

NHS WALES WORKFORCE REVIEW

David Jenkins OBE, Professor Ceri Phillips, Professor Stuart Cole CBE and Martin Mansfield

February 2016

CONTENTS

CHAPTER 1 – BACKGROUND.....	2
CHAPTER 2 – INTEGRATION.....	10
CHAPTER 3 – DEVELOPING THE STAFF AND SKILL MIX.....	26
CHAPTER 4 – AREAS OF POTENTIAL EFFECIENCIES.....	37
CHAPTER 5 - PAY AND OTHER TERMS AND CONDITIONS OF EMPLOYMENT.....	44
ANNEX A – TABLE OF RECOMMENDATIONS.....	55
ANNEX B - NHS WALES WORKFORCE REVIEW WRITTEN STATEMENT.....	58
ANNEX C - COMPOSITION OF THE REVIEW PANEL.....	59
ANNEX D(1) - CALL FOR EVIDENCE LETTER FROM DAVID JENKINS	60
ANNEX D(2) - BACKGROUND AND CONTEXT ISSUED WITH LETTER	61
ANNEX D(3) - CALL FOR EVIDENCE QUESTIONS	65
ANNEX E – WRITTEN EVIDENCE PROVIDERS.....	68

CHAPTER 1 - BACKGROUND

- 1.01 At the same time as agreeing a two year pay award in 2014 for NHS Wales staff employed on Agenda for Change (AfC) contracts, the Minister for Health and Social Services, Professor Mark Drakeford AM, announced his intention to set up an NHS Wales Workforce Review to consider a range of workforce and pay issues in the context of the Nuffield Trust Report *A Decade of Austerity in Wales?*¹ The ministerial written statement is provided at Annex B.
- 1.02 A Review Panel, independent of Welsh Government, was established in April 2015. David Jenkins, Chair of the Aneurin Bevan University Health Board, was asked to chair the Panel and Professor Ceri Phillips, Head of the College of Human and Health Sciences and Professor of Health Economics at Swansea Centre for Health Economics, Professor Stuart Cole, Emeritus Professor of Transport at the University of South Wales, Martin Mansfield, General Secretary of the Wales TUC and Dr. Clare Gerada, Partner in the Hurley Group London and former Chair of the Council of the Royal College of General Practitioners were asked to serve as Panel members. (Having initially agreed to join the Panel, Dr. Clare Gerada had to subsequently withdraw due to her other commitments.) The full panel composition is provided at Annex C.
- 1.03 The Minister invited the Review Panel to consider the following matters and to report no later than February 2016.
- a) The identification of new models of service delivery which are at the forefront of the integration of health and social care together with an analysis of the barriers experienced by such models and associated ways of working.
 - b) The workforce of the future and the staff and skill mix the NHS needs to ensure people receive high-quality care as close to their homes as possible.
 - c) Areas of efficiency, taking into account the principles of prudent healthcare, to help address the long-term financial challenge between 2016-17 and 2025-26 as identified in the Nuffield Trust report *A Decade of Austerity in Wales?*.
 - d) The long-term strategic direction for pay and reward for people currently covered by the UK Agenda for Change contract terms and conditions and for people employed in executive and senior posts. This will include the affordability of future pay and rewards within the context of the Nuffield Trust report *A Decade of Austerity in Wales?*; and the approach to considering, determining and setting future pay and rewards.

¹ Nuffield Trust Report: A Decade of Austerity in Wales?:
http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140617_decade_of_austerity_wales.pdf

The context

- 1.04 The Review Panel was asked to look ahead within the context of the findings of the Nuffield Trust Report, *A Decade of Austerity in Wales?* The Nuffield Trust Report was published in June 2014 and was, in part, an analysis of what was then the known budget of Welsh Government and its financial allocations to NHS Wales through until 2015/16. Since the publication of that report, Welsh Government has upwardly revised its financial allocations to NHS Wales in 2014/15 and 2015/16 and this means that NHS Wales is in a better financial position at the end of 2015/16 than was anticipated by the Nuffield Trust.
- 1.05 In looking forward to 2025/26, the Nuffield Trust used three scenarios to describe the level of NHS Wales funding that might be made available by Welsh Government in the years between 2016/17 and 2025/26. The first scenario assumed that funding would be held flat in cash terms with no allowance for inflation. The second scenario assumed that funding would be held flat in real terms with funding rising in line with inflation. The third scenario assumed that funding would be increased in real terms with funding rising in line with inflation and the predicted increase in UK gross domestic product.
- 1.06 The Nuffield Trust then examined the predicted growth in our population (5% growth between 2012 and 2025), the predicted growth in our older population (26% increase in the number of people aged over 65 between 2012 and 2025), the increasing incidence of chronic conditions within our population (35% increase in hospital admissions for chronic conditions between 2002 and 2011), the growing number of items prescribed by community pharmacists (up by 4% per year between 2002 and 2010) and the increasing number of GP and practice nurse consultations by people aged 16 or over (10% increase between 2004 and 2010).
- 1.07 It then looked at the long term trend for pay in the NHS and it found that pay for NHS staff (including doctors, nurses, other professionals, support staff and managers), had risen on average by about 2% per year in real terms between 1975 and 2010.
- 1.08 They then considered the likely financial consequences if these trends were to continue through until 2025/26 under each of their three funding scenarios. They deliberately made no allowance for productivity improvements or other cost saving measures in these calculations since the purpose was to identify the size of the productivity and cost saving challenge. Under the first scenario, (where there is no increase in funding), the funding shortfall in 2025/26 was predicted to be £3.6 billion (in 2013/14 prices), under the second scenario, (where funding increases in line with inflation), the funding shortfall was predicted to be 2.5 billion and under the third scenario, (where funding increases in line with inflation and predicted economic growth), the shortfall was predicted to reach £1.1 billion. Putting this another way, under the first scenario the NHS in Wales would need to reduce its expenditure every

year by 5.8% in order to keep in balance. Under the second scenario expenditure would need to be reduced by 3.7% each and every year and under the third and most favourable scenario expenditure would still need to be reduced annually by 1.5%.

- 1.09 The savings that are identified as being necessary in each of the three scenarios are all greater than the long term trend for productivity improvement in the NHS, which the Office for National Statistics calculates as averaging 0.5% a year between 1997 and 2010. Whilst health boards and trusts in Wales have been delivering higher levels of savings recently, as austerity has demanded both greater efficiency and short term cost avoidance, this suggests that in the longer term, productivity growth of itself will not deliver the savings required, even under the most favourable funding scenario.
- 1.10 As mentioned earlier, the financial position of NHS Wales at the end of 2015/16 will be better than was forecast in the Nuffield Report, with Welsh Government having allocated an additional £200 million each year in 2014/15 and 2015/16 and having stated that this will be recurrent thereafter. In their most recent budget announcement in December 2015, Welsh Government published plans to increase health spending by a further £278 million in 2016/17, which will mean that for three successive years health funding in Wales will have risen in line with and for 2016/17 ahead of the 3.2% cost inflation rate which the Nuffield Report identified as the underlying cost pressure facing NHS Wales. However, given the scale of the financial challenges that emerge under each of the three funding scenarios, these additional resources, whilst certainly helping to ease immediate funding pressures, do not remove the longer term challenges that lie ahead.
- 1.11 With demand for NHS services changing as our population becomes older and with the number of people living with chronic conditions increasing, it is essential that our NHS workforce is deployed and equipped to deliver the new models of care that will be required to meet these changes in demand. With workforce costs accounting for almost two thirds of hospital costs and approximately half of all NHS Wales spending, it is essential that we get our workforce plans right, both for service and financial reasons. Getting it wrong will mean poorer, less accessible services, with staff unable to meet the new demands in a timely fashion. Getting it wrong will also mean a highly inefficient use of resources with staffing not aligned to demand and managers forced into financial expediency.
- 1.12 This then has been the context for the Review. A decade in which if we do nothing different we will see demand for NHS services in Wales outstripping available resources.

Engagement and evidence taking

- 1.13 If carrying on as we are is not an affordable option, what changes should we be looking to make and what sort of workforce will we need to deliver the changes? In seeking to address these matters the Review Panel sought the views of all who have an interest in the future of the NHS in Wales, writing to health service staff unions and professional bodies, health boards and trusts, executive directors, universities and colleges that provide the education and training for our health workforce, local government which carries responsibility for social services and community care, private health care providers who play a major role in providing nursing and care home services, the voluntary sector which provides valuable support to patients and their families and which is the main provider of palliative care, and last but not least the Community Health Council which represents the users of the National Health Service in Wales. The Panel received over sixty written submissions and heard oral evidence from NHS staff organisations and Directors of Workforce & OD.
- 1.14 The call for evidence documentation and a list of organisations that contributed views to the Review are included at Annex D and E.

NHS Wales workforce

- 1.15 NHS services in Wales are delivered by a broad and diverse range of professionals and support staff. There are those directly employed by the NHS, such as doctors and nurses, either on an AfC, medical and dental or executive contract and those who are independently contracted staff in primary care, such as general practitioners and their support staff, dentists, pharmacists, optometrists, who are not employed by the NHS. In considering the terms of reference of the Review we have focused primarily on the directly employed 'NHS workforce' with consideration to other staff groups where appropriate.
- 1.16 Actions in respect of primary care are being considered through the *Welsh Government/NHS primary care workforce plan*².
- 1.17 NHS Wales employs some 84,000 people – (73,600 full-time equivalent), along with an additional 4,000 independently employed practitioners. The workforce is one of the primary drivers of current and future health and social care costs, accounting for over 60% of health boards' revenue expenditure and amounting to £3.2 billion in 2014/15. Medical staff account for 8% of the workforce and 21% of the cost with nursing representing 30% of the workforce and 32% of the cost. The cost of training health professionals differs significantly between staff groups. For example the estimated

² A Planned Primary Care Workforce for Wales:
<http://gov.wales/docs/dhss/publications/151106plannedprimarycareen.pdf>

cost to educate and train a medical student to registration is £235,000, while a physiotherapist is £68,000 and a nurse is £79,000³.

1.18 The number of staff employed in NHS Wales has remained fairly consistent over the recent past but there has been significant growth in certain groups, as shown in Fig 1. There has been little change in the band profile of the workforce in recent years (Fig 2), but the age profile of NHS Wales workforce has increased, showing an ageing medical demographic (Fig 3).

³ Unit Costs of Health and Social Care 2014: <http://www.pssru.ac.uk/project-pages/unit-costs/2014/>

Fig. 1 - NHS Wales Workforce Profile⁴

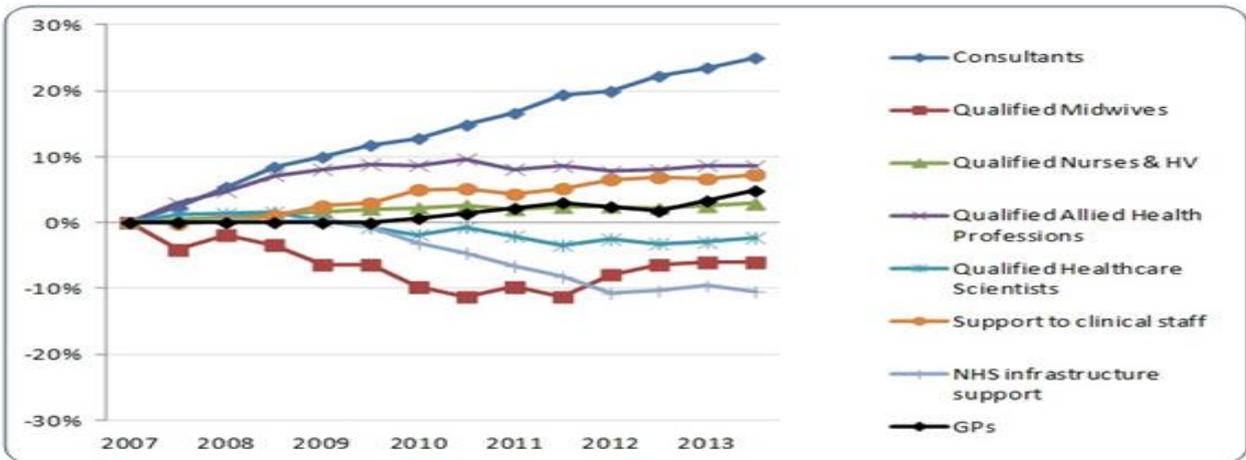


Fig. 2 - NHS Wales Workforce Agenda for Change Band Profiles (WEDS data, 2015)

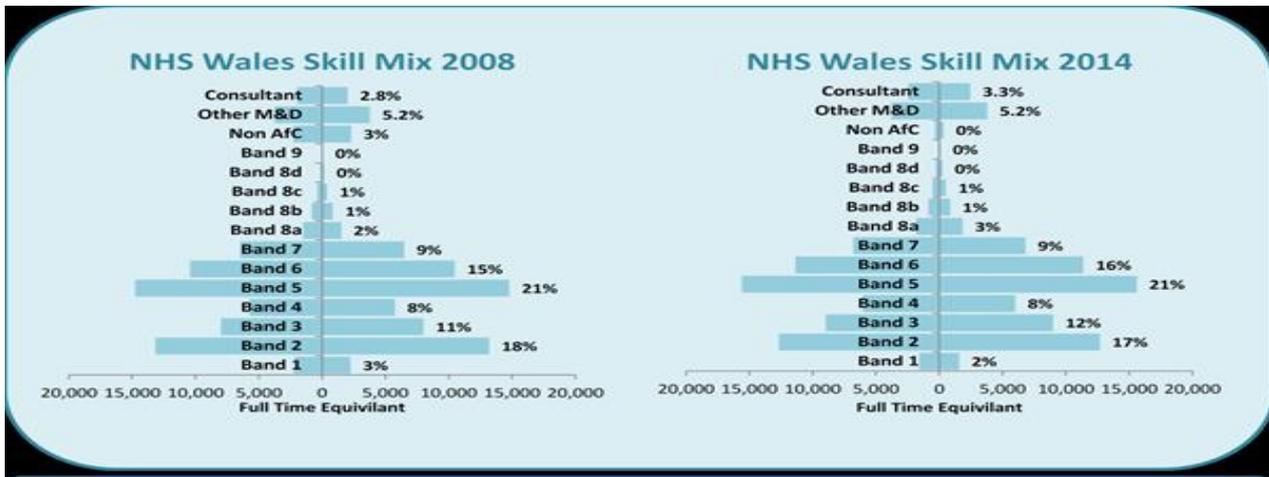
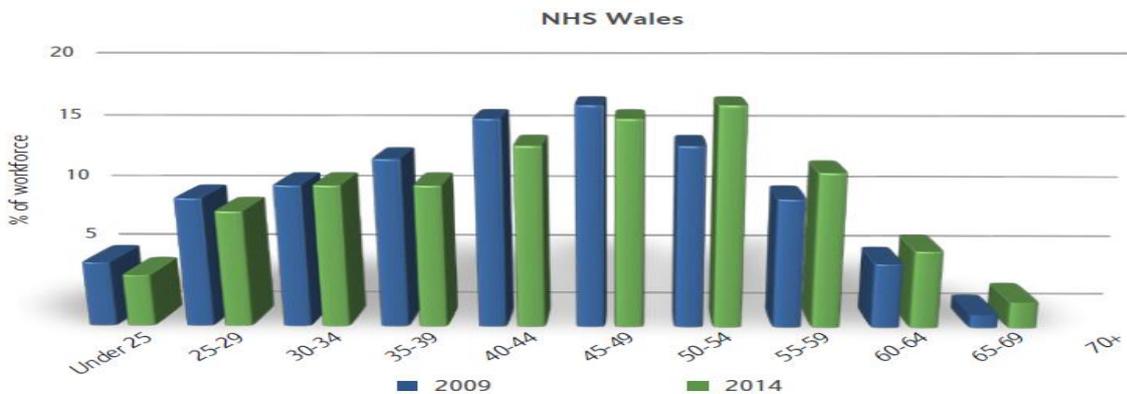


Fig. 3 - NHS Wales Workforce Age Profile (WEDS data, 2015)



⁴ NHS Wales Key Themes and Trends:

<http://www.wales.nhs.uk/sitesplus/documents/866/3.3%20Appendix%20NHS%20Wales%20Workforce%20Key%20Themes%202014%20-%202017.pdf>

General observations

- 1.19 Before we start to examine the four specific questions that we have been asked to address, there are three general observations we need to make.
- 1.20 A common starting point for any discussion about workforce planning and redesign has been to question what the expectations are for the services that the workforce will be delivering. It has been generally held that since the purpose of a workforce is to deliver a service, it is best to know what your service plans look like before embarking on any workforce analysis. It is difficult to disagree with this view. The widely held view across the service is that we currently lack an agreed strategic vision of what the NHS is intended to look like in Wales in ten years' time, regardless of what may be thought about *Together for Health*, and that this inhibits the planning of new workforce models, new skill mixes and new roles. If this is true with regard to the health service it is even more the case with regard to an integrated health and social care service. Whilst recognising the Welsh Government's commitment to developing a refreshed strategy for the health service over the coming decade and whilst also recognising the contribution that the Review is intended to make to that process, it would be remiss not to emphasise how important such an agreed and refreshed strategy will be in facilitating the workforce developments referenced in the Review. It would also be remiss not to emphasise the benefit that would be gained from having this as an agreed cross party strategy against which the service can develop and deliver its workforce plans with confidence.
- 1.21 Another commonly expressed view has been that you tend to get what you ask for. NHS Wales is generally seen as being driven on a day to day basis to achieve immediate improvements in performance against measures and targets that are largely process orientated and acute care focused. Much as the service and the staff hear calls for longer term planning, for transformation rather than transactional focus, for a shift from acute cures to primary prevention and healthier communities; much as they hear these messages, the service and staff generally conclude that when push comes to shove it will be against their delivery of tier one performances that they will be judged. There is an old adage that organisations only manage what is measured. This may well be an oversimplification of reality but it serves as a useful reminder that management behaviour and associated priorities should be expected to become focused on those activities that are measured and evaluated. Recent changes in the tier one targets introduced by Welsh Government, which have started to shift the focus from processes to outcomes, recognise the impact that targeted performance measures can have on organisational behaviour. If Welsh Government want to increase the pace of change in relation to service integration, prudent working and workforce remodelling they should consider shifting the balance of expectation and performance requirements towards the achievement of measurable progress in these areas; a shift that would be consistent with an increased emphasis on Integrated Medium Term Plans (IMTPs) and service outcomes.

1.22 It has been clear from the detailed evidence we have received there is a willingness and enthusiasm for health organisations in Wales to engage and discuss the future of NHS services and workforce matters. The Welsh Government should take advantage of this level of enthusiasm to engage.

1.23 A table of recommendations is provided at Annex A.

CHAPTER 2 – INTEGRATION

2.01 We have been asked to identify new models of service delivery which are at the forefront of the integration of health and social care and to provide an analysis of the barriers that are experienced by such models and associated ways of working.

2.02 There is no common definition of integrated care. The lack of an agreed definition of integrated care (see paragraph 2.10) inhibits the extent to which agreement is evident in relation to the commissioning and delivery of health and social care services and makes comparisons difficult. However there was a clear consensus amongst those providing evidence to us that integration should be about delivering joined up services around the interests of the individual service user/patient, with the emphasis on service quality ahead of cost reduction. The evidence presented to us was also unequivocal in that there was no appetite for using structural change as a means of progressing the integration agenda. For example:

- a) *The Chartered Society of Physiotherapy (CSP)* told us that they are supportive of moves to integrate health and care services more closely but consider that the NHS does not need any more structural reorganisation, which carries significant associated costs and disruption, to achieve that aim.
- b) *UNISON* told us that integration should be motivated primarily to benefit patients and service users, shifting care from hospital to home, rather than as something that can bring about large cost savings and if these accrue then they should be seen as a secondary benefit not the initial aim.
- c) *The British Medical Association (BMA)* told us that the key measures of success had to be improved clinical outcomes and better patient experiences and that the individual must be the organising principle for any changes.
- d) *The Association of Directors of Social Services (ADSS) and Welsh Local Government Association (WLGA)* reminded us that the integration of health and social care is only a means to an end, not an end in itself. The end is for people to experience improvement in the services that they receive, to play a greater part in determining what will best support them to lead fulfilling lives and to have easier access to information that enables them to make good choices about their health and well-being.
- e) *The Chief Medical Officer (CMO)* reinforced this view in commenting on the need to keep the focus on better outcomes and experiences rather than on integration as an end in itself.

Identified enablers

2.03 The evidence also demonstrated that there is a large measure of agreement concerning what the main enablers of successful integration look like. For example:

- a) *The Directors of Workforce & OD* told us that there is a need to focus on leadership skills; management of change; development of team working; common education frameworks and language; developing understanding of scope of delegation guidance; and challenging accepted workforce models through competency based approaches to workforce design.
- b) *Aneurin Bevan University Health Board* told us that consistency of standards across sectors is a key enabler to any meaningful integration and that common standards will provide an important basis to provide cross sector training and development and to ensuring transferability of skill knowledge and expertise.
- c) *The Care Council for Wales* supported this view, reminding us that that jointly developed occupational standards and qualifications across health and social care at the vocational end already exist and that the Code of Practice for Health Care Support Workers had been based on the Care Council's original Code.
- d) *The BMA* told us that establishing collaborative cultures with shared values, good professional relationships and effective leadership are essential if integration is to get off the ground.
- e) *The CSP* emphasised the importance of addressing pooled budgets, co-location of multi-agency teams and facilitating support in areas such as informatics, team/line management and outcome measurement.
- f) *The British Association of Occupational Therapists (BAOT)* also drew attention to the use of pooled budgets as an enabler of service integration.
- g) *The Royal College of Nursing (RCN)* reminded us of the central importance of good communications, seeing the provision of an information and communication technology (ICT) infrastructure as a key enabler and essential to improving the interface between health and social care. The RCN also told us that the implementation of a strategy for cross co-ordination of records and other information should be as extensive as possible whilst being consistent with confidentiality concerns.
- h) *The National Specialist Advisory Group for Older People* shared this view seeing the development of shared electronic records as a key enabler of successful integration.

- i) *The ADSS and WLGA* urged a radical approach in order to shift focus and resources towards prevention and early intervention rather than on treatment or resolving crises and they identified the need for public health outcomes to be seen as a key part of the integrated services agenda.

Identified barriers

2.04 With regard to barriers, these were often identified as the opposite side of the enabler coin. Lack of shared values, differing cultures, non-compatible information systems, unaligned standards and performance requirements were clearly seen as barriers to successful integration. In addition to this however the evidence pointed us to some particular barriers which will need to be addressed. For example:

- a) *The BMA* told us that for those parts of Wales where cross border flows are commonplace, the lack of integration with social care in England will serve as a practical barrier to effective service integration.

2.05 A significant potential barrier to progressing integration, referred to by both employer and employee organisations, is the differing terms and conditions of employment that exist between staff employed on NHS contracts, those employed by local government and those employed by the independent sector. For example:

- b) *The Directors of Workforce & OD* and *Powys teaching Health Board* identified differing terms and conditions of employment as a potential barrier. *The Social Services Directorate in Welsh Government* drew our attention to what they saw as the inferior terms and conditions of employment for social care staff carrying out direct care. *The BAOT* told us that differing terms and conditions will need to be addressed through engagement with staff and trade union representatives in order to ensure parity and equal opportunity within the integration agenda. *UNISON* shared this concern and broadened it to include differing career development opportunities. *Aneurin Bevan University Health Board* told us that although their recent experience of integrated working had shown it was possible to 'manage around the barriers', different terms and conditions for staff doing broadly similar tasks was a risk to longer term sustainability.

2.06 More generally, some organisations expressed concern regarding the cost of change and whether this was sufficiently recognised. For example:

- c) *The Directors of Workforce & OD* told us that insufficient resource to focus on the OD needs for developing change may well prove to be a barrier to successful integration. *Unite* identified staff morale as a potential barrier and echoed the concern of the Directors of Workforce & OD that successful integration will require investment. *The National Specialist Advisory Group for*

Older People shared this concern and told us that discharge back into the community from the NHS is often delayed because of shortage of home carers and care home beds. They said that the lack of carers in the community is often exacerbated by the pay gap between social care and other employment opportunities which has led to a shortage of community carers. They told us that although the move to community care and new ways of working is good in principle it is likely to require a considerable expansion of manpower and associated resources and may not provide the sought for financial savings.

Identified good practice and new models of delivery

2.07 The evidence pointed us to a number of examples of current good practice. Mostly these were examples from within Wales and we received little evidence relating to international examples of health and social care service integration.

- a) *Hywel Dda University Health Board* drew our attention to the Cylch Caron Development in Ceredigion which is a new model of integrated care. Engagement with stakeholders has been key and design around population need has been integral. The model includes joint posted and pooled budgets; section 33 arrangements where necessary; and increased capability in leadership, management and OD.
- b) *The CSP* drew attention to the Re-ablement service as an example of an integrated service positively benefitting people's lives, with 70% of all individuals who receive re-ablement not requiring any ongoing care.
- c) *The ADSS and WLGA* referred us to the Intermediate Care Fund which has provided the opportunity for health boards and local government to jointly develop new models of service delivery that have involved the integration of health and social care, along with the essential contribution of housing, third and private sector agencies.
- d) *The Society of Chiropodists and Podiatrists* drew attention to the Keir Hardie Health Park, a state of the art development by Cwm Taf University Health Board, which brings together community health and GP services, outpatient clinics and therapies, mental health and learning disability services and community dentistry, all under one roof. The site is also home to local authority-run services and will provide a base for voluntary sector organisations, including Citizens Advice, the Alzheimer's Society, Age Concern Morgannwg and MIND Cymru, to run drop-in sessions.
- e) *The Royal College of Psychiatrists* drew our attention to Oxleas NHS Foundation Trust and their successful implementation of a fully integrated service 'taking care of the whole person – body and mind', which has

improved patient outcomes and delivered cost savings in its first year since implementation.

- f) *The CMO* made reference to the health and social care models in NUKA (south central Foundation Alaska) and Australia as well as referring us to the Kings Fund report⁵ on population health systems.
- g) *The RCN* drew our attention to the Netherlands where in 2006 a group of district nurses designed a model of integrated home care provision that has grown to an organisation with 4,000 employees across the country, 70% of whom are nurses. These local multi-disciplinary teams each with no more than 12 professionals care for 40-60 chronically ill, functionally disabled, and elderly clients as well as providing end-of-life care.

2.08 These examples, when considered alongside the previously commissioned research which we report on in the following section, have served to reinforce our view that there is no magic bullet, no model template for delivering health and social care integration. The evidence points to a large number of initiatives and programmes, some strategic and some opportunistic, all of which have sought to address aspects of the interface between health and social care. However, whilst they do not provide us with new models to follow, what can be identified as common across these initiatives and programmes are the enablers and barriers to successful integration that we identify in this report.

Previous research on service integration

2.09 It should be noted that in 2012 a Health and Wellbeing Best Practice and Innovation Board was established by the then Welsh Government Minister for Health and Social Services to accelerate the adoption of innovation and the dissemination of best practice relevant to health and social care in Wales. As one of its initial actions, the Board established an Integrated Care Workstream which provided advice to Welsh Government in 2013 on the determinants to drive health and social care integration. This advice was intended to support national policy development, including the development of, and implementation of, the *Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs* which was published by Welsh Government in March 2014. The work undertaken by the Board and in particular its Integrated Care Workstream continues to be directly relevant to the Review.

2.10 The Board found that there were many definitions of integrated care, reflecting the degree of integration and the maturity of the collaboration and partnership

⁵ The King's Fund – Population Health Systems:
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf

relationships in place. There is no common definition of integrated care. Integration is sometimes defined in terms of integrated team work, sometimes in terms of having integrated service alignment and sometimes in terms of having an integrated organisational structure. Integration can refer to anything from a single discreet time limited project through to all embracing whole service provision.

2.11 Most definitions of integration talk about bringing together service inputs, service delivery and service management in a way which improves service access, service user satisfaction and resource utilisation efficiency. Integration has invariably been driven by a combination of an aging population, an increasing incidence of chronic conditions, workforce pressures, a commitment to having a patient centred service and a need to contain costs. Evidence of benefit however usually follows the health service focus on process and cost (eg reduced waiting times, earlier hospital discharge and fewer acute beds) with implied rather than measured patient outcomes.

2.12 Whatever definition is adopted however the Board found that the organisational and cross sector service models invariably include a number of key principles, namely:

- a) The need to target integration where it is most needed – it is not a universal solution;
- b) The need to recognise and develop strategies to manage fundamental differences across sectors, such as the management and accountability mechanisms related to resources;
- c) The recognition that integration is not a ‘quick win’; it requires investment, both in time and resources, to establish and progress what can be complex cultural and systems change;
- d) It should be designed in partnership with service users, and have citizen centred services at its core;
- e) It requires local ‘buy in’ and policy statements alone will not result in an effective and sustained model of integrated services.

2.13 The Board also found that the reasons why we need to move towards integrated health and social care services are based on:

- a) recognition that person centred services delivered as a single model of service delivery provide better quality care and result in improved outcomes;
- b) demographic projections of an increasingly older population, both in numbers and as a proportion of the general population, with a significant increase in those aged 85 years and over;

- c) the increased incidence of chronic conditions based upon an increasingly older population and poor lifestyle choices;
- d) the increased incidence of dementia that longevity brings with a 30% increase projected in Wales in the coming decade alone;
- e) the need to provide co-ordinated, single service responses to promote and protect what can be fragile independent living.

2.14 The Board undertook a comprehensive literature review and identified academic and policy studies focused on England, Scotland and Northern Ireland as well as studies that looked at Finland, Denmark, New Zealand, Norway and Sweden. They found that the evidence indicates that there are a number of determinants that influence the shape of effective integration of health and social care:

- a) *Clarity of strength of purpose*, having a shared vision, culture and values that deliver person centred services based on shared outcome frameworks. The evidence shows that a shared vision and common goals are crucial to the success of integrated care, whatever the model. Some evidence suggests that the Care Programme Approach to mental illness in England was undermined by the lack of a shared vision. In Northern Ireland health and social care trusts have established professional forums to deal with problems arising from cultural differences and these forums focus on issues of professional development, training and governance. Clear, realistic and achievable aims and objectives, understood and accepted by all partners are essential and differences in organisational processes, priorities or planning cycles can create a climate for conflict rather than co-operation.
- b) *Collaborative leadership at all levels*, with expert change management skills and the ability to drive cross sectoral working. The skills and challenges of working across sectors to deliver a single service model needs to be identified and supported through a single knowledge management approach.
- c) *A culture of learning and knowledge management*, that seeks to support the sharing of best practice, improvement and service development across organisational and sectoral boundaries.
- d) *A supportive legislative/policy environment* that seeks to create the environment within which integrated services can develop. Much of the commentary on integrated care highlights the importance of a legislative and policy framework that consistently supports and encourages integration.
- e) *Integrated management structures*, incorporating the use of joint appointments, with unified leadership and joint governance arrangements and accountability. These are seen as necessary in order to address the 'soft'

issues such as culture, training and attitudes, as well as the 'hard' issues like employment terms and conditions.

- f) *Trust based interpersonal and inter-professional multidisciplinary relationships* across sectors, building on the strengths and unique contribution of each partner. Good inter-professional collaboration is associated with success, measured by lower hospital admission rates, fewer GP visits and improved patient function, in studies of people with long-term conditions. Evidence shows that sharing office space and client groups makes integrated working easier. Outcomes are better when clinical staff worked in multi-disciplinary teams with social care staff. However, the perceived lower status of social care staff compared to healthcare staff can create significant difficulties in developing integrated systems.
- g) *Appropriate resource environments and financial models* seeking to ensure collaborative financial models, including the need for pooled budgets. Specific to pooled budgets, experience from Northern Ireland suggests a single source of funding, used to deliver integrated care is a significant factor. In separate organisations, funding earmarked for either health or social care cannot easily be redirected from one service to the other as managers cannot commit resources from budgets they do not control. However, where a single budget exists, the medical profession and a medical model of care can lead to funds being diverted from community-based services to support hospital services as acute care takes priority and this has been observed in Northern Ireland and New Zealand. Evidence shows that Integrated structures and are not enough in themselves to secure integrated service delivery. Budgets need to be integrated too, and pooled budgets have succeeded in improving interdisciplinary working in Sweden.
- h) *Compatible IT and information sharing systems* that facilitate ease of communication. Evidence shows that good communication improves the ability of teams to work together successfully. Clear communication structures are needed to keep all staff aware of, and involved in, the processes surrounding integrated care, design and implementation. Robust information systems are needed for rapid communication between sectors/organisations and within teams including using a single record gathered from shared assessments.
- i) *Unified performance management systems and common assessment frameworks.* The need for unified performance systems, and a single approach to assessment is routinely identified as essential.
- j) *Collaborative capabilities and capacities,* with all practitioners being skilled in integrated working and management. Joint training is considered central to building a shared culture. Cross-agency secondments also help to prepare

people from different agencies and professional backgrounds for integrated working and to appreciate other people's roles and perspectives.

2.15 In 2013 a Welsh Government Social Research published a report *A Realistic Evaluation of Integrated Health and Social Care for Older People in Wales, to promote independence and wellbeing*⁶. The report, which was commissioned by the Public Service Leadership Group's Effective Services for Vulnerable Groups Programme, sets out the interim results of research undertaken by Dr. S. Carnes Chichlowska et al. This research included a literature review, a series of stakeholder engagements, an assessment of health and social care integration approaches adopted elsewhere in the UK and a detailed review of health and social care integration activity across Wales. The report reached a number of conclusions which are consistent with the evidence we have received and has served to reinforce our own thinking.

More recent activity

2.16 Further to the work of the Health and Wellbeing Best Practice and Innovation Board, the Welsh Government has progressed the development of integrated health and social care services through its Social Services and Integration Directorate where the focus has been on improving services, care and support, particularly for older people with complex needs. December 2013 saw the publication of new statutory integrated assessment, planning and review arrangements for older people (aged 65+), to be used by all health, local government professionals and others involved in assessing and responding to the care needs of older people. March 2014 saw the publication of the *Integration Framework for Older People with Complex Needs*, which focused on ensuring the development and delivery of integrated services, care and support for older people, particularly the frail elderly.

2.17 A £50 million intermediate care fund (ICF) was announced by Welsh Government for 2014/15 and this has seen a range of integrated activities being developed and taken forward by health and social care together with voluntary and independent sector partners. The purpose of the fund has been to enable older people to maintain their independence at home, avoid unnecessary hospital admission and to prevent delayed discharges. In January 2015 an additional £20 million was made available to the ICF by the Minister for Health and Social Services to help reduce pressures on the unscheduled care system and Welsh Government announced an additional £30 million for 2016/17 as part of its Budget statement.

2.18 Evidence suggests that the ICF has helped to develop a culture of collaboration, with improved communication and joint decision making and this is seen to be a positive

⁶ A Realistic Evaluation of Integrated Health and Social Care for Older People in Wales, to Promote Independence and Wellbeing: <http://gov.wales/statistics-and-research/realistic-evaluation-integrated-health-social-care-older-people-wales-promote-independence-wellbeing/?lang=en>

indication as to what can be expected when the Social Services and Well-being (Wales) Act is implemented in April 2016.

Social Services and Wellbeing (Wales) Act 2014

- 2.19 The Social Services and Well-being (Wales) Act 2014 requires local authorities and health boards to jointly carry out an assessment of the need for care and support, including the support needs of carers. The population assessment must include an assessment of the range and level of preventative services required to meet the identified need. This key provision is intended to ensure that local authorities and local health boards (LHBs) jointly produce a clear and specific evidence base in relation to care and support needs and carers' needs and that this will inform planning and operational decisions, so ensuring services are developed to meet and deliver the needs of people in an efficient and effective way. It is also intended that it will underpin resource and budget decisions in order to ensure services are sustainable.
- 2.20 The Regulations that support the requirement for the population assessments specify that all local authorities in a LHB area must form a partnership arrangement with that health board to undertake the population assessment. This will provide for seven combined population assessment reports on the local health board footprint.
- 2.21 Part 9 of the Act is intended to ensure that local authorities, health boards and trusts work effectively together, along with other partners, to plan and ensure the delivery of integrated services, care and support to best meet the needs of people in their local area. The intention is to improve outcomes and well-being through improved partnership working and cooperation and to improve effectiveness and efficiency of service delivery.
- 2.22 The enactment of this legislation is a hugely significant development in relation to the health and social care integration agenda
- 2.23 Part 9 also provides the Minister with the necessary powers to ensure appropriate structures and resources are in place to enable the provision of integrated services to respond effectively to the joint population assessment. The regulation-making powers will ensure that partnership arrangements and partnership boards are established, as well as the establishment of pooled funds.
- 2.24 In relation to pooled funds, the intention of the Act is for health boards and local authorities to work together to maximise their influence to secure the future development of an appropriate range of good quality services to respond to the needs of their area. Health board, trusts and local authorities will be expected to develop an integrated approach to the commissioning of services from care homes, agreeing the range, capacity and quality of services required.

- 2.25 It is the intention of Welsh Government that the implementation of the Act and these new arrangements will be an important enabler in delivering their vision for integrated services. In particular it is intended that the new partnership and cooperation model will facilitate more effective cross-sector and government collaboration, reflecting the important contribution of areas such as housing and education in developing more people-centred, integrated services.
- 2.26 Surprisingly perhaps we have received little evidence regarding the Social Services and Wellbeing (Wales) Act 2014 and how it may be expected to influence health and social care integration. Whilst the Chartered Society of Physiotherapy and the Association of Directors of Social Services both positively referenced the Act in their evidence to us, the general lack of focus on the Act's potential may well reflect the 'Social Services' status of the legislation and a somewhat limited engagement to date from organisations that are principally health service orientated.

Future Generations (Wales) Act 2015

- 2.27 Whilst the Social Services and Wellbeing (Wales) Act is specific in relation to the duties of health boards, trusts and local government to collaborate in the planning and delivery of care, the Future Generations (Wales) Act requires public bodies to work together in delivering sustainable services that support future wellbeing. Health boards, trusts and local government will be required to participate in local Public Service Boards, established on local government boundaries, with a duty to work together and with others to improve the economic, social, environmental and cultural wellbeing of Wales.
- 2.28 The Future Generations (Wales) Act will provide a broad collaborative framework within which the more directly focussed Social Services and Wellbeing Act will operate and together they represent a considerable step change for the collaborative environment in Wales.

Conclusions and Recommendations

- 2.29 The success of health and social care integration will depend in no small measure on the extent to which health boards and trusts are able to deliver an integrated health system in terms of their responsibilities for public health, primary and secondary care, and physical and mental health services. The establishment of all-purpose LHBs in 2009 was intended, in part, to achieve this, but six years on there remains much to be done. The record to date in achieving greater integration within the health service serves as a pointer to the challenges that service integration provides as well as demonstrating that structural integration, by itself, is unlikely to deliver the changes aspired to. From the evidence we have received it is clear that there is an ambition for

the integration of health and social care to deliver joined up services around the interests of the individual service user/patient. This is the same ambition that has driven the case for better integration within health and in widening the integration remit it will be important that we do not lose sight of the work that is still needed to be done within the health service itself. In particular it will be essential to have the full engagement of primary care in the development of integrated health and social care services. **Health boards and trusts must maintain a clear focus on achieving health service integration if the benefits of integration with social care are to be properly realised.**

2.30 We have found that integration is a widely supported term that is often used to describe different levels of engagement. As was pointed out to us by the RCN, there is currently no agreed definition of integrated care in Wales and therefore there is the potential for uncertainty as to the degree of integration we are aiming for in regard to health and social care services. Are we aiming to integrate at a commissioning level, with health boards and local government social services coming together to jointly agree what needs to be provided and who will provide it? This could be delivered with or without a pooled budget although a pooled budget would considerably assist the process. Are we aiming to integrate at the operational level with health and local government social care staff working together in multi-disciplinary teams with jointly appointed managers? And are we looking to develop a totally integrated service in which the services and the staff providing them in the independent sector are fully encompassed into the integrated arrangements. The Social Services and Wellbeing Act will certainly require joint needs assessment and joint commissioning, but whether we progress further down the integration agenda remains uncertain. There is no doubt that the majority of those who submitted evidence to us are viewing integration as more than just joint commissioning. The emphasis on delivering joined up services around the interests of the individual service user/patient makes this clear, as does the emphasis on service quality ahead of cost reduction. The extent to which integration is to be implemented will have clear implications not only for the services provided and the service users but also for the staff providing the services and potentially their terms and conditions of employment. Greater clarity regarding the extent of the integration we are aiming for will be welcomed by those involved in service planning and delivery. **Welsh Government should set out a clear vision for service integration within a refreshed strategy for health and social care services in Wales.**

2.31 The issue identified most consistently as a potential barrier by both employer and employee organisations, is the differing terms and conditions of employment that exist between staff employed on NHS contracts, staff employed by local government and staff employed by the independent sector. There is evidence to suggest that when integrated working occurs in relation to a specific project, where it is of a fixed term nature, or importantly if and when it is initiated by staff themselves, the differing terms and conditions are generally 'lived with'. However, we are extremely doubtful as to

whether such an accommodation would continue were the integrated working to become seen as a permanent feature. We would expect the principles of equal pay and equal pay for work of equal value to be raised as a consequence. Although we have considered this issue mainly from the standpoint of integration between health and social care, with the independent sector being the staff employed in independent care homes, the need for continuing integration within the health service itself means that this issue may also arise in regard to the primary care workforce, most of whom are employed on non NHS contracts.

- 2.32 The principles of equal pay and equal pay for work of equal value are enforceable under UK equality legislation which enables men or women to compare their pay with a comparator of the opposite sex who is working for the same employer and who is either doing the same job or a job which can be shown to be closely comparable in terms of its value to the employer. Equal pay claims can be defended where it can be shown that the difference in pay is not as a consequence of a difference in gender and is for a different material reason.
- 2.33 Whilst the legal enforcement of equal pay principles will always depend on the particular circumstances of each case the detrimental effect on staff relations of employing people on different terms and conditions when expecting them to undertake similar and shared work cannot be overstated. As the organisation of health and social care services becomes closer, with the stated aim of making services seamless and indistinguishable from the standpoint of the service user/patient, this is an issue that will need to be addressed.
- 2.34 Our initial conclusion was that this was not an immediate issue and that much would depend on the extent and structure of service integration. We are aware that in Powys, discussions have been taking place between the Health Board and the Local Authority with the view to fully integrating their health and social care services. Joint appointments are being made and a detailed and accelerated work programme is now underway. We have been told that concerns regarding equal pay have already arisen as part of this work and NHS Workforce Directors have advised us that the issue of equal pay needs to be considered as an immediate rather than a longer term issue.
- 2.35 As an immediate issue, equal pay is only legally enforceable where an opposite sex comparator can be identified within the same employer. Any transfers of employment which retain the transferee's previous terms and conditions of employment could potentially give rise to an enforceable claim. But where staff are employed by different employers, such as a health board, an independent GP contractor, a local authority or an independent care home, there is no enforceable claim across employment boundaries. It is therefore a matter for health boards, trusts, local authorities and others to consider the equal pay implications of any decisions they are intending to make which result in the transfer of staff.

- 2.36 Assuming that the integration of health and social care services is arranged in such a way as to maintain most if not all existing employment contracts, the issue is more likely to be one of fairness and good practice rather than legally enforceable rights. It is also likely however that differences in pay between people undertaking similar work but for different employers will create a hierarchy in relationships which may run counter to the aim of integrated working. It is also probable that recruitment will be influenced if the differences are material, with vacancy rates, staff turnover and the quality of staffing reflecting the differential salaries being paid.
- 2.37 We are conscious that the trade unions, who represent staff across the NHS, local government and independent sectors, would strongly resist downward harmonisation of pay and terms and conditions of employment and that the cost of upward harmonisation could be significant. Pressures for harmonisation will increase the more that staff are encouraged and enabled to work across health and social care systems. Therefore whilst there is need for clarity as to the extent of integration being aimed for under the Social Services and Wellbeing (Wales) Act there is also need to ensure that the integration agenda is developed and delivered in accordance with the partnership principles that underpins social partnerships and the collective bargaining arrangements in the Welsh public sector. **Health boards, trusts, local authorities and others must consider the equal pay implications of any decisions they are intending to make which will result in the transfer of staff. Health boards and trusts must discuss their integration plans within their Partnership Councils. The NHS Wales Partnership Forum and the local authority Joint Council for Wales must be kept fully informed of developments in health and social care integration.**
- 2.38 The importance of developing a shared culture is well referenced as a key enabler of successful integration and its absence is invariably identified as a major barrier. Establishing a shared culture is likely to prove a significant challenge, with culture change usually identified as the largest challenge in any change management programme. The value base for the NHS in Wales has been undergoing a change in recent years with an increasing emphasis on person centred care, service user experience and co-production. Health unions, NHS employers and Welsh Government undertook a review in 2015 of the core principles that underpin the NHS in Wales and these were launched as *The Core Principles of NHS Wales* in February 2016. Whilst these principles provide a strong basis for establishing a shared culture across health and social care it needs to be recognised that traditionally health and social care come to the culture table from different directions. The value base for social care has come largely from a social work, social science standpoint where the emphasis has traditionally been put on service user empowerment, rights to self-determination and social justice. The value base for health however has traditionally reflected the medical model of paternalism, care and protection, perhaps best evidenced in the concept of the 'patient'. Health and Social Care staff, who will be expected to work in new integrated arrangements to deliver high quality, person

centred care, need to be involved at the earliest stage in discussing and planning service changes and the values that underpin them. The evidence we have received shows that where integration has occurred in Wales in recent years its success has been founded on joint awareness, discussion and agreement by those providing the service. **Health boards, trusts and local government social services departments must ensure that health and social care staff are able to jointly discuss and influence the development of integrated services and the values that will underpin such services going forward.**

2.39 A key enabler of service integration is the establishment of a common standards and regulatory environment. Currently health service regulation and inspection is the responsibility of Health Inspectorate Wales (HIW), with the Care and Social Services Inspectorate Wales (CSSIW) having responsibility for the social care sector. In responding to the publication of the Ruth Marks report into HIW, *The Way Ahead: To Become an Inspection and Improvement Body*⁷, in January 2015, the Minister for Health and Social Services, Mark Drakeford, noted that the report advocated close working between HIW and CSSIW in order to develop an integrated inspection framework and said that Welsh Government would consider in due course whether the two inspectorate should be merged. The integration of the two inspectorates was subsequently one of the matters raised in the Welsh Government's Green Paper *Our Health, Our Health Service*⁸. This consultation ended in November 2015 and the Welsh Government's response is still awaited. From the perspective of the Review however we can see clear advantage in having a common regulation and inspection environment for health and social care. The close integration or merger of HIW and CSSIW would provide a regulation and inspection environment which would support service integration.

2.40 With regard to future Welsh Government legislation we have observed that Welsh Government has set out its thinking in regard to local government re-organisation. Whilst it is not part of our remit to comment on these proposals and we express no view regarding the number of local authorities in Wales, we think it appropriate to comment on the importance of maintaining the relationship between health boards, trusts and local government which is at the core of the joint arrangements required by the Social Services and Wellbeing Act. We see co-terminosity of health board, trusts and local government boundaries as an important enabler of health and social care service integration and believe this should be an important consideration in any future reorganisation. **Welsh Government should recognise the importance of co-terminosity with health board boundaries in any future reorganisation of local government.**

⁷ Independent Review of Healthcare Inspectorate Wales (HIW):
<http://gov.wales/topics/health/nhswales/organisations/review/?lang=en>

⁸ Green Paper – Our Health, Our Health Service:
<http://gov.wales/consultations/healthsocialcare/service/?lang=en>

2.41 A fundamental difference between health and social care is that health services delivered by the NHS are free at the point of use and fully funded by general taxation whereas social care services are charged for at the point of use, with service users means tested to determine what funding support, if any, they may be entitled to from local government social services. Decisions as to an individual's eligibility for health care or social care are made on the basis of an assessment of the person's health needs. These assessments are carried out against criteria determined by Welsh Government and can carry significant financial implications for the individuals concerned. Whilst moves to integrate health and social care services and provide them more seamlessly around the needs of the individual through the use of pooled budgets do not in themselves change the funding regime, the more seamless that health and social care becomes the more difficult it may become in practice to draw the distinctions regarding an individual's financial liability. It will be important to monitor the impact, if any, that service changes have in this respect and to review the funding criteria accordingly should it prove necessary. **Welsh Government should keep the funding criteria and guidance under review in light of the experiences that will be gained through service integration and pooled budgets.**

2.42 Finally with regard to health and social care integration, the BMA has raised with us the issue of cross border patient flows. Whilst this may well provide a challenge to implementing health and social care integration along the border between Wales and England, it does not evidence itself to us as a workforce issue and we have not examined it in any detail. It is nonetheless a potential problem that will need to be addressed. **Welsh Government and affected health boards should consider the issue of cross border flows with the view to agreeing appropriate protocols as necessary with English health and social care providers.**

CHAPTER 3 – DEVELOPING THE STAFF AND SKILL MIX

3.01 The second issue we have been asked to consider is the workforce of the future - the staff and skill mix the NHS needs to ensure people receive high-quality care as close to their homes as possible. In considering future workforce requirements within health and social care, there are a number of significant challenges, which were clearly highlighted by the evidence presented during the Review.

Challenges facing NHS Wales in developing the future workforce

3.02 As outlined in Chapter 1, The Nuffield Trust Report, *A Decade of Austerity in Wales?*, highlighted the potential financial deficits that are likely to confront NHS Wales. The scenarios presented all indicate that productivity gains will not be sufficient to deliver the savings required, even under the most favourable funding scenario. With workforce costs accounting for almost two thirds of hospital costs and approximately half of all NHS Wales spending, it is essential that we get our workforce plans right, both for service and financial reasons. Getting it wrong will, in all probability, result in less accessible services with staff unable to respond to demands in a timely fashion, increased pressure to maintain quality and safety standards and the prospect of a vicious circle emanating from inefficiencies as health boards and trusts are forced into ever more extreme financial expedencies.

3.03 Healthcare professionals have traditionally been trained and developed to work in a system that is primarily based on hospital-based care, whereas the majority of current and future demands for health and social care arise from an increasingly elderly population with multi-morbidities, whose needs require multi-skilled staff working in an integrated environment across professional and organisational boundaries and across different settings.

3.04 The current configuration of the NHS workforce has evolved in recent years as service provision has tended to focus on secondary and acute care more than primary and community services – and counter to policy initiatives (for example, *Setting the Direction, 2009*⁹) that have emphasised the need for less reliance on hospital-based care. This has led to a considerable expansion in the numbers of hospital consultants in response to these specialisation trends.

3.05 Workforce planning within health and social care has traditionally adopted an incremental approach, has also focused on secondary health care and been profession specific. Furthermore it has not fully considered the developmental skill needs for the unregistered health and social care workforce. The result has been the

⁹ Setting the Direction: <http://www.wales.nhs.uk/sitesplus/documents/829/Setting%20the%20direction.pdf>

establishment of a workforce, the skills and expertise of which do not equate with those needed to address the health and social care needs of the changing population.

- 3.06 Recruitment challenges and retention of key professionals pose major, additional problems for health boards and trusts, along with the commissioners of educational provision, and there is little evidence that this will change significantly in the short-medium term.
- 3.07 Further, the age profile of GPs is a cause for concern¹⁰. The *British Medical Association (BMA)* argued that based on current trends the primary care service would be unsustainable within three years. The supply deficits of GPs and other staff groups represents a major inhibitor to re-focusing care away from the hospital and a move towards a system of delivery nearer to the patient in primary and community settings.
- 3.08 The reliance on agency and locum staff to address these supply deficits has resulted in significant levels of expenditure that are unsustainable in moving forward and have potentially compromised quality of care and patient safety. The evidence from the *Directors of Workforce & OD* highlighted that in 2014/15 total agency and locum spend was £88 million, an increase from £48 million the previous year.
- 3.09 In recent years, NHS Wales received significant media and political attention much of which has been negative and unfair and there have been views expressed that low morale among the workforce is a major issue that has to be addressed.
- 3.10 The geography of Wales means that there is not a one-size-fits-all model for effective and efficient patient management. While appropriate use of technology for managing patients remotely has been advocated to overcome issues relating to distance, rurality and the like, obstacles have constrained the implementation of such developments.

Potential solutions for developing the future NHS workforce

- 3.11 It became clearly evident that the reconfiguration of the workforce to address the changing demands for health and social care, arising from an increasingly elderly population with multi-morbidities, required new roles, skills and competences in both the regulated and unregulated workforce, as well as supporting services. For example, the *Directors of Workforce & OD* reinforced the need to consider the development of new roles, along with skills development among existing professional groups, to address future demands on service provision. Further, a common theme emerging from an analysis of the health board and trust Integrated Medium Term Plans (IMPTs) is of increasing demands on dementia and frailty service provision. The

¹⁰ StatsWales – General Practitioners Workforce Trend by Age and Gender:
<https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/General-Medical-Services/gpworkforcetrend-by-age-gender->

Association of Directors of Social Services (ADSS) and Welsh Local Government Association (WLGA) highlighted the Social Services and Wellbeing (Wales) Act 2014 as promoting the concept of a single workforce and that is based on people appreciating a service, around which they do not have to continually ‘negotiate’ between professionals and organisations. This view that the NHS workforce cannot be viewed in isolation, given the increasing prevalence of dementia and frailty, was stressed by a number of respondents and organisations, among them for example, *Unite* and the *Care Council for Wales*, which emphasised the critical role of social care, particularly in prevention and on-going care and support. The role of the third sector in this regard was also referred to in evidence provided by, for instance, *Marie Curie, ADSS and WLGA*, with the latter also arguing that the independent sector should be included within planning decisions for the future workforce.

3.12 There was general consensus that there needs to be a switch in focus towards appropriately trained generalists to counter the increasing supply of specialist practitioners within professional groups over the past ten years. We were made aware of some evidence to suggest that the trend is being re-balanced, with, for example, *The Shape of Training Review, Greenaway*¹¹ leading to a greater focus on the generalist skills. A large number of respondents, organisations and professional bodies, reaffirmed the need for greater emphasis on generalist skills across all professions – as evidenced by *Aneurin Bevan University Health Board* – alongside multi-disciplinary and multi-professional working to meet the changing needs of the population. The *Royal College of Physicians (RCP)* were particularly vocal, arguing that “we need to do more to promote the value of the ‘generalist,’” and “that the case for more ‘generalists’ is particularly pertinent to Wales with its disperse and rural populations, geographical barriers and the close working which exists between general practitioners and primary care clusters across Wales.” They also advocated a larger number of physicians with training in acute and internal medicine to engender greater flexibility and a more equitable workload. The *BMA* emphasised more caution however, given that specialists can be more efficient in delivering high volume provision, while cognisance should also be taken of the longer time required to train generalists across a wider skill base. Other respondents, such as the *British Association of Occupational Therapists (BAOT)*, expressed the view that allied health professionals should be more fully utilised to counter medical supply shortages and, as their roles enable greater focus on community based care, they would make a significant contribution to the integration agenda. The *Chief Medical Officer (CMO)* also referenced work that therapists are engaging in with regard to rebalancing professional boundaries, whereby shared knowledge and skills can be utilised in team working for the efficient delivery of healthcare. However, as the *BMA* was at pains to point out, the shift in emphasis towards primary and community care has to be

¹¹ Shape of Training – Securing the Future of Excellent Patient Care:
http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf 53977887.pdf

accompanied by a commensurate, real shift in funding allocations in the same direction.

3.13 The *Health Professions Education Investment Review*¹² had recognised that workforce planning had been, at best, sub-optimal with very little thought and attention given to the process over and above an incremental approach, which has done little, if anything, to consider and embrace strategic changes and develop professional roles in line with re-modelled service requirements. It advocated that the process required significant adaptation to bring it into line with policy directions, the prudent healthcare agenda and the future requirements of NHS Wales. The need to improve workforce planning was a common theme that emerged during evidence gathering sessions, with organisations across the spectrum highlighting the need for a workforce planning mechanism that reflected service planning in place to address the health and social care needs of the population. The CMO indicated that “workforce planning needs to be better aligned to the competencies required rather than numbers of specific professionals” and referenced the Llanelli model of joint service provision, which has eliminated duplication by adapting lead roles and coordination roles. The CMO said there is evidence from dentistry and therapies in relation to this (Borthwick 2000; Frith and Walsh 2009; McPherson et al. 2006; Sibbald et al 2004; Thompson et al 2014). The views of the BMA were reflective of other submissions:

“BMA Cymru Wales calls for a whole-system approach to workforce planning across primary, community, secondary, public health and social care. Workforce planning needs to take account of the changing demands, current and projected future demands – and therefore needs to also look at training requirements as well as measures to support greater retention such as portfolio careers and mentorships. We welcome this review, as we hope it will help take a comprehensive approach to ensure the workforce plan is aligned to a strategic vision for the NHS in Wales; and in line with prudent healthcare will avoid duplication and deliver multi-professional teams working to the benefit of the clinical needs of patients and their experience of using healthcare services. It needs to move forward with the engagement of all healthcare professionals.”

Therefore, greater priority has to be given to the identification and development of the skills and competencies required to address patients’ needs as these change over time and the work currently undertaken by the Workforce, Education and Development Services (WEDS) should be reviewed and developed to match the requirements of the service in moving forward. The workforce planning process should be sufficiently flexible to reflect policy initiatives and developments while also being cognisant of local needs and contexts.

¹² Health Professional Education Investment Review:
http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf 53977887.pdf

- 3.14 As indicated above, the changing health needs of the population require the potential advent of new roles and an up-skilling and realignment of existing roles. A considerable body of evidence emerged for the adoption of physician's associates (assistants), an enhanced role for healthcare support workers and a continuation of the developments relating to advanced practitioners within some professions. The *General Medical Council (GMC)*, for example, were of the view that physician associates could have an important role to play in addressing the challenge of medical staffing and the demands on the health service. However, the issue of regulation also featured during discussions, especially in relation to prescribing. Interestingly, the GMC expressed a willingness to consider taking on this function and were actively in discussions with NHS in Scotland. We were also encouraged by the work being undertaken by WEDS, in conjunction with RCP, to commission the education of physicians associates for NHS Wales.
- 3.15 The Panel received a number of responses relating to the deployment of healthcare support workers (HCSWs). The *Directors of Workforce & OD* expressed the view that the development of HCSWs across health and social care and investment in their education and training was an essential ingredient in the transformation of the workforce and support of the principles of prudent healthcare, while a number of *Health Boards* believed that NHS Wales had failed to maximise the benefits from developing and utilising the skills of the support worker workforce. There was cautionary advice from the *RCN* in relation to greater deployment of HCSWs in terms of their scope of practice and potential safety implications, while recognising their importance as part of nursing teams. Their submission highlighted the inconsistency and variability in the training, experience and qualifications of HCSWs. There is a role for health boards and trusts to support the training and up-skilling of this group and to ensure that an appropriate regulatory framework is developed – in conjunction with the Office of the Chief Nursing Officer (CNO), Nursing and Midwifery Council (NMC) and RCN. The EAGLE (Excellence, Assurance and Governance in a Learning Environment) Framework, employed by Hywel Dda University Health Board since 2009, provides a robust governance process when new, expanded and extended roles are introduced and should be considered as an exemplar for supporting the introduction of new and expanded roles.
- 3.16 The need for a stronger pool of advanced practitioners amongst nurses, social workers and occupational therapists to carry out the developing number of leadership roles as well as offering coaching and mentoring and modelling best practice was emphasised by a range of stakeholders (for example, *ADSS/WLGA, Health Boards, third sector organisations, the CNO, professional bodies*). The rationale for the development of this group was that front-line workforce would, as a result, be better valued and better prepared, for the challenging nature of the tasks that they have to carry out. The role of the advanced practitioner was implicit in the statement offered by *Macmillan Cancer Support* that rather than considering professional substitution to address supply deficits, “the term ‘complementary roles’ would better describe the

desired outcome from staff supporting each other and operating at the peak of their expertise. This should include consideration around how specialists can better support generalists and vice versa.” Such a view was echoed by the *CNO* and resonates very closely with the notion of delivering the *right treatment and care for the right patient in the right place at the right time by the right professional(s)*, which can be viewed as a summary of the prudent healthcare principles, and to which the Review subscribes.

- 3.17 Supply shortages within professional groups were also considered by *the Health Professions Education Investment Review*, where the Panel was made aware of the processes involved in return to practice schemes and the view that there may be perverse incentives inherent in such schemes, relating to time requirements and funding arrangements. It advocated that NHS Wales should work with commissioners, professional bodies, unions, GPC Wales and Royal College of General Practitioners (RCGP) Wales to instigate schemes and programmes that facilitated the return to practice of professionals in a speedy and efficient manner, especially in areas where there are noticeable shortages of supply. This coupled with the development of new roles and up-skilling of existing staff groups emphasises the need for a multiplicity of approaches to address the supply deficits that are very evident across NHS Wales and, in some areas, particularly acute. These should also include the creation of a culture of continuous improvement across all staff groups and in all sectors of health and social care, to reinforce the developments afforded to new roles and advanced practice.
- 3.18 However, there has to be an assurance that the introduction and implementation of new, expanded and enhanced roles is subject to on-going monitoring and evaluation to ensure that there is no compromise to the quality of patient outcomes and that such roles are demonstrated to be cost-effective.
- 3.19 The increasing dependence on agency and locum staff to remedy supply deficits was highlighted by the majority of respondents. This was widely regarded as unsustainable and unacceptable and while the Panel is aware of work being undertaken within NHS Wales to address the costs associated with locum and agency staff, a more immediate response is required. The Panel was impressed by the proposal from *RCN* to establish a workforce that is ready and able to cover sickness absence, maternity leave and other supply shortages as required, recommending that an “all-Wales Bank register be created that guarantees those employed on the Bank a 37.5 hour week contract. This would ensure that the unplanned absences across Wales were covered by a workforce that could be moved within its geographical area at times of immediacy and slightly further afield when known staff challenges are going to present.” Such a ‘facility’ would also go a long way to addressing the negatives associated with reliance on agency staff – for example, lack of familiarity with the context and culture of the healthcare facility, reduced productivity, poorer patient outcomes. Further work is proposed, as a matter of urgency, to consider this potential remedy.

3.20 Much of the negative criticism levied at NHS Wales, by media and politicians, has been unjustified when viewed against the findings of the recent *OECD report*¹³ and by earlier *King's Fund* and *Nuffield reports*. However, the Panel was made aware, by *UNISON*, that in a recent survey of their members, morale in Wales appeared to be lower than elsewhere in the UK. Therefore, concerted and sustained effort from all stakeholders, as advocated by *BMA* and *RCP*, is required to present NHS Wales as an attractive place to train, work and live. The evidence surrounding 'financial incentives' to secure recruitment and retention remains equivocal but the *Health Professions Education Investment Review* was made aware of the need for NHS Wales to have training and development writ large, to embrace continuous development and improvement, across all staff groups, irrespective of grade and length of service. All staff should expect to have contracts of employment that commit them and the NHS as an employer to provide necessary training and development. A concerted drive to achieve workforce modernisation through investment in skill development and staff wellbeing programmes would represent important indicators of the extent to which staff would feel valued and cared for. The nature of such training and development would need to vary between professionals, where for some, research would be an important component of their developmental portfolio, while for others, opportunities to reach their potential and maximise their career aspirations would be the negotiated order. Respondents to that review had indicated that such a culture could be perceived as a possible incentive in relation to recruitment and retention, which could provide NHS Wales with a competitive advantage in attracting quality staff at all career stages. It would also serve as an attractive employment option, help to dispel negative perceptions about training and working in Wales and the myths surrounding the mandatory use of the Welsh language, referred to by the *BMA*, when engaging with media and politicians.

3.21 Further, the *BMA* for example, highlighted the opportunities afforded by the health boards and other organisations connected with NHS Wales engaging more with schools in Wales to broaden access to professional courses and demonstrate the potential for careers within health and social care. The *Health Professions Education Investment Review* suggested that all school children in Wales should be offered work awareness and work experience opportunities in NHS and related facilities and organisations. The aim of these schemes would be to instil a sense of pride among young people in the NHS in Wales, while interactions with patients and motivated professionals, along with the development of appropriate work programmes, would serve to inculcate the values of the caring professions into youngsters and inspire them to select careers in health and social care in Wales. In addition, the specification of clear well-defined career pathways would also contribute to the attractiveness of such career choices. Further, there would be other potential benefits from such an initiative in that potential students would have a more informed awareness of the care

¹³ OECD Reviews of Health Care Quality - United Kingdom 2016: http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/oecd-reviews-of-health-care-quality-united-kingdom-2016_9789264239487-en#page1

system prior to making career choices, with less risk of attrition and improved value for money resulting.

3.22 NHS Wales needs to capitalise on the opportunities to lead the way in developing research and innovative service models that reflect the nuances of geography, population flows and critical mass. The *RCP* highlighted The *Mid Wales Healthcare Collaborative* as offering significant potential as a focus for the future service models, incorporating technological innovations. The Panel suggests that the *Mid Wales Healthcare Collaborative* liaise with RCP to evaluate work relating to rural models within the *RCP Future Hospital Programme* and its potential relevance for Wales. It was widely acknowledged that technology will have a critical role in providing quick access to specialist opinions. For example, the *Care Council for Wales* argued that technology can be the key enabler and referenced its *Technology to Care* document¹⁴ which provides a framework for the appropriate use of technology and support individuals to do what matters to them. The *Directors of Workforce & OD* referenced the Imison/Bohmer work on tele-stroke as being a potential model for other services including emergency, paediatrics, surgery and radiology, along with the use of technology to monitor patients remotely. *Aneurin Bevan University Health Board* are piloting the use of mobile tablet devices with GPs and other professionals to access the GP patient record during home visits or when the patient is in a community hospital bed. The tool will also allow updated records to be remotely uploaded back to the hosted database, improving timeliness and quality of data collection and avoiding unnecessary journeys back to the surgery.

Conclusions and recommendations

3.23 Although we have been asked to specifically consider the nature and composition of the workforce of the future, there was general agreement across all stakeholders that the workforce strategy must be aligned to the strategic vision for the NHS in Wales and incorporate the development and utilisation of multi-professional teams working to the benefit of the clinical needs of patients and their experience of using healthcare and social services. Further, from the evidence received it was apparent that the alignment of the workforce skill mix to case mix across patient pathways throughout the health/social care system has to become a major feature of policy initiation and development. **Welsh Government needs to develop a clear, refreshed strategic vision for NHS Wales as a matter of urgency, based on the prudent healthcare agenda, which should inform the strategy for the workforce currently being developed.**

3.24 The utilisation of evidence and the use of routine information to inform effective patient management pathways need to be applied in determining the professional skills and

¹⁴ Care Council for Wales – Technology to Care: <http://www.ccwales.org.uk/technology-to-care/>

expertise required for efficient delivery. We were given examples of some excellent facilities in Wales that would serve to facilitate such endeavours and counter examples – of which we were given insight - of considerable variation in practice across Wales, which has resulted in excessive expenditure occurring but which cannot be justified on clinical grounds. **Welsh Government, health boards and trusts must be fully cognisant of respective performance in relation to patient pathways and the optimum approach to patient management required. A system for dealing with ‘unacceptable’ patient management needs to be developed and implemented as soon as possible.**

3.25 We were very conscious that the intelligence relating to workforce needs to be improved to underpin and inform the workforce planning system for NHS Wales. A whole-system approach to workforce planning across primary, community, secondary, public health and social care must be employed, embracing education and training requirements. While the work of the Centre for Workforce Intelligence in England, in conjunction with WEDS, has proved to be of use, it was recognised that a more focused Welsh dimension was required that reflected the differences between the respective health systems in moving forward. Further, the nature of the workforce required to deliver future health and social care services requires much greater thought, insight and analysis than is currently afforded to the workforce planning process at health board level and among commissioning bodies. Consideration needs to be given to the development of an intelligence unit, which can improve the collection and use of relevant workforce data to better inform strategic planning. Further, the unit could facilitate the employment of analytical and modelling approaches to generate potential future scenarios and assess the implications of future needs projections which would include the specific needs of patients whose primary language is Welsh. **Welsh Government should engage with the Welsh Partnership Forum and undertake a review of existing workforce planning arrangements across health boards, trusts and the work undertaken by WEDS and initiate an improved system that would both reflect local healthcare and other needs (such as language requirements) and the agreed workforce strategy in moving forward.**

3.26 The need to develop new roles, skills and competences in both the regulated and unregulated workforce, as well as supporting services, was made very clear. However, such initiatives should not be implemented without a proper evaluation of their relative effectiveness and efficiency. The polarisation of views around new roles and their relevance for NHS Wales indicates that more work needs to be undertaken. The Panel are aware of the recent Ministerial announcement relating to the next steps of the *Health Professional Education Investment Review*, which highlighted the need for change, underpinned by a single flexible, funding stream freed from arbitrary and historical boundaries and to ensure that investment and planning decisions about education and training were based on the needs of patients and local populations and a holistic approach to the workforce. It would therefore seem sensible for the terms of

reference for the group, led by Professor Robin Williams in taking this work forward, to include an appraisal of the costs and benefits of the new roles being considered. **Welsh Government needs to ensure that further work relating to the establishment of a single body for workforce planning, development and commissioning of education and training, should include an assessment of the costs and benefits relating to introduction of new roles in NHS Wales.**

- 3.27 We were reminded on many occasions of the need to protect and develop the existing workforce. Schemes, including the greater use of retire and return options and the removal of potential obstacles for return to practice schemes, were discussed with the Panel. The diminution of expertise, experience and, more significantly, intelligence resulting from the loss of staff cannot be simply offset by a replacement policy that is based on traditional models of vacancy management and a reliance on locum cover to manage the intervening time period between departure of staff and their replacements. The development of a workforce plan that is aligned to the strategic vision for the NHS In Wales will serve to minimise disruption caused by staff leaving, but there is also a need for health boards and trusts to adopt greater proactivity in workforce management and development based on more informed intelligence relating to the demands on their services.
- 3.28 In developing the current workforce, the Panel was made aware of some of the potential barriers to career progression opportunities. It was evident that these should be removed wherever possible and commission bodies should work with regulatory bodies to adjust and develop routes towards professional qualifications that will enable non-professional staff groups to gain professional qualifications while remaining in employment. **Welsh Government, in conjunction with WEDS, should continue to actively engage with relevant regulatory bodies to ensure that relevant programmes are sufficiently flexible in relation to modes of study that allow staff to pursue relevant qualifications and enhance the skills and capabilities among the existing NHS workforce.**
- 3.29 In the current climate financial incentives relating to recruitment and retention are severely constrained, but non-financial incentives, such as learning contracts, should be offered to the current workforce, trainees and those considering a move to train or work within NHS Wales. We were reminded by a number of respondents that career development and skill enhancement can serve as a clear demonstration that staff are valued and counter the issues that are contributing to some of the morale problems among the workforce. In an age of austerity such opportunities are easy targets for expenditure cuts, whereas a commitment to 'ring-fencing' these can also serve to enhance rates of productivity and reduce levels of sickness absence. **Health boards, trusts and commissioning bodies should be tasked by Welsh Government to develop education and training strategies that are aligned with IMTPs – to be introduced in the 2017/18 discussions - and which should be subjected to approval prior to the IMTP being agreed.**

3.30 The notion of the NHS in Wales as a learning organisation could be further enhanced by the extension of its use of apprenticeships, including those with a run through to degree level training, along with the creation of Talent Banks, linking health boards and trusts, universities and FE colleges, with appropriate funding streams being developed. The opportunities for young people to be inspired and enthused to work in the future NHS in Wales, having had exposure to dedicated professionals and a culture of care and compassion, represent an opportunity that warrants further exploration. **Welsh Government should, as part of its policy developments in health and economic development, consider how best for the NHS (in conjunction with health boards, trusts and Education authorities) to take an active role in the utilisation of apprenticeship schemes.**

3.31 We were enthused by the opportunities identified for technological advancement within NHS Wales and the contribution that it would make to improve the health and wellbeing of the population. However, we were dismayed – in equal measures – by the barriers that inhibit wide-scale implementation. Research needs to be commissioned as to how to utilise technological advancements within care delivery plans, especially where shortages of appropriate skill mix and appropriate critical mass of expertise is evident. Further the wealth of expertise evident in relation to data management in Wales needs to be channelled into informing the workforce (and other) agendas through the determination of effective and efficient patient management pathways, resource utilisation and planning and commissioning of services. **Health and Care Research Wales should establish a series of research programmes to generate repository of effectiveness and efficiency of technology schemes in health and social care that have relevance for Wales and to commission new programmes where gaps are evident. In addition, they should commission a programme of research, in conjunction with NWIS, to determine the most appropriate configuration for information management within NHS Wales.**

CHAPTER 4 – AREAS OF POTENTIAL EFFECIENCIES

4.01 We have been asked to scope potential areas of efficiency, taking into account the principles of prudent healthcare to help address the long-term financial challenge between 2016-17 and 2025-26, as identified in the Nuffield Trust report, *A Decade of Austerity in Wales?*

Context

4.02 The findings of the Nuffield report, *A Decade of Austerity in Wales?*, 2014 were discussed earlier in the context section of this report and provided the rationale for the Review. More recently, the *OECD Review of Healthcare Quality in the UK*, 2016, recommended that Wales should “back up the prudent healthcare agenda with an Implementation Action Plan – a menu concrete, measurable time-bound set of changes to bring tangible results to the prudent healthcare objectives” and “develop an ambitious workforce strategy, which includes planning, piloting and evaluating innovative staffing models.” Further, the Bevan Commission paper *A Workforce fit for Prudent Healthcare* (September 2015¹⁵) also made a number of recommendations that are relevant for the Review.

4.03 Firstly, the Bevan Commission argued that a workforce fit for prudent healthcare must be designed to address individual and population health needs now and in the future. It should not perpetuate existing roles, but should be open, flexible and responsive to adopting new roles, skills and new ways of working together with patients and the public to best meet their needs.

4.04 Secondly, the Commission was of the view that resources currently in place are not adequate or are not being used in the most effective way to manage or meet current or future demands. Prudent healthcare requires skills and resources to be utilised to best effect and proportionate to need, ensuring the right mix of people are in the right places and with the right competencies. This will require a strategic and holistic perspective, including the skills and resources held by the wider workforce, including social care, housing colleagues and patients, carers, volunteers and the third sector.

4.05 Thirdly, a strategic vision of what a prudent healthcare system will look like in the future is required to help guide and stimulate change to meet health needs and ensure the most effective use of the workforce. This requires a different culture, mindset, model and way of working to deliver prudent healthcare in practice and a workforce with strong leadership and ‘future proofed’ skills. It requires a fundamental change that involves more than ‘only do what only you can do’, based on a wider shared

¹⁵ Bevan Commission – A Workforce Fit for Prudent Healthcare:
http://www.bevancommission.org/sitesplus/documents/1101/Workforce%20fit%20for%20Prudent%20Healthcare_FINAL.pdf

commitment and responsibility for prudent healthcare outcomes. It is a considerable task and will take time, courage and commitment by all, professionals and the public to achieve the outcomes we all want.

- 4.06 Finally, the Commission was firmly of the view that the NHS' greatest asset is its workforce, which should be nurtured, trusted and encouraged to find better solutions and improved outcomes.
- 4.07 The previous iteration of prudent healthcare was based on five principles which included the 'only do what only you can do' principle, primarily to reflect the human interaction between professional and patient. The current iteration is based on four principles, but whichever version of the principles is employed, it embodies the notion of delivering the right treatment and care to the right patient in the right place at the right time by the right professional(s). It must be emphasised that the adoption of such principles does not necessarily imply that there will be expenditure released from within existing budgets, but rather that expenditure which is incurred unnecessarily and/or to remedy problems created within the system can be utilised more productively to enhance the health of the population.
- 4.08 As NHS Wales therefore aspires to move towards a healthcare system based on the principles of prudent healthcare, it is imperative that the development of a workforce fit to deliver the requisite care and treatment is underpinned by such principles. The scale of the transformation required to address shortages in the supply of the formal and informal workforce and equip existing professionals with new and relevant skills has been described as 'immense.' However, the alternative is that 'we risk being perpetually out of step and continually rebuilding our workforce to do yesterday's, not tomorrow's, health care work.'¹⁶

Scope for efficiencies

- 4.09 A number of the proposed solutions highlighted in the previous section are pertinent within this component of the Review. For example, measures designed to align the workforce of the future to the health and social care needs of the relevant population will generate efficiencies and help to minimise financial waste, while also increasing levels of productivity within the system. Local health needs assessment should be actively utilised to inform workforce requirements, where those with greatest needs are treated first by appropriate staff.
- 4.10 NHS Wales should ensure that the benefits gained from further utilisation of the support workforce should be embraced, although it is imperative that the introduction and implementation of new roles, up-skilling and realignment of existing roles and

¹⁶ The King's Fund – NHS and Social Care Workforce: Meeting Our Needs Now and in the Future: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/perspectives-nhs-social-care-workforce-jul13.pdf

development of advanced roles should aim to be at least cost neutral over the longer term. The *Directors of Workforce & OD* made us aware of roles being added without the consequential decommissioning and therefore a net increase to expenditure on workforce. There were a number of references to professionals needing to operate at the 'top of their licence' to ensure that the principle of 'only do what only you can do' was implemented, with *UNISON* alluding to the impact on morale of "our professional members being under-utilised or not being given the opportunity, or the authority to work to their approved skill level. At the same time, other, more senior professionals are working below their skill level delivering patient care that could be more done in a more cost-efficient way by other highly-skilled professionals." while at the same time eliminating levels of wasted expenditure. However, the development of healthcare support workers (HCSWs) across health and social care and the investment in their education and training is essential in transforming the workforce and supporting the principles of prudent healthcare. While there is important work being undertaken within health boards and trusts and the mechanisms for training and development are being developed, this should be undertaken with a greater degree of urgency, as this was a common theme that emerged during the evidence sessions, with many stakeholders making reference to the opportunities afforded (for example, *Cwm Taf University Health Board*). However, these initiatives and developments should not be at the expense of investments in current workforce to extend their skills, work flexibly, remain in work, or to work in different ways, and supported by appropriate technology and effective communication channels, in order to deliver enhanced care that generates improved patient outcomes.

4.11 While technological advancement can be viewed as potentially resource saving (*Royal College of Emergency Medicine Wales*), its implementation has to be carefully managed to ensure that staff are available to utilise the technology and that organisations are willing to invest ahead of the potential benefits, as highlighted by the *Chief Medical Officer (CMO)*. The imperative to embrace technology however was strongly emphasised by the *Royal College of Physicians (RCP)*, who argued that "the geography of Wales needs maximum uptake of the benefits of technology. Its influence is growing at a rapid pace not just within medicine but also amongst patients and the community as a whole. Its application to improve personalisation and control will significantly affect how we move forward. Students, healthcare professionals and patients will need to be educated to take advantage of technology at point of care. Clinicians will need to challenge resistance." What is evident is that technology, when implemented consistently and within commissioning frameworks, can contribute to a prudent approach to workforce configuration, but it is also apparent that technological advancements must be subjected to rigorous and sustained evaluation across different contexts to identify the scope for efficiencies and opportunities for decommissioning of services that provide no clinical benefits.

4.12 As well as aligning the workforce plan within NHS Wales with the health and social care needs of the relevant populations, there should be a more consistent and

determined focus on measuring and evaluating patient experience and clinical outcomes, in line with the prudent healthcare principles. Previous work has demonstrated that the enhancement of patient outcomes and focus on minimisation of adverse events and errors will yield resultant cost savings, whereas the current emphasis on cost improvement programmes is too simplistic to grapple with the pressures in an age of increasing resource constraint.

- 4.13 Schemes to enhance value and ensure productivity need to be rolled out across NHS Wales, with examples of good practice being made speedily available to all. We were made aware of many such schemes, but were disappointed that they had not been mainstreamed within NHS Wales. It was very evident from our discussions with stakeholder organisations that there is considerable scope for improving efficiency and securing productivity gains that will effect staff usage and costs and will continue to be fundamental in managing costs into the future. *Aneurin Bevan University Health Board* alluded to “building a positive culture, having good leadership and management, engaging and empowering staff – all of which have a good evidence base in impacting on staff motivation, productivity and patient outcomes.” In particular, there will need to be improvements in productivity across the patch – and should include areas such as length of stay, numbers and types of procedures undertaken - where indicators are consistently out of step with reasonable benchmarks etc. In addition, managers will need the confidence to deal with staff that consistently fail to perform to recognised standards, resulting in sub-optimal care and treatment and, in many cases, a waste of limited resources.
- 4.14 The issue of reliance on locum and agency staff was discussed in some detail in the previous section. However, its impact was a consistent theme that featured in most of the conversations and discussions that the Panel engaged with stakeholders and the written evidence presented to accompany their oral contributions. A range of measures designed to reduce and then, ideally, eliminate reliance on agency and locum staff was provided as a solution to this manifestation of system deficiencies, which included issues such as addressing sickness absence management, improving staff rostering systems, skill mix and role design. NHS Wales should consider developing existing staff bank arrangements to allow such staff to move between organisations, ensuring that unplanned absences across Wales are, whenever possible, covered by the existing NHS workforce. The proposal from the *Royal College of Nursing (RCN) Wales* to establish “an all-Wales Bank register that guarantees those employed on the Bank a 37.5 hour week contract” was particularly pertinent and would serve to ensure that a specialist pool of nurses to call upon was available. In parallel, health boards and trusts should review their existing arrangements to ensure that local banks are sufficiently attractive, for potential employees, to meet service needs and avoid the need to utilise premium rate agency staff.

- 4.15 Another illustration of where efficiencies can be secured was in relation to the processes and procedures relating to recruitment and management of vacancies and to the information relating to these areas. The *British Medical Association (BMA)* advocated improved availability, quality and accuracy of NHS data collection, particularly around workforce numbers and vacancies and, as an organisation, would welcome the opportunity to work with the Welsh Government so that accurate data is routinely collected and reported. It was apparent from discussions that NHS Wales should review its recruitment processes to ensure they respond in an effective and timely manner when a vacancy arises; in parallel greater consideration should be given to the impact on the departing NHS organisation when a member of staff moves between health boards and trusts. A better alignment of the time between offering a new post and commencement of duties with the time necessary to recruit to the resulting vacancy would help reduce reliance on agency and locum demand.
- 4.16 A more routine and systematic approach to the commissioning and de-commissioning of services, based on evidence-based guidelines and recognised professional contributions, should become increasingly evident, to ensure that outcomes are maximised given resource availability, again closely aligned to the prudent healthcare agenda.

Conclusions and recommendations

- 4.17 Local health needs assessment should be actively utilised to inform workforce requirements, where those with greatest needs are treated first by appropriate professionals. In addition, NHS Wales should focus on routinely measuring and evaluating patient experience and patient related outcomes, with a view to developing and informing strategy. **NHS Wales should undertake a review of current schemes being used to collect information relating to patient experience and patient related outcome measures. The review should recommend the most appropriate instruments to use and measures to collect and this should become the norm for all health boards and trusts.**
- 4.18 NHS Wales needs to develop the culture of being a learning organisation, recognising good practice and establishing effective dissemination mechanisms to facilitate roll-out across the country. Schemes that enhance value and ensure productivity gains, in particular, need to be rolled out across NHS Wales, while inappropriate variation in practice and examples of waste and inefficiencies must become features of the past and removed from current delivery plans and commissioning models. **Welsh Government should offer greater challenge to health boards and trusts as part of their Integrated Medium Term Plan (IMTP) with regard to the implementation of schemes pertaining to prudent healthcare, including the identification of services that will no longer be provided and those that will release resources as a result of service provision modification.**

- 4.19 There was general recognition that actions to minimise rates of sickness absence need to be implemented across health boards and trusts and that programmes designed to improve the health and wellbeing of the workforce are worthy of consideration in addressing absence, morale and productivity factors. **Health boards and trusts need to consistently implement evidence-based approaches to minimise rates of sickness absence. The Welsh Government should challenge the Welsh Partnership Forum to identify measures that will reduce rates of sickness absence.**
- 4.20 Intelligence relating to optimal patient management pathways and reasons for excessive variation from such should be factored into relevant discussion, connected, for example, with performance relating to delivery plans, between Welsh Government and health boards and trusts. Examples of good practice and other illustrations of other productivity gains, in general, must be made available to all health boards and trusts on a regular basis through regular dialogue between Welsh Government officials and executives within the respective health boards and trusts. **Health boards and trusts should, within their IMTPs, provide an indication of the extent to which efficiency gains will be achieved as a result of productivity enhancements. These should be assessed by Welsh Government within the respective performance reporting framework.**
- 4.21 NHS Wales should ensure that the benefits gained from greater utilisation of the support workforce should be embraced, while at the same time eliminating levels of wasted expenditure. In this regard, the development of health care support workers across health and social care, and investing in their education and training, is essential in transforming the workforce and supporting the principles of prudent healthcare. **Welsh Government needs to ensure that further work relating to the establishment of a single body for workforce planning, development and commissioning of education and training, should include an assessment of the costs and benefits relating to introduction of new roles in NHS Wales (as at paragraph 3.26).**
- 4.22 There were very strong views presented that measures designed to initially minimise and then eliminate reliance on agency and locum staff must be introduced as a matter of urgency. The risks to quality, along with the excessive financial pressures, warrant serious and concerted efforts to address this issue. There are a number of approaches that were advocated to reduce reliance on premium rate agency staff. **Health boards and trusts should consider the effectiveness of overtime payments as a way of reducing the overall pay bill. Further, they should, as a matter of urgency, initiate appropriate schemes to reduce reliance on locum and agency staff. Among such schemes should be the creation of an all-Wales bank, a reconfiguration of existing staff bank arrangements to allow staff to move between organisations, ensuring that unplanned absences across Wales are whenever possible covered by the existing NHS workforce. In parallel, health**

boards and trusts should review their existing arrangements to ensure that local banks are sufficiently attractive meet service needs.

- 4.23 There is considerable scope and potential for more creative use of technology in the health and social care system in Wales. As was outlined in Chapter 3, while technology can assist in implementing a prudent approach to workforce configuration, technological advancements must be subjected to rigorous and sustained evaluation across different contexts to identify the scope for efficiencies and also opportunities for de-commissioning of services and approaches to service delivery. **Health and Care Research Wales should establish a series of research programmes to generate repository of effectiveness and efficiency of technology schemes in health and social care that have relevance for Wales and to commission new programmes where gaps are evident (as at paragraph 3.31).**
- 4.24 Issues relating to recruitment and vacancy management were considered in Chapter 3, but it is clear that NHS Wales should review its recruitment processes to ensure they respond in an effective and timely manner when a vacancy arises; in parallel greater consideration should be given to the impact on the departing NHS organisation when a member of staff moves between health boards and trusts. A better alignment of the time between offering a new post and commencement of duties with the time necessary to recruit to the resulting vacancy would also help reduce agency and bank demand. **Health boards and NHS Shared Services Partnership should evaluate current recruitment systems to identify factors contributing the time lags between staff leaving and new staff arriving and initiate new processes to improve the efficiency of the relevant systems.**
- 4.25 The principles of prudent healthcare embody the notion of delivering the right treatment and care to the right patient in the right place at the right time by the right professional(s). The BMJ campaign on 'Too Much Medicine' provides a fertile source of information relating to the threat to human health posed by over-diagnosis and the waste of resources on unnecessary care. **Health boards and trusts – in conjunction with commissioners and Welsh Government - should avail themselves of such intelligence and ensure that they are factored into their respective IMTPs. A more routine and systematic approach to the commissioning and de-commissioning of services should become increasingly evident, to ensure that outcomes are maximised given resource availability.**

CHAPTER 5 – PAY AND OTHER TERMS AND CONDITIONS OF EMPLOYMENT

5.01 In this chapter we consider the pay and terms and conditions for staff employed on Agenda for Change (AfC) contracts and staff in Executive and Senior Posts (ESPs). Whilst the chapter does not consider matters relating to staff on medical and dental contracts, we do not exclude these staff from our more general views regarding long term pay trend and pay arbitration processes.

Agenda for Change pay

5.02 In this section we consider the issue of pay for AfC staff.

5.03 The issue of pay and reward in the Welsh NHS has been the subject of much attention and discussion in recent years owing to the challenges faced by employers, government and staff representatives in response to the UK government public sector pay policy. Indeed, the creation of the Review is itself a product of the AfC pay award for 2014-15 and 2015-16 announced by the Minister for Health and Social Services in 2014.

5.04 In considering what should be the long term strategy for AfC pay it is important to reflect on the decisions and outcomes arrived at in recent years and the impact of these on NHS spend and staff pay. The Nuffield Trust report, *A decade of austerity in Wales?* demonstrates that staff (including doctors, nurses, support staff and managers) pay rose on average by around 2% a year in real terms over the 35 years to 2009-10. Between 2011-12 to 2015-16 AfC staff have been awarded a mixture of zero percentage uplifts, 1% increases and non-consolidated payments. Despite a policy of pay restraint since 2011-12 the NHS pay bill accounts for almost two thirds of hospital costs and expenditure has continued to increase as a proportion of overall NHS spend.

5.05 The independent pay review body system for AfC staff is currently provided by the NHS Pay Review Body (NHSPRB) (doctors and dentists in the UK are covered by the Review Body on Doctors' and Dentists' Remuneration – the DDRB). While the NHSPRB's remit covers the whole of the UK, it is for individual countries to set out the remits they would wish the pay review body to work within in recommending pay for AfC staff. Historically this system has helped to depoliticise NHS pay and is considered to be trusted by employers and staff. However the current UK government pay policy and acute budgetary pressures are placing unprecedented strain on this process, either resulting in pay remits not being issued or governments subsequently rejecting pay recommendations on the grounds of affordability.

5.06 The evidence we received highlighted growing discontent amongst the workforce following several years of pay restraint as a result of the UK government's policy to

limit wage increases in the public sector. The UK Chancellor's announcement on 8 July 2015 confirmed a further four years where funding for public sector pay increases is to be limited to 1% with the consequence that increases in NHS pay (and other public sector pay) can be expected to fall behind pay increases in the wider economy and fail to keep pace with price inflation. Furthermore, upcoming changes to National Insurance contributions for employers and employees will, in all likelihood, add further pressure on take home pay.

Evidence provided

- 5.07 As part of the evidence we received on pay, the *All Wales Orthoptic Advisory Committee* said if pay does not mirror that available in the wider economy, ultimately staff will move away from public services to better paid employment. This view was consistent with the submissions from the majority of other respondents. For example, the *Society of Radiographers* said the combination of pay restraint and increasing demands on NHS staff has resulted in a challenging working environment which is unsustainable in the longer term, while *the staff representatives of the Welsh Partnership Forum Business Committee* said continuing pay restraint for NHS staff is both unsustainable and unacceptable. The *British Association of Occupational Therapists (BAOT)* told us that NHS pay and rewards should at least keep pace with the wider economy as it recovers. *Aneurin Bevan University Health Board* told us the temptation might be simply to suggest that the affordability of the workforce is achieved by suppressing wages over the next 10 years and the danger of this as a simplistic approach is that an already fragile workforce will become increasingly unattractive as a long term option if real time wages continue to rise in the private sector.
- 5.08 The *Directors of Workforce & OD* said pay, reward and terms and conditions are part of the wider collective bargain and change in one area can drive change in another. The value of non pay aspects such as the working week or annual leave are inextricably linked to the whole contract and the pay and reward associated with a role. Pay recommendations and potential uplifts in pay are not just about cost of living increases and there needs to be a dialogue on how we consider the broader reward package and its "value".
- 5.09 The evidence we received was also in agreement when considering the pay review body system. The *Chartered Society of Physiotherapy (CSP)* said continuing pay restraint is unsustainable and the organisation is receiving increasing evidence that managers are finding it more difficult to recruit staff - their members trust the Pay Review Body process which is seen as independent. However the *CSP's* support is on the basis that all parties, including government, accept and implement recommendations in full. The *Royal College of Midwives (RCM)* said it is committed to UK wide pay bargaining, through the NHS Staff Council, and the independent Pay Review Body. It believes that AfC is the most transparent, fair and equal system as it

is underpinned by the job evaluation system which is based on equal pay for work of equal value. The *RCM* continued by saying it would like to see a more positive approach to pay, terms and conditions for NHS staff; it would like to see the end to interference with the NHS Pay Review Body and a recognition that pay, terms and conditions should be considered as part of a total workforce strategy and a fundamental part of how the NHS delivers a high quality and safe service. It believes that investment in staff is an investment in care. The *Royal College of Nursing (RCN)* told us it is committed to the AfC approach that will ensure that nurses speak with one voice on major issues, such as pay, across the UK. It is their strongly held conviction that the Pay Review Body has served staff well and that since its introduction, nurses have been treated more fairly than previously and the RCN supports its continuance. Any divergence from the AfC approach would have dire consequences for its membership in relation to pay and terms and conditions of employment, which are intrinsically linked to clinical services and the overall healthcare delivery. *UNISON* said Wales has a tradition of partnership and co-production which demands that decisions are not made unilaterally but with due consideration for the opinions and aspirations of staff who work for the NHS and are members of UK-wide organisations. It said that if the Pay Review Body is to remain as the mechanism for determining pay in NHS Wales, then there must be a commitment from the Welsh Government to apply those recommendations in full. If not, *UNISON* would question the value of the use of the Pay Review Body, and other mechanisms would need to be considered to address a four-nation approach to pay and reward. The *staff representatives of the Welsh Partnership Forum Business Committee* said they support the Pay Review Body process on the basis that all parties, including government, accept and fully implement any recommendations.

5.10 The *CSP* also told us that in the future the pay for all NHS staff irrespective of what role/job they perform should be considered together. At a time when the NHS in Wales (and elsewhere) is under increasing financial pressure they saw an increased recognition that workforce planning and development and investment needs to be considered as a whole and as an integral part of delivering services more effectively and affordably. They therefore considered it as untenable for employers and governments to consider the pay for different groups of staff separately, or in isolation from other parts of the complex health and social care agenda.

Conclusions and recommendations

5.11 We recognise that affordability is and will continue to be a material issue for NHS Wales, one that we expect to influence pay decisions in the short and medium term. However efforts to control the pay bill should not focus on salaries alone. Significant savings can be made by improving service efficiency, reducing agency spend, streamlining recruitment processes, improving staff utilisation through more effective use of rostering and reducing sickness absence. These have been explored further in chapter two and three. **The long term strategic direction for pay in the NHS must**

be to keep pace with wage growth in the wider economy if the NHS is to avoid serious recruitment and retention difficulties, a worsening of staff morale and a decline in levels of competency.

- 5.12 The NHSPRB is not constituted as an arbitration process. Arbitration occurs when parties who are in dispute or who anticipate being in dispute, voluntarily agree to submit the matter of disagreement to a third party for decision and agree in advance that they will accept and be bound by the outcome. In contrast, the NHSPRB only undertakes a review at the request of the relevant government minister (in Wales this is the Minister for Health and Social Services), and neither government ministers nor AfC trade unions are committed in advance to accepting the NHSPRB recommendations. The Pay Review Body mechanism is essentially an independent advisory mechanism which provides advice to the parties concerned.
- 5.13 Nonetheless, the NHSPRB mechanism has become seen as an arbitration process and the trade unions in their evidence to us were keen to emphasise its importance as a way of resolving conflicting positions regarding pay and reward. It is clear to us that since its establishment the NHSPRB mechanism has been an important factor in ensuring an orderly resolution of pay issues within the NHS. The NHSPRB can and should serve as an arbiter between NHS employers, governments and trade unions. However, the failure to implement recommendations by any party is certain to undermine confidence in the system and generate conflict.
- 5.14 The NHSPRB system is consistent with the partnership principles as set out in the partnership agreement between Welsh Government and the trade unions and as such we would expect Welsh Government to regularly engage the Pay Review Body by issuing a remit and then, together with NHS Wales employers and trade unions, to implement the recommendations.
- 5.15 As we have noted however, Welsh Government has the discretion not to issue a remit to the NHSPRB in circumstances where it believes it will be unable to fund the likely recommendations. In such circumstances we consider it better not to issue a remit rather than to issue one and then decline to accept the outcome. **When a remit is issued to the AfC Pay Review Body by Welsh Government it should be on the basis that all parties agree in advance to accept and implement the central recommendations arising from the review.**
- 5.16 We note the BMA's support for this principle and its view that it should equally apply to medical and dental staff.

Agenda for Change collective agreement

- 5.17 The AfC pay system has been in operation across the UK since 2004. In Wales approximately 78,000 staff are employed on AfC contracts. The evidence we received was strongly in support for retaining the existing UK framework for the pay and terms and conditions of staff covered by AfC, with little appetite to negotiate any separate arrangements in Wales. There was general agreement that any deviation from the core contractual framework could have a detrimental effect on recruitment and retention, particularly for those roles where there is a UK recruitment market.
- 5.18 Notwithstanding a collective view in support of retaining the core UK framework, some of the evidence highlighted concerns about the operations of the UK NHS Staff Council within the context of the devolved settlements in health.
- 5.19 In their evidence some organisations expressed support for a separate pay system for bands 1-3 where staff are sought primarily within a local labour market. We are not persuaded by these arguments at this time, which are inconsistent with our wider support for the continuation of the UK AfC framework. We are also concerned that any move towards more local arrangements could lead to the worsening of pay and terms and conditions for staff in these bands and would be inconsistent with the tackling poverty agenda in Wales.
- 5.20 We also note the ongoing work through the NHS Staff Council to review the AfC pay structure.

Evidence provided

- 5.21 The *Directors of Workforce & OD* explained that the AfC structure of common pay bands underpinned by the Job Evaluation Scheme provides consistency across the four countries comprising the UK NHS Staff Council. This is an important feature for recruitment and retention of NHS staff in Wales. The terms and conditions are also common to all NHS employers and an employee's continuous previous service with any NHS employer counts as reckonable service in respect of NHS agreements on redundancy, maternity, sick pay and annual leave. They then went on to say that NHS Wales is involved in partnership discussions at a UK level with representatives from the UK NHS Staff Council to consider the potential for pay reform and any associated changes to the AfC terms and conditions and that employers welcome this approach and wish to ensure that collaborative approaches, developed in partnership within the auspices of the NHS Staff Council are maintained. However, the *Directors of Workforce & OD* also said that the UK Staff Council constitution and operating arrangements are in need of revising, particularly in the light of their needing to be sensitive to how the devolved parts of the UK operate. As such it would be helpful to establish a mechanism to agree changes through NHS Staff Council where Wales (or indeed one or more parts of the UK) would want to see changes.

- 5.22 The *CSP* said it considers the current pay system (AfC) provides a national pay system underpinned by a specific NHS job evaluation scheme which delivers equal pay for work of equal value. Physiotherapy is a highly mobile workforce and their members can, and do, move within the four UK countries and between them. As such they believe a UK system best delivers a pay system for staff working in a UK labour market. *Cwm Taf University Health Board* said it strongly supports the maintenance of UK pay and terms and conditions for NHS professional staff and considers that deviation from the core contractual frameworks for medical and dental, nursing and midwifery, allied health professionals and scientists would have detrimental consequences on recruitment and retention. The AfC structure of common pay bands underpinned by the Job Evaluation Scheme provides consistency across the four countries comprising the UK NHS Staff Council. The terms and conditions are also common to all NHS employers and an employee's continuous previous service with any NHS employer counts as reckonable service in respect of NHS agreements on redundancy, maternity, sick pay and annual leave.
- 5.23 The *BAOT* said it expects that NHS Pay and Conditions will continue to be determined by a National Agreement - AfC - albeit refined to make it sustainable for the future and with flexibilities for local variation to meet local need in pre-determined circumstances, negotiated through the National Staff Council. The *RCM* told us there are some flexibilities within AfC to allow variations to deal with specific workforce issues, e.g. recruitment and retention premia. It believes that UK wide pay bargaining is the most transparent, fair and equal system for the NHS and the current pay structure has the trust and confidence of NHS staff. In their oral evidence to us, the *RCN* said it has concerns that health boards are not fully utilising the full range of terms and conditions within AfC. It said that, for example, some health boards and trusts are not willing to pay overtime rates and the provision of recruitment and retention premia is not utilised. *Hywel Dda University Health Board* said that in general terms, there needs to be a more strategic approach to pay and terms and conditions. It is evident that some of the terms and conditions are outdated and out of step with the private sector and other public sector bodies. They said that pay protection is one such area which urgently needs reforming and that sick pay is also very generous in comparison to the private sector.

Conclusions and recommendations

- 5.24 We support the continuation of a common contract across the four countries of the UK which we believe significantly benefits Wales in terms of recruitment and retention. This is particularly the case in relation to England, where a shared labour market is most in evidence. Any move away from the core framework could impact on recruitment and retention where there is a UK recruitment market. **The existing UK framework for pay and terms and conditions for AfC staff underpinned by NHS job evaluation should be maintained.**

5.25 We recognise that changes to terms and conditions, agreed recently to reflect local system needs in England and Wales, demonstrate the flexibility built into current NHS Staff Council mechanisms. However we remain concerned about the responsiveness of these and, for example, the ability for Wales to drive through changes without them first being endorsed or introduced elsewhere in the UK. The opportunities for greater flexibility that emerged through AfC need to be re-visited and evaluated for their feasibility in the current climate. **Welsh Government, NHS Wales employers and trade unions in Wales should promote a four country review of the NHS Staff Council operating arrangements to ensure they continue to appropriately reflect, and keep pace with, devolution settlements in health.**

Executive and Senior Posts (ESPs)

5.26 ESPs are defined as 'all directly employed staff that are not covered by an Agenda for Change or medical and dental contract – excluding bank staff'. There are approximately one hundred and twenty ESPs with salaries ranging from £80,000 to £200,000.

5.27 The term 'Executive and Senior Posts' was only introduced in 2015 as a result of recommendations made by a task and finish group set up by the Minister for Health and Social Services to consider matters concerning the employment of very senior managers in NHS Wales. We are aware this task and finish group had been asked to articulate a definition of very senior managers, to confirm the terms and conditions of employment that apply to this group of staff and to consider the mechanisms in place for engagement with them and for reviewing employment matters, including their pay.

5.28 We are also aware the task and finish group concluded that very senior managers in NHS Wales should be referred to as ESPs and defined as above. The group also concluded that ESPs were subject to the same policies and procedures as staff employed on AfC contracts and that any future variations could be carried out through existing engagement mechanisms which were seen as being fit for purpose. With regard to pay and reward the group concluded that those matters should be referred to the Review Panel for an independent assessment of ESP pay arrangements.

5.29 The current pay arrangements for what are now termed ESPs were largely determined during the reorganisation of health boards and trusts in 2009. As part of that reorganisation, Welsh Government set down salary ranges for the newly appointed health board and trust chief executives and executive directors, using the Job Evaluation for Senior Posts (JESP) process that had been introduced for senior posts in the Civil Service in 1994. JESP had been designed to provide a fair and consistent approach to making pay decisions for senior civil servants working throughout the UK, regardless of their department or location.

- 5.30 In applying JESP to the new ESPs created by the 2009 reorganisation, Welsh Government decided that appointments would be made at the bottom of the relevant salary range. Guidance was issued as to the circumstances in which an ESP could be paid at a higher point within the relevant band should the post subsequently attract additional responsibility. A procedure was also established by which a business case could be submitted to Welsh Government for permission to pay a newly appointed ESP above the relevant band when filling a vacancy.
- 5.31 Since 2009 several things have happened. The definition of ESPs has been clarified and a number of other senior posts have been included by the ESP definition. The JESP process has been used to re-evaluate some but not all of these other posts. A significant number of ESPs have become vacant at some point, resulting in new recruitment and appointments being made. Welsh Government has decided each year that the pay uplift for ESPs should be nil and there has been no change to ESP salary ranges since 2009.
- 5.32 The effect of this has been to create distortions in the salaries being paid to ESPs across NHS Wales. A significant number of ESPs are now being paid at a higher rate than the bottom of their appropriate salary range and some ESPs, with the approval of Welsh Government, are being paid salaries beyond the maximum of their pay band.
- 5.33 These distortions have arisen in part due to changes having been made to role responsibilities and pay without the posts having been formally re-evaluated, but also because of a willingness at times to negotiate when making new appointments.

Evidence provided

- 5.34 As part of the evidence we received on ESP pay, *Betsi Cadwaladr University Health Board* told us there is evidence that arrangements introduced during 2009 for remuneration of ESPs have become problematic, in that a large number of posts are no longer remunerated within the pay range. They told us that some payments outside the JESP range involve a significant premium. The *Directors of Workforce & OD* told us that new ESP appointments can be remunerated higher than an equivalent and existing member of staff based on pay negotiations at the time of appointment and that an experienced ESP could be lower paid than an ESP that has just joined an organisation. They emphasised the importance of ESP salaries remaining competitive with salaries being paid for similar posts elsewhere in the UK. They recommended a full review of the ESP salary ranges, but told us that the JESP system, having been designed for the Civil Service, is not a good system for the evaluation of senior posts in the NHS. They also told us that more local discretion is required on the negotiation of ESP salaries in order to secure good staff. *Staff representatives of the Welsh Partnership Forum Business Committee* said there should be a job evaluation for all

ESPs across the public sector to ensure consistency and to enable the transfer of talented individuals across organisations.

Conclusions and recommendations

- 5.35 We consider the current distortions and anomalies within the pay arrangements for ESPs as unacceptable. Although the number of ESPs in NHS Wales is small, representing less than 0.2% of the workforce, the roles that are undertaken by ESPs are high profile leadership roles within the NHS. We believe it is important that the principles of fairness and transparency which apply to the pay arrangements for the rest of the workforce are seen to apply equally in relation to ESPs.
- 5.36 We have noted that the pay of ESPs ranges from £80,000 to £200,000 per annum and that many ESPs will be the highest earners within NHS Wales. The level of these salaries will always be a matter for public discussion and political comment. In 2011, Lord Hutton published a review of fair pay in the public sector across the UK which found that the pay ratio between the highest earner and the median mid-point earner within public sector organisations typically ranged between 8:1 and 12:1. We have noted that the ratio for NHS Wales is currently 7.4:1, slightly below the range typically found by Lord Hutton. We are aware that the salaries paid to clinical staff within the NHS results in a higher median mid-point than will be the case in some other public sector organisations. However, despite this, the 7.4:1 ratio suggests to us that the salaries being paid to ESPs in NHS Wales are not excessive.
- 5.37 In order to address the drift which has occurred between JESP based pay ranges and the salaries being received, we agree with the Directors of Workforce & OD that there should be a full review. This review should be commenced immediately and undertaken in two stages.
- 5.38 The first stage should be a re-evaluation of each ESP, using the existing JESP process. This should be completed as soon as possible in order to re-establish an objective basis on which ESP salaries should be paid. We would expect those anomalies that have arisen through lack of JESP updating to be corrected by this re-evaluation. However, the exercise is likely to identify ESP salaries that remain inconsistent despite re-evaluation. Should any of these be salaries that are below the re-evaluated range we would expect the salary to be increased to the bottom of the range. Where any are above the re-validated range, the salary should be ring-fenced and we would recommend that the ring-fencing arrangements that were used during the implementation of AfC should be adopted for this purpose. **Welsh Government should undertake an immediate re-evaluation of ESPs within NHS Wales, using the existing JESP process.**

- 5.39 The second stage should be to recognise the deficiencies in utilising the Civil Service JESP for ESPs in NHS Wales. As we identified earlier, the Civil Service JESP is applied throughout the UK and serves to provide a common pay evaluation system across a single labour market. In applying the same scheme to ESPs in NHS Wales, there is the risk that the criteria being used do not adequately capture the role requirements for health service senior managers. More certain however is the lack of accounting for what is happening elsewhere in the NHS, despite the fact ESPs form part of a single UK labour market for senior health service managers. We agree with the Directors of Workforce & OD that the Civil Service JESP may not provide a sufficiently focussed evaluation process for evaluating ESPs in the longer term and for providing a sound basis on which pay can be determined.
- 5.40 We note that the task and finish group, referred to earlier, concluded that the mechanisms in place for engaging with ESPs are fit for purpose. We therefore recommend that Welsh Government should use these mechanisms to engage with ESPs in order to review the criteria that should be used in job evaluating executive and senior posts within NHS Wales with the view to introducing a revised JESP (or JEESP) in 2017/18. **Welsh Government should engage with ESPs and agree a revised system of job evaluation for executive and senior posts in NHS Wales for introduction in 2017/18. Welsh Government should also establish a salary comparison mechanism to regularly compare the salary ranges for ESPs in NHS Wales with the salaries being paid to equivalent NHS posts elsewhere in the UK and to consider the relationship between ESP pay to the pay of other staff in NHS Wales. This information should be placed in the public domain and should be used to inform the process of setting salary ranges against job evaluation outcomes and in deciding any uplifts to ESP pay.**
- 5.41 Whilst we have noted the view of the Directors of Workforce & OD that more local discretion should be allowed to health boards and trusts in negotiating ESP salaries, we are not persuaded that this would benefit NHS Wales. Local discretion would result in variation in pay for similar roles and would promote a competitive pay market for ESPs within Wales which would be inconsistent with Welsh Government policies which promote partnership and collaboration.
- 5.42 Our recommendations concerning a revised job evaluation process and a salary comparison mechanism are intended to ensure that ESP salaries in NHS Wales are objectively justified, fair and appropriate within the wider UK market for ESPs. We are not persuaded that ESPs should additionally be allowed to individually negotiate their salary. We have noted that where such local negotiations have occurred in recent years the result has always been to push the salary up and sometimes beyond the relevant salary range.
- 5.43 Contrary to the view of the Directors of Workforce & OD, we have concluded that local discretion in negotiating ESP salaries should be reduced. **Welsh Government**

should review and reinforce its ESP pay guidance, making it a requirement that ESP recruitment should clearly state the salary range within which a post is to be filled and that ESP appointments should normally be made at the bottom of the relevant pay range. Welsh Government should discontinue the procedure by which it considers business cases for ESP payment outside the relevant salary ranges having first assured that the salary ranges are appropriate.

5.44 Looking to the longer term we are aware of the work which the Public Services Staff Commission will be undertaking and we can see merit in the suggestion put forward by the staff representatives on the Welsh Partnership Forum Business Committee that a Welsh public service approach to evaluation and pay for ESPs should be established. **The Public Services Staff Commission should be asked to consider, in due course, the potential for establishing a common framework for job evaluation and remunerations for executive and senior posts across the Welsh public sector, taking into account our comments regarding the UK wide nature of the labour market for ESPs.**

ANNEX A – TABLE OF RECOMMENDATIONS

Integration

1.	Health boards and trusts must maintain a clear focus on achieving health service integration if the benefits of integration with social care are to be properly realised (paragraph 2.29).
2.	Welsh Government should set out a clear vision for service integration within a refreshed strategy for health and social care services in Wales (paragraph 2.30).
3.	Health boards, trusts, local authorities and others must consider the equal pay implications of any decisions they are intending to make which will result in the transfer of staff (paragraph 2.37).
4.	Health boards and trusts must discuss their integration plans within their Partnership Councils and the NHS Wales Partnership Forum and the local authority Joint Council for Wales must be kept fully informed of developments in health and social care integration (paragraph 2.37).
5.	Health boards, trusts and local government social services departments must ensure that health and social care staff are able to jointly discuss and influence the development of integrated services and the values that will underpin such services going forward (paragraph 2.38).
6.	Welsh Government should recognise the importance of co-terminosity with health board and trusts boundaries in any future reorganisation of local government (paragraph 2.40).
7.	Welsh Government should keep the funding criteria and guidance under review in light of the experiences that will be gained through service integration and pooled budget (paragraph 2.41).
8.	Welsh Government and affected health boards should consider the issue of cross border flows with the view to agreeing appropriate protocols as necessary with English health and social care providers (paragraph 2.42).

Developing the Staff and Skill Mix

9.	Welsh Government needs to develop a clear, refreshed strategic vision for NHS Wales as a matter of urgency, based on the prudent healthcare agenda, which should inform the strategy for the workforce currently being developed (paragraph 3.23).
10.	Welsh Government, health boards and trusts must be fully cognisant of respective performance in relation to patient pathways and the optimum approach to patient management required. A system for dealing with 'unacceptable' patient management needs to be developed and implemented as soon as possible. (paragraph 3.24).
11.	Welsh Government should engage with the Welsh Partnership Forum and undertake a review of existing workforce planning arrangements across health boards, trusts and the work undertaken by WEDS and initiate an improved system that would both reflect local healthcare and other needs (such as language requirements) and the agreed workforce strategy in moving forward (paragraph 3.25).
12.	Welsh Government needs to ensure that further work relating to the establishment of a single body for workforce planning, development and commissioning of education and training, should include an assessment of the costs and benefits relating to introduction of new roles in NHS Wales (paragraph 3.26).
13.	Welsh Government, in conjunction with WEDS, should continue to actively engage with relevant regulatory bodies to ensure that relevant programmes are sufficiently flexible in relation to modes of study that allow staff to pursue relevant qualifications and enhance the skills and capabilities among the existing NHS workforce (paragraph 3.28).
14.	Health boards, trusts and commissioning bodies should be tasked by Welsh Government to develop

	education and training strategies that are aligned with IMTPs – to be introduced in the 2017/18 discussions - and which should be subjected to approval prior to the IMTP being agreed (paragraph 3.29).
15.	Welsh Government should, as part of its policy developments in health and economic development, consider how best for the NHS (in conjunction with health boards, trusts and Education authorities) to take an active role in the utilisation of apprenticeship schemes (paragraph 3.30).
16.	Health and Care Research Wales should establish a series of research programmes to generate repository of effectiveness and efficiency of technology schemes in health and social care that have relevance for Wales and to commission new programmes where gaps are evident (paragraph 3.31).
17.	Health and Care Research Wales should commission a programme of research, in conjunction with NWIS, to determine the most appropriate configuration for information management within NHS Wales (paragraph 3.31).

Areas of Potential Efficiencies

18.	NHS Wales should undertake a review of current schemes being used to collect information relating to patient experience and patient related outcome measures. The review should recommend the most appropriate instruments to use and measures to collect and this should become the norm for all health boards and trusts (paragraph 4.17).
19.	Welsh Government should offer greater challenge to health boards and trusts as part of their Integrated Medium Term Plan (IMTP) with regard to the implementation of schemes pertaining to prudent healthcare, including the identification of services that will no longer be provided and those that will release resources as a result of service provision modification (paragraph 4.18).
20.	Health boards and trusts need to consistently implement evidence-based approaches to minimise rates of sickness absence (paragraph 4.19).
21.	The Welsh Government should challenge the Welsh Partnership Forum to identify measures that will reduce rates of sickness absence (paragraph 4.19).
22.	Health boards and trusts should, within their IMTPs, provide an indication of the extent to which efficiency gains will be achieved as a result of productivity enhancements. These should be assessed by Welsh Government within the respective performance reporting framework (paragraph 4.20).
23.	Welsh Government needs to ensure that further work relating to the establishment of a single body for workforce planning, development and commissioning of education and training, should include an assessment of the costs and benefits relating to introduction of new roles in NHS Wales (this is also a recommendation under ‘developing the staff and skill mix’) (paragraph 4.21).
24.	Health boards and trusts should consider the effectiveness of overtime payments as a way of reducing the overall pay bill (paragraph 4.22).
25.	Health boards and trusts should, as a matter of urgency, initiate appropriate schemes to reduce reliance on locum and agency staff. Among such schemes should be the creation of an all-Wales bank, a reconfiguration of existing staff bank arrangements to allow staff to move between organisations, ensuring that unplanned absences across Wales are whenever possible covered by the existing NHS workforce (paragraph 4.22).
26.	Health boards and trusts should review their existing arrangements to ensure that local banks are sufficiently attractive meet service needs (paragraph 4.22).
27.	Health and Care Research Wales should establish a series of research programmes to generate repository of effectiveness and efficiency of technology schemes in health and social care that have relevance for Wales and to commission new programmes where gaps are evident (this is also a

	recommendation under 'developing the staff and skill mix) (paragraph 4.23).
28.	Health boards and NHS Shared Services Partnership should evaluate current recruitment systems to identify factors contributing the time lags between staff leaving and new staff arriving and initiate new processes to improve the efficiency of the relevant systems (paragraph 4.24).
29.	Health boards and trusts – in conjunction with commissioners and Welsh Government - should avail themselves of such intelligence and ensure that they are factored into their respective IMTPs. A more routine and systematic approach to the commissioning and de-commissioning of services should become increasingly evident, to ensure that outcomes are maximised given resource availability (paragraph 4.25).

Pay and other Terms and Conditions of Employment

30.	The long term strategic direction for pay in the NHS must be to keep pace with wage growth in the wider economy if the NHS is to avoid serious recruitment and retention difficulties, a worsening of staff morale and a decline in levels of competency (paragraph 5.11).
31.	When a remit is issued to the AfC Pay Review Body by Welsh Government it should be on the basis that all parties agree in advance to accept and implement the central recommendations arising from the review (paragraph 5.15).
32.	The existing UK framework for pay and terms and conditions for AfC staff underpinned by NHS job evaluation should be maintained (paragraph 5.24).
33.	Welsh Government, NHS Wales employers and trade unions in Wales should promote a four country review of the NHS Staff Council operating arrangements to ensure they continue to appropriately reflect, and keep pace with, devolution settlements in health (paragraph 5.25).
34.	Welsh Government should undertake an immediate re-evaluation of ESPs within NHS Wales, using the existing JESP process (paragraph 5.38).
35.	Welsh Government should engage with ESPs and agree a revised system of job evaluation for executive and senior posts in NHS Wales for introduction in 2017/18 (paragraph 5.40).
36.	Welsh Government should also establish a salary comparison mechanism to regularly compare the salary ranges for ESPs in NHS Wales with the salaries being paid to equivalent NHS posts elsewhere in the UK and to consider the relationship between ESP pay to the pay of other staff in NHS Wales. This information should be placed in the public domain and should be used to inform the process of setting salary ranges against job evaluation outcomes and in deciding any uplifts to ESP pay (paragraph 5.40).
37.	Welsh Government should review and reinforce its ESP pay guidance, making it a requirement that ESP recruitment should clearly state the salary range within which a post is to be filled and that ESP appointments should normally be made at the bottom of the relevant pay range (paragraph 5.43).
38.	Welsh Government should discontinue the procedure by which it considers business cases for ESP payment outside the relevant salary ranges having first assured that the salary ranges are appropriate (paragraph 5.43).
40.	The Public Services Staff Commission should be asked to consider, in due course, the potential for establishing a common framework for job evaluation and remunerations for executive and senior posts across the Welsh public sector, taking into account our comments regarding the UK wide nature of the labour market for ESPs (paragraph 5.44).

Written Statement - NHS workforce review

Last updated 27 March 2015

Share    

Mark Drakeford, Minister for Health and Social Services

As part of the two-year pay deal for 2014-15 and 2015-16, which was reached with trade unions representing NHS staff on Agenda for Change contracts last year, it was agreed to set up an NHS review to consider a wide range of workforce and pay issues in the context of the Nuffield Trust report *A Decade of Austerity in Wales?*

This statement informs Assembly Members about the membership of the review panel and the main areas of its work.

The review panel will be chaired by David Jenkins, chair of Aneurin Bevan University Health Board. The other members are:

- Professor Ceri Phillips, head of the College of Human and Health Sciences and professor of health economics at Swansea Centre for Health Economics (SCHE);
- Dr Clare Gerada, partner in the Hurley Group, London and former chair of the council of the Royal College of General Practitioners;
- >Professor Stuart Cole, emeritus professor of transport, University of South Wales;
- Martin Mansfield, secretary to the Workforce Partnership Council trade union side, trade union leader on the Council for Economic Renewal and General Secretary, Wales TUC.

Each of the members have been carefully selected to ensure the review panel has a wide range of experience, abilities and competencies – both from within and outside the health arena. Additional members may be appointed to the panel in the coming weeks and I will update Assembly Members if any further appointments are made.

The review will consider the following:

- The identification of new models of service delivery, which are at the forefront of the integration of health and social care together with an analysis of the barriers experienced by such models and associated ways of working;
- The workforce of the future; the staff and skill mix the NHS needs to ensure people receive high-quality care as close to their homes as possible;
- Areas of efficiency, taking into account the principles of prudent healthcare to help address the long-term financial challenge between 2016-17 and 2025-26, as identified in the Nuffield Trust report *A Decade of Austerity in Wales?*; and
- The long-term strategic direction for pay and reward for people currently covered by the UK Agenda for Change (and executive and senior posts) contract terms and conditions. This will include the affordability of future pay and rewards within the context of the Nuffield Trust report *A Decade of Austerity in Wales?*; and the approach to considering, determining and setting future pay and rewards.

The review will take evidence from a range of key stakeholders and will publish its final conclusions and recommendations once its work is complete.

ANNEX C – COMPOSITION OF THE REVIEW PANEL

David Jenkins OBE (Chair)

David Jenkins is the chair of Aneurin Bevan University Health Board, a position he was appointed to in June 2009. David previously worked for 21 years as the General Secretary for the Wales Trade Union Congress. David is also the Chair of the Wales Co-operative Centre and a member of the Employment Appeal Tribunal.

Professor Ceri Phillips

Ceri Phillips is Head of the College of Human and Health Sciences and Professor of Health Economics at Swansea Centre for Health Economics. Ceri is also a non-executive member of Abertawe Bro Morgannwg University Health and the Bevan Commission.

Professor Stuart Cole

Stuart Cole is an emeritus Professor of Transport at the University of South Wales. Stuart was previously the first director of the Wales Transport Research Centre at the University of Glamorgan and the first director of Transport Research and Consultancy at the University of North London.

Martin Mansfield

Martin Mansfield is the secretary to the Workforce Partnership Council trade union side, trade union leader on the Council for Economic Renewal and General Secretary, Wales Trade Union Congress.

*Dr Clare Gerada

Clare Gerada is a partner at the Harley Group, which runs a number of GP practices and walk-in centres across London, and the former chair of the council of the Royal College of General Practitioners.

*Having initially agreed to join the Panel, Dr. Clare Gerada had to subsequently withdraw due to her other commitments.

ANNEX D(1) – CALL FOR EVIDENCE LETTER FROM DAVID JENKINS



Dear Consultee

Call for Evidence - NHS Wales Workforce Review

I am writing to invite you to provide input to the above call for evidence into the NHS Wales Workforce Review. The purpose of the review is to consider a wide range of workforce and pay issues in the context of the Nuffield Trust report *A Decade of Austerity in Wales?*

The following documents are included with this letter:

- Background and context to the review
- Call for evidence questions

Please return your written evidence by e-mail to tomas.clarke@wales.gsi.gov.uk (copying ian.owen@wales.gsi.gov.uk) by 25 September 2015.

For any queries please contact tomas.clarke@wales.gsi.gov.uk or 02920 823230

Yours sincerely

A handwritten signature in black ink, appearing to read 'David Jenkins', with a horizontal line underneath.

ANNEX D(2) – BACKGROUND AND CONTEXT ISSUED WITH LETTER

Background

Alongside the two-year pay deal for 2014-15 and 2015-16, which was reached with trade unions representing NHS Wales staff on Agenda for Change contracts last year, the Minister for Health and Social Services, Professor Mark Drakeford AM, announced his intention to set up an NHS Wales Workforce Review to consider a wide range of workforce and pay issues in the context of the Nuffield Trust report *A Decade of Austerity in Wales?*

The Minister has now set up this Review, which is independent of Welsh Government and chaired by David Jenkins, Chair of the Aneurin Bevan University Health Board. Other members of the Review Panel are Professor Ceri Phillips, Head of the College of Human and Health Sciences and Professor of Health Economics at Swansea Centre for Health Economics; Dr. Clare Gerada, Partner in the Hurley Group, London and former Chair of the Council of the Royal College of General Practitioners; Professor Stuart Cole, Emeritus Professor of Transport at the University of South Wales; Martin Mansfield, Trade Union Side Secretary to the NHS Wales Workforce Partnership Council and General Secretary of the Wales TUC.

The Minister has invited the Review Panel to consider the following:

- The identification of new models of service delivery which are at the forefront of the integration of health and social care together with an analysis of the barriers experienced by such models and associated ways of working
- The workforce of the future and the staff and skill mix the NHS needs to ensure people receive high-quality care as close to their homes as possible
- Areas of efficiency, taking into account the principles of prudent healthcare, to help address the long-term financial challenge between 2016-17 and 2025-26 as identified in the Nuffield Trust report *A Decade of Austerity in Wales?*
- The long-term strategic direction for pay and reward for those currently covered by the UK Agenda for Change terms and conditions of service and for people employed in executive and senior posts. This will include the affordability of future pay and rewards within the context of the Nuffield Trust report *A Decade of Austerity in Wales?*; and the approach to considering, determining and setting future pay and rewards

The Minister has asked the Review Panel to report no later than February 2016.

Engagement and Evidence Taking

With demand for NHS services changing as our population becomes older and with the number of people living with chronic conditions increasing, it is essential that our NHS workforce is deployed and equipped to deliver the new models of care that will be required to meet these changes in demand. With workforce costs accounting for almost two thirds of hospital costs and approximately half of all NHS Wales spending, it is essential that we get our workforce plans right, both for service and financial reasons. Getting it wrong will mean poorer, less accessible services, with staff unable to meet the new demands in a timely fashion. Getting it wrong will also mean a highly inefficient use of resources with staffing not aligned to demand and managers struggling to cope by deploying expensive agency workers and making excessive use of additional hours payments. This review goes to the heart of our National Health Service in Wales and the service that our citizens can expect to receive in the future.

The Review Panel recognises the importance of fully engaging with all those who have an interest in the future of the NHS in Wales. Health service staff, their unions and professional bodies; health service managers and directors; universities and colleges that provide the education and training for our health workforce; local government which carries responsibility for social services and community care; private health care providers who play a major role in providing nursing and care home services; the voluntary sector which provides valuable support to patients and their families and which is the main provider of palliative care; and last but not least the users of the National Health Service in Wales and the citizens it serves. The Review Panel will clearly want to hear the views and opinions from all these key players.

The Context

It is important to remember that the Review is focused on workforce issues and that the Review Panel has been asked to look ahead within the context of the findings of the Nuffield Trust Report, *A Decade of Austerity in Wales?*

The Nuffield Trust Report was published in June 2014 and was, in part, an analysis of what was then the known budget of Welsh Government and its financial allocations to NHS Wales through until 2015/16. Since the publication of that Report, Welsh Government upwardly revised its financial allocations to NHS Wales in 2014/15 and 2015/16 and this means that NHS Wales is in a better financial position in 2015/16 than was anticipated by the Nuffield Trust.

In looking forward to 2025/26, the Nuffield Trust used three scenarios to describe the level of NHS Wales funding that might be made available by Welsh Government in the years between 2016/17 and 2025/26. The first scenario assumed that funding would be held flat in cash terms with no allowance for inflation. The second scenario assumed that funding

would be held flat in real terms with funding rising in line with inflation. The third scenario assumed that funding would be increased in real terms with funding rising in line with inflation and in line with the increase in UK gross domestic product.

The Nuffield Trust Report then examined the predicted growth in our population (5% growth between 2012 and 2025), the predicted growth in our older population (26% increase in the number of people aged over 65 between 2012 and 2025), the increasing incidence of chronic conditions within our population (35% increase in hospital admissions for chronic conditions between 2002 and 2011), the growing number of items prescribed by Community Pharmacists (up by 4% per year between 2002 and 2010) and the increasing number of GP and Practice Nurse consultations by people aged 16 or over (10% increase between 2004 and 2010).

They then looked at the long term trend for pay in the NHS and found that pay for NHS staff (including doctors, nurses, other professionals, support staff and managers), had risen on average by about 2% per year in real terms between 1975 and 2010.

They then considered the likely financial consequences if these trends were to continue through until 2025/26 under each of their three funding scenarios. They deliberately made no allowance for productivity improvements or other cost saving measures in these calculations since the purpose was to identify the size of the productivity and cost saving challenge. Under the first scenario the funding shortfall in 2025/26 was predicted to be £3.6 billion (in 2013/14 prices), under the second scenario the funding shortfall was predicted to be 2.5 billion and even under the third scenario the shortfall was still predicted to reach £1.1 billion. Putting this another way, under the first scenario the NHS in Wales would need to reduce its expenditure every year by 5.8% in order to keep in balance. Under the second scenario expenditure would need to be reduced by 3.7% each and every year and even under the third and most favourable scenario, with an assumed income growth of 2.2% each year, expenditure would still need to be reduced annually by 1.5%.

The savings that are identified as being necessary in each of the three scenarios are all greater than the long term trend for productivity improvement in the NHS, which the Office for National Statistics calculates as averaging 0.5% a year between 1997 and 2010. Whilst Health Boards in Wales have been delivering higher levels of savings recently, as austerity has demanded both greater efficiency and short term cost avoidance, in the longer term it is reasonable for us to assume that productivity growth, of itself, will not deliver the savings required, even under the most favourable funding scenario.

As mentioned above, the financial position of NHS Wales at the end of 2015/16 will be better than was forecast in the Nuffield Report, with Welsh Government having allocated an additional £200 million each year in 2014/15 and 2015/16 and having stated that this would be recurrent thereafter. However, given the scale of the financial challenges that emerge under each of the three funding scenarios, this additional resource, whilst certainly helping to ease immediate in year pressures, does not materially affect the longer term challenges that lie ahead.

To put the prospective funding shortfalls identified by the Nuffield Trust into perspective, the shortfall in 2025/26, as identified in their second scenario with NHS funding keeping pace with inflation, is equivalent to about half the current total expenditure of NHS Wales. If funding were to fail to keep abreast with inflation, as in their first scenario, the shortfall reaches almost three quarters of current expenditure and even under their best case scenario, with funding growing in line with overall economic growth, the shortfall still stands at just over a fifth of current spending on the NHS by Welsh Government.

This then is the context for this Review. A decade in which if we do nothing different we will see demand for NHS services in Wales easily outstripping available resources.

Rising to the Challenge

If carrying on as we are is not an affordable option, what changes should we be looking to make and what sort of workforce will we need to deliver the change?

In response to the first part of this question, what changes should we be looking to make, a number of answers have been routinely provided during the twenty years and more since the publication of the Wanless Report first focused public attention on these matters.

- Health care in the future will need to become more community focused and person centred.
- More care will need to be provided and more conditions will need to be managed out of hospital, with multi professional teams working with networked GPs.
- Primary and secondary care will need to become fully integrated with specialist secondary services working in support of primary care teams.
- Health and social care will need to become fully aligned with integrated teams and pooled budgets.
- Mental health services will need to be given equal status and attention and be provided alongside other health services.
- Population health and wellbeing will need increased attention with a strong emphasis on tackling health inequalities.
- Specialist, emergency and critical care will need to be provided in fewer centres, concentrating expertise on a 24/7 basis.
- More recently the Wales Health Minister has emphasised the importance of co-production and prudent healthcare to the future delivery of health services in Wales. This can be simply stated as the need for our future health services to be based on a fully engaged partnership between prudent professionals and informed citizens.

It is the second part of the question, what sort of workforce will we need, that we are now seeking to answer through this review and on which we are seeking your views.

ANNEX D(3) – CALL FOR EVIDENCE QUESTIONS

Review of the NHS Workforce – Call for Evidence Questions

We would welcome your views on the following areas.

Integration of health and social care

The identification of new models of service delivery which are at the forefront of the integration of health and social care along with an analysis of the barriers experienced by such models and associated ways of working. We would welcome your views in this regard and in particular we would welcome your views concerning:

- How have other countries/health systems adapted to meet exponential increases in demand for health and social care provision?
- What factors have led to the increases in demand for provision within these countries/systems?
- What criteria have been used to assess degree to which integration of services has contributed to effective management of demand?
- To what extent can these models be replicated in Welsh system of health and social care?
- What barriers have been identified in inhibiting successful implementation of such models?
- How might such barriers be overcome within Welsh context?

Future workforce skill and skills mix

The workforce of the future; the staff and skill mix the NHS needs to ensure patients continue to receive high-quality care as close to their homes as possible. We would welcome your views in this regard and in particular we would welcome your views concerning:

- To what extent has service provision changed within NHS Wales and across social care in Wales over past 10 years?

- How has the composition of workforce changed within the same time period – numbers, type, location, etc?
- What are the key strategic drivers that will influence trends in service provision over next 10 years?
- What structural/organisational changes may be required to address such changes?
- What are the likely workforce requirements to meet such demands on service provision over next 10 years?
- What are the likely deficits in workforce supply over next decade?
- How can such workforce supply deficits be addressed?
- What policies are in place to address such deficits?
- What new professional groupings and roles will be required? e.g physician assistants, advanced practitioners.
- What is the evidence for the effectiveness of such groups and roles in meeting supply deficits?

Efficiency and prudent principles

Areas of potential efficiency, taking into account the principles of prudent healthcare, in order to address the long-term financial challenge between 2016-17 and 2025-26 set out by the Nuffield Trust. We would welcome your views in this regard and in particular we would welcome your views concerning:

- How can the ‘only do what only you can do’ principle be translated into an estimate of workforce configuration in the future?
- How can the ‘only do what only you can do’ principle be factored into workforce planning mechanisms?
- What is the scope for professional substitution?
- What are the financial implications of professional substitution?
- What is the role of technology in compensating for time and distance?
- What are the financial implications of technological developments in this area?

Pay and reward

The long-term strategic direction for pay and reward for those currently covered by the UK Agenda for Change (and Executive and Senior Posts) contract terms and conditions. This will include the affordability of future pay and reward, set in the context of the Nuffield Trust's report; and the approach to considering, determining and setting future pay and reward. We would welcome your views in this regard and in particular we would welcome your views concerning:

- What are your expectations for the long term strategic direction for pay and rewards within the NHS and in relation to pay and rewards within the wider economy?
- What are your expectations with regard to the continuation of, or changes to, current pay and reward differentials?
- What are the existing arrangements for A4C staff, executives and senior posts and how have these operated in each of the past five years?
- To what extent does Wales have autonomy, authority and powers to be able to determine pay and reward mechanisms and to what extent does this vary as between A4C staff, executives and senior posts?
- To what extent can the long-term strategic direction for pay and reward for people currently covered by the UK Agenda for Change contract terms and conditions be considered separately from a similar consideration of pay and reward for staff covered by the Doctors and Dentists Review Body?
- To what extent can pay and rewards be considered in isolation from all the other terms and conditions of employment?

ANNEX E – WRITTEN EVIDENCE PROVIDERS

Abertawe Bro Morgannwg University Health Board	Health Care Support Worker Workforce Skills and Career Framework Development Group	Royal College of Psychiatrists in Wales
All Wales Orthoptic Advisory Committee	Hywel Dda University Health board	Royal College of Radiologists
Aneurin Bevan University Health Board	Institute of Osteopathy	Royal College of Surgeons of Edinburgh
Applied Psychologists in Health National Specialist Advisory Group	Macmillan Cancer Support	Society of Chiropodists and Podiatrists
Association of Directors of Social Services Cymru / Welsh Local Government Association – joint submission	Marie Curie	Society and College of Radiographers
Betsi Cadwaladr University Health Board	National Joint Professional Advisory Committee	UNISON Cymru Wales
Betsi Cadwaladr Healthcare Professionals Forum	National Specialist Advisory Group for Older People	Unite
British Association of Occupational Therapists	NHS Wales Shared Services Partnership	University of South Wales
British Dental Association Wales	Nursing and Midwifery Council	Welsh Independent healthcare Association
*British Medical Association Cymru Wales	Powys Teaching Health Board	Welsh Institute of Chiropractic
Board of the Community Health Councils	Royal College of Anaesthetists Advisory Board in Wales	Welsh Government – Chief Medical Officer
Care and Social Services Inspectorate Wales	Royal College of Chiropractors	Welsh Government – Chief Nursing Officer
Care Council for Wales	Royal College of Emergency Medicine Wales	Welsh Government – Chief Optometric Adviser
Care Forum Wales	Royal College of General Practitioners Wales	Welsh Government – Chief Pharmaceutical Officer
Chartered Society of Physiotherapists Wales Office	Royal College of Midwives	Welsh Government – Chief Scientific Adviser
Cwm Taf University Health Board	*Royal College of Nursing Wales	Welsh Government – Social Services Directorate
*Directors of Workforce & OD	Royal College of Ophthalmologists	Welsh Government – Therapy Adviser for Wales
General Medical Council	Royal College of Paediatrics and Child Health Wales	Welsh Government – Welsh Language Policy Unit
General Optical Council	Royal College of Pathologists	Welsh Institute of Chiropractic
	*Royal College of Physicians Wales	*Welsh Partnership Forum Business Committee

*provided oral and written evidence