

Parliamentary Review of Health and Social Care in Wales

Interim Report



Mae'r ddogfen yma hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Interim Report, July 2017

In November 2016, Vaughan Gething AM, Cabinet Secretary for Health, Well-being and Sport announced, with cross party support, an independent review into the future of health and social care in Wales by an international panel of experts. This interim report sets out the case for change and initial findings. The final report and recommendations will be submitted to the Cabinet Secretary by the end of 2017.

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Foreword

The health and social care sectors are valued assets, offering reassurance to the people of Wales that they will receive care and support when they need it. Both sectors make a substantial contribution to improving people's well-being – on which a productive economy, social and community networks and vibrant cultural life depends. Both comprise a significant part of the Welsh economy as major employers and by generating business – for example, through scientific research and innovation activity. Welsh Government spending on health, well-being, and sport is £7.3bn, 48.4% of the overall resource budget, and social care comprises a significant element of local government funding.¹

Given their importance, it is right to review the progress of the health and social care sectors and systems and how they could be improved regularly. In November 2016 Vaughan Gething AM, Cabinet Secretary for Health, Well-being and Sport, announced with cross-party support, the establishment of an independent panel to undertake such a review and to report back by December 2017.

The review panel was asked to assess and make recommendations on how the health and care systems might deliver improved health and well-being outcomes for people across Wales, reduce existing inequalities between certain population groups, and best enable the whole health and social care system to be sustainable over the next five to ten years. The intention is for the findings of this review to inform the forthcoming NHS Wales strategy.

The Terms of Reference for the report are:

1. Define the key issues facing health and social care;
2. Identify where change is needed and the case for change;
3. Set out a vision for the future, including moving health and social care forward together and developing primary care services out of hospitals; and
4. Advise on how change can be delivered, building on the positive aspects of the current system.

The terms of reference for this review do not include analysis of alternative methods of financing the health and social care system, or question the overall range of services available to the population funded by the public sector. For the NHS, this means we have taken as given a tax-funded, free at the point of use to those eligible, comprehensive service, based on need and not ability to pay. For social care, we have assumed the current means-tested method of public financing, the current degree of private payment, and the thresholds for publicly funded care applied by local authorities. However, several stakeholders have suggested that funding arrangements for health and social care need to be considered.

Our remit has focused on the challenges to and the opportunities for improvement by the current services. Wales is not alone in the world in facing complex challenges to meet population needs and can exchange learning with other countries. This interim report defines the key issues facing health and social care as we see them and outlines our initial proposals for a way forward.

The fact that people are now living longer and healthier lives is one of society's great achievements. At the same time, there are persistent differences in health and well-being across society which we highlight. At various points in their lives everyone in Wales relies on health services, and social care is a critical service for people who become vulnerable for a wide range of reasons. These interdependent services can deliver good outcomes for people, and public and patient satisfaction with NHS Wales is relatively high. However, the growing demand for care in the face of modest economic growth means that health and care services must change and adapt to best meet need and help people achieve the outcomes they desire. As we will show, the health and care system is not sustainable into the future in its current form; change which delivers major improvement to services is urgently required much faster than in the past.

There are enormous assets in Wales which can be mobilised to achieve this. This report signals the direction of our thinking, sets out some practical action we want to take immediately with stakeholders, and points to areas we will explore further over the next six months before delivering a final report and recommendations to Welsh Government.

There have been many reviews into health and social care, and the people we interviewed were clear that they do not want another report that does not lead to prompt and tangible action.

This interim report therefore signals our thinking as to the overall strategy for the whole health and care system for discussion with Welsh Government and the Political Reference Group. It will be used to test our findings with service users, local service providers and stakeholders in health and social care, the third sector, and independent sector over the coming months.

Building on this dialogue, in our final report, we aim to list recommendations that command widespread support, are implementable, and give Wales the best chance of delivering the changes needed to achieve a quality driven, sustainable, whole health and social care system and services that the population rightfully expects.

We extend our sincere thanks to all the people and organisations we have heard from so far, via interviews, written submissions, web feedback, and workshops. These are listed in the annexes to this report. All have been generous with their ideas and commitment to change. We particularly appreciate the input from social care colleagues who have provided extensive information and advice.

We have grouped our findings into ten points and will be using these over the coming months to engage further to inform our final recommendations. We want to use the interim report to extend the discussion so that, together, we can inform the way forward for Wales.

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Parliamentary Review of Health and Social Care in Wales

Executive Summary

In November 2016, Vaughan Gething AM, Cabinet Secretary for Health, Well-being and Sport announced, with cross party support, an independent review into the future of health and social care in Wales by an international panel of experts. This is our interim report, which sets out the case for change and our initial findings. Our findings are grouped around ten key points which are highlighted below and expanded upon in this report. We will submit our final report and recommendations to the Cabinet Secretary by the end of 2017.

Ten Key Points

- 1** The case for change is compelling. Wales can attain better health and well-being outcomes for its citizens and meet the goals of the Well-being of Future Generations (Wales) Act 2015. But to do this it will need to speed up how the health and social care system adapts to the changing needs of the population and other major challenges.
- 2** Wales has very significant assets that can be used more effectively. A bold and unified vision for the whole health and social care system, underpinned by a clear strategy based on the relentless pursuit of continuous quality improvement and prevention, will be needed urgently to drive this forward.
- 3** The Social Services and Well-being (Wales) Act 2014 and Prudent Healthcare offer powerful sets of principles, which can apply equally to both the Welsh NHS and social care and have a high level of support. Widespread and comprehensive use of these principles will transform health and social care in Wales.
- 4** To translate the vision into concrete action, in the first instance a limited set of new models of care should be developed, trialled, evaluated, and scaled up rapidly. These should be developed and tested against clear standards, tailored to local circumstances and needs, and supported by a national learning programme and robust independent evaluation. A number of exemplars that can be built on already exist.

- 5** The people of Wales, staff, service users and carers should be encouraged to have far greater influence and involvement in the design, implementation, evaluation and subsequent development of new models of care and have clearer shared roles and responsibilities. The best results will come through active co-production.
- 6** New skills and career paths for the health and social care workforce need to be planned on a large scale now, aligned with the developing new models of care. Current workforce shortages which inhibit change need to be addressed. A more systematic and effective approach to continuous quality improvement is needed, and a culture that creates a supporting and engaging environment should be actively encouraged.
- 7** Effective new models of care are necessary, but not sufficient, to guarantee a health and social care system that is sustainable in future. Effort needs to be made to boost critical infrastructure to support new models and also drive higher quality and efficiency. Successful digital and infrastructure initiatives need to be systematically identified and spread better. Capital planning needs to be done in a way that supports new models of care. How the health and social care system supports and spreads innovation needs emphasis and more work. Data and information need to be made far more accessible and consistent to aid design and monitor the progress of change.
- 8** There is substantial consensus on the case for change but less clarity on how possible changes can best be developed, implemented and adapted. Progress has been made. But faster change is needed if the health and social care system is to be sustainable into the future. This needs stronger national direction and a better balance across the continuum of national direction and local autonomy in generating change. This must be supported by a more developed performance management approach, which holds people to account effectively but also encourages system-wide learning and is based on outcomes for citizens across the whole health and care system.
- 9** An effectively integrated health and social care system, which offers higher quality care for the people of Wales is an explicit aim. This requires the levers and incentives for change to be aligned and therefore to be acting in synergy. This means they must also be deployed across the whole system, not just one part of it.

10 Governance, finance, and accountability arrangements should be streamlined and aligned across health and social care. There are a number of leadership and cultural issues that need to be addressed, and resolved to enable more rapid and effective progress.

The Case for Change

1 The case for change is compelling. Wales can attain better health and well-being outcomes for its citizens and meet the goals of the Well-being of Future Generations (Wales) Act 2015. But to do this it will need to speed up how the health and social care system adapts to the changing needs of the population and other major challenges.

- The current health and social care system in Wales was developed to serve the needs of the post-war population. Over time these have changed and increased. At the same time, there have been significant advances in care and treatment; however, the challenge of a wide gap in health outcomes between different population groups remains.
- Wales has made good progress in developing its ambition for people to be healthier and in evolving its system of health and social care. There is strong support for, and pride in, the health and care system from the staff who work in it and the Welsh people. Whilst the purpose of this review is to take a step back to look at the challenges and opportunities that are presenting themselves, we also recognise that advances are being made in many areas.
- The changing make-up of the population presents a particular challenge. Wales has the largest and fastest growing proportion of older people in the UK. Strong intergenerational support can improve well-being amongst the population; however, an increasing older population will also lead to greater need for care. The demographic change has been underway for some time, and by 2039, there will be a further 44% more people aged over 65 compared to 2014. By 2035, the proportion of adults living with a limiting long-term condition is expected to increase by 22%.
- Whilst the number of children and young people in Wales will increase slightly up to 2039, it is a concern that there is expected to be a 5 per cent relative decrease of working age adults in this period. This will mean a potentially shrinking tax base, increasing pressure on this cohort as carers, and a smaller pool from which to draw the health and care workforce of the future.
- Across OECD countries for the last 20 years the costs of healthcare have outstripped growth in the economy and thus the tax base. Without effective action to reduce cost pressures, increase efficiency, or reduce the demand for services, NHS spending in Wales will need to rise by an average of 3.2% a year in real terms to 2030/31 to keep pace. Cost pressures for adult social care are projected to rise faster than for the NHS, by an average of 4.1% per year. Increasing effectiveness and efficiency is essential for future sustainability.

- Notwithstanding recent successes in recruiting to GP training places, there are acute shortages of staff in certain clinical fields. In many areas of Wales, the viability of the social care system is being put at risk by shortages of domiciliary and residential care staff. This is largely due to pay and conditions often being less competitive than low-skilled jobs in other industries that offer a more comfortable working environment. The uncertainty relating to how the UK will exit the European Union means that no easy assumptions can be made about drawing a health and care workforce from Europe and beyond.
- The scale of these challenges mean the system is becoming unstable, which cannot be resolved by incremental changes to the current models of care. This creates an urgent need for services to be reformed – including not just where care is delivered but how and by whom.
- An increasing number of frail elderly people are hospital inpatients, and there are problems in discharging patients back into the community because of a lack of primary, community, and social care capacity. There is a shortage of GPs, and their limited time is often absorbed with problems that could be better resolved by alternative support in the community and by colleagues from other professional and care groups - all aided by new technology. There is evidence that concentrating services together can improve the quality of some specialised forms of hospital care as expertise and equipment are utilised more effectively.
- Health and care is not always organised effectively around the needs of the service user. Not ‘joining up’ care can lead to numerous assessments and visits to different providers, delays in provision of services, poorer outcomes, and poorer levels of satisfaction for patients. It has long been recognised that the separation of health and social care services at the point of delivery creates problems, despite much good practice seen in co-ordinating care on the ground. Within the NHS greater integration is also needed – between primary and secondary care and for mental and physical health.
- A wider set of ‘social determinants’ – in particular poverty, poor education, and worklessness – have a bigger influence on the well-being of a population than direct provision of health or social care. Although the review has been asked only to look at the health and care system, it is evident that health and care organisations must work effectively with their partners to address the root causes of ill health; taking action expected under the requirements of the Well-being of Future Generations (Wales) Act, 2015.

Future Vision

2 Wales has very significant assets that can be used more effectively. A bold and unified vision for the whole health and social care system, underpinned by a clear strategy based on the relentless pursuit of continuous quality improvement and prevention, will be needed urgently to drive this forward.

- The pressures identified in the case for change mean the system has to adapt quickly to meet future needs. The challenges are not unique to Wales, but the extent of some of them here is greater. Given the huge assets in the country, Wales has the potential to be a global leader in confronting and managing these challenges well.
- To make progress, a strong vision of a new system is required. This must be translated into practical new models of integrated health and social care services that can be quickly developed on the ground. The vision should be underpinned by a relentless focus on quality, prevention, and efficiency, supported by technology and staff who have fulfilled and productive working lives. The scientific foundations for quality improvement to enable continuous adaptation of care to meet needs and best practice need to be much better understood, acted upon, and supported.
- There is a strong consensus amongst the stakeholders that we spoke to on the broad direction of travel towards the provision of seamless health and social care, focused on outcomes that matter to the individual. Key features of the health and care system to achieve this should include accessible proactive primary care; boosted preventative care; individuals supported to self-manage where possible and safe; and services provided on a home first basis or in the community where possible.
- We heard and saw good examples of efforts in Wales that are working towards this future vision. Many of the leaders involved are starting to implement change by developing models of care with other stakeholders and drawing from international examples. However, current practice seems to be 'let a thousand flowers bloom'. Whilst potentially supporting local innovation, this risks dissipating effort, making evaluation unnecessarily complex, adding difficulty to identifying 'the signal from the noise' and reducing effective learning across organisations.

3 The Social Services and Well-being (Wales) Act 2014 and Prudent Healthcare offer powerful sets of principles which can apply equally to both the Welsh NHS and social care and have a high level of support. Widespread and comprehensive use of these principles will transform health and social care in Wales.

- The Social Services and Well-being (Wales) Act 2014 applies to both health and social care. Its underpinnings, including individuals and professionals co-producing care, are similar to Prudent Healthcare and are a strong basis for citizen empowerment.
- Prudent Healthcare is a philosophy for the healthcare system that encompasses service improvements that benefit people and patients. The prudent approach sees healthcare as fitting the needs and circumstances of patients. It actively avoids wasteful care that is not to the patient's benefit and aims to rebalance the NHS in Wales to create a truly patient-centred system by remodelling service user and provider relationships based on co-production. It also implies a de-escalation of care, giving permission to develop and deliver services in a way which better meets people's needs.
- Whilst there is broad agreement that Prudent Healthcare should be the foundational principle of the NHS, more attention is required to put Prudent Healthcare into practice. This will help the NHS deliver its obligations under the Social Services and Well-being (Wales) Act 2014.

4 To translate the vision into concrete action: in the first instance a limited set of new models of care should be developed, trialled, evaluated and scaled up rapidly. These should be developed and tested against clear standards, tailored to local circumstances and needs, supported by a national learning programme and robust independent evaluation. A number of exemplars that can be built on already exist.

- To make faster progress towards the overall vision, Wales needs a clear, evidence-informed strategy for whole system models of health and social care and a practical transformation programme to achieve it.
- The next step for Wales is to identify the most promising broad models of whole health and social care services (locally and internationally) and adopt them or use their characteristics to develop a manageable set of new models of care for Wales. They should include a combination of primary care, hospital care, and community health and social care provision.

- The set should be developed with clear standards, which can be tailored to local circumstances and needs. The models require input from the public, staff, and health and social care organisations.
- The models should then be scaled up rapidly and adapted as necessary to be trialled, evaluated, and used to steer local and regional service plans, commissioning arrangements, and future investment. Rigorous formative and summative evaluation (including the context which best supports the models) and benchmarking against others should take place. Ineffective models should be stopped after robust and timely evaluation.
- Due to the growing impact of demographic changes, the initial focus should be on models that meet the needs of older people, before moving on to models which address other groups, most critically children and young people. Therefore, models which help to integrate health and social care support for older people must be a priority.

Capacity to Care

5 The people of Wales, staff, service users and carers should be encouraged to have far greater influence and involvement in the design, implementation, evaluation and subsequent development of new models of care; and clearer shared roles and responsibilities. The best results will come through active co-production.

- We heard repeated calls for a stronger public voice in all aspects of the health and care system. This included involving individuals in decisions about their care and supporting self-management as standard practice.
- Stakeholders emphasised the importance of dialogue with individuals and groups on how they can best play a part in influencing the design of services. Stakeholders also emphasised the need for a shared understanding of the challenges facing health and social care to be developed with the public.
- We repeatedly heard about the need to involve the public, staff, health and social care system and other sectors in a meaningful dialogue about the respective roles and responsibilities of services and individuals. Existing efforts to do this were valued, but thought to need significant strengthening.

6 New skills and career paths for the health and social care workforce need to be planned on a large scale now, aligned with the developing new models of care. Current workforce shortages which inhibit change need to be addressed. A more systematic and effective approach to continuous quality improvement is needed, and a culture that creates a supporting and engaging environment should be actively encouraged.

- The vital role that both unpaid carers and volunteers play in the health and care system is acknowledged, and we heard that informal carers should be included when planning and developing the workforce. This would relieve pressure on unpaid carers, making sure their views and needs are considered as part of the overall care team.
- We heard a call to move to integrated health and care workforce planning and multi-disciplinary training on a health board or regional footprint, based on population need and new models of care. Planning should be focused on the needs of the individual and deliver the 'right professional at the right time'. Sufficient carer capacity is required for home or community settings. Utilising allied health professionals, pharmacists, advance nurse practitioners and others to the maximum of their abilities, aided by technology, will help meet the demand in primary care, where all can operate at the full scope of their practice. In addition, the trend in healthcare of specialists growing at a faster rate than generalists must be rebalanced to meet the needs of the population.
- Recruitment to rural posts is an ongoing concern. New models of care should address specific rurality issues, not least access to care. Career structures in which staff can move with ease between health and social care are required. Flexible employment is needed to retain dedicated and trained staff in the health and care system. Stakeholders also identified the need to improve bilingual services to drive quality improvement in health and care.
- Central to establishing more effective models of high quality integrated health and care is effective leadership and management, including engagement with staff to improve morale, motivation, and retention. The quality and safety of care can be improved by creating a supportive and engaging environment.

7 Effective new models of care are necessary, but not sufficient, to guarantee a health and social care system that is sustainable in future. Effort needs to be made to boost critical infrastructure to support new models and also drive higher quality and efficiency. Successful digital and infrastructure initiatives need to be systematically identified and spread better. Capital planning needs to be done in a way that supports new models of care. How the health and social care system supports and spreads innovation needs emphasis and more work. Data and information need to be made far more accessible and consistent to aid design and monitor the progress of change.

- The opportunities offered by technology to improve the quality and efficiency of healthcare in particular were highlighted by many. Progress towards realising these opportunities must be accelerated. It is evident that digital transformation should be driven nationally within a clear framework, which allows for local innovation and progress. We agree with the emerging approach of developing mechanisms for fostering innovation across the board, identifying good practice, and replicating rapidly across the system.
- To realise the ambition of seamless, integrated care for both service users and professionals, an integrated IT infrastructure is required to facilitate the sharing of systems, data, and information. Respondents have criticised how patient and condition-specific data are difficult to share, link and transfer within NHS Wales and to other providers – pertinent as Wales aspires to the collaboration and co-ordination of care across a range of providers. For managerial and clinical staff, a prerequisite of seamless care is good data flows to provide the basis for decisions. For service users and their carers, stakeholders consistently called for a transformation in experience that could be brought about by faster, better exchange of data across providers and between providers and service users. While we received evidence of good initiatives, they were not widespread enough.
- In some areas, the quality of the health and care estate is inadequate for today's needs, let alone tomorrow's. Capital budgets have been under significant pressure. It is therefore imperative to maximise the use of resources that are available through effective capital planning, including joint planning with other public and third sector partners. In particular, we heard the importance aligning housing policy with approaches to care in view of the growing emphasis on care provided at home. It was apparent that single routes to accessing capital funding, where resources in Welsh Government are combined nationally and accessible using one process, would improve collaborative working on the ground.

Making Change Happen

8 There is substantial consensus on the case for change but less clarity on how changes can best be developed, implemented and adapted. Progress has been made. But faster change is needed if the health and social care system is to be sustainable into the future. This needs stronger national direction and a better balance across the continuum of national direction and local autonomy in generating change. This must be supported by a more developed performance management approach, which holds people to account effectively but also encourages system-wide learning and is based on outcomes for citizens across the whole health and care system.

- Many stakeholders agreed with the OECD conclusion that a stronger central overall guiding hand and greater accountability in the system are needed to drive meaningful improvement in the Welsh NHS. This includes a number of ‘Once for Wales’ decisions that would be beneficial to make at a national level and a clearer mechanism to enable leaders to transcend local interests.
- A unified national performance management framework and specific shared metrics for health and social care are needed to prompt and guide progress. This would move beyond measuring processes and targets, often centred on secondary care, to one which focuses on care outcomes and patient experience across the whole system, especially population health and care outside hospitals.
- While a stronger central ‘guiding hand’ is needed, a balance needs also to be struck with local autonomy: the balance is not yet right in Wales. The ability to plan and take decisions at both regional and local levels within nationally set priorities can facilitate innovation and encourage new ways of working to meet local population needs more rapidly. Empowering leadership and decision-making at the frontline is essential here.
- We heard calls to develop the current financial system and incentives in health and social care to prompt needed change. For example, to encourage integrated care across whole care pathways, stakeholders wanted resources to flow more easily between organisations. To encourage proactive population health, stakeholders were interested in exploring capitation financed models of care.
- Regulation was also identified as an area that could more effectively encourage speed of change, especially to improve quality and efficiency of care, and new models of integrated care.

9 An effectively integrated health and social care system, which offers higher quality care for the people of Wales is an explicit aim. This requires the levers and incentives for change to be aligned and therefore acting in synergy. This means they must also be deployed across the whole system, not just one part of it.

- Wales has seen useful developments over recent years via new legislation and the organisation of bodies responsible for delivering health and social care.
- However, change must be delivered more quickly and barriers to change overcome. At national level, the government needs to review the range of approaches it uses to encourage change in health and social care and consider their adequacy given the prime need to speed up change. These approaches include directive extrinsic levers on organisations to change in specified ways and those which are less directive, but support the intrinsic motivation of staff within organisations to do the right thing within a local framework. The near universal consensus from stakeholders that the speed of change was not fast enough at present implies that the balance of current approaches is suboptimal and can be improved upon. This will be a central consideration of our final report.

10 Governance, finance, and accountability arrangements should be streamlined and aligned across health and social care. There are a number of leadership and cultural issues that need to be addressed and resolved to enable more rapid and effective progress.

- If the principles set out for the health and social care system are to be realised, all leaders need to possess the skills we saw in some of Wales' best leaders: a willingness to take informed risks and an ability to work closely with other sectors. Overall, the health and social care system needs to boost skills among leaders to plan, drive and deliver the transformational change now needed.
- Many thought the systems they worked in were far too bureaucratic, and slowed needed change. It is now critical to streamline - clarify, simplify and unify - governance and accountability arrangements for health and social care.
- We were encouraged by the energy and drive we saw in initiatives largely operating outside of traditional governance structures, in particular in primary care clusters. How these will develop, and where they fit in existing

accountability and governance structures, needs to be clarified, without damping their potential.

Next Steps

- The scale and pace of the challenges facing Wales requires urgent and sustained effort in order to meet changing needs. In order to translate the overall vision into practical action, which improves quality and the efficiency of the health and social care system, we recommend as a first step that a set of integrated whole-system models of health and social care be identified for further development and evaluation.
- We will establish a stakeholder forum to work with the review panel to outline these new models and the principles that should be used to plan future service development. The forum should:
 - Draw membership from service users, NHS, local government, academia, professionals, third sector, and independent sector;
 - Outline a set of new models; and
 - Suggest how the models might be implemented effectively to allow faster change and what action is needed over the next two years to achieve this.
- We will also work on a range of further issues outlined above and detailed at the end of this report to develop more detailed recommendations in the final report.

We invite you to have your say. Have we identified the right issues and prospective solutions that will help Wales address the challenges ahead? What might we have missed so far? What matters to you in ensuring Wales will offer high quality, sustainable health and social care in the future?

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1. The Case for Change

The current health and social care system in Wales was developed to meet the needs of the post-war population. Over time these needs have increased, and along with advances in care and treatment, have added pressure to the existing delivery models in health and social care services. These are exacerbated by staff shortages, low morale in the workforce, and funding challenges. The system is becoming unstable, which creates an urgent need for services to be reformed. In this section, we outline these drivers for change and the pressure on the current models of care.

The Needs and Demands for Services

“Need will continue to grow in the medium term, affecting the least well off the most.”

Demographic Change

Wales has the largest and fastest growing proportion of older people in the UK.² By 2039, the number of older people over 65 years in Wales is projected to be 44% greater than 2014.³ In rural communities, 54% of people are aged over 45 years compared to 48% in small towns and 42% in large towns.⁴ Increased life expectancy is something to celebrate, and not only as a measure of human progress. Strong intergenerational links can improve the well-being of others in the population. Nevertheless, Wales must understand how to manage the impact of this success, which will further increase and change the need for services over the next twenty years, as more people suffer ill health, including dementia. 86% of people aged 85 years and over report health problems that limit them a little or a lot.⁵

Wales can also look forward to an increase in the number of children and young people in the population up to 2039, although this will be a smaller increase than that expected for older people.⁶ However, a 5% decrease of working age adults is expected in this period. This means the tax base may shrink, there will be increased pressure on this cohort as carers, and there will be a smaller pool from which to draw the health and care workforce of the future⁷. These changes are an important part of the case to reshape health and care over the next twenty years.

Risk Factors, Illness, and Need for Care

Risk Factors

There is now compelling evidence that a wider set of factors, namely ‘social determinants’, have a bigger influence on the health and well-being of a population than direct provision of health or social care.⁸ Social determinants include poverty, poor education, and worklessness as well as social exclusion. Economically disadvantaged groups have a higher prevalence of social harms, illness, and early death. In Wales, the least socioeconomically deprived population groups have 18 to 19 more healthy years of life than the most deprived.⁹ Measures of individuals’ well-

being also show differences across populations according to socio-economic deprivation.¹⁰ Inequalities in health arising from these ‘social determinants’ have been estimated to cost Wales £3-4 billion per year through additional illness, productivity losses, lost taxes and welfare funding.¹¹

While there has been action in Wales to tackle these social determinants of health, as across the UK, there is still a lot of progress to be made. 23.2% of working age adults in Wales are economically inactive, compared to 21.5% across the UK.¹² Likewise, Wales has one of the highest rates of out-of-work benefit claimants in Great Britain, with 11.4 per cent of the population claiming, compared to 8.6 per cent of the British population.¹³ Almost one in three children in Wales lives in relative poverty – the highest proportion in the UK – posing a risk to children’s health and development. The highest number of children since data collection began in 2002 report being bullied.¹⁴

Adverse childhood experiences (ACEs) (such as domestic or sexual abuse and violence) can lead to poor development and poorer life chances. In Wales, one in every seven adults aged 18-69 years had experienced four or more ACEs during their childhood.¹⁵ While people living in areas of deprivation do not experience ACEs exclusively, individuals living there are at greater risk.

Healthcare inequalities do not just occur amongst economically disadvantaged groups. Certain BME groups have higher rates of some health conditions. For example, people in Wales from South Asian and Caribbean-descended populations have a substantially higher risk of diabetes. For people with learning disabilities too, health inequalities potentially arise because of increased risk from genetic and biological factors, social determinants, poor health literacy, personal health risks, and difficulty in accessing services.

Across Wales life expectancy is slowly increasing, mortality rate in the under-fives is decreasing, and people are staying healthy for longer. But while life expectancy has been increasing, there isn’t clear evidence that healthy life expectancy is increasing at the same rate.¹⁶ The risk factors driving death and disability in the population are relatively unchanging: smoking; poor diet; high blood pressure; obesity; alcohol and drug misuse; and lack of exercise. However, many of these are amenable to change with greater action.

There has been good progress on some of the lifestyle and behavioural changes that help to reduce premature deaths from conditions such as heart disease, cancer, and stroke. For example, fewer children are showing unhealthy lifestyle behaviours. Between 2010 and 2014 the number of children drinking on a weekly basis and smoking tobacco fell significantly; the number of children smoking cannabis also decreased.¹⁷ Smoking rates in Wales have decreased to 19% and are projected to decrease to 15% by 2025, though this is still higher than the best achieved in other European countries.¹⁸

Notwithstanding this, not all indicators of a healthy lifestyle are on an improving trend. Smoking rates in the most disadvantaged populations in Wales are 28%, over three times those of the least disadvantaged populations at 9%.¹⁹ There is also a

very high proportion of people who are overweight (59%) and physically inactive (32%).²⁰ Obesity has been estimated as costing NHS Wales £73 million a year.²¹ Levels of fruit and vegetable consumption have fallen.²²

Illness and Need

The pattern of ill health across Wales is very similar to that across the UK as a whole, and has little changed over the last ten years²³. The conditions causing the most premature death are: ischaemic heart disease; lung cancer; cerebrovascular disease; chronic obstructive pulmonary disease; lower respiratory infections; Alzheimer's disease; colorectal cancer; breast cancer and self-harm. Those causing the most disability are: low back and neck pain; sense organ diseases; depression; asthma; skin diseases; and migraine. Preventable illness is still widespread, and is a key cause of lost lives, lost quality of life and lost economic productivity in Wales.

The prevalence of multiple chronic conditions is rising in Wales. There was an increase in the number of new cancer cases of 10% over the ten years to 2015.²⁴ Wales has the highest rates of long-term limiting illness of the four nations in the UK.²⁵ This is in part because chronic illnesses increase with age, but it must be emphasised that there is growth across all age groups.

By 2035, the proportion of adults living with a limiting long-term condition is expected to increase by 22%, with the greatest increases in stroke (33%) and heart conditions (31%).²⁶ Assuming dementia prevalence rates remain as they are, there is projected to be a 30% increase in the number of people with dementia between 2015 and 2025, with some age groups increasing by more than 50%.²⁷ And between 2016 and 2035 there is predicted to be an increase of 8% in people with common mental ill health disorders aged 16 and over.²⁸ All of these factors are leading to an increase in demand for both health and social care services.

Medical advances have turned many life-threatening conditions, including premature birth, into long-term conditions as more people survive acute episodes of illness and live many years with their conditions. It is notable that there has been a 44% fall in the burden of disease due to cardiovascular disease over the last 15 years.²⁹ Although there is a paucity of data and evidence in relation to the prevalence of mental health issues in Wales, there has been an increasing trend of adults reporting being treated for mental illness, estimated to cost at least £7.2 billion per year in Wales.³⁰ Research from the UK found people with severe and enduring mental health problems die on average 10 years earlier than the general population.³¹

The health and well-being of children is changing for the better in some regards but is also facing new challenges. There has been a positive trend of children with learning disabilities living longer. The health and care services will need to adapt to a 10% increase in people with a learning difficulty in the UK in 2020 than in 2008.³² These individuals need complex support for many more years, and their carers need support. There are worrying trends in terms of young peoples' mental health and emotional well-being. There was a 75% increase in referrals for child and adolescent psychiatry between October 2013 and October 2016, including referrals

to Children and Adolescent Mental Health Services (CAMHS), though there may be complex reasons for this trend.³³ Moreover, there is variation between health boards, with some children and young people waiting a considerable amount of time for appointments, which are not always appropriate for their needs.

Social Factors

People's expectations of services offered by health and social care are changing, in part driven by factors outside the care system. More people use online services for help, information, and consultation and are accustomed to a rapid response from some online-facing services. This contrasts with some experiences in the NHS; for example, according to the National Survey for Wales, 39% patients find it difficult to make a convenient GP appointment.³⁴ Much has been written about the decline in deference to the authority of professionals and the expectation of the public for information about their care and dialogue as equal partners in care.

The changing patterns of work, community, and family will have complex ramifications for services. For example, we are seeing recently retired people playing important roles in the care and support of their older parents, as well as caring for grandchildren, and there are many children and young people taking on crucial care and support responsibilities for siblings or parents. For others, loneliness is recognised as an important factor leading to poor health and well-being.

A Sustainable Workforce

“The health and care system will need to be staffed differently.”

A major challenge for the health and care system is the number of available staff now and in the future. 218,000 people are employed in the health and care system, 15% of employment in Wales.³⁵

There are acute shortages of staff in certain clinical fields, including higher paediatrics and acute medicine, especially in rural areas. In 2016, 14% of medical and dental trainee places were not filled.³⁶ Shortfalls in NHS staff make it very difficult to maintain safe medical rotas, leaving services vulnerable, with poorer outcomes for patients and at higher cost to the NHS. Although the number of nurses in Wales stands at a record high of 29,000, Wales suffers from recruitment challenges similar to those faced around the world. 69% of nurses work overtime at least once a week.³⁷

GP recruitment problems are putting great strain on practices. The pattern of disease in Wales has increased the workload in General Practice, yet the number of GPs remained static between 2010 and 2015.³⁸ Although the number of junior doctors training as GPs increased by 16% this year following a recruitment drive, there is still an overall shortfall against growing demand.³⁹

Retention is also a challenge, with the Welsh NHS due to lose some of its most experienced members of staff over the next ten years through retirement. This is disproportionate compared to previous years because of the increasing age profile

of the workforce.⁴⁰ Wales has the second oldest GP population of any UK country, with 22% of GPs aged 55+.⁴¹

In many areas of Wales, the viability of the social care system is being put at risk by staff shortages, especially of domiciliary and residential care staff. Recruitment is challenging, with pay and conditions often less competitive than jobs in other industries that require less complex skills and offer a more comfortable working environment.

The uncertainty relating to how the UK will exit the European Union means that no assumptions can be made about drawing a health and care workforce from Europe. Currently around 6% of people working within the Welsh NHS and 7% of people working in the UK social care system are EU nationals.⁴² In the last 12 months, there has been a sharp decline in nurses from the EU applying to register in the UK.

Dealing with the challenges set out so far will require a skilled and motivated health and care workforce - in the most recent NHS Wales Staff survey, 71% of staff said they are satisfied with their present job. However, 48% said they cannot meet all the conflicting demands on their time. Just 30% said there are enough staff for them to do their job properly.⁴³ In social care, 11% say they want to leave their job, although this compares favourably with the 17% working in social care across the UK as a whole⁴⁴

Sickness absence, often associated with low staff engagement, is higher in the Welsh NHS than the average in both the Welsh labour market and the NHS in England.⁴⁵ Meanwhile 28% of staff in the Welsh NHS say they have been injured or felt unwell as a result of work-related stress in the previous 12 months, and 15% have experienced harassment, bullying or abuse.⁴⁶

Addressing the above is a very complex task. What is clear is that the methods used to plan staff numbers for the medium term and strategies for retention in the short term need to be reviewed and strengthened.

Funding and Efficiency

“Services have made improvements but could be more efficient.”

Across OECD countries for the last 20 years the costs of healthcare have outstripped growth in gross domestic product (GDP). Without effective action to reduce cost pressures, increase efficiency or reduce the demand for services, NHS spending in Wales will need to rise by an average of 3.2% a year in real terms to 2030/31 to keep pace with demographic and cost pressures, the rising prevalence of chronic disease, and changes in the expectations of the public about the role they play in maintain their own health and well-being.⁴⁷ Advances in medical knowledge and technology have been the main reason for raised costs in the health services.

Cost pressures for adult social care are projected to rise faster than for the NHS, by an average of 4.1% per year.⁴⁸ At the same time, UK GDP is projected to increase by 2% (2017), 1.6% (2018) rising to 2% in 2021⁴⁹ – projections which are uncertain

not least given the UK's exit from the EU.⁵⁰ Across the wider economy, productivity has been lacklustre since 2008 and is 20% lower than the UK average in Wales.⁵¹

The Welsh government's 2017/18 Main Expenditure Group (MEG) budget for Health, Well-being and Sport is £7.3bn, representing 2.3% real growth on 2016/17.⁵² This followed an 8.2% real terms reduction in funds available for day-to-day spending in Wales on health and social care between 2009-10 and 2015-16.⁵³ At national level the 'gap' between the projected resources (if current trends apply) and cost pressures is £2.5bn by 2030/31.⁵⁴

Some of the gap could be narrowed if the health and social care system could become more efficient and productive. Productivity compares how the quantity and quality of care provided has changed compared to the inputs (e.g. staff medicines and equipment). Efficiency takes into account the costs as well as the volume of inputs used to deliver care. In the UK, as a whole, the NHS has achieved efficiency growth of an average of 1% a year in real terms since 1997 – this is an estimation given the known limitations of current measures of efficiency for healthcare.⁵⁵ If this trend continues in the NHS in Wales, then an average real increase in spending of 2.2% will be needed to 2030/31 just to maintain current standards of care.⁵⁶ For social care, ONS figures show an average fall in productivity by 1.5% a year, although, unlike the figures for healthcare, productivity for social care is not adjusted for quality.⁵⁷

If the quality or amount of care provided is not to deteriorate given the funding likely to be available, there needs to be a serious and unrelenting focus on improving the efficiency and productivity of healthcare in particular. This means policies and initiatives which curb cost growth, reduce costs and waste and/or increase the outputs used by labour or capital. For example, more effective public health, preventive care, self-management, and primary, community, and social care would reduce the need for expensive hospital care.

In this report, we identify some of the many initiatives in Wales which are active in these areas. These approaches need to be stepped up significantly to meet the challenges ahead.

We are also clear that greater efficiency of care is not enough in itself. Professional and public expectations will need to be redefined about what makes great health and social care. Good health and well-being will need to be promoted for all citizens, ensuring systems are geared towards independence; actively promote self-care; intervene quickly and proportionately when needed; and reduce the need for complex, chronic or substitute care. Best use of community resources will be essential to ensure that the number of people who need, for example, acute, residential, ongoing nursing, and safeguarding services are minimised. Services need to be both efficient and most effective. It is essential that other public services are recognised as key building blocks for sustainable whole health and care systems.

Outcomes and Performance

“Quality is improving but could be better and improve at a faster pace.”

It is important to note that public satisfaction with NHS Wales’ services is high: in 2016-17, 90% were satisfied with care from their GP and 91% were satisfied with the care at an NHS hospital.⁵⁸ Results are lower in social care: 70% of social care users rated the service as either excellent or good.⁵⁹ Notwithstanding this, the recent CSSIW report into domiciliary care found that most people, most of the time, are happy with and appreciate the care they receive.⁶⁰ This is an achievement for a sector that provides more than 14 million hours a year of care in Wales.

For NHS care, trends show steady service improvements in many areas at a similar rate to the other home nations.⁶¹ For example, cancer survival rates are improving overall and fewer people are dying from heart disease. In 2015, 9,000 people died from cardiovascular disease, down from just over 12,000 in 2005.⁶²

Yet there is clear scope for improvement in reducing avoidable mortality, improving cancer survival, and reducing hospital admissions due to chronic obstructive pulmonary disease (COPD). From an international perspective, recent figures show that the healthcare system across the UK as a whole scores relatively poorly with respect to preventing death from conditions amenable to healthcare.⁶³ And for the top ten causes of premature mortality in Wales, the years of life lost per 100,000 population are higher in Wales for every condition relative to England, although on an improving trend.⁶⁴ Avoidable mortality rates in Wales are 16% higher than in England, with 256 deaths per 100,000 population. Comprising deaths that could have been prevented through public health interventions or treated through good quality healthcare, avoidable mortality rates are on an increasing trend, driven by increases in the mortality rates for respiratory illnesses.⁶⁵

Survival rates for breast cancer in the UK overall are below the EU average.⁶⁶ In Wales, lung cancer survival rates are lower than the UK average too – the five-year survival rate is only 6.5%.⁶⁷ UK hospital admissions for chronic respiratory problems (COPD) are well above the EU average (212.7 per 100,000 population compared to 180.6 per 100,000).⁶⁸

Given the specific issues of poverty and unemployment which exist in Wales, developing a better understanding of mental health and its impacts is key to improving access to healthcare. The Together for Mental Health strategy appears to have made progress in improving access to therapeutic interventions services at a primary care level.⁶⁹ However, at this point in time there is no up to date financial, economic or clinical analysis for how well the current shape of services is meeting demand, particularly for secondary care, or how well equipped it is to meet future needs.

While waiting times for NHS care are very important to the public, they are a small measure of the quality of care in the health system. But it is clear that waiting times targets in the NHS in Wales are not being achieved, as in other areas of the UK. The

number of patients seen within 26 weeks of referral has decreased over the past five years, although there has been improvement in the most recent few months.⁷⁰ In the first quarter of 2017, none of the health boards met waiting time targets for urgent cancer treatment and only three met targets for non-urgent treatment.⁷¹ The high-occupancy rate in hospitals was part of the reason the four-hour A&E waiting time target was met on 83.1% of occasions in May 2017.⁷² There is ample evidence across the UK health services that there are wide variations in clinical practice and service performance, which are unexplained.

Notwithstanding this, some services are showing improvement. May 2017 ambulance response times were the best since Welsh Government introduced a new target in October 2015.⁷³

In 2015-16, only 85% of adult social services met standards of care.⁷⁴ The Older People's Commissioner found quality of care to vary unacceptably and concluded some care homes focus too much on the functional aspects of care, failing to deliver person-centred care.

The Organisation of Services

“There is a mismatch between the needs of the population and the delivery of services. The health and care system is fragile.”

The current pattern of services has deep historic roots. The NHS was designed in 1948 for people with different illnesses, with limited treatment options. Significantly, there were fewer frail older people with multiple comorbidities. Local authorities led the development of the social care system but the public, private, and voluntary sectors have delivered it. It has focused on meeting the care, support and safeguarding needs of the population.

What we have heard, and has been amply recognised in previous reviews, is that the way in which health and care is delivered has not changed that much, even where healthcare treatments and social care interventions have changed beyond recognition. It is this model of care that needs to change in the light of life today – this means not just where care is delivered but how and by whom.

Primary Care and Community Services

Primary care is under severe pressure across the UK, in part due to an increase in demand and a shortage of GPs, as well as a changing clinical practice.

In the short term, there are options to increase the funding of primary and community care and boost the number of GPs, but these are not likely to be sustainable, and additional measures will be required to close the gap between need and capacity. As other reviews and policies have highlighted, the route ahead must include the following ingredients:

- Greater telephone and online access to advice and care for patients;

- Expanded roles for other professional care groups, particularly in the care of people with known chronic or simple conditions;
- Advice and support to patients to build confidence to self-care where appropriate;
- Better care co-ordination and integration for people with multiple health and social needs;
- Early and proportionate assessment and support for people to promote well-being and reduce the need for complex packages of care;
- New technologies to improve self-management and for remote monitoring;
- Better use of data to identify and support those most needing health or care support.

This is not only the direction of care across the UK, but is the aspiration in almost all developed countries with evidence to back it up.⁷⁵

At present in Wales, as across the UK, General Practices are usually relatively small enterprises. To make serious progress, the infrastructure supporting General Practices will need to be scaled up significantly, including IT and management, while maintaining the much-valued microenvironment and continuity of care provided. This is a significant and complex agenda to design and implement and will need investment. General Practices are a lynchpin of community-based healthcare and progress here is crucial.

Without progress, the pressures will mount. Many appointments in General Practice are taken up by people with social or low-level mental health problems, contributing to high levels of anti-depressant prescribing.⁷⁶ Other approaches to support patients in the community might be far more effective. Across Wales people reported to us there are still too many GPs doing tasks that could be done just as well by other healthcare professionals with enabling technology. The short appointment times with GPs militates against co-production. Similarly, there are still too many patients in acute hospitals whose health and care needs could have been anticipated and be better met by more extensive primary and community services.

The challenges facing GPs apply more widely to the whole primary and community health sectors and make it hard to provide continuity of care. Yet the evidence shows that patients who experience good continuity of care are more likely to have their problems recognised, have their needs met in an appropriate way, and have fewer diagnostic tests, prescriptions and hospitalisations. We heard that there could be more co-ordination between dentists, pharmacists, optometrists, and GPs to make best use of their skills.

NHS community services have historically also received lower growth in investment and lower scrutiny relative to the hospital sector (in part due to limited data being

available on the level of quality and costs of care). They have too often been the poor relation of other services, yet this area is particularly ripe for development. Patterns of illness and disability mean that more people with predictable needs will need to be cared for in the community. Community services can have an important role in co-ordinating care for patients and liaising with other sectors, in particular to avert the need for admission to hospital and to ease earlier discharge of patients from hospital. There is also ample evidence that the majority of people prefer to die at home rather than in a hospital; yet in 2015 only a quarter died while being cared for at home.⁷⁷

Equally, the much called for increased focus on prevention and early intervention can best be achieved through support from services that are close to citizens. Prevention and early intervention are important issues in their own right. Achieving both means a greater emphasis on well-being and applying the Prudent Healthcare principle of shared responsibility. Public Health Wales' report, 'Making a Difference', sets out key areas for action.⁷⁸

Whilst the wider social determinants of health are not a focus of our terms of reference, we are clear that the key to sustainable health and care services is in large part better population health. Health boards in Wales have a population health remit, and this opportunity to address the social determinants of health requires more attention. Much of what can be done to support a healthier and more active population sits outside the health and care system. Health and well-being at work, the promotion of healthy behaviours through schools, colleges and universities and building resilience across all these settings require concerted cross-government action.

Hospital Services

The district general hospital model evolved in the twentieth century to provide care for people with acute problems, in particular infectious diseases. Hospitals now face an increasing number of frail older inpatients admitted as emergencies with acute problems but with underlying multiple chronic conditions, not least dementia. Average bed occupancy in Wales in 2015/16 was 86.9%, the highest recorded level to date.⁷⁹ This figure is higher than the OECD average but lower than countries such as Norway and Canada.⁸⁰ There are problems, similar to those throughout the UK NHS, in discharging patients back into the community because of insufficient primary, community, and social care capacity.

Hospital stays are not optimal for frail older people and can cause harm. Many hospitals are not 'dementia friendly', leading to avoidable distress and further ill health. Every day in hospital reduces the muscle function of older people by 5%.⁸¹ A knock-on problem is that there is suboptimal capacity in hospitals to treat patients waiting for planned care, with the concomitant rise in waiting times: 34,000 operations were cancelled in Wales in 2015-16 due to non-clinical reasons.⁸²

While admissions to hospital have been rising, the number of hospital beds has reduced by 25% in the first 15 years of this century, and the average time people

stay in hospital during an admission has reduced from 8 days to just under 7 in the ten years to 2015/16.⁸³ There have been attempts, with mixed results to date, to improve the flow of patients through hospitals by training staff in quality improvement techniques; for example with the Wales 1000 Lives Improvement programme.⁸⁴ As we have heard in the review, to date there have been many important initiatives to improve efficiency.

Having a smaller number of larger facilities for some specialised forms of care, which are concentrated together so that expertise and equipment are utilised more effectively, is also a way to improve quality of care. The evidence is strongest for stroke, trauma, and heart attack services, even if this means patients travelling further to receive care. In London, the development of eight hyper-acute stroke units in 2010 led to 168 fewer deaths over a 21-month period.⁸⁵

Despite some developments, there is still a long way to go. In particular, there is clearly not enough co-ordination of care for patients between hospitals and other sectors, such as primary, community and social care, and suboptimal communication between staff and sharing of information. Hospitals need to reshape their approach to meet the changing needs of the population, to deploy their workforce effectively, and to be supported to do so to be sustainable in the long run. This has been well known for some time. There is some progress but it is slower than is needed.

Social Care

Social care is very important to support vulnerable individuals, particularly in old age, to live independently in their own homes or with their families for as long as possible. While residential and nursing homes do provide great security, they can reduce self-reliance, separate people from their families and communities, and are expensive. Decreasing the reliance on care homes is particularly relevant in areas of Wales with a low population density, where care homes' wide catchment areas can mean individuals are geographically distant from their families and communities. The Welsh Audit Office found that access to alternatives to residential care, such as extra care housing, sheltered housing, and housing based support services has reduced recently, and construction of extra care housing is not keeping up with the projected demand.⁸⁶

Social care services are under substantial pressure at present, because of a large demand for local authority funded care, a squeeze on funding, and a shortfall in staff available. People are expected to contribute to the cost of social care, based on an assessment of their financial means. For non-residential (domiciliary) care the cost to the individual is capped at £70 a week. For residential care, individuals with capital assets of £30,000 or more do not qualify for local council funded care.

Demand for care is predicted to grow further in the future. The number of over 65s needing local authority funded domiciliary care or residential or nursing homes is predicted to rise by 47% and 57% respectively between 2013 and 2030.⁸⁷ As local authorities are increasingly unable to meet demands for care, more people in Wales

are responsible for arranging for their own care. Approximately 51% of care home beds are filled by local authority placements.⁸⁸ Those with assets over £30,000 pay for care privately.

The majority of care homes, and domiciliary services in Wales are provided by the independent sector.⁸⁹ Small home care firms are currently facing severe pressures as the fees paid by local authorities for those people who qualify for funding support struggle to keep pace with wage rates and other business costs. This is leading to challenges recruiting and retaining staff. This all risks business failure: 13 of Wales' 22 (59%) local authorities have reported that they have had domiciliary care contracts handed back to them by the independent sector, compared to a UK average of 48%.⁹⁰

Similarly, the number of looked after children has increased in the past five years (although the figures have been stable for the last three years), with a number of those children displaying complex and difficult behaviours at a young age.⁹¹ Provision of residential care for children with complex needs is expensive. There is concern in the sector about the ability to recruit sufficient and skilled foster carers.

The emotional well-being of young people was also raised to us as a concern. We heard that steps have been taken to address the waiting times for Child and Adolescent Mental Health Services, but that provision across Wales is variable. We also heard that there is a tendency for early intervention and preventative youth work to be based on short-term funding, which presents a risk to good quality sustainable provision by qualified and motivated staff.

Integrating Services

“Care is not always organised effectively around the needs of the user”

It has long been recognised that the separation of health and social care services creates problems despite the best efforts to co-ordinate care on the ground. Within the NHS, greater integration is needed – between primary and secondary care and mental and physical health. In social care, transitions for young people between child and adult services are not centred on the individual as much as they could be.

Uncoordinated care is known to be poor quality and inefficient. Not joining up care can lead to numerous assessments and visits to different providers, delays in provision of services, poorer outcomes, and poorer levels of satisfaction for patients. It can result in multiple trips to hospitals for tests, diagnostics and treatment, or different professionals advocating different solutions to an individual's problem. The fragmentation of services is a key contributor to increasing emergency admissions and delayed transfers of care.

It is clear that suboptimal preventative care and treatment in the community increases the risk of emergency admission, particularly for people with frailty and multiple chronic conditions. Seamless integration between all parts of the system was described as the exception, not the rule. We are also aware of instances where

low-level preventative services sometimes accelerate a person's need for care if they are not effectively targeted or addressed with sufficient skill or intensity. Greater efforts to support high-risk individuals in residential and nursing homes has been a feature of some integrated models across the UK and internationally. Similarly, there are many examples across the UK of stronger links between the health and social care services and other public services such as housing and education to meet needs effectively and prevent the unnecessary use of care services.

There has been progress in reducing the delays patients experience between being ready to leave hospital, and actual discharge. Nevertheless, many frail older people are left at risk of harm by waiting in hospital for care and support in the community. Although the NHS is the main cause of the number of delays, community care accounted for around a quarter of delayed transfers on average in 2016.⁹² Again, another focus of initiatives in Wales and elsewhere in the UK has been hospital-led 'discharge to assess' schemes, boosted integrated community support, and incentives for hospitals to design and implement safer and faster discharge. There is still a lot of work to be done and faster progress needed.

2. Future Vision

The pressures explored in the case for change mean Wales will have to adapt quickly to meet future needs. Whilst the challenges faced in Wales are replicated all over the world, Wales is at the forefront of changes in demand due to its changing population and pattern of ill health. This gives Wales the opportunity to adapt services with service users and potential to become a global leader. The Well-being of Future Generations (Wales) Act 2015 provides a strong integrated framework for public services to address current and future needs.⁹³ To make progress, a strong vision of a new system is required, which is translated into transformation on the ground through practical new models of care. In this section, we look at what this vision may be and the progress Wales is making towards new models of care.

It is not in our remit to look at future funding; instead, we focus on practical steps to develop sustainable services over the medium term. To do this, Wales requires models of care that are more effective and efficient and support people to be more involved in their own care.

Future Shape of Care

There was a remarkable degree of consensus amongst the stakeholders we spoke to on the case for change. There was equally as much agreement on the broad direction of change and the change needed in specific areas.

There was consensus on the overarching principles shaping both the health and social care sectors. Most often referred to were the Social Services and Well-being (Wales) Act 2014 and Prudent Healthcare, not least as the underlying imperative for organisations to collaborate to coordinate care for patients more effectively.⁹⁴ It was clear that representatives of both health and social care believed a seamless health and care service is the desired direction of travel; indeed, it is a longstanding Welsh Government objective and will have a significant impact on those who use both sectors. Although each Local Health Board had different local priorities, there was broad agreement that future models of care must also address new approaches involving people, processes, and technology.

The features of the future shape of care include the following:

- Universal primary health services with a proactive approach to preventative care – improving population health.
- Individuals to be supported to self-manage where possible and safe.
- Greater access from care providers to online support, which includes information, consultation, communication, comparisons of quality, appointment bookings, and test results.
- Services provided at home or in the community in the first instance wherever possible. Hospital service restricted to assessment and treatment that only a hospital facility can provide. A more flexible model of home-

based care and support, which enables the individual to have control over when and for how long they use a service.

- Seamless co-ordination between different types of care; for example, primary and secondary care, health and social care, and mental and physical health.
- A care culture orientated towards the outcomes the citizen wants and can achieve: 'what matters to me'.
- A relentless focus on quality and efficiency. Services should be more efficiently run and represent good value (quality for the cost).
- Staff should have fulfilled and productive working lives and work towards continuous quality improvement.

New technology can enhance and shared data and analytics can inform all the above. For example, social services can support people to live in their own home via telecare. Data analytics of routine NHS data can help to identify high-risk patients who should be a priority for targeted support. Integrated electronic records can help streamline the provision of care for citizens across care boundaries and give them more control through direct access to their information.

Many policies and initiatives have already described these and many more features we heard, and to an extent, they are already being implemented. Wales is well served with legislation and national health and social care policies, including:

- The Well-being of Future Generations Act 2015;
- The Social Services and Well-being (Wales) Act 2014; and
- The Nurse Staffing Levels (Wales) Act 2016).Taking Wales Forward;
- Prudent Healthcare;
- Our Plan for Primary Care Service in Wales up to March 2018;
- Informed Health and Care: A Digital Health and Social Care Strategy for Wales;
- Strategic outline programmes (SOP); and
- Integrated medium term plans (IMTP).⁹⁵

Local authorities have a clear shared agenda, partly due to the clarity provided by the Social Services and Well-being (Wales) Act 2014.

Policies have helped to establish an approach to quality improvement in Wales that provides the basis of a future vision. The Social Services and Well-being (Wales) Act 2014 applies to both local authorities and NHS Wales, requiring both to arrange the right preventative services; give people an equal say in the support they receive;

and require assessments to be carried out in the best way to meet an individual's needs. Prudent Healthcare supports this by providing a model that encompasses the majority of the dimensions of quality set out by the Institute of Medicine and meets the Institute for Healthcare Improvement's Triple Aim.⁹⁶ We see capacity here for the themes to be integrated to cover health, care and well-being.

We believe the Prudent Healthcare approach is the right one for Wales, a view that stakeholders shared. Whilst we heard frequent references to Prudent Healthcare, more action is required to align it with the principles of the Social Services and Well-being (Wales) Act 2014 and put Prudent Healthcare into practice.

Prudent Healthcare

The essence of Prudent Healthcare is four principles set out by the Bevan Commission, which are:

- Achieve health and well-being with the public, patients and professionals as equal partners through co-production;
- Care for those with the greatest health need first, making the most effective use of all skills and resources;
- Do only what is needed, no more, no less; and do no harm.
- Reduce inappropriate variation using evidence based practices consistently and transparently.

When published by Welsh Government, these principles were associated with a commitment to rebalance the healthcare system by strengthening primary and community-based care. They support an equal partnership between patients and professionals and aim to change the relationship between healthcare services and the public, forming a shared responsibility for securing improved health outcomes.

It is a philosophy for the whole healthcare system, which encompasses all service improvements that benefit people and patients. Through placing greater value on patient outcomes than the volume of activity and procedures delivered, as we currently do, Prudent Healthcare aims to create a patient-centred system. An NHS based on Prudent Healthcare principles would ensure patients receive the most appropriate treatments to achieve mutually agreed goals.

Prudent Healthcare encompasses the idea of 'quality' as the degree of concordance between work and its results, on the one hand, and the need that work is intended to meet, on the other. When work matches need, quality is high; when work fails to match need quality is, to that extent, defective. This is a dynamic goal, which means the quest for quality is never ending. It is not a matter of compliance and ticking boxes; it is a matter of continual learning and adjustment as knowledge grows, contexts vary, and needs evolve.

What is missing is a shared understanding of how transformational change is delivered in practice. Policies are too often long on the ‘what’ and short or silent on the ‘how’. For example, the roadmap for improvement across the whole of the mental healthcare system is not clear. There are many examples of interesting developments across Wales, but practice currently seems to be to ‘let a thousand flowers bloom’. Whilst potentially supporting local innovation, this risks dissipating effort, making evaluation unnecessarily complex, reducing effective learning across sites, and making it more difficult to spot the ‘signal from the noise’. Neither, as we heard, is it appropriate or desirable for a one size fits all model to be imposed on different localities.

Our view is that the first tangible step on this journey should be the establishment of a bold and unified vision for the whole health and social care system, underpinned by a clear evidence-based strategy based on the relentless pursuit of continuous quality improvement and prevention. They should focus on how changes can be delivered fast, learning from past experience and trusting models used elsewhere.

Making Progress

Wales has considerable assets that could be leveraged to change the system faster and achieve commonly shared principles. Clearly, there is significant political consensus and support for the NHS and social care. The Social Services and Well-being (Wales) Act 2014, for example, builds in a focus on early intervention and prevention to the legislative framework, underpinning the responsibilities of local government and its partners. The structure of the NHS, with the seven health boards and no commissioner-provider split, makes conditions more favourable for developing integrated care (across secondary, primary, and community care), although governance across so many different parts is complex. The size of the country allows for closer analysis of developments and their impact. The ‘Once for Wales’ principle is widely agreed where the benefits are clear and require a standardised approach.

Wales has many examples that are showing the path to the future. The leaders involved have the ability to develop models with other stakeholders, drawing from international examples, and are starting to implement change.

For example, Wales’ plan for primary care up to March 2018 outlined that GPs, grouped in localities, and pharmacists would deliver more care, whilst clinical networks would enable people over a wide area to benefit from the best blend of skills and equipment. Primary care clusters showed us impressive energy and initiative. Healthy Prestatyn Iach is an emerging example of innovation. The group of GP surgeries use ‘KeyTeams’ made up of GPs, nurse practitioners, occupational therapists, pharmacists and a dedicated co-ordinator to provide a person-focused experience, supported by other professionals such as physiotherapists. The model drew ideas from the Nuka model in Alaska, which uses multidisciplinary teams to

provide care, combined with a broader approach to improving family and community well-being.

Nuka System of Care, Alaska

The Nuka System of Care, developed by Southcentral Foundation in Alaska, is recognised as one of the most successful and innovative primary care systems in the world. Benefits include improved quality of services and fully engaged staff, together with improved health outcomes. The model involves spending more on primary care per person, but spending less in total on healthcare per person. Importantly, the 4-week average delay to schedule a routine appointment has been reduced to same day access, and staff turnover is just a quarter of the previous rate. Recruitment is based on values not skills (which can be learnt), and induction is standard, regardless of position, including three days with the Chief Executive Officer exploring the values and operational principles of the organisation. Genuine ownership of the system has resulted in improvements in population health. Measurement of employee and customer owner (patient) satisfaction is measured continuously and used to improve performance.

Similarly, the Choose Pharmacy service launched nationally in 2016 with the aim of encouraging people to see a pharmacist about minor conditions and free up GPs' time to focus on more complex conditions.

There are clear examples of Wales moving care into the community. The National Planned Care Programme focuses on reforming the way care is provided in ophthalmology, orthopaedics, ENT, and urology, so that many more patients are seen in community-based settings.

There is a further sense of emerging progress across community care. More GP practices in Wales are open between 8.00 am and 6.30 pm in the week, and more appointments are being made available to patients early in the morning and later in the day. We saw examples of increased telephone and web use, better integration with mental health and social care staff, better supporting diagnostics, and experimentation with direct access (without GP referral) for talking therapies and musculoskeletal treatments. Work has been undertaken to develop directories of services and to develop an integrated approach to out of hours' care.

Colocation of staff was often associated with more integrated service provision in community care. In order to build on this, we heard that the next steps to further integration should include shared management, communications, systems, assessments, and protocols for working.

Many examples exist of new approaches to joining up services within and between health and social care so that people have the best possible experience and outcomes. For example, we heard from leaders of the Mid-Wales Collaborative,

which comprises three health boards seeking to raise quality through creating new models of care and more integrated working. In Powys' virtual ward project, frail patients who are at risk of emergency hospitalisation are cared for at home. A GP, district nurse, and social worker meet daily where they discuss and assess the patients on the 'virtual' ward, with the most appropriate professional attending to them and co-ordinating care with the wider team. The project has led to a 12% drop in emergency admissions to hospitals.

The best examples of seamless services identified so far shared the characteristic of every member of a multidisciplinary team being focused on the service user. In Bridgend, the integrated care model is based around, 'What is best for Mrs Jones?' and shares similarities with the Esther model established in Sweden (see box). Services are co-located, and communication problems between different elements have been addressed, so each part of the system respects each other's requirements. The time slots in the community, where staff were on hand to manage a transfer of care, were respected and acted upon by hospital staff; equally, community staff were able to respond to requests for patients to leave hospital on the same day. Resources have been aligned to that vision. What 'Mrs Jones' receives is accessible, integrated care by the right professional with the right skills at the right time, provided closer to home, with access to specialist treatment when necessary. Services in this area were characterised by single approach, which demonstrated holistic service user health and care as the predominant concern that trumped all others.

Jönköping County Council, Sweden

For more than 20 years, Jönköping County Council has implemented a population-based integrated model of health and social care. Planners use population-level data to understand different groups' needs, and a wide range of indicators to assess health outcomes; for example, rates of obesity, social deprivation, and educational outcomes. The approach has resulted in improved and sustained performance when compared with other parts of Sweden across the range of indicators, including life expectancy and emotional well-being.

The workforce has focused on the fictional resident, 'Esther', and her needs. Benefits have included reductions in hospital admissions and appointment waiting times.

They use group meetings called 'life cafés', where people come together to discuss how they can improve different aspects of their health and well-being. These meetings have focussed on different topics, including physical activity, nutrition, intergenerational activities, and the needs of minority groups.

The Council has developed strategies for four main population groups: children and young people, people with mental health conditions, people living with drug and alcohol addiction, and older people. Staff from different sectors come together to plan and implement new models of care across each of these areas.

We also heard about positive steps to address the fragmentation of services. In some areas, Local Authority funded 'Community Connectors' play a valuable role in actively signposting people to local provision. The Integrated Care Fund has played an important role in supporting these endeavours. Many local authorities have created hub-based resources for their local communities, which offer local people easy access to information, advice, assistance, and local services to promote their well-being and help them address their care and support needs.

Progress on concentrating highly specialised services in South Wales has been slow but is underway. Independent experts are currently reviewing plans from Swansea's Morriston Hospital and Cardiff's University Hospital of Wales to house a major trauma centre. Trauma patients in north Wales already access the major trauma centre in Stoke. Specialist services in the Aneurin Bevan Health Board will be centralised in the Specialist and Critical Care Centre near Cwmbran, planned to open in 2022. Wales is also on the path to concentrating hyper acute stroke units to the 3-8 units recommended by the Royal College of Physicians.⁹⁷ Aneurin Bevan University Health Board has redesigned its stroke services and introduced a new care pathway for patients, including the development of a specialist Hyper-Acute Stroke Unit at the Royal Gwent Hospital.⁹⁸

There is some evidence of empowering the service user through Choosing Wisely and Prudent Healthcare.⁹⁹ In social care, we saw examples of largely integrated service provision as it would appear to a service user 'on the ground'. The move in social care to a collaborative, strengths-based approach is seen as a positive step, and the 'what matters' conversation is beginning to have an impact in ensuring services are focused on all the needs of the individual.¹⁰⁰ This can often result in the relationship with the individual in social care being less prescriptive than in healthcare and less centred on professional specialisms. Overall, however, this is an area for Wales to develop further – as we expand upon in the Public Voice in the following chapter.

We heard about the significant number of important national initiatives shaping health and care services in Wales that have a direct bearing on efficiency, such as the NHS Wales Efficiency, Healthcare Value and Improvement Group (NWEHVIG). Whilst many of the recommendations of the Carter review in England are relevant to Wales and are being pursued via the NWEHVIG, we heard that Wales is well-placed in some respects. For example, 90% of NHS expenditure for consumables is via the 'national catalogue', a national procurement service for the NHS in Wales.¹⁰¹

Making Faster Progress

To translate the vision into concrete action, we think there is merit in identifying a limited set of the most promising broad models of whole health and social care services and adopting them or their characteristics to develop a manageable set of models for Wales. We are not talking about re-arranging governance, organisation, or political boundaries here. Whole system health and social care is about models of service delivery that ensure that citizens, patients, families, and carers get reliable

and joined-up care and support and that precious resources are not wasted in inefficient, poorly targeted, or inappropriate care.

A generally permissive approach is used currently to develop new models of care, which has resulted in a wide range of practice being developed, only some of which will prove to be effective. We have not seen enough emphasis on the consistent and comprehensive evaluation or assessment of the value and benefits across the whole system of different models. If there is no mechanism to assess these and scale up the most effective, then variation becomes a permanent state, effort is dissipated, and there can be little learning. This provides little basis for systematic quality improvement and the transformation necessary to meet future need.

The set of models should be developed with clear standards, which can be tailored to include service provision in different contexts in Wales (for example, urban, rural, predominantly Welsh speaking), and different types of conditions (for example, acute conditions, chronic conditions, mental health needs, frailty needing long-term care in the community, and possibly palliative care). Based on the evidence we have received so far, we think that the models can be developed through peer learning from the best local and international practice and by drawing on the evidence and the expertise of the public, staff, and health and care organisations.

The models should then be scaled up rapidly and adapted as necessary to be trialled, evaluated, and used to steer local and regional service plans, commissioning arrangements and future investment. There needs to be rigorous evaluation of initiatives, benchmarking against others, learning from best practice and robust dissemination across Wales. Such evaluation should be as 'real time' as possible to allow national and local 'course correction', including in some cases halting an ineffective model.

Due to the growing impact of demographic changes, the initial focus should be on models that meet the needs of older people and then move on to address other areas of the life-course, most critically children and young people.

National programmes for unscheduled care, planned care, and primary care and learning from the Integrated Care Fund provide wide knowledge and experience of change. Learning from this work needs to be translated into integrated models of service delivery.

A national support programme to aid progress in broad models could be designed with sites and patients. Such a support programme could have a mission to identify and reduce barriers to change that are currently in the system and that are amenable to national policy.

From our stakeholder meetings to date it seemed to us that other key elements are crucial to making faster progress on a whole system approach to health and social care:

- A stronger and explicit strategy for achieving greater efficiency and productivity, particularly in the NHS.

- An improved approach to filling short-term acute shortages in the workforce and better long-term planning for a sustainable workforce in future;
- An effective strategy to enable staff to carry out continuous quality improvement as part of everyday work;
- Boosted digital infrastructure, which supports new models of care and analysis of quality and costs of care; active fostering and trialling of innovation;
- A transformation in service user experience, involving easily accessible and high quality information made available to the public consistently; and
- In some cases, redesign and redevelopment of buildings across the public sector estate.

For example, regarding efficiency, the Welsh Government has not explicitly set efficiency targets for NHS and social care organisations. Regarding continuous quality improvement, while there have been efforts to train staff in quality improvement techniques, such as in the 1,000 Lives Improvement initiative, we rarely heard specific mention of quality in oral and written evidence, indicating it might not be the guiding principle throughout the sectors.

3. Capacity to Care

In previous chapters, we have illustrated the growth in capacity needed to meet future demands. Some of the capacity will come from people being more involved in their care and undertaking more self-care. Further capacity will be generated through greater efficiency and effectiveness achieved by focusing on the five key enablers we have heard are needed to help accelerate high quality new models of care and efficiency. These are:

- A better enabled and supported workforce;
- Continuous quality improvement carried out by staff as part of everyday work;
- Improved digital and technology infrastructure;
- A transformation in service user experience; and
- In some cases, better use of buildings across the health and care estate and with other partners to deliver integrated care.

We now outline our thoughts to date on public involvement and the key enablers.

Public Involvement

We repeatedly heard calls for a better conversation with the public about:

- their role in their own health and well-being;
- their expectations of services; and
- the rights and responsibilities they will have in the future.

This is not least because public support is vital to developing and delivering policy and change. Making this a two-way conversation is vital. We feel that the public voice in Wales could be stronger by going beyond the current arrangements (for example, the Community Health Councils in healthcare).

Many people are more informed and expect more involvement in decisions about their care. There are clear opportunities here for the health and care system. For example, there is clear evidence that patients who self-manage and share decision-making where possible have safer and better outcomes, follow appropriate drug treatments, avoid over-treatment and are less likely to be hospitalised.¹⁰²

Although this co-production is happening in parts of the health and social care system, for a culture change to take place, more users of services need to be viewed as partners to involve in decision-making. 10% of all healthcare interventions are associated with some harm, and approximately 20% of all work done by the health service has no effect on outcomes.¹⁰³

Wales needs to develop a shared understanding of the challenges facing health and social care and to explore with individuals how they can best play a part in influencing the design and use of services. We heard examples of this in practice. The Mid-Wales Healthcare Collaborative had facilitated engagement between clinicians and both small and large groups of the public. Disability Wales have the ongoing 'Citizen-directed Co-operative' project, which gives those in receipt of direct payments an opportunity to discuss ideas and make decisions on the services they receive.

There are further opportunities for Wales to involve the public – including children – in wider decision-making. Involving the community in service design can align services to their needs and utilise their assets and strengths. Making greater use of social enterprises to deliver services is one model that might enable the public voice to be heard louder. Many people we have spoken to emphasised the importance of measuring patient experience to assist services in decision-making, yet mechanisms both nationally and sub-nationally are piecemeal.

There was a desire to reach an explicit agreement with the public on the respective roles and responsibilities of services and individuals. There is a base for this – 91% of people believe they have responsibility for their own health.¹⁰⁴ We noted that in many ways social care services are more advanced in this area and have valuable experience to share with healthcare partners. Historically, there has been a more flexible boundary between formal and informal social care, and budget cuts to local authorities in recent years have created much more negotiation about what the state should provide.

There were mixed views on who should lead this conversation. Some suggested that it is led best by health and social care professionals rather than by politicians. Others emphasised the importance of government level backing.

We will explore the issues raised during our public engagement sessions over the next few months.

Workforce

The review panel heard that central to establishing more effective models of high quality integrated health and care must be effective workforce planning to meet future needs; multidisciplinary training to drive integration; enhanced engagement with staff to improve morale, motivation, and retention; and development of staff so they practice continuous quality improvement in everyday work.

Planning

We heard that workforce planning is mainly undertaken within individual sectors at the organisational or professional level. A key issue raised by stakeholders was the need for an integrated approach to health and social care workforce analysis, planning, and development. There is a clear wish for greater alignment between professional groups and a need to address the mismatch of demand for health and

care services and current staffing structures. Our discussions revealed the need for fully developed, costed plans that describe the shift of services to the community to direct and inform the workforce planning processes. Tackling workforce shortages requires forward planning and takes time to address. Exiting the European Union will have an impact on the health and care workforce in Wales, and this needs to be planned for. Workforce planning at the organisational level was described as suboptimal for the provision of high quality integrated services. We heard a call to move to an integrated approach to workforce planning across health and social care organisations on a health board or regional footprint.

Some key areas stand out as requiring attention, including domiciliary care, residential care, care nursing, and stabilising and developing the primary and community care workforce, but the data are not strong in some areas, which makes workforce planning difficult. The recent Nurse Staffing Level (Wales) Act 2016 was welcomed as a radical and innovative piece of legislation, which puts patient safety at the heart of the NHS and puts Wales ahead of all European nations in following international best practice. It is also a hugely significant step in improving workforce planning for nurses in Wales. It does not extend to some areas such as mental health and community settings, and further work to identify appropriate staffing in wider health and care settings was suggested or was being planned.

Workforce planning should be based on robust population health needs assessments, and these have been produced recently across Wales. Whilst we see services under pressure, there may be significant gains to be made from more effective work design. The OECD recently reported that 76% of doctors and 79% of nurses reported being over skilled for parts of their work.¹⁰⁵ This suggests that alongside better workforce planning, there is also significant scope for the adoption of new job roles and different models of care. Stakeholders identified the need to accelerate the expansion of the use of well-trained non-medical staff to care for people in their own homes and communities using allied health professionals, pharmacists, and advance nurse practitioners to the maximum of their abilities to help address the gap between demand and workforce supply in primary care. Similar ideas were promoted for aspects of hospital care, such as in surgical teams.

An expansion of some current roles is required to grow capacity in the community. The new models of care, which aim to provide holistic personalised care, will require more generalist skills from some healthcare professions. Specialist skills need to be planned and deployed on an all Wales basis so that there is equitable access to care whether by face to face or via telehealth or telecare.

We heard that the trend in healthcare of specialists growing at a faster rate than generalists needs to be rebalanced to meet the needs of the population. The increasing number of consultants reflects the focus on secondary and acute care in recent years, counter to policy initiatives to expand community services. There is a growing need for generalists, not only in primary but also in secondary care, where evidence shows the benefits of generalists co-ordinating the care of acutely ill

patients.¹⁰⁶ The Royal College of Physicians has reported that in 2015, 40% of consultant physician vacancies in Wales could not be filled.¹⁰⁷

We know that demand for health and care services have seasonal fluctuations, with increased demand in winter due to influenza-like illnesses, respiratory complications, cardiovascular complications of cold weather, and increased falls. It is necessary to plan the workforce to account for these seasonal fluctuations.

Recruitment, Morale, and Retention

There are staff shortages in several areas including residential and domiciliary care assistants, experienced child care social workers, GPs, nurses, and junior doctors. Wales has started to address these issues through the recent ‘Train. Work. Live. in Wales’ recruitment campaigns. 16% more GP training places have been filled this year compared to 2016.¹⁰⁸ Phase two of this campaign (launched in May 2017) targets nurses in primary care, secondary care, and the care home sector, and future phases will target pharmacists and allied health professionals.¹⁰⁹ We believe that the successful response to these campaigns is in part due to the emphasis on work-life-balance, which was consistently described as an important feature of improving job satisfaction and retention of staff.

A supportive and engaging environment can improve the quality and safety of care – staff well-being is highly correlated with productivity in health and care services.¹¹⁰ Health and care employers should act as exemplars, promoting the health and well-being of the workforce in and out of the work place and eradicating fear. We heard that many health and care organisations are working towards workplace health initiatives and seeking to improve staff engagement; and this will be an area that we will explore further.

Whilst we identified a huge amount of commitment and dedication amongst the staff that work in the health and care system in Wales, we also heard that culture and morale in health and social care need urgent attention to ensure the workforce is attracted, supported, and then retained. This is supported by several staff surveys, which reveal a worrying level of stress and anxiety as well as adverse working experiences. The need to value, reward, train, trust, and empower staff was raised in discussions about morale. A key issue is developing leadership and managerial skills to improve the communication between senior managers and staff; improve awareness of organisations’ long-term goals; and involve staff in discussions and decisions on changes that are introduced.

Team Manager Development Programme for Wales

The Social Services Improvement Agency for Wales has been working with Oxford Brookes University since 2013 to deliver a comprehensive programme of management development for social services and other community team leaders in Wales. The programme has become the quality standard for operational managers, focusing on leading practice quality, change and improvement. Over 400 people in 25 cohorts from across the country have already completed the yearlong programme, which offers individuals the opportunity to secure a post-graduate certificate worth 60 CATS points.

We heard that the high level of turnover in direct care roles was a particular issue: making continuity of care for vulnerable individuals difficult and services complex to manage. There was a clearly articulated need for more attractive roles and a clear career structure for those working in care services. Social care providers were often described as being ‘in competition’ with the NHS for nursing and care staff, with the NHS in a position to offer better terms of employment. The disparity of terms and conditions for workers in different sectors providing similar services was also highlighted to us as a key workforce issue. We will consider the need to provide career structures where staff can move across organisational boundaries with ease further. There were a number of ideas that were put forward which could aid workforce flexibility including rethinking employment conditions to meet the needs of the future services, with staff less attached to organisations and buildings and more able to work across different settings in a locality. An integrated framework for career progression across health and care services in Wales is not yet available, and this may benefit from greater facilitation at a national level. We will explore this further in the coming months.

We heard that social care providers are finding it difficult to recruit staff with the right skills and aptitude for the work. There is increased competition for jobs, with staff able to earn similar wages working in supermarkets. It is widely recognised that home care for individuals has become harder over the years due to multiple illnesses and higher levels of dependency.¹¹¹ The ethical care charter for care workers was highlighted to us as an example of good practice: this calls for home care workers to be treated with dignity and allowed to do their jobs better, to be paid at least a living wage (including travel time), and to receive regular quality training. We were also urged to increase awareness of social care as a potentially fulfilling career option.

There was a clear and consistent view that designing jobs that fit with people’s lifestyles is required to retain dedicated and trained staff in the health and care sector. The current high and increasing use of locums and agency staff makes providing care more expensive, which is unsustainable and may demonstrate the desire of staff to work flexibly. Between 2008 and 2013, the number of consultants in Wales who worked part time increased from 6% to 14%.¹¹² Portfolio careers,

where people do several jobs over a lifetime, was highlighted as a new way of working that should be taken into consideration when planning the workforce. We heard frustrations from clinicians that 'bureaucracy' was preventing staff working across health board areas.

Recruitment in Rural Areas

Recruitment to rural posts is an ongoing concern: many health and care employers described increasing recruitment difficulties away from the urban areas and were concerned with equity and quality of service issues. This is set in the context of a growing elderly population in rural areas with multiple chronic conditions.

Any new models of care for health and care services need to recognise and take into account rural issues. Rural models will need a particular set of skills, delivered both by generalists on the ground and specialists via networked links and telehealth. We will further explore how Wales can provide innovative and dynamic job roles; increase new care models, such as local care hubs in residential homes; and expand services provided by advanced practice nurses in under-doctored areas. An important part of meeting rural need is training. Suggestions included more rural placements, high quality support in rural training, and encouraging local people to train. We noted some progress in this area; for example, some medical training schools have put in place rural modules across Wales. We welcome further suggestions of solutions to this problem, and we will review international evidence in this area.

Welsh Language

There was a consistent view from stakeholders that to drive quality improvement, services should be provided in Welsh whenever and wherever service users required. Respondents reported variation in the availability and standard of Welsh language services in health and social care. This matters in the context of international evidence, which emphasises the importance of communicating in one's first language with health and care professionals. It is especially true for elderly people, those with dementia or who have experienced a stroke, and young children who only speak Welsh. The challenges of recruiting and retaining health and care staff that can work confidently in Welsh is set within the context of broader recruitment and retention challenges in many parts of the workforce.

'More than just words' is a strong framework that has been put in place by the Welsh Government to guide greater availability of public services in Welsh.¹¹³ Despite this, recruitment campaigns, and the availability of Welsh language training in health and social care, we note that a concerted effort is needed to increase Welsh language skills in the workforce.

Training

Stakeholders raised a number of training issues that we will look at further including teamwork, system leadership, middle management skills, training needed to support new models of care, and continuous quality improvement. We heard that

training programmes should change to meet future service needs; for example by increasing training in the community setting and embedding prudent principles in health and social care training so it becomes standard practice. There was much support for staff from different professional backgrounds learning new skills together to become more aware of other roles and understand the whole system.

Many observed that internal management processes often hampered translating an organisation's ambitions into practical action. Training of middle managers was described as crucial to promoting innovation, a supportive environment, and the spread of best practice across Wales. We heard training managers to engage staff was essential to address morale issues and improve staff well-being.

Whilst digital savvy workers are required, both health and care stakeholders were keen to ensure that the softer skills of good communication and compassion were also retained. The need to handle highly complex situations is critical in this environment. Staff development for community professionals needs to be based on a common set of shared generic skills. Training everyone in preventative skills was also highlighted as having potential. We recognise that if all areas of the system are working towards this aim it is vital that all staff are given the skills to co-produce and advise service users of evidence-based preventative measures. There were calls for 'Making Every Contact Count' training to become mandatory for all health and care staff.¹¹⁴

We were pleased to hear of some examples where health and care staff were training together, (for instance the Welsh Ambulance Trust and Social Services) resulting in collaboration and cultural change across organisations and positive outcomes for patients. However, we also heard that a pipeline for future health and care leaders is not yet well developed and that more should be done to develop primary care leaders, perhaps drawing on the experience of existing programmes.

Confident Primary Care Leaders Programme

The first cohort of primary care leaders has completed a course to enhance their leadership skills. The course brought together a diverse range of participants from across Wales. Modules included: Examining the role of primary care in NHS Wales; Examining ways to engage with stakeholders; Engaging with patients and the public; Population health and maximising the patient experience; Business planning and finance; and Governance and legal frameworks.

The second cohort of primary care leaders have already started on their learning journey and are due to finish in September 2017.

The establishment of Health Education Wales was described as a positive step towards integration within the health sector. This new body, which will be designated as a Special Health Authority with an independent board, will have

responsibilities including strategic workforce planning, education commissioning, and organisational role design. It will be crucial that as this organisation (due to be established in April 2018) works closely with Social Care Wales to deliver on an integrated approach to workforce development across the sector.

Carers

Wales is a caring country, with a higher proportion of unpaid carers than any English region at 12%.¹¹⁵ This 'care force' makes an enormous contribution to society that needs to be nurtured and supported. It is also acknowledged that unplanned admissions into the health and care system are often a result of the carer having their own health issue or reaching crisis point. We intend to investigate further the benefits to both individuals and the wider system of providing further support for carers.

We recognise the important role that both unpaid carers and volunteers play in the health and care system and believe that informal carers need to be taken into account when workforce plans and development nationally and regionally. The benefit of this would be more effective working between paid and unpaid carers and better consideration of unpaid carers' views and needs.

Digital Technology and Innovation

The opportunities offered by technology for health and care efficiency and effectiveness have been highlighted to us repeatedly. The Nuffield Trust suggests that despite interest in new models of care, 'the most significant improvements in productivity over the next few years are likely to come from the combined impact of large numbers of small changes and extracting the full benefit from the technologies currently available.'¹¹⁶ Those working on the front line of care need to be provided with the technological tools to do their job. IT and shared data can help underpin redesigned internal processes and remove duplication and waste. Care recipients have the right to benefit from improvements brought about by digital and technological advances – not least those that help people stay in their own home. We see many good digital solutions in Wales; it is now important to accelerate progress across the system.

At the service user level, we have seen positive use of technology, such as My Health Online, which allows patients of some GP practices to manage appointments and prescriptions online, and My Health Text for appointment reminders and other messages, though they have not been widely adopted in practice.

My Health Text

In Caerleon, one of the six GP practices that first piloted the text messaging service “My Health Text” has been using the service to send a text message reminder to patients 24 hours before their appointment. The message reminds the patient of the time of their appointment and asks them to call the surgery if they are unable to attend.

As well as providing a useful reminder to patients, the service has delivered cost efficiencies. The “Did not attend” (DNA) rate for the practice has fallen by around 60 appointments per month, an improvement of 36.6%. Taking into account the cost of a GP appointment (£11), this equates to a cost saving of £7920 a year for one GP practice alone.

The practice has also used the text service to reduce the number of patients missing routine appointments such as flu jabs or asthma clinics.

For professionals, we heard reports of staff having good access to IT to help their daily work and others who had limited access to computers. Ideas we have frequently heard to help staff include mobile access to existing applications to realise efficiencies and streamline patient flow and the deployment of accredited apps.

At an organisational level, we have seen the benefits of a ‘Once for Wales’ approach in creating national shared service and digital organisations: NHS Wales Shared Services Partnership (NWSSP) and NHS Wales Informatics Service (NWIS).

We have been pleased to see the streamlining of e-learning, recruitment, and procurement initiatives by NWSSP. The next steps for Wales are to achieve greater collaboration to drive further efficiencies from operational systems, with a sharper focus on benefits realisation and benchmarking against other systems.

NWIS offers a national architecture, which spans organisational and sector boundaries. We heard comments that resourcing here needs addressing. The majority of NWIS’ 534 staff are currently involved in maintaining digital services and infrastructure (key components of which need replacement) rather than developing new systems. The few that work on a wide collection of initiatives usually require the agreement of individual health boards. We would like to look at what else is needed for both NWIS and NWSSP to make faster progress.

There is a commendable growing focus on innovation and technology across the system, including via the Efficiency Through Technology Fund, the forthcoming Digital Health Ecosystem (which seeks to open up NWIS architecture to independent software developers), and the work of the Life Sciences Hub and the Bevan Commission. Rather than looking at specific examples of innovation and good practice, the approach focuses on the mechanisms to foster innovation across the

board, identify good practice, and replicate across the system with more pace and purpose.

At a system level, we heard that existing national initiatives yielding efficiencies, including via the national architecture, such as digitised patient records, Choose Pharmacy, and e-rostering, could be accelerated by more effective and co-ordinated action nationally and by local boards and local authorities. We heard that Wales should still identify specific examples of innovation and good practice, but primarily in order to strengthen the approach to rapid evaluation (with a focus on outcomes) and benchmarking. Where there is evidence of significant improved value the developments should be rapidly introduced system-wide.

If Wales is to realise the widely held ambition of seamless, integrated care for both service users and professionals, the IT infrastructure needs to be similarly integrated within and between health and social services to allow for the sharing of systems and data. There are already some national systems in place in the health service, such as the Laboratory Information Management System (LIMS). We heard about the roll out of the Welsh Community Care Information System (WCCIS), which is starting to enable safe sharing of information such as case management and referrals between social care and community health services. Choose Pharmacy allows pharmacists to access patient's health records with their consent. There are some good examples of sharing data with patients but more could be done.

Welsh Community Care Information System (WCCIS)

WCCIS is helping health and social care professionals work together to provide care closer to people's homes, reducing unnecessary hospital stays and improving consistency of care.

WCCIS allows access to relevant information about the care provided and when fully implemented will overcome the obstacles posed by organisations using a variety of different IT and paper-based systems. Information covering a range of activities, including community nursing, health and social care visits, mental health, learning disabilities, substance misuse, complex care needs, and social care therapy, is shared securely across regional and organisational boundaries. Community health, mental health, social services, social workers, and therapists use WCCIS to record the care they provide.

Frontline staff access and record information 'on the go' using mobile devices including tablets and smartphones. They can access the most current information and so know who was the last person to see the patient, what happened, and what treatment or service plans are in place. This negates the previous issues of printing paperwork and having to return to the office or a home location to access key information.

The system is currently live in Powys, Ceredigion and Bridgend, with a further 11 implementations planned for this year.

However, in general, respondents have criticised how patient and condition-specific data are difficult to share and transfer within NHS Wales and also to other providers – especially as Wales aspires to a whole system approach. Clinical records are not yet consistent across disciplines, care settings or geographical boundaries. Some we met spoke of a lack of trust between organisations that each will apply the same security procedures to the information.

This is an area we would like to explore further – delivering digital transformation nationally within a clear framework which allows for local innovation and progress.

Service User Experience

Stakeholders consistently called for a transformation in service user experience as part of fitting service around the person. There were concerns that easily accessible and high quality information is inconsistently available for the public.

There are some good initiatives. The Choose Well website provides clear information on the most effective services for different conditions. Dewis is a single system that provides information and advice about well-being, self-care, and health issues at different stages of a person's life – although only with regards to social care.

In general, an area that stood out as needing attention was the information available to users of health and social care to help them make informed decisions about their care and treatment. Whilst this is acknowledged in Welsh Government documents and strategies, we heard from Macmillan Cancer Care, whose cancer information review found that there is no national, strategic approach to information content, production, and co-ordination.

Stakeholders painted a picture of information that is provided piecemeal and/or in duplicate by different services – if at all. Responses stressed the need to inform the public of what services are available, how to access them, and the relationships across the whole system – including healthcare, social care and the third sector. The development of 111 service is an example of this approach. Respondents emphasised the need to provide timely and relevant information to service users and carers about pathways and to support self management, delivered in a way that is appropriate for the individual. This included informing children and foster parents of the rights they have to services. The lack of standards across Wales for information quality was also raised.

We are mindful that these issues can exacerbate health inequalities in Wales. Focusing care on the individual means producing guidance that is not always communicated through leaflets and the written word, but consistently provided in the most appropriate way to different people.

In our final report, we will consider what steps can be taken to increase the ability of people to self-manage and take part in decisions about their treatment; improve service user experience; and reduce variation.

The Health and Care Estate

In some areas, the health and care estate quality is of concern. We heard examples of GP surgeries not able to expand to deliver a modern range of services and adult residential care based in buildings that militated against good quality care. We are also aware of the wide range of quality in residential care provision across the country and concerns about the future viability of some provision. The age of the infrastructure raises questions about whether the current estate can be a basis for delivering effective new models of community-based health and care consistently across Wales and whether it fits with Welsh Government's decarbonisation agenda.

Capital budgets have been under significant pressure. Following the global crash in 2008, the UK government reduced capital budget allocations to the devolved administrations, and this is only now recovering to pre-recession levels. Health boards do not have borrowing powers. The Welsh Government has assumed borrowing powers; however establishing revenue funded capital borrowing will be challenging at a time when revenue budgets are under considerable pressure.

It is imperative to maximise the use of the resources that are available. This will involve effective capital planning and making better use of the wider public estate. For example, the Welsh Government has undertaken asset mapping with Rhondda Cynon Taff local authority, which has identified some opportunities. In the future, investment in new community facilities should be done in a way that reflects the whole system health and care models that we propose should be developed. Seamless service provision will require all local partners to have a voice in decisions about major new investments. Regional Partnership Boards and Public Service Boards should be a useful forum for facilitating this. In new developments, we would expect to see space for multi-disciplinary working, including the third sector. A plural approach to planning GP surgeries may need to be taken to attract new practitioners into the field who do not find buying into a practice attractive.

As more people are treated and cared for in their own home, housing has become a setting for health and care. The Expert Group on Housing an Aging Population in Wales has emphasised the need to make better use of existing stock and plan homes that can be adapted and sustain people at different stages of the life course.¹¹⁷ Potential adaptations need to take account of sight loss, sensory loss, dementia, and include barrier-free design features to facilitate access and mobility.

We also heard that single routes to accessing capital funding, where resources in Welsh Government are combined nationally and accessible using one process, would support collaborative working on the ground. Previous practice was said to be separate budgets with separate governance processes. The establishment of a combined social care and housing budget is a progressive move.

4. Making Change Happen

Change is not easy in a complex, high-risk organisation like the NHS or in a network of more locally organised social care systems with multiple small providers, especially in a resource constrained and pressured environment. Many reports have made recommendations for system change in Wales with varying success. For example:

- *The Review of Health and Social Care in Wales* (Derek Wanless, 2003) warned that unless Wales took prevention seriously, it would be faced with a sharply rising burden of avoidable illness.
- *Setting the Direction: Primary and Community Service Strategic Delivery Programme* (CDV Jones, 2010) recommended the changes necessary to rebalance care between acute hospital and community settings.
- *The Commission on Public Service Governance and Delivery* (Paul Williams, 2014) addressed governance, leadership and management challenges in public sector bodies, including the NHS and local authorities responsible for health and care.
- *The OECD Review of Health Care Quality: United Kingdom 2016* (OECD, 2016) extensively reviewed the quality system underpinning Welsh healthcare.
- *The NHS Workforce Review* (David Jenkins, 2016) examined the sustainability of the NHS Wales workforce and the strategic developments required to address the funding challenges.
- The Bevan Commission has also considered future workforce, barriers to change and remodelling the relationship between the citizen and the NHS.

Many of the themes from these reports are still relevant and remain key issues for stakeholders according to the evidence we received.

That is not to say that Wales has not already seen much change. New legislation, in the shape of the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014 have been introduced in recent years. The Well-being of Future Generations (Wales) Act 2015 established Public Services Boards (PSBs) in each local authority area in 2016 to help integration between different public sector organisations. health boards have created local planning mechanisms by clustering several adjacent GP practices together to collaborate more effectively and plan for their combined population's needs. There are 64 of these primary care clusters in Wales.

However, we have heard that the next steps for Wales are to capitalise on this progress by moving faster towards a 'whole health and social care system' and to address the barriers to implementing the recommendations in reports preceding this Parliamentary Review. We heard a desire to provide seamless integrated services, but those who were struggling to deliver this in practice pointed to

separate governance, accountability, regulatory and financial systems of health and social care as barriers to achieving it.

Approaches to Change

Within the health and social care system, ‘extrinsic’ and ‘intrinsic’ approaches to change are needed. Extrinsic national approaches tend to ‘direct’ health and social care organisations to do specific things that can create added focus and momentum for delivery. Regulation, targets, national performance management, national contracts and nationally designed financial incentives are examples. Intrinsic approaches rely on supporting key individuals to do the right thing. This includes developing leaders to manage staff better to instil more effective cultures and behaviours within an organisation and providing professionals with information and analysis to allow them to review their performance and that of their peers. A successful seamless health and social care system needs a balance of both.

From the evidence we have taken so far, there is consensus that the speed of change is too slow, the balance in approaches is suboptimal, and the areas outlined below need further development.

Extrinsic Approaches

Stronger Overall Central Guiding Hand

The OECD’s review of the healthcare systems in Wales was supportive of the Health Boards’ aims but concerned that they showed less innovation than expected and fewer radical approaches to system change and quality. It called for a ‘stronger guiding hand’ from the centre and for the centre to make ‘more prescriptive demands’ of health boards to drive meaningful improvement.¹¹⁸

The Commission on Public Service Governance and Delivery reflected that:

“There must be much greater clarity about which organisation or partnership is responsible for what, how well they have discharged that responsibility, and what can be done to challenge and change that. Only then will there be a consistent and effective “visible hand” driving continuous improvement.”¹¹⁹

Some stakeholders have agreed that there could be clearer co-ordination, direction, and stronger accountability regarding expectations on bodies and organisations from Welsh Government. Some proposed a vehicle for all-Wales planning and decision-making in health and social care, and identified a small number of ‘Once for Wales’ decisions, which would be clinically beneficial to make at a national level. We heard a clearer mechanism is needed to enable leaders to transcend local interests.

There is evidence that accountability in the NHS is increasing with the use of a new escalation and intervention arrangements framework.¹²⁰ There is more work to do to embed it and ensure it is understood at all levels, within the context of a future vision that encompasses whole system outcomes. Overall, we observed that Wales

needs to simplify responsibilities, improve reporting and make information clearer to achieve a step change in accountability.

More fundamentally, the range of extrinsic approaches currently used could be reviewed to see if there are gaps (e.g. relative to elsewhere in the UK) that would be worth filling, or to assess the evidence to see if the strength of current extrinsic levers (e.g. regulation, accountability, planning, performance management, financial incentives) should be boosted.

The objectives of such an exercise might be threefold to assess:

1. If current extrinsic approaches could be enhanced to improve the quality of care;
2. If there could be more central effort to boost efficiency and productivity. From our assessment so far, national policies and other national efforts are commendable and all in the right direction, but they could more explicitly describe the need for efficiency, what the various policies are expected to contribute, and how they are evaluated. This will be a focus of our work in the second half of the review; and
3. As noted above, how extrinsic approaches could be used to accelerate the progress of a set number of the most promising new models of care, in particular those requiring robust collaboration and effective commissioning of independent providers.

Performance Management

There was strong acknowledgement that a unified national performance management framework and specific shared metrics for health and social care – agreed by all political parties - would be helpful.

There are currently four different outcome frameworks used: NHS Outcomes Framework; Social Services National Outcomes Framework; Public Health Outcomes Framework; and Early Years Outcomes Framework.¹²¹ However, the health and social care frameworks are different, creating difficulty in measuring the impact of initiatives on the totality of health and social care and hindering a shared narrative of what success looks like across the whole system.

We heard Wales needs to move beyond measuring processes and targets to a performance management system that focuses on population health, clinical outcomes, and patient experience across the whole system, perhaps drawing on the Institute for Healthcare's Triple Aim. This may be an effective way to put the principles of Prudent Healthcare into widespread action too. It was positive to see the Social Services and Well-being (Wales) Act 2014 has defined outcomes in social care based on quality of practice – local authorities will start to report on these soon. The next steps for Wales include combining these with health outcomes.

In healthcare, all stakeholders acknowledged the importance of waiting times and were proactive in working to reduce them. Nevertheless, most reflected that targets

can drive behaviour in adverse ways. Focused on acute and secondary care, they do not always support attempts to redesign services, such as the shift to primary and community care. This was seen to be particularly the case within mental health services. People we spoke to highlighted the lack of meaningful success indicators to know whether people are benefiting from the treatment they receive and what models of care may have the most impact in improving and maintaining mental health and well-being.

The new Clinical Response Model for the Welsh Ambulance Services NHS Trust is an example of Wales leading the way in this. It has used evidence to deliver a clinically appropriate response to patients, only using a target time where clinical evidence supports this decision and focusing instead on improving outcomes and experience for patients.

Data and Analytics

Effective performance management that improves quality and safety requires robust data that describes the whole system. People raised a number of ways in which the sector can use data more effectively to support this.

Currently information on healthcare performance is available online and monitored by health boards at public meetings. Local authority performance is also accessible online. These data, however, focus on certain health and care processes and organisational performance rather than outcomes for service users across a whole pathway of care. For example, compared to other parts of the UK, there is little in the way of monitoring data for learning disabilities to assess how well Wales is delivering the outcomes required and how effectively it meets the aims and objectives of the existing policy framework.

There has been good work done on developing patient reported outcomes of care (health outcomes or experience of care). We had many positive discussions about the importance of service user experience in its own right, building it into reporting and governance mechanisms, and consistently acting upon it to improve services. Many of the stakeholders we met were clear that patient experience was equally as important an indicator of healthcare quality as clinical outcomes and patient safety. A positive example was Aneurin Bevan University Health Board's partnership with the International Consortium for Health Outcomes Measurement (ICHOM) to draw upon their set of globally agreed standards for Parkinson's disease. Though there has been a commitment to roll out the ICHOM approach across the system, initiatives such as this generally remain experiments and are not replicated as standard across the system.

The Parliamentary Review panel will continue to look at the use of data to incorporate the service user's perspective alongside other outcomes. We will look at the metrics used to measure effectiveness and efficiency at a national and local level to track progress and reduce variation.

As we further develop our ideas, it is worth highlighting that data need to be supported by a strong infrastructure and published for the public to see – enhancing

transparency, understanding and therefore trust in the system. Rather than gathering data in anonymous form, Wales would benefit from studying the causes of successes and failures in different areas to drive improvements in quality and safety for the service user.

Measuring Outcomes in Parkinson's Disease

Aneurin Bevan University Health Board, in partnership with the International Consortium for Health Outcomes Measurement (ICHOM), developed an electronic form that interfaced with the Board's clinical informatics system, to test the effectiveness of value-based care in Parkinson's disease.

The questionnaire looked at key areas, including health-related quality of life, falls, hospital admissions, the ability to work, and motor functioning. It helped patients and clinicians to prioritise the main issues together, and included the patient perspective in the outcomes data, which has in turn enabled doctors to set their expectations more effectively.

The programme's success was immediately evident, not only in terms of individual patient experience but also on the level of service provision. The team realised they could redesign the care they offered to provide a full-day specialist clinic where a multidisciplinary team was present, rather than scheduling sequential visits for patients. This shift not only improved the patient experience but also made the practice more efficient by reducing the number of patients lost in follow-up. The value-based care pilot highlighted areas where previous financial decisions had accrued unforeseen and costly effects, both in terms of the patient experience and in funding allocations. Perhaps most crucially, it forced doctors and staff to reconsider every aspect of what they were doing, a useful process for clinicians who may have worked in the system for years.

Financial System and Incentives

Effective financial management aids change in any public service system. We heard calls to reform financial systems so that they facilitate transformative change.

This involves aligning resources with outcomes that create value for the whole health and care system, including well-being. The focus of performance management on service access measures, such as waiting times, tends to mean that money flows in that direction. As an example, between 2010-11 and 2015-16, the growth in health boards and Trusts' secondary care spend was 20%, compared to 3% in primary care.¹²² Yet if care were boosted in the community, the risk of needing hospital care and waiting times for those who have to access hospital care might be reduced. Similarly, local authorities are finding it a challenge to adequately resource measures that help prevent children needing care in local authority funded

homes or by foster parents, as well as safeguarding and addressing poor educational attainment.

It was often put to us that excellent examples of innovation get lost without long-term funding to mainstream them. In responses, we heard support for mechanisms that would enable resources to flow easily between organisations to incentivise change and a single route to Welsh Government capital funding. Some respondents praised the Integrated Care Fund as an initiative that encourages joint-working. Some favoured stronger direct financial incentives to facilitate rapid change.

Regulation

Wales has different national inspection and support bodies across health and social care. Health Inspectorate Wales (HIW) inspects healthcare. The Care and Social Services Inspectorate Wales (CSSIW) inspects social care. The two regulators work collaboratively in some common areas, such as healthcare in care homes in north Wales, and focus on the experience of people using care. The functions of each organisation are clearly set out, although there is complexity over which regulator inspects different aspects of care.

As new models of integrated care are clearly desirable, it is time to look at whether the two regulators might develop their approach to assess the quality of care in these new models, and in doing so set expectations in the health and social care systems that this is the future direction. Similarly, there are secondary questions as to the merits of developing a single regulator or inspection body for both health and social care, which measures against common standards for the whole system. The advantages of this would seem to be a less complex system, which prevents issues falling between organisations. The disadvantage in the short term would be distraction of management effort in administrative reform, rather than the much-needed service reform.

We also heard some calls for national regulatory oversight of larger independent providers of social care when failure might mean major problems for one or more local authorities. For the most part, however, independent social care providers in Wales are small enterprises. This poses inherent risks due to their size and the age profile, with many looking to leave the sector due to retirement. This emphasises the importance of larger professional providers to long-term sustainability in this sector – whether profit distributing or not – notwithstanding the risks posed above.

Intrinsic Approaches

Local Autonomy Supported by an Enabling National Framework

There is consensus from the evidence received that there is a balance to be struck between taking decisions at the national and at the local level which is not currently optimal.

Many interviewees were enthusiastic about the autonomy of a regional (i.e. health board boundary) approach to planning and delivery, encompassing social care, community health, public health, and well-being. Flexibility and local knowledge can aid resource-effective solutions that meet the needs of local populations within priorities set nationally.

We were impressed with the energy and innovation we witnessed when local autonomy had been given to GP clusters or to community service hubs, providing a positive impetus to drive change. From our evidence to date it seemed that a combination of a small grant, the incentive to earn QOF (Quality and Outcomes Framework) points, a degree of autonomy, significant local pressures on services, plus the obvious desire to improve care by practice staff were the active ingredients spurring change. Further developing these, based on the examples of good practice, will help Wales take the next steps to truly locally based planning and service delivery.

However, the key twin issues here are what national support would best help local bodies to accelerate the change they want to make and how best to hold localities to account to reduce unnecessary variation. We noted the struggle of primary care clusters, for example, to secure relatively small amounts of funding, which was described to us as a key brake on local progress. Some questioned the maturity of regional planning and the willingness of regional leaders to take big decisions.

Stakeholders generally felt that a regional approach should underpin agreed national priorities and outcomes. In our comments to date, we have focussed on robust scaling up of demonstrably effective local initiatives, such as new models of care or digital innovations. We have also echoed the OECD's view about a 'stronger central guiding hand'. Let this not be mistaken for a call for over-centralisation. We see a spectrum of decisions, with those that would benefit from a strong 'guiding hand' (such as mandatory improvements to safety) at one end and those that would benefit from local autonomy at the other. A national set of standards appeared to our interviewees as essential, but this should not be confused with standardisation of approaches. Stakeholders considered this would stifle local innovation and initiatives. While a small number of 'Once for Wales' decisions are important, in general decisions made at the regional and local level according to local population needs, informed by good practice elsewhere, and with agreed outcomes, can aid progress towards a more effective and efficient system more compellingly than mandating nationally. Local implementation can flourish when the expected outcomes are clear; indeed clarity of intended outcomes is the golden thread that links action at all levels.

We will be working further to develop our recommendations on how best to align the levers and incentives for change across the system, identifying where on the national to local spectrum decisions are best made.

Quality Improvement

Improvement is not automatic. Over the past 50 years, the quality movement has developed the scientific foundations for improvement and outlined the organisational forms and leadership behaviours that reflect them in service delivery systems. Famously, the quality scholar, W. Edwards Deming, categorised scientific elements supporting improvement as a system in four groups: knowledge of systems; knowledge of variation; knowledge of human psychology; and knowledge of how understanding can grow under conditions of complexity.¹²³ The successful pursuit of quality improvement will draw momentum from the mastery of these methods by the workforce, their leaders, and ideally, the public at large. Improvement sciences matter in practice.

Internationally, there are respected voices that show the dominant approach to improvement in the public and private arenas today, in most nations and at most times, does not conform to these scientific foundations. Instead, it rests almost entirely on extrinsic levers through a combination of targets, scrutiny, incentives, accountability, exhortation, and at worst, 'naming and shaming', to produce improvements. Such approaches almost inevitably introduce their own costs and ill will between those 'policing' the system and those delivering services. In turn, this militates against true learning and improvement. This characteristic is understandable when viewed through the prism of 24-hour media and short political cycles, which require the immediate presentation of apparent solutions as problems inevitably arise, even though this cannot always truly be delivered. However, a confident country can make choices about which approach to favour, or at least where to strike a balance. The cause of scientific quality improvement would be aided if more people who work in the system became skilled in its techniques and tools.

Wales has made good start on building knowledge and skills for quality improvement. 1000 Lives Improvement is the national improvement service, which is integrated into the work of every health board and trust in Wales, supporting national and local improvement programmes across primary, community and acute care. The philosophy of Prudent Healthcare and the Triple Aim underpin its work. 8,000 people have gained an awareness of improvement by completing the Improving Quality Together Bronze award, and these staff, along with others who have trained in further aspects of quality improvement, are a resource that must be utilised fully. But we also heard, in particular from junior clinical staff working in hospitals – the staff we will depend on in the future – that too often the environment they work in is not supportive in helping them skill up in this area or to design and help implement change effectively. Similarly, Social Care Wales works with people who use care and support services and a broad range of organisations to lead improvement in social care. It aims to make sure the people of Wales can call on a high-quality social care workforce that provides services to fully meet their needs.

However, we also heard concerns that detailed knowledge of the breadth and depth of learning disability services across Wales remains patchy. This is likely to improve

as regions produce population assessments in line with the Social Services and Well-being (Wales) Act 2014, but does raise questions about whether the findings from the Confidential Inquiry into Premature Deaths of People with Learning Disabilities are being delivered in Wales.¹²⁴

Crossing the 'quality chasm', as it has been described, and meeting changing population health and care needs cannot, as we have argued throughout this report, be achieved through traditional service configurations and ways of working.¹²⁵ Nor can it be achieved without a greater focus on the principles and practice of quality improvement.

Staff Engagement

The link between staff engagement and the delivery of high quality services is well established. Ongoing and continuous engagement of staff in health and care is required to maintain motivation, harness ideas, and ensure continuous quality improvement. We heard examples of healthy respect between managers, practitioners, and clinicians and, likewise, examples where improvements could be made. Some of the frustrations expressed to us included where professionals had been heavily involved in the development of solutions but the implementation of these had not yet occurred – this had subsequently led to disengagement. The pace of managerial change, levels of bureaucracy, cultural barriers, and lack of change skills and information were described as barriers to implementation of change. There will be further consideration of how professionals and clinicians are empowered to innovate and lead significant new models of care, as well as carry out continuous quality improvement initiatives as part of everyday work. Here, the joint working commitment between the BMA, the Welsh NHS Confederation, and NHS Wales Employers on increasing clinical engagement is an important development, as is the introduction of core principles for the NHS in 2016.¹²⁶

Within the health service, we noted that the staff survey is neither comprehensive nor takes place every year, although it was positive to note new metrics in staff and service user experience in the social care sector. Given the importance of an engaged workforce to deliver the principles set out in the Social Services and Well-being (Wales) Act 2014 and Prudent Healthcare, the results of the most recent survey, and ongoing change, we believe leaders need to monitor this aspect of change management more closely, own the results, and build clear whole system action plans to improve results year on year.

In social care, one suggestion we received was to consider adopting UNISON's 'ethical care charter' as the baseline for the treatment of all care workers.¹²⁷ It noted that Southwark and Islington local authorities had taken this step and seen improvements in staff retention and recruitment.

Architecture and Systems for Change

Governance

Wales, through the seven Local Health Boards (LHB), has spent recent years integrating hospitals with local primary and community services in terms of structures but not comprehensively in the delivery of services. Public Service Boards (PSBs) have been introduced as part of the Well-being of Future Generations (Wales) Act 2015, and enable public services to commission and plan collaboratively. Regional Partnership Boards (RPBs) work between health boards and social care to plan services and pool budgets.

The decision-making landscape is very complex, with a range of differing roles and responsibilities and different funding, accountability and reporting arrangements. Some stakeholders were concerned by the number of small organisations in Wales, given inherent risks to governance and delivery.

A recurring theme raised by stakeholders was whether there is an overload of governance, which affects the pace of change and decision making by the right people at and across the national, regional and local levels, including on the big health and social care programmes. We received many comments concerning tensions surrounding the different boundaries of Health Boards and local authorities when planning and developing services. There were calls from across the sector to streamline - clarify, simplify and unify – the governance of health and social care. There were also calls for health boards to work more collaboratively, with some recommending the creation of a national decision-making body to achieve this. We will consider the Welsh Government's white paper on NHS Quality and Governance with interest.¹²⁸

Numerous organisations have raised the inconsistencies between the roles of PSBs and the RPBs. The PSBs must undertake well-being assessments and produce well-being plans under the Well-being of Future Generations (Wales) Act 2015. RPBs must undertake area assessments and produce area plans focused on joint health and social care outcomes for the population across health board boundaries under the Social Services and Well-being (Wales) Act 2014. We have been told there are overlaps between these assessments and plans, but their processes and desired outcomes are different, duplicating some of the reporting demanded of Local Authorities. In addition, we heard concerns that the difference in the number of boards and the size of the area they are responsible for adds to a confusing picture, although we note that Welsh Government is currently reviewing public services and greater regional working through a white paper.¹²⁹

The CSSIW/HIW report on provision for people with learning disabilities stated that, whilst there was a strong value base of multi-agency and multi-disciplinary working at the frontline, it had concerns about the ability of local areas to adequately plan services.¹³⁰ We saw little evidence of a co-ordinated approach to understanding what models of care are most likely to improve outcomes for this group of people; how well this is reflected through existing and potential providers;

and what commissioning approaches may be needed to develop services in line with good practice. Whilst the forthcoming commissioning guidance will offer some insight into what 'good' looks like, there is still considerable work to be done to share detailed good practice and ensure this is strategically embedded across local authorities and Health Boards.

We heard that the primary care clusters' place within the governance structure in relation to NHS Wales and local authorities needs to be clearer. Currently, the clusters occupy different positions in the different decision-making and governance maps. We note that the National Assembly for Wales' Health, Social Care and Sport scrutiny committee will shortly present a report on clusters, and we will draw on the findings to inform our thinking.

Some stakeholders suggested that decision-making structures should include leaders in the independent sector and provider forums. We heard from community organisations that spoke about the importance of community assets, such as parks and swimming pools, to a preventative health approach and emphasised the importance of local authorities making cross-organisational decisions to maintain the preventative infrastructure.

For the rest of this review we will explore the qualities needed from a governance system. We will also look at planning, commissioning, and delivery to best secure improvement.

Bureaucracy and Culture

We heard evidence to suggest that the Commission on Public Service Governance and Delivery (2014) findings are still relevant.¹³¹ One of the Commission's conclusions was that many organisations in the public sector, including the NHS, local authorities, and others responsible for health and social care, were slow to respond to pressure for change due to their internal bureaucracy and arrangements with partners. Innovation was inadvertently discouraged from spreading by multiple accountability channels demanding compliance and assurance, creating a risk-averse culture. This may help explain third sector frustrations that their services – often preventative in nature and difficult to evidence – are sometimes not used in lieu of perceived 'safer' options such as hospital or residential care.

The Commission assessed that culture and values within public sector organisations allow 'parochialism, defensiveness and insularity rather than innovation, flexibility and responsiveness'. This is something that stakeholders have raised with us, with concerns that it gets in the way of shared and joint leadership and enabling staff to do their job most effectively. Many emphasised that health boards should work together where services must be planned on a national footprint. Wales must do everything it can to promote an open culture of learning from others and sharing why things did not work in pursuit of quality.

A common reason given for innovative change not being sustained – especially from those in the third sector – was the barriers to scaling up innovative initiatives. We heard complaints about the difficulties in getting those who hold the purse strings in

different sectors to commission innovative pilots and evaluate them effectively. Innovation that does succeed was characterised by some as being owned by likeminded individuals, rather than being engrained in the system's operational procedures.

We have seen many good examples of innovation that come from local organisations being given autonomy. However, it is also clear that the local bureaucracy and culture we have heard so much about are stalling progress. What could overcome this is a focus of interest for us over the next six months.

Leadership and Management

Clarity about the future design of services and how to achieve the ambition will need strong transformational leadership skills and a clear method and timetable for change.

We saw this in some of the places we visited. For example, in Bridgend we saw integrated community services, which had embraced the need to work differently. Leaders here understood the strategic direction of travel and had solved immediate problems within their setting, such as closer working with other sectors, to enable staff to centre care on the patient. Staff were supported to take the next level of risk in decision making and discussed these with service users to co-produce care.

In light of the strong consensus on the way forward, we are keen to identify what would help leaders make more progress. Whilst there are many outstanding leaders and examples of innovative change in the sectors, we heard more could be done to recruit and retain good leaders and to identify and develop future leaders.

We also learned Wales needs to resolve systemic problems, which militate against good leadership and effective change. Successful transformation requires leaders to have the capacity and skills to plan, drive, and deliver change. Despite this, we frequently heard that the challenges of day-to-day problems and navigating the complexity of the system meant many leaders struggled to find time to look at the long-term future of their organisation. Likewise, we detected a lack of capacity to establish cultures that are more positive, engage with staff, and use data to improve frontline delivery.

Some said that the health and social care systems need more leaders who are adept at dealing with complex and changing situations and can adapt to new ways of working. We heard concerns about the role of middle management from stakeholders and the importance of changing its mandate to being about learning, spread, improvement, and accountability.

5. Next Steps

This Interim Report sets out the review panel's initial views of the opportunities and challenges facing the health and social care system. It also highlights areas which we will explore further before making recommendations in the final report. We have heard from a wide range of stakeholders and service users in this first six months, and we want to continue to involve service users, service planners, and providers in health and social care, the third sector, and the independent sector in the next stage.

Our focus in this next stage will include the following areas:

New Models of Care

What is already clear is a consensus on the broad direction of travel and the need to consolidate effort behind a small number of shared seamless whole system models of health and social care delivery that can be identified now.

These new models of care should be based on the principles of integration of care, quality, efficient ways of working, and putting patients and service users at their heart. They should include a combination of primary care, hospital care, and community health and social care provision and work in different settings such as urban and rural. We envisage a limited number of models, which could be widely trialled, developed and evaluated, with the intent to rapidly test and scale to all-Wales coverage.

The scale and pace of the challenges heading towards Wales create urgency for a practical way forward. We are therefore proposing to set up a stakeholder forum to work with the review panel to develop these new models and the principles that should be used to plan future service development.

Doing this work now will create an environment for progress after the review has concluded. It will also provide a platform to support existing efforts to develop new models of community and locality provision and encourage innovation by providing targeted support.

We will establish a stakeholder forum to work with the review panel to outline these new models and the principles that should be used to plan future service development. The forum should:

- Draw membership from service users, NHS, local government, academia, professionals, third sector, and independent sector;
- Outline a set of new models; and
- Suggest how the models might be implemented effectively to allow faster change and what action is needed over the next two years to achieve this.

As this work progresses, we envisage that a support programme will provide support, peer learning, and independent evaluation of progress, building on work already underway.

Further Areas for Consideration

We will also work on a range of further issues outlined in the interim report to develop detailed recommendations in the final report. These are:

Public Involvement

We will consider what we have heard about a two way dialogue between service providers and the public and the importance of the ‘public voice’. This will focus on the following: understanding and developing new models of care; boosting useful information about care; promoting self-care; and accessing the right advice in the right place.

Workforce

We will expand upon what the key areas of focus should be for a national health and care workforce strategy. This will include how to develop and plan new skills needed for the future health and social care system, including flexible working, boosting skills in making change happen, and continuous quality improvement.

Digital and Infrastructure

There are real opportunities to deploy technology to underpin initiatives to meet the challenges facing Wales. Digital and technological developments will deliver benefits to care recipients, enable self-care, and support the health and social care workforce in their roles. Sharing data to provide integrated services and drive quality and value, performance, pace, and innovation is an area that we will focus on for the final report.

We will examine the metrics used to measure efficiency and effectiveness at the national and local level to track progress, highlight best practice, eliminate waste, and resolve unwarranted variations within sectors and over time. In particular, the metrics might cover care across different integrated settings – for example primary and hospital care, primary, community and self-care, and health and social care.

We will consider what other steps might be needed to support digital transformation and greater efficiency.

Innovation

We will examine the extent to which systems and structures are being put in place to embed innovation in the business of health and care organisations. We aim to explore a ‘triage’ process for valuing and prioritising initiatives and to identify and up-scale those compelling innovations that have the potential to deliver substantial benefits.

Making Change Faster

We will consider barriers to systematic quality improvement and how governance could be a stronger enabler for change. We will also look at the methods used for planning and commissioning and the impact on delivery of services.

Specifically, we will further examine the governance, finance, and accountability arrangements in the health and social care system to see if they could be improved.

We will do more work to assess the current range of national approaches - extrinsic and intrinsic - to motivate and enable change to occur.

We will also assess the support, investment, and leadership skills required for the health and social care sectors to deliver substantive 'transformational' change, at speed. We will draw upon examples of UK and international best practice and the successes and challenges experienced in Wales to date, with the focus on outcomes.

There is much to do to reach our final recommendations. As we continue our work, we invite you to have your say. Have we identified the right issues and prospective solutions that will help Wales address the challenges ahead? What might we have missed so far? What matters to you in ensuring that Wales will offer high quality, sustainable health and social care in the future?

You can contact the Parliamentary Review through the following routes:

Email	ParliamentaryReviewHealthandSocialCare@wales.gsi.gov.uk
Post	Parliamentary Review of Health and Social Care Life Sciences Hub 3 Assembly Square Cardiff CF10 4PL
Website	www.gov.wales/futurehealthsocialcare www.llyw.cymru/dyfodoliechydgoalcymdeithasol

Annex A: Parliamentary Review into the Future of Health & Social Care in Wales - Terms of Reference

The establishment of a Parliamentary Review into the long-term future of health and social care in Wales is a key commitment in the Programme for Government launch in September 2016. The independent panel of experts, established in November 2016, was tasked with producing a report in 12 months focussing on the sustainability of health and social care in Wales.

The report should consider the current situation and draw out the challenges facing health and social care over the next 5-10 years bearing in mind the context set by the Social Services and Well-being Act, and the seven goals of the Well-being of Future Generations Act alongside rising demand, demographic changes and financial sustainability.

The review is tasked with producing recommendations that will deliver improved health and well-being outcomes for people across Wales with a particular focus on reducing health inequalities.

The Terms of Reference for the report are:

- Define the key issues facing health and social care
- Identify where change is needed and the case for change
- Set out a vision for the future including moving health and social care forward together, developing Primary Care services out of hospitals.
- Advise on how change can be delivered, building on the positive aspects of the current system.

These areas will be explored initially via six strands across health and social care:

- Situational analysis including learning from previous work
- Future Vision including Delivery Models, & Organisational Issues and the citizen's perspective
- Metrics, Systems, Governance and pace of change
- Workforce including culture, morale, education & training, rurality and Welsh Language
- Quality and Safety including, R&D, and Innovation
- Productivity including Data and Insight, Digital, & Finance

Annex B: Panel Biographies

Dr Ruth Hussey CB, OBE (Chair)

Ruth currently chairs the Welsh Food Advisory Committee of the Food Standards Agency. She retired as the Chief Medical Officer for Wales in 2016.

Professor Sir Mansel Aylward CB

Professor Sir Mansel Aylward CB is Chair of the Bevan Commission and is currently the Chair of Public Health Wales.

Professor Don Berwick

Donald M. Berwick, MD, MPP, FRCP, President Emeritus and Senior Fellow, Institute for Healthcare Improvement, is also former Administrator of the Centers for Medicare and Medicaid Services.

Professor Dame Carol Black DBE

Professor Dame Carol Black DBE, FRCP, FMedSci was appointed Principal of Newnham in September 2012. She is a past-President of the Royal College of Physicians, of the Academy of Medical Royal Colleges, and of the British Lung Foundation and has chaired the UK Health Honours Committee.

Dr Jennifer Dixon CBE

Dr Jennifer Dixon joined the Health Foundation as Chief Executive in October 2013, and was Chief Executive of the Nuffield Trust from 2008 to 2013.

Nigel Edwards

Nigel Edwards is Chief Executive at the Nuffield Trust. Prior to becoming Chief Executive in 2014, Nigel was an expert advisor with KPMG's Global Centre of Excellence for Health and Life Sciences and a Senior Fellow at The King's Fund.

Eric Gregory

Eric is currently Chair of the Assembly Commission Audit and Risk Assurance Committee and also holds non-executive director/independent adviser roles in the Cabinet Office, Ministry of Justice and Home Office. He previously worked for the John Lewis Partnership.

Professor Keith Moultrie

Keith has led the Institute of Public Care at Oxford Brookes University team as director since 2008.

Professor Anne Marie Rafferty

Professor Anne Marie Rafferty CBE, FRCN is a British nurse, administrator, academic and researcher. She is currently (as of 2010) Professor of Nursing and Dean of the Florence Nightingale School of Nursing and Midwifery, King's College London.

Annex C: Organisations and Individuals that Submitted Written Evidence

Action for Children

Age Alliance Wales

Age Cymru

Aizlewood Group

Aneurin Bevan UHB

Applied Psychologists in Health National Advisory Group

ARCH

Association of British Pharmaceutical Industry

Association of Directors of Social Services

Betsi Cawaladr UHB

Bevan Commission

Bliss

British Dental Association

British Heart Foundation

British Medical Association Cymru Wales

British Red Cross in Wales

Cancer Research UK

Cannabis 4 MS in Wales

Cardiff and Vale of Glamorgan Integrated Health and Social Care Partnership

Cardiff Third Sector Council

Care Forum Wales

Carers Trust Wales

Chartered Society of Physiotherapy

Children's Commissioner for Wales

Citizens Advice Cymru

CLIC Sargent

Community Health Councils

Cwm Taf UHB

Directors of Primary, Community and Mental Health

Directors of Public Health

Directors of Therapies and Health Sciences

Exercise for All Campaign

Expert Reference Group Domiciliary Care Wales

Faculty of Public Health

Faculty of Sport and Exercise Medicine UK

Future Generations Commissioner for Wales

General Medical Council

Hafal

Health, Social Care and Housing Group

Hospice UK

Jeff Cuthbert, Police and Crime Commissioner for Gwent

Learned Society for Wales

Lyndon Miles

Macmillan Cancer Support

Marie Curie

Mid Wales Collaborative

Mind Cymru

Motor Neurone Disease Association

MS Society Cymru

National Osteoporosis Society

National Provider Forum

Dr Neil J Kitchiner

Older People's Commissioner for Wales
Paediatric Continence Forum
Pembrokeshire Association of Voluntary Services
Powys Teaching Health Board
Public Health Wales
Public Service Ombudsman for Wales
RNIB Cymru
Royal College of GPs
Royal College of Midwives
Royal College of Nurses
Royal College of Occupational Therapists
Royal College of Paediatrics and Child Health
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Speech and Language Therapists
Royal College of Surgeons
Royal College of Surgeons Edinburgh
Royal Pharmaceutical Society
Samaritans Cymru
Sandeep Hammedi on behalf of Consultant Orthopaedic Surgeons
Social Care Wales
SOLACE
Dr Sue Fish
Swansea Centre for Improvement and Innovation
Swansea University Medical School
Tenovus Cancer Care
UNISON Cymru

Wales Ambulance Services NHS Trust

Wales Cancer Network and Cancer Implementation Group

Wales Principal Youth Officers Group

Welsh Language Commissioner

Welsh Language in Health and Social Services Partnership Board

Welsh Local Government Association

Welsh NHS Confederation

Annex D: Organisations and Individuals that Provided Oral Evidence

111 Roll Out Team

Academy of Medical Royal Colleges

Allied Health Professionals

Association of Directors of Social Services

British Dental Association

British Medical Association

Care and Social Services Inspectorate Wales

Care Council for Wales

Chief Medical Officer for Wales

Children's Commissioner for Wales

Community Health Councils

Director General of Health and Social Services, Welsh Government and Chief Executive of Welsh NHS

Director of Finance, Health and Social Services, Welsh Government

Director of Social Services, Welsh Government

Director of Workforce & Organisational Development, Welsh Government

Directors of Nursing

Directors of Therapies and Health Sciences

Directors of Workforce and Organisational Development

Primary Care Clusters

Health Inspectorate Wales

Macmillan Cancer Support

Medical Directors

Mid Wales Collaborative

National Provider Forum

NHS Chairs

NHS Chief Executives

Older People's Commissioner

Public Health Wales

Sir Paul Williams

Royal College of GPs

Royal College of Nursing

Royal College of Physicians

SOLACE

Welsh Council for Voluntary Action

Welsh Language Commissioner

Welsh Local Government Association

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