

## **FUTURE OF HEALTH AND SOCIAL CARE**

**John Osmond examines a new report that will shape policy in the Welsh NHS and social services for the next decade**

Excessive emergency admissions to acute hospitals are clogging up bed space and directly causing the lengthening waiting lists for elective treatment in the Welsh NHS. At the other end of the process patients are not being transferred quickly enough out of acute hospitals into social care.

These are among the main conclusions of a report by an Assembly Government team on the future of Welsh health and social care that was advised by the business and finance expert Derek Wanless. Published in early July 2003, the report found that Welsh GPs, who refer 40 per cent more emergency admissions per head than occurs in England<sup>1</sup>, are the main source of Wales's high demand for acute emergency services. In turn this was "driving out the ability of the NHS in Wales to meet the demand for elective activity".<sup>2</sup> The report does not explain why Welsh GPs behave so differently to their English counterparts, except to say:

"... at present there is often no perceived option other than the District General Hospital available to GPs seeking help with medical emergencies."<sup>3</sup>

However, the Audit Commission - which described "a vicious circle of a failure to meet elective demand and rising emergency admission rates" – provided the following explanation :

"... primary care practitioners often feel that admission is the only way to access trust services."<sup>4</sup>

Presenting *The Review of Health and Social Care in Wales* to the National Assembly in July, Health Minister Jane Hutt said she would provide a detailed policy response in the Autumn. In the meantime she was allocating an additional £4 million to the 22 new local health boards across Wales to help them tackle alternatives to hospital admission

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<sup>1</sup> *The Review of Health and Social Care in Wales*: Report of the Project Team advised by Derek Wanless, June 2003, para. 3.25. The report can be accessed on: [www.wales.gov.uk/subieconomics/hsc-review-e.htm](http://www.wales.gov.uk/subieconomics/hsc-review-e.htm)

<sup>2</sup> *Ibid.*, para. 3.16.

<sup>3</sup> *Ibid.*, para. 4.20

<sup>4</sup> *Ibid.*, para. 3.26.

and delayed discharges. She said placing responsibility in their hands was a reflection of their cross-cutting role:

“I do not intend for this money to be channelled through NHS trusts nor local authority social services departments, but through local health boards, where all health and social care interests will be represented. I intend to issue the funding in a way that ties our input more firmly to the outputs required, in a way that the review suggests.”<sup>5</sup>

Later the Health Minister provided a strong indication that she would be following the Wanless Report’s recommendations with future additional funding to:

- Improve recruitment and training of the health and social care workforce.
- Enhance intermediate and primary care.
- Invest in information and communication technology.
- Continue funding for NHS Incentive Fund.<sup>6</sup>

Derek Wanless was appointed to review health and social care in Wales by then Finance Minister Edwina Hart in October 2002 at the same time as she announced her budget plans for the next two years. She explained that the review would have far-reaching consequences and would determine the health budget post 2004:

“This report will be crucial in terms of setting the agenda for the NHS and social care reform in Wales. It is also the reason why the budget table circulated contained relatively modest increases in the existing health budget lines for 2004-05 and 2005-06 and a significant reserve provision for those two years. The allocation of resources beyond the end of the next financial year will be determined by the direction in which that review can lead us in ensuring that investment is matched by reform and delivery.”<sup>7</sup>

Derek Wanless is former chief executive of Natwest Bank and author of the (Wanless) report on the future of the NHS in the UK, commissioned by Chancellor, Gordon Brown in the run-up to his 2001 budget. In undertaking the review he advised a high powered Project Board chaired by David Richards, the Assembly Government’s Principal Finance Officer. Other members were: Dr Ruth Hall, Chief Medical officer; Ann Lloyd, Director of NHS Wales; Steven Phillips, Head of the Financial Planning Division; Helen Thomas, Head of the Social Policy Department; Mike Chown, Head of the Local Government Finance Division; two Cabinet Policy Advisers, Dr Mark Drakeford and Paul Griffiths; Jan Williams, Chief Executive of Bro Taf Health Authority; Sandy Blair, Director of the Welsh Local Government Association; and Hugh Gardener, of the City and County of Swansea.

Given this make-up it is clear that the report’s recommendations point to new directions for the provision of health and social care in Wales for at least the next decade. Major changes can be expected in four main areas:

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<sup>5</sup> Jane Hutt, Statement on the Wanless Report, *Assembly Record*, 9 July 2003.

<sup>6</sup> Health and Social Services Committee paper, *Budget proposals 2004-05*, 16 July 2003, see Section on Finance.

<sup>7</sup> *Assembly Record*, 15 October 2002.

1. Improving general practice.
2. Focusing on the core role of acute hospitals with more comparative performance measurement undertaken across the Welsh health trusts.
3. Enhancing the role of small community hospitals.
4. Breaking down divisions between health and social care.

## **1. General Practice**

The report observes that, although Welsh GP lists are generally smaller in Wales than in England, the areas of the country with the greatest health need have practices with the highest list sizes, the lowest number of female GPs, the highest number of single-handed GPs, and the highest numbers of GPs due to retire soon. As the report concludes:

“The configuration of primary care is poorest where it is most needed and this has inevitable consequences for the quality of service provision for patients, and for additional pressures on hospital in these areas.”<sup>8</sup>

To tackle these shortcomings it recommends:

“We envisage development of capacity – including increasing numbers of specialist GPs and nurse practitioners, and development of resource centres – within primary care services which actively manage chronic disease, provide an effective first contact service, undertake a greater range of diagnostic and therapeutic services, and undertake more elective services e.g. minor surgery.”<sup>9</sup>

It advocates:

- Development of robust disease management services in primary care settings and more GPs with specialist interests.
- Re-designation of existing minor acute facilities as diagnostic and treatment centres.
- Development of new service models, which will see specialist, currently secondary care, services also being delivered in primary and community settings where they are a clinically and cost-effective solution.

## **2. General and Acute Hospitals**

Wales has just over 11,000 general and acute hospital beds – 37 per cent more per head of population than in England. Yet, as the report notes, in March 2003 some 5,000 Welsh residents had been waiting more than 18 months for inpatient treatment. In England nobody had been waiting that long. As the report says:

“This places enormous pressure on those working in acute hospitals. Occupancy levels of around 98 per cent are reported rather than the maximum 82-85 per

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<sup>8</sup> Wanless report, para. 3.27.

<sup>9</sup> *Ibid.* para. 4.21.

cent maximum stable level. These hospitals are ever-nearer to supplying an emergency service only as elective activity is crowded out by emergency admissions (which accounted for 73 per cent of admissions and 77 per cent of inpatient bed days in 2001).<sup>10</sup>

On the basis of these figures the report judges that 479 extra beds would be needed to bring the occupancy rates down to stable level of 85 per cent. However, it also concludes that this is not the appropriate answer, pointing to research that shows that communities with a relatively greater supply of hospital beds tend to use hospital services at a greater rate.<sup>11</sup> Instead, it recommends that a combination of reducing emergency admissions and combating the wide variations between the best and worst performing hospitals over a range of indicators should be followed. It gives examples of many areas where performance could be improved by universalising best practice:

“For example, trusts in Wales typically carry out lower levels of day surgery than those in England. We need to work with auditors and best practice units systematically to benchmark and scrutinise elements of service to ensure they are in line with good practice.”<sup>12</sup>

More widely the report recommends that:

“NHS hospitals should not any longer provide nursing or respite care without the need for other specialist interventions and support.”<sup>13</sup>

### **3. Community Hospitals**

There are 3,100 beds in community hospitals, mostly in Wales’ 78 non-psychiatric hospitals with 100 beds or more. They provide inpatient care which does not require highly technical support and so have the potential of relieving pressure on acute hospitals. Yet many are under-utilised, as the report notes:

“In 2001-02, beds in community hospitals had an average gap between patients of over seven days, as opposed to less than one day for most acute beds. Variations in average length of stay in community hospitals are so large (from over 40 days in Ceredigion to 13 days in Powys) that questions arise as to how far some of these hospitals are really providing medical care (i.e. characterised by medical interventions) at all.”<sup>14</sup>

The report recommends that more effective use of community hospitals should be made as step-down facilities from acute care; for invigorated intermediate care incorporating active rehabilitation; and as resource centres for primary care.<sup>15</sup>

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<sup>10</sup> *Ibid.* para. 3.11.

<sup>11</sup> *Ibid.* para. 3.13.

<sup>12</sup> *Ibid.* para. 4.52.

<sup>13</sup> *Ibid.* para. 4.22.

<sup>14</sup> *Ibid.* para. 3.21.

<sup>15</sup> *Ibid.* paras. 4.14 and 4.16.

#### 4. Seamless Provision across the Health and Social Services

Social care provision was even more difficult for the report team to get to grips with than the NHS. For instance, in 2001-02 it found that the highest spending authority, Neath Port Talbot, spent just over £300 per head on social care compared with £200 by the lowest, Flintshire – a variation of 53 per cent. As it put it:

“We found no obvious relationships between spending and outcomes and performance in social care. For example, there seems to be little overall direct correlation between the cost of residential care for older people and the extent to which it is used, or between the cost of residential care, the extent of delayed transfers and individual authorities’ expenditure per capita on services for older people. Higher as well as lower spending authorities have been the subject of unfavourable Joint Review reports and vice versa.”<sup>16</sup>

Patterns of employment in social care are much more heterogeneous than those in the NHS. Some 70,000 people are employed in the sector - of whom about 3,000 are qualified social workers. Numbers are divided almost equally between the 22 local authority public employers and the private sector. As the Wanless report puts it:

“Different structures make it harder to work together. We have a national health service and 22 local authority social service departments. Information exchange is impeded by practical obstacles such as differing systems, and understandable concerns about client or patient confidentiality. Planning, performance management, accountabilities and resource allocation systems for the NHS and social care are quite different. We understand the overall public sector context for the differences, but the differing accountabilities create the danger that members of the public with health and social care needs find that nobody seems to be responsible for meeting them because everybody involved can refer the matter to someone else.”<sup>17</sup>

The interface between the health and social care systems is most problematic at the point of transfers between the two. Thus, at any one time acute hospitals are caring for a significant number of patients whose transfer to another setting has been delayed. In 2001-02 there were an average 806 delayed transfers of care at any one time, and 57 per cent of patients were delayed for social care reasons arising from difficulties in arranging funding for care packages. By early 2003 the delayed transfer figure exceeded 1,000 – or more than twice the number of extra acute beds that were needed.<sup>18</sup> For these reasons the Wanless report recommends what it describes as “seamless provision” between the sectors. As it says:

“Seamless provision is an objective that enjoys near universal support. But we are a long way from achieving it in Wales. We need to be resolute in breaking down barriers between health and social care. We believe that the Assembly needs to look again at what might be done to bring it about. By this we do not

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<sup>16</sup> *Ibid.* para. 3.46

<sup>17</sup> *Ibid.* para. 3.35

<sup>18</sup> *Ibid.* para. 3.34.

mean structural change. What is needed is integrated thinking, across social care and health services, about achieving the best possible outcomes together.”<sup>19</sup>

The report points to the advent of 22 new Local Health Boards as presenting an opportunity to create an integrated approach. It says that national standards for health and social care should be delivered locally through the boards, which have a duty to develop health and well being strategies for their areas. It lists the following options for developing seamless provision:

- Hypothecating the element of Revenue Support Grant to be spent on social care.
- A single integrated budget for older people’s services held by Local Health Boards.
- Joint consideration of health and social care budgets, locally and nationally.
- Placing a responsibility on local authorities to pay the NHS the costs of delayed transfers of care.<sup>20</sup>

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<sup>19</sup> *Ibid.* para. 4.25.

<sup>20</sup> *Ibid.* para. 4.28.