indicators (for example, GDP per head is around a fifth lower than the UK average), and the relationship between social and economic disadvantage and ill-health is well documented.
- 10 *Well-Being in Wales*, Welsh Assembly Government, 2001; *Health in Wales: Chief Medical Officer's Report*, National Assembly for Wales, 2002. There is a difference in life expectancy of around five years between the local authorities in Wales with the highest and lowest figures (Health Statistics Quarterly No. 13, Office for National Statistics, Spring 2002).

- 11 *Securing Our Future Health, Taking a Long Term View*, Wanless, 2002, page 39
- 12 *Preventing Ill-Health: The Case for More Investment – Report submitted for the Review of Health and Social Care in Wales*, Office of the Chief Medical Officer, 2003. Unpublished
- 13 *Social Services Statistics Wales 2002*, Table 2.3
- 14 Authorities are under a statutory obligation to conduct an assessment of needs when asked to do so, if it appears to them appropriate, but they set their own criteria for service provision. If the criteria are met and the authority undertakes to do so, then there is an obligation to provide a service.
- 15 It can be argued that the growing proportion who do not receive services indicates more effective targeting rather than need which is not being met. In our view the significant increase in numbers being assessed cannot be fully explained without acknowledgement that there is growing need.
- 16 *Bed Use Statistics (Acute and Geriatric Specialties)*, National Assembly for Wales, 1981 and 2002
- 17 This figure fluctuates significantly from one month to another; for example, it touched 16,000 in the autumn of 2002
- 18 NHS Wales Waiting Times: at end March 2003 (SDR 26/2003) National Assembly for Wales.
- 19 Average daily bed availability 2001-02, on basis of 2001 population. General and acute, rather than just acute, beds are given since some beds are classified 'general' in England which might be classified 'acute' in Wales. *Hospital Bed Use Statistics*, National Assembly for Wales, 2003
- 20 National Assembly for Wales, monthly waiting times collection
- 21 DoH press release 'Both waiting lists and waiting times are down' 4th April 2003
- 22 Williams, op cit, p101
- 23 *An Analysis of the Pressures on NHS Hospital Beds in Wales*, Gof Cockell, 2002, p92. Unpublished.
- 24 Williams, op cit, p110, 119
- 25 Shain and Roemer (1959), cited in *An Analysis of the Pressures on NHS Hospital Beds in Wales* Gof Cockell, 2002, p123
- 26 All Wales Medical and Dental Workforce Development Expert Advisory Group, December 2002
- 27 *Isolated Acute Medical Services: Current Organisation and Proposals for the Future*, Royal College of Physicians, July 2002
- 28 *Reconfiguring health systems*, Andy Black, BMJ 2002;325:1290-1293

- 29 Minister with responsibility for Health, Social Services and Public Safety, 24 February 2003
- 30 Scottish Minister for Health and Community Care, 12 August 2002
- 31 Average occupancy of Wales stock of community hospitals is 77 per cent. Williams, 2002, op cit, p 114-6
- 32 Williams, 2002, op cit, p114
- 33 See *A study to establish the roles, necessary relationships and resource consequences of urban community hospitals*, Lead Researcher, Dr Carole Rawlinson, London: Department of Health, 1998; Also *Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente*, Feecham et al BMJ 2002; 324: 135-143, which estimated a release of £10bn per annum if the length of stay in the NHS (UK) was equivalent to length of stay in the Kaiser health plan;
- 34 Wanless, 2002, op cit, p 106
- 35 Wanless, 2002, op cit, p 25 and 110
- 36 Williams, 2002, op cit, p 75
- 37 *Analysis of Patient Episode Database for Wales (PEDW) and Hospital Episode Statistics (HES)*
- 38 *Improving Health in Wales*, Welsh Assembly Government, 2001, p10
- 39 Three quarters of adults report visiting their family doctor in the previous 12 months. 1998 Welsh Health Survey
- 40 *Local Health Groups in Wales*, National Assembly for Wales statistics bulletin, 15 March 2002. In 2000-2001 the average age of a doctor leaving general practice was 54 years for male GPs and 42 years for female in Wales: source: *Workforce Statistics for General Practitioners in Wales, 1991 – 2001*, National Assembly for Wales statistics bulletin, 10 July 2002. The Inverse Care Law, The Lancet, Julian Tudor- Hart, Feb 1971.
- 41 See footnote 12 above
- 42 *Circular 9/02 Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care*. National Assembly for Wales, 2002
- 43 For example, the flexibilities introduced by the Health Act (1999) and grants to local government to encourage joint working, which currently fund 50 formal joint working schemes.
- 44 *Public Expenditure Statistical Analyses 2003*. There is some fluctuation in the reported figure from year to year. The 2001-02 suggests a differential of around 11 per cent but at first sight this is not easy to reconcile with other published data.

- 45 The North East is not an NHS region, and the nearest comparator is Northern and Yorkshire (population about twice that of Wales). As a rough approximation, the Northern and Yorkshire NHS region combines the standard regions of the North East and Yorkshire and the Humber. While Y&H has a better health profile than the North East, its expenditure on health is only a little above the English average. The health indicators in Regional Trends show a broad similarity between Wales and Northern and Yorkshire.
- 46 Regional Trends 2002. Table 7.15. Office for National Statistics
- 47 Figures for the North East were calculated from data for constituent local authorities in *Social Services Performance Assessment Framework Indicators 2001-2002*, Department of Health, 2003. Wales figures were taken from *SDR 3/2003 Local Authority Social Services Performance Statistics: Year Ending 31 March 2002*, National Assembly for Wales, 2003.
- 48 Audited Accounts of NHS Trusts
- 49 The write-off is conditional on, among other things, Trusts achieving two years of financial balance. The two years has not yet expired, which is why £16m is yet to be written off.
- 50 Trusts also received over £2m from Health Authorities in 2001-02
- 51 Wanless, 2002, op cit, p 87
- 52 *Annual Staffing Census NHS Wales 2002*, Welsh Assembly Government published statistics.
- 53 NHS Vacancies unfilled after three months, NHS Vacancy Survey, Welsh Assembly Government Statistics, September 2002
- 54 We have used March, rather than September, 2002 Welsh vacancy data to enable comparison with England for which more recent data was not available to us
- 55 Welsh Assembly Government NHS Workforce Plans 1996-2002
- 56 Non-practising nurses and midwives in Wales, Sheila Drayton, April 2002
- 57 *Annual Staffing Census*, NHS Wales, 2002 op cit
- 58 *Welsh Health Survey 1998; General Medical Services Census 30 Sep 2001*, National Assembly for Wales, July 2002
- 59 Wanless, 2002, op cit, p75
- 60 *TOPSS Cymru Workforce Audit* (the predecessor organisation to the Care Council), May 2000
- 61 *SSIW Report*, 2002
- 62 *Recruitment and Retention*, Audit Commission, 2002

- 63 *The Social Care Workforce in Wales – Definitions and Challenges*, NAW, September 2001
- 64 Wanless, 2002, op cit, p55, 63
- 65 *Informing Healthcare*, Welsh Assembly Government, 2002, p16
- 66 Child Health systems, which are integrated across Wales, are the one exception
- 67 For example, there is no integration between pharmacy systems and other ICT systems in any of the trusts
- 68 All Wales Consortium Systems Modernisation Report, KPMG, 2003
- 69 Wanless, 2002, op cit, p31
- 70 From National Audit Office questionnaire sent to all NHS Trusts and Health Authorities in Wales in 2001 which found, among other things:
- Only half the estate held by Trusts in Wales was reported to comply fully with statutory health and safety requirements, including fire safety;
  - Less than half of Trusts were in a position to meet the 2002–03 target for 90 per cent of the active estate to be sound, operationally safe and exhibiting only minor deterioration;
  - Only half of the estate held by Trusts was assessed as fully or reasonably fit for purpose and about one fifth was below the acceptable standard.
  - Almost one quarter of the surveyed estate was assessed as underused or empty.
- 71 *Managing the Estate of the National Health Service in Wales*, Auditor General for Wales, November 2001. The estimated existing use value of the NHS Wales estate is some £1.2 billion. Central funding typically provides between £70 million and £130 million a year for spending on capital investment in the estate. In addition, NHS trusts and health authorities currently spend over £250 million a year to operate and maintain their estate.
- 72 Welsh Health Estates paper to Director NHS Wales on the outcome of the All-Wales Survey of GP Premises
- 73 *NHS Wales, National Estates Strategic Framework*, Welsh Assembly Government, 2002
- 74 Eg North West Wales, North East Wales, Pontypridd & Rhonda and Bro Morgannwg NHS Trusts
- 75 A report by the Audit Commission into Accident and Emergency Services published in October 2001 found that on the measure of those waiting less than an hour to see the doctor, Wales performed more favourably than the regions of England. This was welcome, but some caution is needed. The measure used was

the performance of the median trust, and so may reflect the configuration of A&E departments in Wales rather than the experience of the 'average' patient.

- 76 *Learning the Lessons from Joint Reviews of Social Services in Wales 1999–2000*, Audit Commission, Oct 2000. *Pathways to Improved Social Services in Wales, The Second Overview Report of Joint Reviews in Wales*, Audit Commission, Oct 2002.
- 77 *ibid.*
- 78 There are shortcomings in the service provided as well as in financial performance. One example is that the rate of day surgery for a range of procedures is considerably below English rates. (*The Audit Commission in Wales' Response to the Wanless Review*, p23). Others appear elsewhere in this Chapter.
- 79 *Review of Health and Social Care in Wales, Response to Consultation Questions*, North Wales Public Health Service
- 80 *The 2002 Overview report on the joint (Audit Commission in Wales/National Assembly) reviews*
- 81 The Sustained Quality Payments scheme, introduced in 1999, provides for payments of £1,000 per GP for achievement of high quality medical services measured against a basket of indicators. The figures on sustained quality payments were provided by the contractor services department of the NHS Wales Business Services Centre.
- 82 North West Wales, North East Wales, Pontypridd and Rhondda, and Bro Morgannwg
- 83 *Social Services in Wales 2001–2002: The Report of the Chief Inspector*
- 84 *Access and Excellence, Creating the Climate, Improving Health in Wales*. Welsh Assembly Government
- 85 *The Audit Commission in Wales' Response to the Wanless Review*, p 14. See also Professor Townsend's finding in reviewing the NHS Wales resource allocation mechanism that there is inadequate financial information to ensure consistency and reliability of information about the costs of providing healthcare services at every level. *Targeting Poor Health – Professor Townsend's Report of the Welsh Assembly's National Steering Group on the Allocation of NHS Resources*, October 2001.
- 86 GP Prescribing Statistics, Prescribing Management Services Wales; 1998 Welsh Health Survey; ONS (mid year estimates 2001);
- 87 For at least 25 years the cost of prescribing has been around 20 per cent higher per head in Wales than England, only half of which can be explained by demographic differences (including morbidity) *Why do residents of Wales receive more prescription medicines than do residents of England?* Alan Willson, 1999. The

cost per item prescribed is lower in Wales, but the overall cost is greater because more prescriptions per head are dispensed (15.9 compared with 11.8). Welsh residents are more likely to go to their GP, and having gone, are more likely to receive a prescription;

- 88 *Prescriptions by General Medical Practitioners*, National Assembly for Wales, October 2002
- 89 *Signposts - A practical guide to public and patient involvement in Wales*, Office for Public Management, National Assembly for Wales, 2001
- 90 WHC (91)47
- 91 *Dynamics of bed use in accommodating emergency admissions :stochastic simulation model* Bagust, A., Place, M. and Posnett, J. W., British Medical Journal, July 1999
- 92 Williams, 2002, op cit
- 93 *Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente*, Feecham et al, BMJ 2002; 324:135-143
- 94 *All Wales Mental Handicap Strategy*, Welsh Office, 1983
- 95 *An evaluation of the use of winter monies in Dyfed Powys Health Authority*, AJ Beddow, 1998.
- 96 Wanless, 2002, op cit, p23
- 97 *Time to be radical?* Edwards, B., Health Management, May 2003, p09
- 98 Wanless, 2002, op cit, p101-2
- 99 *Informing Health Care*, Welsh Assembly Government, 2002
- 100 *Potential of new ways of using technology needs to be considered*, Jardine, I, BMJ 2003; 326:599 (15 March)
- 101 *Reconfiguring health systems*, Black, A., BMJ 2002; 324 1290-293 (30 November)
- 102 *Central Governments in 2000: A Global Perspective*, Kettl, DF (2001): Paper prepared for Performance and Innovation Unit, Cabinet Office, London, 2001.