Parliamentary Review of Health and Social Care
Oral Evidence Session – Kate Chamberlain, Health Inspectorate Wales and Gillian Baranski, Care and Social Services Inspectorate Wales
6th April 2017

Present:	Panel Members	Notetaker
Kate Chamberlain HIW Gillian Baranski CSSIW	Jennifer Dixon Mansel Aylward	**REDACTED – WELSH GOVERNMENT OFFICALS**

Question: What are the top three priorities that you would like to see in the report?
There is an issue that social care is not valued and viewed as the 'junior partner'. This needs to change as it has massive operational implications. We need to change public perceptions. There are some very good providers as well as a vast number of very committed care workers, but the media portrays a different perspective. We therefore need a clear and professional career pathway for care workers, with schools and colleges all highlighting the opportunities of entering this sector. We need to raise the status of social care. There are currently 23,000 domiciliary care workers as well as those who work in care homes. However, LHBs pay more, and there is constant churn of staff through low pay, and the lack of a valued career pathway. In CSSIW inspections in 2015/16, 90% of the standards were met by care homes. These standards are outcome based and the statement of purpose of the home is used to judge the criteria.

The data available in this area is as good as it gets. However, there are 3 frameworks in Wales, which cause some confusion and double counting.

We fully recognise the impact of domiciliary care in Wales. Currently, we have 370,000 unpaid carers delivering 90% of care needs. Las also commission 20%.

Staff skills need consideration. The elderly now go into care homes with more complex needs (e.g. dementia). Staff skills therefore need to be updated to reflect these changes and ensure that residents are cared for appropriately.

We need to think about wider and longer-term care needs. People need to receive care and support of their own choices where possible. Hospital admissions should be a last resort. We have worked with the ambulance service to determine when people have been admitted, and considered what their care needs are.

We need to improve the commission of care. Currently the rules about funding are a barrier. We therefore need more competent procurement.

In addition, people need to be looked after in their own community where possible. We thus need to address the options of where care can be given, and need more flexibility and less emphasis on care home categorisation in order to achieve this. A seamless pathway and staffing would be needed also.

There needs to be a huge amount of will and partnership involved to commit funding. A clear mandate for integration is also required between health and social care.

The ability to work collaboratively. Even in their areas it is difficult to work collectively on everything. CSSIW inspections are more outcome-based, and look at the perspective of the person receiving care in line with legislation.

Kate and Gillian do some collective work, such as Deprivation of Liberty orders. However, the Care Standards Act makes it establishment-based, and therefore joint inspections are not possible. There is also some collaborative work in North Wales about healthcare input in care homes. This is examining core themes such as whether the care home is affected by the level and/or type of care required, as well as whether expectations are able to be met and achieved in practice. However, there is not always a straightforward pathway to working together.

The quality of nursing in care homes is regulated by CSSIW. However, there is a question about definitions: given the type of care provided when does a nursing home become a hospital.

here are also issues over the use of GPs. In some care homes, the local GP is a key player. However, in others, patients maintain their previous GPs, thus making understanding of issues and collective care needs more difficult.

How do you see the inspection models changing over the next 5 years? Where are there any overlaps?

6,500 settings are currently inspected by CSSIW. Of these, 4,500 are children-based, 1,568 are adult care settings, 244 are children's homes, 426 domiciliary care. There are also other areas inspected such as boarding schools. Therefore, the opportunity for crossover is small, but they are working hard to produce a joint approach with a clear interface that fulfils legal requirements.

2nd opinion doctors under the Mental Health Act are covered by Kate's area.

An operational plan has just been published. This proposes a small number of inspections per annum, but less are expected. Typically, acute areas in hospitals are inspected where there are concerns raised. However, are developing plans to cover areas such as GPs, dentists, operating theatres and outpatients. Nevertheless, there is still a gap with community programmes.

What is your alert mechanism?
The NHS has responsibility for managing its own concerns – unless they are brought to the attention of WG. However, WG does have its own processes in place: - There are flows of data reported to WG through DATIX. - There is a relationship manager for every hospital. We also have a concerns team and a panel that meets weekly. - There is a Risk and Escalation Committee which will question if a plan is right. - There is an escalation and intervention framework to determine monitoring/measures required. - Rapid response if an emergency is involved.
Where care is changing (e.g. online apps) are you active in these areas?
Some providers are active and we use them to make credible judgements or to look for the right support (e.g. Royal Colleges). In the case of apps. it is possible that there are a number that are operating that we are not aware of. We have the CQC guidance for apps. However, recently the BBC reported that there were 2 available that were not working with WG. However, in relation to apps, we rely on intelligence because we do not have the in-house capacity to monitor the web.
What can we do for the future? Why not go down the regulation route?
This is a good question to be asking now as we are looking to update regulation and policy areas. Because we can only inspect, there are problems with registering private services. There are also gaps in the legislation [Kate Chamberlain to send a paper to the panel].
Forward view: what do you think you need to adapt the existing models?

CSSIW have enough. However, HIW needs to be more service-based with better governance.

What would you like to see included in the review?

In 2003 there was the Wanless review, and 2011 the 'Transforming Your care review in NI. There is an expectation that the first two bullets of this review will be the same as those in the latter.

However, in terms of what expect to see in this review, it was felt that they were unable to describe what they wanted to see as they did not have a clear picture. However, the following was suggested:

- A future vision was needed.
- Engagement – it was not felt that Wales engages enough with the public. This is important as they need to want the changes.
- Make the vision local and not just national.
- WG needs to enable the people to do the things they want to do.
- Knowledge is needed on which areas of the statutes provide guidance on care.
- The end perspective needs to be citizen-based – i.e. about the end user. All complexity around this needs to be unpicked – otherwise outcomes will not improve.

Parliamentary Review of Health and Social Care

Oral Evidence Session – Sue Evans, Social Care Wales

6th April 2017

Present:	**Panel Members**	**Notetaker**
Sue Evans, Social Care Wales	Eric Gregory Anne-Marie Rafferty	**REDACTED –** **WELSH GOVERNMENT OFFICALS**

Question: What is a priority?
Priority was foundation level services that provided support at home and allowed citizens to maintain their independence. To do this, the service infrastructure needed to be as robust as possible. The NHS tended to be driven by diagnostic labels, whereas social care services tended to be more 'people' focused. SE was concerned that all too often when people spoke of 'integration' they were referring to organisational change, whereas the focus should be the alignment of the front line team and adopting a 'team around the family' approach. Focus on organisational or structural change was simply overcomplicating things – a more effective way was to let the front line arrange themselves in the best way. Regional Partnership Boards provided the appropriate level for planning and for delivering as effectively as possible, where local needs and contexts could be reflected in service models. SE provided the following examples of projects that had broken organisational management boundaries:

- The Frailty Service in Gwent and other services for OP in Wales, as described in the Social Services Improvement Agency's report about integrated services for older people.
- Mixed model housing development in Torfaen where private housing, social housing, an extra care facility, accommodation for people with learning disabilities were all available on one site.
- Aneurin Bevan LHB working with Housing Associations to accommodate people with NHS Continuing Healthcare Needs, moving them from institutional settings and achieving significant savings.

These schemes and projects relied entirely on strong local leadership and determination, and a commitment not to let boundaries, professional or geographical, act as a barrier to innovative projects.

Key principles?

The focus on the citizen – the start point was identifying the desired outcome and working backwards from there. Citizens were not generally given a strong enough voice. The best way to engage was to deliberately adopt multi-disciplinary approach – sometimes you had to push change, using evidence to "convince" reluctant practitioners, managers or leaders.

The processes that facilitated flexibility across professional boundaries included:

- adopting a problem solving approach, where evidence is used to agree the "problem"
- using independent facilitators where possible, to elicit common endeavour
- using Universities – they had academic rigour and were independent so did not play into the 'power'
- acceptance that there would always need to be compromise when working in a coalition of people

There needed to be a frank and honest conversation about resources (staff, skills and money). There seemed to be a rhetoric that integration would lead to money saving. This, however, was not necessarily true - it might not save money but it would be a better use of money. The uncertainty surrounding the future of Local Authority boundaries did not help the situation.

Local Government collaboration?

Social Services lent themselves to collaboration in planning and commissioning services. However, there needed to be parity in rates of pay as both health services and the social care sector were recruiting from, and competing for the same workforce, especially at the foundation care and support level. Regional partnerships should be maximised to agree common principles in terms of the rates of pay, but also to do some workforce planning, with potential to develop a "public sector bank" to avoid the use of independent agencies.

Staff morale – what would lead to a greater feeling of engagement?
Organisations needed to listen to their front line staff, as they often had solutions. Some organisations were better at doing that than others - Public Health Wales were cited as a good example at developing their staff and encouraging team building.

This aligned with citizen engagement.
Good examples of innovative projects to encourage citizens to strengthen their voice and to help themselves were:

- PHW Health Champions
- ICF funded Community Connectors
- Aneurin Bevan LHB CHAT team, which uses NHS retired volunteers to give OP in residential settings a stronger voice
- Wales Co-operative Centre & Disability Wales joint work to promote Direct Payments
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There needed to be a more consistent approach in communicating key messages – lifestyles changes were generational, therefore messaging to the public on public health matters needed to be regularly reinforced. For those reluctant to listen, the push needed to come from community leaders. This did not necessarily mean "health" officials – it should be whoever was well respected and had gained the trust of the local community for instance a police officer, play group leader, faith leader, housing officer.

There also should be more flexibility in funding arrangements such as centrally awarded grants management. The current process did not allow for variation or community involvement, which reflected local needs and contexts.

How to get the balance right between national and local decisions?
It was about finding the right level, and being pragmatic about it. Generally, people were not good at quickly sharing and adopting best practice – This may be due to time and capacity restraints but this is a missed opportunity. Some people could be precious about their successes if they had not been recognised for their endeavours, others may be reluctant to share lessons learnt from unsuccessful projects. The focus should be on learning and sharing why things did not work. There was also a fear of media scrutiny which impacted on behaviour. The focus in the media was always negative –a balance of good news stories would help practitioners feel more valued. There needed to be transparency and accountability but it was difficult to manage the media as they clearly had their own agenda. SE had a monthly column in the Western Mail, which provided a good opportunity to praise the good work taking place across the sector.

Relationship with the Third Sector?
Fiscal pressures meant more responsibilities were being edged towards the Third Sector. The Third Sector was a valuable part of the system. SE viewed the third and independent sectors as equal partners but this was not a universal perspective.
SE felt that there was a good opportunity to tap into the potential of Social Enterprises. However, they were not growing fast enough for transfer of function from the NHS and Social care. Funding social enterprises might be a wise investment.

There was also a need to look at commissioning groups within Regional Partnership Boards to ensure consistency of commissioning activity between the NHS and Local Authorities, where it made sense to do so, eg care and support at home.

In terms of engagement, are we hearing the citizen's voice? Are young people involved?
There was engagement with citizens, although it was difficult to reach out to those who did not normally get involved with these types of exercises. Engagement with young people was crucial to change perceptions about working in the social care sector. Tapping into career advice and programmes would be a good way of doing that, and presenting social care work as a rewarding and valuable career choice. Social Care Wales will be focussing in this area during 2017. Decisions were sometimes made about qualifications that did not take into account the impact on workforce and Social Care Wales are working with Qualifications Wales to improve current arrangements..

There were 384,000 estimated unpaid carers in Wales – they needed to be acknowledged as an asset. This should also feature in education programmes delivered by health and social care organisations. Most regions had Joint Carers strategies, where priorities for supporting carers were agreed across health and social care and there is potential for learning across Wales.

Parliamentary Review of Health and Social Care
Oral Evidence Session
6th April 2017

Present:	Panel Members	Note takers
Andrew Goodall	Ruth Hussey Jennifer Dixon Eric Gregory Keith Moultrie Nigel Edwards Anne Marie Rafferty Dame Carol Black Mansel Aylward	**REDACTED – WELSH GOVERNMENT OFFICALS**

Question: What would want in this review?
Background: The existing strategy for the NHS has not been renewed pending the outcome of the parliamentary review. Cross party agreement for Parliamentary Review. Scrutiny is high in Wales. Three themes: • Delivery and accountability. • The offer of sustainable systems and services. • Understanding service change in integrated organisational structures (move towards population health and community services). System Culture and Behaviour • As CE of a HB it is possible to get on and do 98% of what is needed. • Concern some organisations seeking permission and direction for difficult decisions. • Some organisations have good plans and implement effectively and others do not. • Accountability is expected and has improved in Wales recently, clear accountability should enable not suppress action.
Question Variance in HB performance- how to boost pace of change?

- Have recently extended planning cycles from 1 year to 3 years, but need to think a decade ahead.
- Have an escalation system now to demonstrate where support is needed and that poor performance is not acceptable. This has not been in place previously and is a shift of tone and accountability.
- Have used quality improvement e.g. 1000 Lives, this needs to be engrained into every day life.

Question If HB's achieving standards but not driving change from secondary to primary care what happens?

- Each HB has responsibility not only to address traditional areas of performance but wider system needs.
- Each HB has a responsibility to address needs of the whole Wales population AND the local population this needs to be restated.
- End of year reviews have provided the opportunity to broaden conversation from acute areas only.
- Primary care plan for Wales sets out actions and a framework for local delivery.
- Funding directly to primary care clusters was used to reach around Health Boards.
- Need mature debate on different outcomes and measures that look at outcomes and value to ensure the system is driven on the right issues.

Question Confidence around supra health board decision making?

- Structures set up in 2009 for a reason, but one of the consequences is that finance does not flow between organisations
- Disappointed at collective decision making across health boards.
- Austere environment with need to make difficult decisions.
- Using allocation process to encourage better joint decision making this year.
- Confusion regarding organisations responsibilities in respect of regional or cross boundary decisions/initiatives for the local and wider population – their role is actually to do their best for the Welsh population also.
- Restate position on population focus in Wales.
- Decision making at National level exposes Ministers to decisions, that need to be made first by the service.
- Intermediate mechanism may be required for supra health board decision making, or a more effective central decision making mechanism to make a decision or call quickly, including the point at which Ministers are involved.

Question Effective Transformation al Change?

- 'Together for Health' set the right aspirations, but it has not all been delivered, but progress has been made.

- Primary care has been a priority for a long time, but it is only now being delivered more practically, for example, via clusters.
- Delivery requires the right mechanisms, endorsement, and incentives with a clear goal and quality narrative.
- Adopt or justify mechanism is needed to ensure compliance at pace, rather than allow slower take-up.
- WAO – use their identified good practice and other sources.

Question Staff involvement?

- Staff need to feel involved.
- Leadership is key.
- The best ideas are staff ideas.
- 1000 Lives has made a difference as it has not been spread too thinly and it provided a mechanism / movement to connect leaders with front-line staff..
- Best change configurations are where staff are fully involved.

Question Workforce

- Long term plans needed (decade) to help workforce planning, three years may not go far enough
- Joint workforce planning for health and social care required.
- Need to focus on community roles and ensure the resource is there to underpin this agreed strategy.
- Needs to consider training and induction.
- There is a new cohort of health and social care workers in Wales that can be utilised across the system with appropriate supervision.
- Terms and conditions aspect needs to be dealt with for the longer term.
- Clusters working well in Wales.
- Good relationships with trade unions in Wales – this gives us a foundation for action.
- Not sure that it is enough clarity for individual organisations to plan – needs workforce planning across health & social care.

Question integration?

- Much success here e.g. Regional Partnership Boards; pooled budgets.
- Harness regional approach.
- Some good examples of integration in Wales.
- No need to wait for legislation to start for integration to occur, but some places appear to be waiting for it rather than moving forward..

- Ideally citizens' needs should be addressed without needing to know which organisation does what.
- There should be no 'tennis match' between organisations about funding. Pooled budgets make sense.
- Structures in place are supportive of integration.

Question CAHMS?

- Has been an intractable issue in Wales, but waiting times improved. Progress has been made in this area.
- Early intervention and prevention should be a focus; getting to people as early as possible.

Question Clinical Plans not implemented?

- Good integrated system in Wales.
- Need to free up GP time for an oversight role; clusters a positive experience
- Able to follow through on plans e.g. Ambulance Services change in measures to be more meaningful, nationally endorsed and adopted. Important to have clinical ownership and support for the measures.
- Easiest change is with the clinicians e.g. South Wales programme.

Question Accountability?

- OECD report described weakness in accountability. This has been responded to in attitudinal and structural terms e.g. IMTP process and sign-off, performance management and escalation. Further to go on this agenda but the system has been pushed much harder over last 3 years.
- The fact that the first "special measures" decision in Wales was taken, is an example. Escalation Framework is there to be used.
- Leadership challenge to explain the seriousness of the situation.
- Governance issue, need engaged Boards.
- Skills and capability issue. Skills are needed including cross sector working; planning capability needs to mature, and the ability to make things happen. Organisations measured on what they do and deliver.

Question Need to be more directive to spread innovation?

- Where there is traction, letting things build organically works well.
- Where there is limited traction a more directive approach may be required. We need to be better at promoting the good practice, so no excuses for knowledge; but also be clear on need for compliance and change.

Question Prudent healthcare?

- Political endorsement to use prudent principles.
- The best 3 year plans use the prudent principles as a challenge.
- Principles can be applied at the strategic and operational levels.
- Need to shift the focus onto broader healthcare – if we keep focusing on acute, then acute is what the service will provide. We should get wellbeing into the health space.

Question Resource allocation?

- Formula in place which has recently been adjusted to include weighting for older people and changes to the population.
- Need a value and outcome focus.
- Every organisation has a view on resource allocation that suits its own "unique" needs – it is important that we act as guardian centrally.

Question Exploit digital and Shared Services Partnerships?

- Procurement approach (Carter Report).
- Innovation and industry contacts.
- NHS as an anchor company in Wales, offers the chance for NHS as a much broader contributor across Wales.

Question Information and Informatics?

- Data is there to be used.
- Citizen Focus.
- Once for Wales e.g. ICT. Should reinforce need for consistency as this brings patient benefits.
- Data for future planning, simulations and modelling could be something Wales is known for in the future. We are seeing some really good examples emerge.

Question Final comments?

- Retain ambition in Wales.
- Proud of achievements in Wales.
- Ambition needs to be matched with delivery now.
- Encourage change in culture and behaviour
- Need mechanisms to deliver the ambitions.

- AG offered a further note as written evidence on six key areas where Wales can be distinctive looking forward (subsequently provided).

Parliamentary Review of Health and Social Care
Oral Evidence Session
4th 5th 6th April 2017

Present:	Panel Members	Notetaker
Alan Brace, Director of Finance, Welsh Government	Ruth Hussey Nigel Evans Carol Black Jennifer Dixon Keith Moultrie Don Berwick (VC)	**REDACTED – WELSH GOVERNMENT OFFICALS**

Question: What are the big things you would advise us to put in the final report?
1. We must move to value-based healthcare. Resources must be mapped onto outcomes – functional outcomes that make a difference to people, not just technical outcomes. The Commonwealth Fund Study sees the NHS as a good system; an outcomes perspective gives a slightly different analysis. We are too preoccupied with measuring things like diagnostics waiting times; but these are difficult to change when we are not preforming well at them. Need differs across Wales, especially between rural and urban areas. We need to allocate resources centrally according to need and be agile in this. 2. The aging population and poor indicators on healthy behaviours are real challenges. It's not just about efficiencies. We need to challenge the view that you can live any lifestyle you want and there will be free healthcare. Structural change is not the answer; lots of answers lie outside healthcare. Leveraging these across different areas is an advantage of a small country government. 3. Integration of health and social care and housing. There are lots of perceived barriers to this. We need to find policy/legal ways to be more flexible. We need to resolve workforce terms and conditions. More can be done to pool people and get them working together.
Question: Which areas should Government focus on?
• Primary care and integration vision in strategies is not matched by money coming from the acute side. Savings coming out of primary care are not going back in. We need to align funding to strategic priorities.

- We must make the system technically efficient to have headroom to move on the resource side. We need to move large chunks of money into the system. In the Intermediate Care Fund, money has made a difference.

Question: In practice how do you shift money out of hospitals to primary care? Do you have enough teeth at the centre?

- Local Health Boards (LHBs) are struggling because of costs in people and buildings. We are wasting money plugging holes we won't fill.

- We could join up more at the centre. We have an advantage in Wales because policy and delivery are knitted together through the Chief Executive of the NHS. But we do lack capacity in the centre. Within Welsh Government there has been a patchy response to Prudent Healthcare. But we do not want a separate body like NHS England.

- LHBs are not maturing quickly enough. But there is stability in the boards. There is something in the intermediate space that we can do. We could do more by pressing boards to do more with tighter timescales and directing the pace.

Question: How rigorously are you going through the Carter Report in England?

- Efficiency productivity boards are managing some of the Carter recommendations now; e.g. on nursing and workforce rostering.

- On some areas Carter identified in England we are ahead. We are further on with standard procurement. E.g. we are less fragmented in our approach to purchasing medical consumables than in England.

- Planned care is pathway driven. We are slow at managing out unwarranted variation. We have too many people advising on flow. We are preoccupied with flow in certain parts of the system, but not the whole.

Question: Would you be able to spot if efficiency/productivity were increasing?

- Measurement is quite blunt currently. We can use a time-driven methodology, valuing clinicians' time.

Question: How does money flow from Cardiff?

- We are starting to benchmark each against each other more now, although a lot of money flows out under an older system, adjusted marginally.

- We could change the formula for allocation. But instead we have tried different ways not to destabilise the system. It is not the wicked issue to solve, however.

- The NHS does not always like grip from the centre – but we put in firm rules for Long Term Agreements (LTAs).

Parliamentary Review of Health and Social Care
Oral Evidence Session – Older People's Commissioner
5th April 2017

Present:	Panel Members	Notetaker
Sarah Rochira	Keith Moultrie Jennifer Dixon	**REDACTED – WELSH GOVERNMENT OFFICALS**

Question - First priority for the report
Increased integration of Health and Social Care, with greater funding flexibility, as has been seen in the Intermediate (soon to be re-named Integrated) Care Fund. Many examples exist of creative, flexible approaches which enable services to be responsive to individuals and their changing experiences. These exist in the Third sector, statutory public sector and in partnership arrangements. However, these only exist when they are enabled by flexibility of funding, e.g. by providing posts which span multiple organisations. Local leadership is also key to the success of these projects. The lack of stability of project funding and lack of flexibility within established contracts can constrain service design and delivery.
Question – Are you supportive of the emphasis on involving the citizen in design and delivery?
Not necessarily as many citizens involved with these services are experiencing difficulties or crises. A strategic approach which relies on citizens in difficult times to take the pressure off the state is inappropriate. Supportive of the **strengthened focus on outcomes** utilising existing opportunities as more likely to be successful. For example, the SSWB Act, the WFGA and the NHS Outcomes Framework are all valuable sources of information. There is a need to consolidate these sources but good data on outcomes is very valuable. Many examples exist in Wales of high impact, low cost, innovative and well-integrated approaches, but very few social enterprises are currently involved in these.

Question – Second Priority for the report

Increased capacity in Primary care and co-location with Community Services.
While in a period of unprecedented demand it can be difficult for services to maintain a focus on prevention; however, it is absolutely vital.
80% of contact with the service user happens in Primary Care settings, so the development of Primary Care hubs is an opportunity to provide many of the services key to maintaining health and well-being. The range of provision of services could be expanded in these hubs, to include housing, social care counselling services and other agencies.
The importance of 'health maintaining services' such as public transport, public toilets, benches, lifelong learning opportunities needs to be recognised. These services have faced disproportionate funding cuts from Local Authorities, yet they have a significant impact on the health and wellbeing of older people.

There are **regional shortages** of carers, nurses GPs and these need to be addressed.

Question – Third Priority for the report

Recognition of Carers as an important asset and strategies to ensure that these assets are fully realised.
Statutory services rely on carers but the relationship needs to be re-defined. Key issues such as respite, training and qualitative indicators of well-being should be included in plans. In many cases the carers are retirees themselves.
It is important to change the paradigm from seeing older people as a burden and recognising that an ageing population is a positive situation.
There is a reasonable expectation from older people that the social compact they entered into during their working life will be honoured.
There are opportunities for raising awareness and understanding of the new, prudent approach to healthcare among older people, for example heath literacy champions in organisations such as the WI.

Closing comments – other areas that need focus:

- Dementia services – skills and training
- Pre Registration and Post Registration basic training to cover engagement with older people

Parliamentary Review of Health and Social Care
Oral Evidence Session
4th 5th 6th April 2017

Present:	Panel Members	Notetaker
Dr Frank Atherton Chief Medical Officer Wales	Ruth Hussey Carol Black Keith Moultrie Nigel Edwards Mansel Aylward Don Berwick (via VC)	**REDACTED – WELSH GOVERNMENT OFFICALS**

Question: What might be headlines of report about current position?
There were good things to highlight and health outcomes were improving. Although inequalities were being tackled, they affected outcomes negatively, as did the state of the Welsh economy. Services needed to be configured to deal with the growing 60 to 80 year old population. Other important issues were engagement with the public and clinicians. There needed to be an underpinning strategy looking 25 years ahead and considering the ageing population, technological developments and inaction as influences on health and the need for services.
Question: Were there areas of deficit compared to other areas?
The recent OECD 4 nations report was accurate in its description of the service model. There was relatively less robust commissioning in Wales.
Question: How could we get change?

Wales had a planned system with integration in place of commissioning. This could fall down outside the LHB area and it could be difficult to move forward at the national level. An example was hyperacute stroke services with 13 facilities whereas 5-9 might be a more rational number. However, there were constraints due to the present structure and financial levers may not always align with outcomes.
Question: Was there a planning gap or an implementation gap?
Good on strategy, poor on delivery had some truth.
Question: There seemed to be parallel health and social care systems – were there gains to be had from integration?
In Nova Scotia there was full integration. Here in Wales there was a good framework in legislation and Partnership Boards. Cwm Taf was well integrated with co-location of staff, but it was not as advanced everywhere. We need to be clear about what integration means. There were sometimes budget issues that led to actions that were not optimal. There were different considerations depending on whether core or marginal budgets were integrated.
Question: Were there levers for more responsive and more integrated systems?
IMTPs for the health service did not often look at joint performance, which would help.
Question: What changes to the workforce or new models were important in the short term?
Workforce planning was a “dark art” to some. However, there were some good things and prudent healthcare was driving some interesting initiatives. An example was GP time being freed up by physiotherapists in practices, with equally good patient outcomes. How could this be rolled out? There was sometimes a “not invented here” syndrome and not enough learning and sharing, which also was not incentivised. In primary care there should be more multidisciplinary arrangements replacing single-handed practices. Examples were the use of therapists,

pharmacists, physician assistants, nurse associates and anaesthetic auxiliaries. Evidently these arrangements would need regulation and appropriate governance.
Question: What was being done to address inequalities?
Income inequalities were not reducing, so holding our own on health outcomes was progress. There were encouraging initiatives such as the Valleys Task Force that might help with wider determinants of health.
Question: Inactivity was an issue – were there better ways of addressing this?
None the less there was enthusiasm and extensive involvement in volunteering. There could be new cadres in the health system, but these people would need training.
Question: Was there a lack of connection between public health services and local authorities?
There had been no migration of services to LAs as in England, but this might not be a problem given the existence of Partnership Boards and investment by Health Boards.
Question: Was the government adequately informed about the quality and level of services?
There is a Quality Delivery Plan for the NHS in Wales and IMTPs have a quality aspect. There needs to be a systematic top-down approach as well as the regular meeting on quality and performance with health boards. We needed to look at extending and making more specific to Wales the “1000 lives” approach.
Question: Was prudent healthcare a concept or structure? Did it deliver results within costs?

The principles were good and well-articulated. However we were not driving forward as we could. There should be a programme as well as a philosophy, engaging with clinicians and the public. Exemplars of good practice in dental care and pharmacy could help to spread benefits.
Question: Was the data available and used to measure prudent healthcare?
There was no shortage of data, but was it being used well? There was fragmentation, with different developments in different places. There was no Chief Knowledge Officer for Wales, unlike other places. Some measures were available, such as DMFT measures for dental services, but it was harder to measure aspects such as co-production, which was more amenable to an academic approach.
Question: What were the barriers to take up of good practice?
The factors included general “busy-ness”, costs and a failure to reward or indeed measure innovation.
Question: Given the difficulties you discussed about actions at a regional and higher level, was there a need for an NHS Wales organisation as in England?
There was a problem but a large NHS Wales taking resources from elsewhere was not necessarily the answer for a population of 3 million. There was a lack of a “controlling mind”. Collaboration should have teeth and there should be an overall strategy for health in Wales – that might need legislation. A long-term view of the future of social care was also needed to set out how institutional care should be provided when it was needed.

Parliamentary Review of Health and Social Care
Oral Evidence Session
1 June 2017

Present:	Panel Members	Note taker
Julie Rogers	Ruth Hussey	**REDACTED – WELSH GOVERNMENT OFFICALS**

Question: What is needed in relation to Workforce for Wales from this report?
• We have all the enablers in place, e.g. legislation, contracts. • There is a need to workforce plan better. • It is convenient to hide behind workforce shortages. • The block in the system is system change thinking. • The vision is clear but the blueprint for change is not.
Question: Update on Health Education Wales (HEW)?
• The programme to create HEW is live. Programme Board is established with 8 work streams. Due 1 April 2018. • There will be an announcement before the summer on the functions of HEW. • HEW will appoint staff from Jan 2018 to allow run in period. • It will cover all health but not social care (Social Care Wales has this remit). • There will be core functions of the organisation plus an annual letter from WG. • It is likely to include a requirement to work in partnership with Social Care Wales. • HEW may also include an improvement element too, a duty to work with 1000 Lives is likely.
Question: Integrated career structure for Health and Social Care?
• Not an integrated health and social care career framework yet. • Work has started but is slow on the development of an integrated career framework. • Health Care Support Worker framework is in place, this could be transferred with tweaks to social care. • HCSW implementation has been patchy. • No joint pay scales for health and social care.

- Unsure if joint workforce planning happens at Regional Partnership Board level this could drive integration.
- There is work on a public sector workforce planning and data was collected for this 2 years ago.
- Principles of workforce planning for health have been established and have been shared with other sectors.

Question: Generalist/Specialist mix- what's happening to address this?

- A report is due after the election.
- We are locked into a UK system.
- There is concern any localisation will mean Wales cannot then attract trainees.

Question Contracts are often hospital based could they be regional or area specific?

- Appointing to a HB or area is possible now, but is not being used widely.
- Medical recruitment occurs at HB level with individual contracts and checks for each rotation, this could be centralised, and has been well received by GP's. there are concerns that some HB's may not attract staff.

Question Leadership and Management especially middle management- how is this being addressed?

- Leadership and Management is the responsibility of each HB.
- When NILAH was disbanded there was a loss of once for Wales leadership capacity, each HB has its own leadership and development scheme.
- There are no common standards or expectations, this is labour intensive.
- Each organisation has been working on their values and behaviours too, and each has an appraisal process in place.
- There is likely to be a bi annual staff survey.
- Some HB's are looking at measuring staff satisfaction more regularly via apps. WAST has a good example of best practice in this area.

Question What progress has been made on digital and workforce?

- Little, most relates to e rotas and e learning.
- There is a general lack of OD capacity in HB's most come from a background of learning and development rather than OD.

Question Cluster progress and workforce issues?

- Clusters are all developing differently. Some models are working and others are not developing at the same pace.
- The route map is not clear.
- Accountability is routed through a Primary Care Board.
- There is a Ministerial Task and Finish Group which includes the cluster leads and workforce planning happens through this group.
- Primary Care Workforce plan and stock take is being undertaken. Julie will send this through.

• Train, Work, Live is being implemented in three phases, GPs, nurses and AHPs.
Question Leadership?
• Need for separate Chief Executive of the NHS and Director General of Health and Social Care. Both are full time roles, with wide ranging responsibilities and this would bring more capacity. • There is a need for operational delivery teams and separate strategic planning functions in WG.
Question % of training in rural areas for Wales?
• Julie will send information through on this as unsure.
Question Other issues?
• Consideration of a medical school in Bangor is underway, there is a lack of infrastructure at the moment. Significant capital investment would be required. There may be an option to have placements in North Wales. Other options would be to look at partnering with Chester or Liverpool. • Imaging Academy- expecting an announcement on this soon.