Health and Social Services Committee **HSS(2)-06-03(min)**

MINUTES

Date: **Thursday, 13 November 2003**

Time: **1.30pm to 3.30pm**

Venue: **Committee Rooms 3 & 4, National Assembly for Wales**

Attendance: **Members of Health & Social Services Committee**

David Melding **(Chair)**	South Wales Central
Jocelyn Davies	South Wales East
John Griffiths	Newport East
Jane Hutt (Minister)	Vale of Glamorgan
Ann Jones	Vale of Clwyd
Val Lloyd	Swansea East
Jonathan Morgan	South Wales Central
Gwenda Thomas	Neath
Kirsty Williams	Brecon and Radnorshire

Officials In Attendance

Ann Lloyd	Director, NHS in Wales

Secretariat:

Jane Westlake	Committee Clerk
Claire Morris	Deputy Committee Clerk

Item 1: Apologies and Substitutions and Declarations of Interest

1.1 An apology was received from Dai Lloyd. There was no substitution.

1.2 There were no declarations of interest.

Item 2: Review of the Interface between Health and Social Care Services

(1.35 – 3.30pm)
Paper: HSS(2)-06-03(p.1)

2.1 The Chair welcomed Mr Derek Wanless. Mr Wanless had advised the project team set up to review health and social care in Wales and had been invited to give his views on the review in the context of the Health and Social Services Committee's review of the interface between health and social care services.

2.2 Mr Wanless said that he had accepted the invitation to advise the review in Wales because of the way in which Wales was prepared to think about the integration of health and social care. He had produced a report for the Chancellor of the Exchequer about the resources required to run the NHS in England in 20 years time, and concluded that more attention should be paid to social and long term care. The rest of the UK had yet to consider integrated health and social care and the resources that would be required in 20 years time. He said that social care was more difficult because of the extent to which patients, their families and carers wanted to influence choice, and there were a lot of issues to address.

2.3 In response to questions from Members, Mr Wanless made the following points:

Reshaping Services - Immediate Steps

2.3.1 Delayed discharge, particularly of older people, had been one of the drivers for looking at integrated health and social care in Wales. His UK review had looked at Sweden, where 10 years ago it had been decided that expensive acute beds should be used more effectively, by not providing continuing care for older people once acute care had been completed. Local authorities were responsible for social care and have to provide care once a doctor had certified a patient was medically fit to leave an acute bed. If necessary, when patients left hospital, the local authority placed them in intermediate accommodation while their longer-term care needs were planned. In the example he visited, local authorities owned the buildings providing long term care. Such ownership ensured there was sufficient capacity to meet projected demand. The running of care facilities he saw was usually contracted out to the private sector.

2.3.2 Sweden did not put responsibility for health and social care in one place, other than in central government setting the policy. Health care was run by the counties and social care by the local authorities. There was nothing comparable to this model in the UK. In some areas of the UK, particularly where land value was high, capacity in social care had been reduced as care homes were being sold for other purposes.

2.3.3 In Sweden, local authorities had to pay the hospital the full amount of keeping a patient in an acute bed after the patient was certified for discharge. There was an incentive for local authorities to maintain adequate care provision. This system was working because it had been in place long enough for local authorities to know what the demand was on social care and to plan with confidence that they could meet likely demand.

2.3.4 The details of the transitional arrangements in Sweden were not known but it was expected that some shift of resources into the social care sector would have been required to create the necessary capacity.

2.3.5 More effective use of community hospitals could be at the heart of the relationship between health and social care. There were people who would benefit from intermediate care and some community hospitals could be used for this. Not all community hospitals would be suitable, it could be too expensive or the buildings might not be appropriate for such a change in use. The health sector or social care sector could lead in implementing regeneration of community hospitals, depending on whether primarily they were providing health or social care. The co-terminosity created by the establishment of Local Health Boards (LHBs) should facilitate any such change in Wales.

2.3.6 In the long term acute hospital beds should rarely be the place where care services ought to be delivered. The exception would be for some intensive care where a high level of medical care was needed.

2.3.7 The care needs assessment was particularly important. One of the weaknesses overall in the UK was that when people’s health and social care became very expensive, there was often a lack of co-ordination to meet their needs. A model developed by private sector corporations in the USA looked closely at the needs of people who used a lot of resources and gave close attention to the care needs assessments of those people.

2.3.8 Some Primary Care Trusts in England were looking at whether it would be possible to predict which patients would be expensive users of services and create a more intensive care service that would be better for them and cheaper overall for the providers.

2.3.9 Some employers were producing individual health improvement plans for their employees. This practice could be extended usefully to primary care.

2.3.10 The Welsh review team had seen great variation in quality of management around Wales and this could probably be equated to effective use of resources.

2.3.11 Premature discharge could also be a problem and the appropriateness of some of the targets placed on the NHS should be considered. Research in Philadelphia showed that there were gains to be made by keeping some people in hospital longer, thus preventing early re-admission.

Reshaping Services - Longer Term Measures

2.3.12 Services should look at what individuals require. Work had been done to reduce repeated A&E admissions of older people by introducing falls clinics, and often a simple modification to the home could prevent such accidents.

2.3.13 The review team had been interested in the extent to which new technologies in the home could enable people to stay there longer, and how they could be used to manage chronic disease in the home. More work was needed in developing the technology and researching people's aspirations for the kind of home they want.

2.3.14 A 'mixed economy of provision' was needed to create a longer term, sustainable solution provided by the private or public sector whichever proved most effective.

2.3.15 Diagnostic and treatment centres had potential for local service provision associated with primary care.

2.3.16 Out-of-Wales options and cross boundary working with specialties in England, and vice versa, were not just short term but something that should be thought about in re-configuring some services.

Seamless Services

2.3.17 The Assembly would be most successful if it established the framework to enable people at the local level to tackle local issues. The Assembly should set the standards and processes, but not micro-manage them.

2.3.18 There was reluctance to spend money from one budget where benefits and savings were to another organisation's budget area. Sweden's mechanisms for transferring costs addressed this.

2.3.19 There was little evidence of people using pooled budgets in Wales, and if this was the case then the Assembly should identify and tackle the underlying problem.

2.3.20 In England, organisations were starting to make joint staff appointments, particularly in the field of public health, where one person was being given the task of working partly in the health service and partly in the local authority. This could work, providing there was a local plan to which all parties

subscribed, and that health and social care were not treated by politicians as political footballs, but rather all parties work consensually to improve services.

2.3.21 If Health and Wellbeing Strategies succeeded in Wales they would provide a better structure for budget sharing.

2.3.22 The Minister said that the flexibilities grant was hypothecated and in the three years since it had been introduced, 160 projects had been funded. The budget for it was £9m and it would continue as a special grant. It had been introduced to enable the embedding of the joint commissioning process.

Information and Communication Systems

2.3.23 Information systems did not enable sharing of information across the health and social care sector.

2.3.24 A balance had to be found between providing individuals with a better service across the whole system and protecting confidentiality. There was more scope for using anonymised data for planning.

2.3.25 ICT would require a national strategy, delivered partly nationally and partly locally, but designed with compatibility between computers.

2.3.26 Productivity gain as a result of improved information and communication technology (ICT) was very difficult to measure. An assumption had been made that the health service could be 3% more productive, but it was difficult to measure because a lot of the benefits would be quality improvements or better directed resources.

2.3.27 The quality of data in the health service was better than in the social care sector where it was not good and was difficult to manage. This was partly a product of poor ICT and partly because people were uninformed about the purpose of the data. Many of these issues could be resolved by improved systems which would collect good quality information with little effort, but that was a long way off.

2.3.28 Very often more data was collected than needed, particularly in the NHS.

2.3.29 The assessment of long-term future demand would probably be determined through use of demographic models. The personal social services data collated by the Statistical Unit might be useful.

Performance Management Schemes

2.3.40 LHBs, Trusts and social care providers needed the freedom to choose what was right for their local area and but should be assessed on those decisions. A lot could be learned from the Commission for Health Improvement’s high quality, rigorous and constructive audits.

2.3.41 People were more likely to provide better services if they were rewarded for success and encouraged to innovate and were not penalised for failure.

Patient Choice

2.3.42 People in Sweden had a greater concept of social responsibility. If they were taking up an acute bed in hospital at great cost that was needed by someone else then there seemed to be a greater willingness to free up that bed and co-operate with whatever social care is being offered. Problems occurred when there was inadequate provision of social care facilities.

Accountability

2.3.43 Responsibility and accountability went together and more responsibility should be given to Chairs and Chief Executives within the NHS, who had to be accountable as the deliverers of services. It would be a mistake to try to micro-manage the NHS from the Assembly.

2.3.44 The public should be encouraged to take personal responsibility for their health.

General

2.3.45 The report on the "Review of Health and Social Care in Wales" should highlight to the public that some services needed to change. It was in every political party's interests to see there were sensible, long-term decisions that needed to be taken. This had been achieved in Holland in the 1980s, when a political truce had been called and properly thought through, care related decisions were made.

2.3.46 The remit of the review had included mental health, although there was little specific mention of it.

2.3.47 Lessons could be learned from NICE, who were setting up panels of lay people to help them make judgements about pharmaceuticals.

2.3.48Many people working in the health service could contribute constructively to improving services if they were encouraged to do so.

2.4 The Chair thanked Mr Wanless for attending the Committee and sharing his views with Members.

Action

- Members' Research Service would provide further information on the Swedish model.