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NHS Wales as a Driver of Economic Value

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NHS Wales as a driver of economic value

Executive summary

NHS Wales is a unique foundational institution. Its primary activities are providing healthcare services across Wales and in doing so it spends almost £10 billion a year and provides around 100,000 jobs. This report sets out an ambitious and realistic agenda to retain and enhance the economic value of that spend for the benefit of Welsh households and firms. (p.7)

Through a foundational economy approach, the potential of NHS Wales to contribute more economic and social benefits as a driver institution can be understood and realised. While there has been much attention on the use of purchasing as a strategic tool to support local firms and supply chains, the nature of that spend and the extent to which it can help retain value locally is often not well understood. The role of NHS Wales in supporting households through wages has not had sufficient attention in policy priorities at central and local level. In a system which has difficulty filling vacancies and where many households struggle on low incomes, there is a large potential here to focus on local economic value created through employment. (pp. 8-10)

The report introduces and applies a framework of driver institutions to outline how NHS Wales spending has the potential to deliver more economic benefits to households and firms through its spending. The nature of the driver effect of any organisation depends on the scale of its operations and the composition of its costs, chiefly external purchases and labour. Comparisons with other activities, including food retailing, show that these two drivers give NHS Wales quite exceptional ability to retain and distribute economic value in Wales. (pp.11-12)

The health boards and trusts account for the largest part of all NHS Wales expenditure and two-thirds of this – around £4.6 billion - is spent on staff. In contrast, we estimate that the big four supermarkets in Wales have a similar combined revenue of £7.5 billion, of which only 10% or £752 million is spent on wages because external purchases account for more than 80%. This comparison highlights the unique value of the NHS as a large employer that already provides jobs with relatively good wages and pensions all over Wales but can do much more (pp.13-14).

Staff numbers have been rising significantly over the last two decades with an increase of 21% since 2015 and 59% since 2000. Average employment costs in NHS Wales were £53,000 in 2020-21, compared with £18,000 to £21,000 across the big four food retailers. Even allowing for differences in the extent of part time working, NHS Wales provides better paid jobs than retail and thus makes an important contribution to households and local economies. (pp.15-17)

The NHS also provides a wide range of jobs, many of which offer development and progression. Medical and nursing staff account for just under half of the workforce, while a

diverse collection of administrative and estates, plus scientific, therapeutic and technical roles are another 40% of the total staff and represent more than a quarter of the wage bill. (pp.18-20)

NHS Wales is a uniquely valuable institution because of its size and the importance of employment costs as the largest element of expenditure. Comparing NHS Wales with other large organisations in Wales, no other institution has the scale and employment sustaining significance. Even at a disaggregated level, the individual health boards are still amongst the most important national employers, with the larger Universities following on. In contrast, the largest private employers generally are no larger than the health boards and spend much smaller amounts in relative terms on their workforce. (pp.20-21)

NHS Wales drives foundational economic value primarily through wage support for Welsh households but there is potential to do more to help address staff shortages and to support communities across Wales. The traditional NHS approach to difficulties in filling vacancies is to recruit 'readymade' workers trained outside the UK. Much attention has been paid to reducing the use of (more expensive) agency and bank staff: pre-pandemic, around 80% of the cost of agency staff was to cover unfilled vacancies. (pp.26-28)

Importing trained staff has been attractive because it gets posts filled and allows healthcare services to be delivered. Dependence on non-UK trained doctors appears to be worsening with 27% of Welsh training grade medical positions filled by non-British/Irish staff. At the other end of the pay scale, estates and ancillary roles have been disproportionately dependent on migrant workers (mostly from the EU). Post-Brexit visa rules will make it more difficult to fill lower paid vacancies through migration. While use of readymades is will become increasingly unsustainable because of expected global shortfalls in medical and nursing staff. (pp.29-31)

More importantly, reliance on imported staff means a failure to take advantage of the longer-term opportunity to recruit and develop local people into roles right across NHS Wales. The problem of NHS Wales staffing shortage should be reframed as an opportunity to 'grow your own'. The 2020 Workforce Strategy acknowledges the contribution that NHS Wales employment can make to the prosperity and sustainability of communities across Wales and there is a need now to learn from new approaches that have been developed in Health Boards, like Hywel Dda and Aneurin Bevan. 'Grow your own' needs to be scaled and spread with appropriate resourcing and cross-institutional support as part of the new 'Made in Wales' approach. (pp.31-32)

These innovative 'grow your own' schemes recognise that many people who have the right capabilities and values lack the academic qualifications needed for entering professional training paths, as in nursing. Workforce development should be an adaptive response that helps develop capability and ambition through opening new recruitment and training pathways. For example, Hywel Dda and Aneurin Bevan University Health Boards have demonstrated with their Flexible Nursing Programmes that it is possible for health care support workers to acquire the knowledge and skills to qualify as a nurse within four years.

Other pathways can be used, for example, to allow facilities operatives to become health care support workers. (pp.32-33)

New training routes open out opportunities for careers in NHS Wales that would not otherwise be possible. An expansion of such schemes would not only help to address significant shortages but also provide good quality employment to local people. While 'genuine' apprenticeships across a wide range of roles in the NHS are essential, especially for recruitment of younger workers, opening up opportunities for older workers seeking second or third careers is equally possible through 'grow your own' schemes. By supporting more households though good wages and conditions, communities across Wales will benefit. (pp.33-34)

Realising the potential of NHS Wales as a driver of economic value at scale and in a sustained way depends on internal support and resourcing, as well as a good deal of collaboration and co-operation inside NHS Wales and with external partners. The professional training organisations are key partners in finding new routes for those who do not meet traditional entry requirements. Health boards need to share what they have already learnt about how to 'grow your own' and innovators need support to allow them to co-operate and work across health boards and with external partners to remove obstacles to doing more. (pp.34-35)

Welsh Government has an important role in promoting collaboration across NHS Wales and with external partners. As part of this, the new NHS Executive can provide high level steer and practical support in clearing obstacles to the development of new career pathways. There is also need for national and local co-operation and co-ordination with social care to help expand the overall number and range of local employment opportunities across health and care. (p.35)

Realising the potential of 'Made in Wales' to contribute to workforce development is a new challenge. In contrast, much more attention has been paid to the localisation of spending and switching suppliers to stop leakage from the Welsh economy. This has led to the development of methods for social value weightings in contracts and high-level support for new approaches in procurement in NHS Wales and across the public sector. However, examination of the data on NHS Wales purchases suggests that using procurement as a strategic tool to create economic value is more complicated than generally assumed. (pp.39-40)

NHS Wales spends around £2.2 billion per year on procurement but only one third of this is purchases of goods and services from private firms. Using the NHS Wales e-procurement dataset, it is possible to break down purchasing into the major categories and then to identify the level of spend with the most important suppliers. In many of the major categories the suppliers are distributors or retailers, and most of the value added and employment in the supply chain is outside Wales. Through this analysis, we can identify those categories with most potential for local spending but overall, the total value of purchasing for a Welsh supplier in any category is relatively small and this limits the leverage of procurement policy. (pp.41-44)

NHS Wales capital spend on new hospitals is relatively large in comparison, but it is 'lumpy', making it difficult to sustain a steady flow of construction work for major Welsh firms. There is more scope for focusing on smaller scale community care facilities and refurbishments as a way to create economic and social value, both through the supply chains and employment and in realising opportunities to co-locate facilities and services, especially in town centres. This requires more forward visibility and planning, more dialogue and co-operation with other public service providers, housing associations and community organisations; and action to allow blending of capital and revenue budgets from different organisations within and outside health. (pp.45-47)

Reframing the responsibilities of procurement in NHS Wales and other organisations should start from the economic value objective of creating and sustaining a base of financially sustainable suppliers that provide regular employment with good wages and conditions and can invest in their own development. After this economic value has been secured from a strong supplier base, social value objectives and priorities can be set and achieved. (pp.47-48)

Social value needs to be understood as the top of a pyramid underpinned by two conditions: first, by fair pay and conditions, creating economic value for households; and, second, by investment and development of firm capabilities which will provide long term stability and growth potential. This should inform procurement processes so that bidders should be screened to select those that meet the financial sustainability criteria, and then relevant price and social value criteria can be applied. (pp.48-49)

Making the most of NHS Wales purchasing then requires a focus on the key sectors and activities where the greatest leverage exists: these key sectors will usually be labour intensive services, with low purchases of material inputs and short supply chains. Here there is potential to help build capability of Welsh suppliers to also sell into England and beyond so as to escape the limits of the Welsh market. A starting point would be for NHS Wales to focus on a small group of suppliers in a few purchasing categories which meet these criteria; and then explore specific opportunities to use contracts to help develop firm capabilities which will strengthen the base of the pyramid. (pp.50-51).

In conclusion, the report argues that it is time to move beyond the idea of an 'anchor institution' and recognise the potential of NHS Wales as a driver institution to deliver economic value in two ways.

- First, NHS Wales should recognise its unique importance as an employer and then refocus workforce development away from a reliance on importing readymade staff to solve recruitment problems to a 'grow your own' approach. In doing so this will create economic value for households and communities across Wales, broadening the recruitment base of health and other NHS roles.

- Second, NHS Wales should better understand its supplier base and the conditions of its financial sustainability and move away from general policies of localising spend by postcode and adding social value weightings. A constructive approach to

procurement would focus on a smaller number of contracts in activities where there is scope to secure meaningful and sustained economic value from which more social value can be created. (pp.52-54)

NHS Wales as a driver of economic value

Introduction

As part of Welsh Government plans for delivering health and care services, NHS Wales has very many worthwhile objectives for improved service delivery. The 2018 action plan for a *Healthier Wales* advocated 'a whole system approach to health and care' with a new 'emphasis on well-being, prevention and early intervention'.[1] Following this, a 2020 'workforce strategy' for health and social care recognised that a motivated, capable workforce was prerequisite for service delivery.[2]

Recently, Welsh Government has begun to focus directly on the foundational impact of health and care services through their backward linkages to households and firms. Thus, Welsh Government now has a 'foundational programme' for 3-5 years with 'strategic intent' in three main areas: first, 'economic leverage' through purchases of goods and service; second, 'employability and inequalities' through employment opportunities for all; and third, 'vibrant communities' through facilities location and access to services.[3]

If the primary NHS output is healthcare services, there are clearly other important foundational issues about what indirect benefits can be obtained and how, by controlling and re-directing the backwards financial flows. Service provision is sustained by a wages flow which supports households and a revenue and capital spend on purchases and construction which supports firms. The 'initial emphasis' in the new foundational programme is on purchasing but that is presented as only the first stage in a journey of 'discovery and delivery'.

If NHS Wales is to move on from discovery of the foundational to delivery of substantial economic and social benefits, two obstacles stand in the way: first, the absence of strong control and executive direction from the centre of the organisation; and second, confusion and blur about the objectives of foundational policy and the levers which can deliver volume results for firms, households and communities.

NHS Wales is a large organisation with about 100,000 employees and the system as a whole has income rising towards £10 billion each year. But NHS Wales is peculiar in that it has a Chief Executive but until now has lacked a strong central executive function which can lead system wide change, manage performance and ensure accountability. *Healthier Wales* in 2018 recognised the need for 'a national executive function'[4] and by 2019, the 'governance model and scope for the new NHS Executive had been confirmed'.[5] After a pause for the pandemic, establishment of an NHS National Executive was included in the 2021 Programme for

[1] https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf
[2] https://heiw.nhs.wales/files/workforce-strategy/
[3] A Healthier Wales foundation economy programme | GOV.WALES
[4] A Healthier Wales (ovals) pp 35-36
[5] nhs-wales-planning-framework-2020-to-2023.pdf (gov.wales)

Government[6] and further plans for its establishment as a 'hybrid model' were announced in May 2022.[7]

Given this organisational structure, in NHS Wales much then critically depends on local initiative by the organisations with operating responsibility for service delivery. Since the 2009 reorganisation, seven regional local health boards have overall territorial responsibilities supported by seven specialist NHS trusts covering ambulance services, specialist cancer care, support services and public health.[8] Substantial regional autonomy produces NHS outcomes for better and for worse: for better, because imaginative local policy development is possible, as we have found with workforce development practices; for worse, because consistent, system wide reformed practice is elusive, despite the best efforts of improvement academies and such like.

But it would be wrong to suppose that all will be well with NHS Wales if it finds the right balance between centralisation and decentralisation and builds an effective working relation between a stronger centre and the area-based boards which organise and deliver operationally. It is at the same time absolutely necessary to clarify the objectives of policy and the levers which can deliver volume results through the foundational backwards linkages to firms, households and communities.

This report aims to begin delivering on the necessary clarification by focusing in the first instance on NHS Wales rather than 'health and care' more broadly, as in some Welsh Government policy documents. We concentrate on health because the reliance system that produces Welsh health services is, in terms of organisation and funding, distinct from the Welsh care system where local authorities distribute funds mainly to small scale private providers.

Of course, the relationships between health and care should be part of the foundational agenda. And here our analysis adds a supplementary reason at the end of our argument. It is generally accepted that more co-operation between health and care service provision is necessary to prevent the blocking of the hospital system which relies on high flow. We would add the point that a stronger inter-connection between the care and health workforce is a long-term objective under a 'grow your own' work force development policy which can benefit many Welsh households as well as help address staffing shortages in both systems.

To grasp the importance of this point, our readers must understand the framework of driver institutions, value retention and distribution which we present in the first chapter of this report; and then follow our argument about the logic of the activity numbers on NHS Wales which lead us towards a concluding recommendation of collaboration in the development of the health and care workforces based on the imaginative credentialization of experience.

This report analyses economic benefits for households and firms in a new framework where organisations are active drivers (not passive anchors). An organisation generates economic

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[6] Welsh Government Programme for government: update [HTML] | GOV.WALES
[7] Written Statement: Update on setting up an NHS Executive for Wales (18 May 2022) | GOV.WALES
[8] Health in Wales | Structure

value for households and firms in its territory in so far as it retains and distributes the value of its revenue within the territory; or captures value from beyond the territorial boundaries through export of goods and services. The driver effect then depends on the scale of the operation and the composition of costs, which determines how value is distributed as wages to households, as purchases to suppliers and as surplus to capital.

As chapter one argues, various activities (like health services or food distribution) all have different composition of costs and therefore different financial flows backwards to households, supplier firms and rentier capital. And the relevant numbers can be relatively easily obtained from the standardised information available in the accounts of public and private organisations. So, the new framework is a conceptual device which opens the possibility of empirical analysis of a single organisation from the accounts of the health boards or the consolidated accounts of NHS Wales. It also allows comparative empirical analysis of health services against other activities.

Within this frame, our method in all three chapters is to put numbers on the relevant magnitudes as we have done in our previous analyses of Welsh reliance systems from the food system to wood economy.[9] The numbers are not the answer, but they allow us to think through objectives and priorities after identifying the linkages and levers which can deliver volume results in terms of value retention and distribution within any territory.

This point may seem elementary, but it continues to be neglected in purchasing policy by arguments both for localisation of public purchasing without considering value retention, or for adding supplementary social value criteria without considering whether value distribution by the purchaser is securing a financially sustainable supplier base.

Furthermore, NHS Wales is primarily a driver of foundational economic value through wage support for Welsh households (not purchasing support for Welsh firms). As chapter 1 shows, the scale of NHS Wales' impact on the Welsh economy through employment reflects the size of its revenue and its composition of costs, whereby each pound of revenue is turned into 66p of wages which directly supports households who spend in Wales.

The key question in the second chapter of this report is: how to maximise the benefits from NHS Wales' employment expenditure? The answer is that NHS Wales needs to go beyond generic workforce planning combined with a default onto solving workforce shortages through import of readymade workers from low- and medium-income countries. Instead, the 'Made in Wales' programme points to new directions in 'grow your own' workforce development. While innovative practice by health boards like Hywel Dda and Aneurin Bevan lead the way in opening up opportunities of career progression for those who do not have standard educational entry qualifications.

By way of contrast, chapter three shows that established policies for the localisation of purchasing by switching to local supplier firms have very modest effects. NHS Wales

[9] For previous reports see, for example, *Serious About Green* Recent Research Reports – Foundational Economy Research

purchasing mainly consists of expenditure from other health service providers and public bodies, so that external purchases with private firms is relatively small scale at around one seventh the value of the employment cost. The effect is further dampened because the spend is divided into multiple categories where the Welsh final supplier typically retains little value as the value added, and employment is mostly in non-Welsh firms further down the chain. Totals of millions switched to local suppliers would therefore give a misleading impression of value distributed and retained.

The implication in chapter three is not that purchasing policy does not matter but that it needs a radical reset. Active purchasing policy needs to become less mechanical and generically focused on final sales invoices; and much more entrepreneurial and selectively focused on SMEs, especially in labour intensive services where Welsh value retention is highest. Much the same point about the need for reset can be made about capital spend policies. Here, support for town centre renewal through locational decisions requires new kinds of working relations and cooperation between the health boards and other driver institutions to co-ordinate development, use public funds effectively and provide a broad range of public service and community outcomes.

This report's argument about household and firm benefits is about the hard economic value delivered through financial flows. But one of the incidental benefits is that this clarifies the relation between the economic value of household and firm support and softer forms of social value through contract weighting for social considerations or supplementary calculation like TOMS, which put a financial value on everything from environmental benefits to hours of volunteering.

Our argument here is that the first duty of public purchasing is economic in that the driver organisation should create a sustainable supplier base of firms who can retain sufficient profit to make capital investment after offering decent wages and conditions. And public purchasers should obtain this basic accounting information from all suppliers so that, where their supplier firms are not sustainable, the task is to reform the public purchasing practice of the driver institution (not organise a beauty contest amongst suppliers according to some social criteria).

As chapter 3 argues, when economic value has been secured and the supplier base is sustainable, it is then possible to impose social conditions (such as environmental responsibilities) upon supplier firms in the knowledge that they can be effectively delivered. Starting with a TOMS calculation or a socially weighted contract and an unsustainable supplier base will produce disappointing outcomes.

1. NHS Wales as a driver of economic value

The primary output of an organisation like NHS Wales is the foundational service of good quality healthcare provided across the territory. We can be more ambitious, of course, and expect that those services should also be delivered in ways that maximise the economic and social benefits, and therefore create positive outcomes for the places where people live. The issue is how to think about the indirect economic and social benefits of activities and organisations that contribute to the delivery of healthcare, and to do so in a way that allows some measurement of their value to firms and households.

In this section we present a new financial driver framework for conceptualising economic value retention and distribution by activities and individual organisations. This draws empirically on the standard information available in the accounts of public and private organisations. Hence it is possible to compare value retention and distribution in NHS Wales health service provision with that in other activities like food distribution or manufacturing; and it is possible to compare organisations like health boards with other organisations and firms in the private sector.

These comparisons presented later in this section highlight the unique value of NHS Wales as a driver of the Welsh economy which hugely supports households. It also has the potential to do more if it develops its driver role, including through 'grow your own' workforce development policies. In this analysis we use the idea of Wales as a territory to emphasise the opportunity for positive outcomes right across the nation. As healthcare provision is a distributed activity, there is a multiplicity of opportunities to make connections with specific places, especially to help ensure that the workforce of NHS Wales reflects and benefits its local populations.

A. The driver framework: value retention and distribution

Every activity or organisation (public and private, foundational and non-foundational) has a capacity to generate economic value for households and firms within that territory in so far as it retains and distributes its revenue through employment, purchasing and investing activities. Some enterprises also have the capacity to capture value from beyond the territorial boundaries through export of goods and services which generate value that can be also distributed internally, including as wages to households.

The nature and potential of the driver effect is contingent upon value retention and distribution in an activity or organisation, and this depends on two factors. First, the scale of the operations and the size of its revenue, which determine the primary throw weight and the opportunity to have a significant impact. Second, the composition of costs that determines how value is distributed: to households through wages; to supplier firms through purchases; and to capital in the form of dividends on equity or interest on debt. At the first round of expenditure, wages will be mostly distributed within the territory, but purchases and payments to capital will typically in Wales involve some leakage to external suppliers and rentiers.

This gives us a simple model of how an activity or organisation can be more or less valuable to a territory. At organisation level, the more valuable firm has (a) a large-scale operation which claims substantial revenue; and then (b) a composition of costs which favours value retention and distribution characteristics because labour costs are a large proportion of total costs, and /or local supply chains and capital ownership prevent leakage to out of territory suppliers and rentiers; and c) benefits will also be multiplied insofar as the activity or organisation can also capture value through exports.

The composition of costs is a complex matter because it is determined by activity characteristics and firm level organisation. The inherent nature of any activity sets structural limits: for example, in retail and wholesale businesses purchases account for around 80% of the sales revenue because the activity is selling bought-in goods. But the variable organisation of activities then complicates matters, as in Welsh construction, where the SME sector is dominated by subcontracting firms which act effectively as intermediaries and employ very few directly. This pushes up the purchases to sales ratio in the SME prime contractors beyond the level that we would expect with integrated firms that employed their own trades people.

The framework is useful because the necessary basic information on labour, purchases and capital costs is readily available from the consolidated accounts of NHS Wales and at single organisation level from the accounts of the seven health boards, so that we can make comparison with all kinds of other activities and organisations which also produce a set of financial accounts.

Some would argue that it is meaningless to compare 'value-creating' privately owned activities and firms drawing market revenues with publicly owned and operated 'value-consuming' activities. But we are not convinced by the arguments against such comparisons. The line between public and private ownership is endlessly redrawn by political fiat as it was by privatisation of a telecoms utility like BT or would be if a government nationalised UK energy companies. A change of ownership in such cases does not make the activity any more or less 'value creating'. And, in the case of foundational essentials, the line between tax funding and market revenue is blurred. Water and energy utility bills are effectively a flat rate charge which all households must pay out of disposable income, just like 20% VAT on a wide range of goods.

But differences in, and changes of, ownership are relevant because they change patterns of distribution. Various forms of ownership involve different claims by capital as with profit seeking PLCs or private equity, which will be looking for at least a double-digit return on capital employed. Publicly owned and operated organisations can notionally draw freely on state funding for capital and revenue. But, practically, may be starved by the UK Treasury whose resource is limited by a dysfunctional and regressive tax system; and complicated by financial engineering when, for example, newly built English hospitals and schools have been burdened with PFI charges.

B. NHS Wales as a large-scale machine for converting revenue into wages

NHS Wales is a labour-intensive service which is a large-scale machine for converting revenue into wages for Welsh households, which are then at the first round spent largely in Wales. In this section we lay out the basic figures from the consolidated accounts and demonstrate the value of NHS Wales by drawing the contrast with the Welsh supermarkets which are engaged in the essential foundational activity of food distribution. In the aggregate supermarkets in Wales have much the same total revenue as NHS Wales each year. However, they have a hugely different patterns of incremental income distribution: NHS Wales turns an extra £1 of revenue into 66p of wages, whereas in supermarkets an additional £1 of revenue turns into just 12.5p of wages for households in Wales.

The consolidated accounts of NHS Wales cover 80% or more of the Welsh NHS. They include all seven territorial health boards, health trusts and NHS Shared Services, but exclude primary care. The combined expenditure of the health boards and trusts covering hospitals, community health services and special health authorities was £6.9bn in 2020-21.[10] In 2020-21, 66% of NHS Wales expenditure was on employment: this share is relatively high as a matter of arithmetic because the capital costs and external purchases are both low in relation to total expenditure (exhibit 1.1).

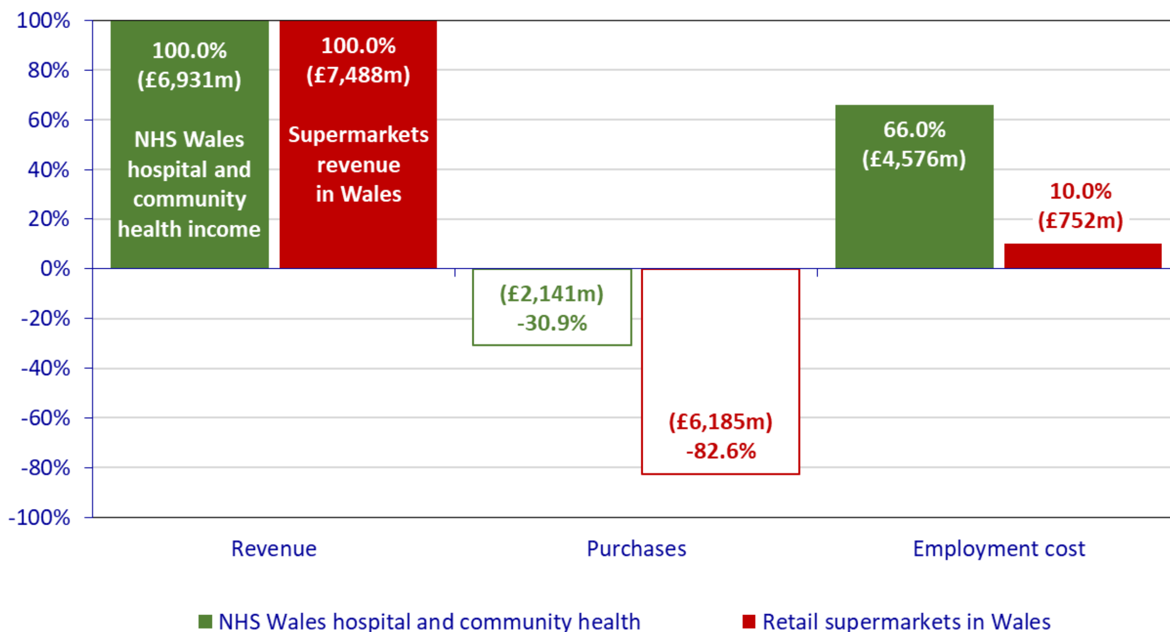
- Capital costs are very modest and in 2020-2021 consisted largely of a token charge for depreciation of £214 million. Almost all of NHS Wales capital arrives by allocation and grant and health boards are not allowed to borrow so they carry no real responsibility for replacing their capital from revenue received. NHS Wales has not been corporatized, unlike the universities which have been made responsible for funding their own capital expenditure[11].

- Purchases are entered at £2.1 billion in the consolidated accounts but, from invoice evidence summarised in section 3 of the report, external purchases from private firms probably account for no more than one third of this total, some £700 million. Using a sample of invoices, two-thirds of the value of purchases in the consolidated accounts are purchases from other health service providers and public sector bodies. A large proportion of these intra-public system financial transactions will also be with labour-intensive organisations such as local authorities, universities and other health providers. If we exclude this intra-public sector transactional churn, NHS Wales' spending on external purchases from private firms was about one seventh the size of the £4.6 billion distributed to households as wages.

[10] The overall NHS Wales expenditure of £9.584 billion in 2020-21 is comprised of £1.560 billion on primary healthcare services, £1.093 billion on other providers and £6.932 billion on hospital and community health services and by special health authorities.

[11] We do not accept the argument against grant provision of capital to public sector organisations, on the grounds that all organisations should be responsible for their capital maintenance and renewal. PFI in England has led to hospital trusts like Barts being burdened with debts they cannot service and loss of control over operations. Corporatized not for profits serving households have a mixed record because of ineffective governance controls on management strategies. In the case of universities this has led to extravagant building programmes at the expense of staff salaries and pensions without any regard for regional provision

Exhibit 1.1: Distribution of revenue to purchases, capital and employment costs in NHS Wales hospitals and community health and in the large supermarkets in Wales, 2020-21[12]



A comparison with Welsh supermarkets[13] brings out the distinctiveness of the distribution ratios and the pattern of retention in NHS Wales. Supermarket food distribution is a highly competitive, low profit margin business, where external purchases from supplier firms ocupy the dominant position in composition of costs at supermarkets (as labour costs do in NHS Wales). Welsh agriculture is narrowly specialised in meat and dairy which depend on export markets so that, for example, only 5% of Welsh red meat is consumed in Wales. The logic of

[12] Source: NHS (Wales) Summarised Accounts Local Health Boards, NHS Trusts and Special Health Authority in Wales 2020-21 and Annual report and accounts for Asda, Morrisons, Sainsbury and Tesco.
https://senedd.wales/media/odndmexj/agr-ld14491-e.pdf
Notes: We employ total expenditure because this should be equivalent to total income on the basis that Hospital, Community Health Services and Special Health Authorities are run at break-even. Under the National Health Services Finance (Wales) Act 2014, the annual requirement to achieve balance against Resource Limits has been replaced with a duty to ensure, in a rolling 3-year period, that its aggregate expenditure does not exceed its aggregate approved limits. The total expenditures are for Hospital, Community Health Services and Special Health Authorities and excludes primary care and some other health expenditures transfers and for which it is not possible to obtain a disclosed breakdown of employee costs, depreciation and purchases. The chart therefore represents 82 percent of total NHS Wales Local Health Board, NHS trust & Special health authority expenditure as at year end March 2021.
For reference and comparison for year ended 31st March 2021 for NHS England the consolidated accounts for all NHS trusts and NHS foundation trusts (termed 'providers') reveal total employment costs in income 63.9%, Depreciation 4% and External Purchases 32.1%
https://www.england.nhs.uk/wp-content/uploads/2021/01/consolidated-nhs-provider-accounts-19-20.pdf
[13] Source: Annual report and accounts
Note: Calculation uses average number of employees employed during year (these are not FTE adjusted). Tesco year end 27 Feb 2021, Sainsbury 6 March 2021, Morrisons, 31 Jan 2021 and Asda Dec 31 2020.
For reference, the gross weekly average earnings for full-time employees on adult rates in Wales was £29.3K per annum as at 2021.

this is that the Welsh supermarket purchases from supplier firms are almost entirely from those who add value and employ labour outside Wales.

The contrast in distribution ratios between the two activities is striking. The total 2020-21 revenues of NHS Wales and the supermarkets in Wales are similar at £6.89 billion for NHS Wales and £7.5 billion for all the supermarkets in Wales. But purchases, largely benefiting non-Welsh firms, eat up 83% of the supermarket revenue so just £752 million or 10% of total revenue is available as wages, compared with £4.6 billion or 66% for Welsh households in the case of NHS Wales.

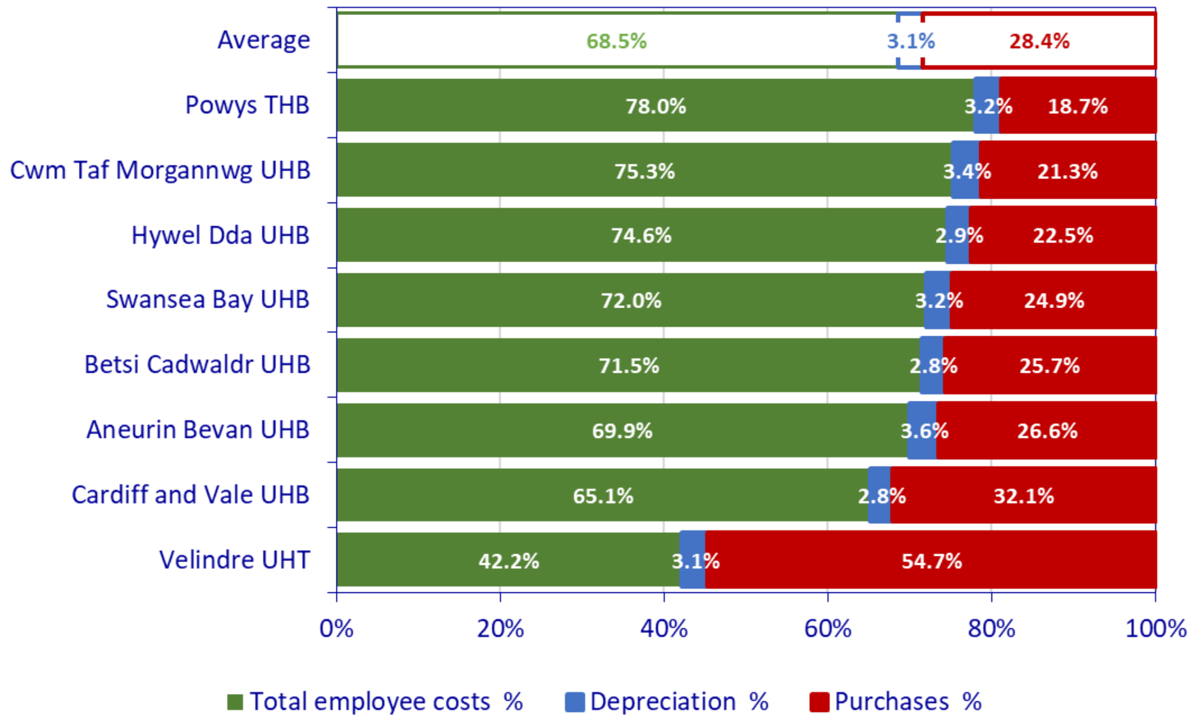
The NHS Wales distribution of wages to households is especially valuable because the number employed is large across numerous roles and specialisms. Moreover, the NHS pays relatively good wages, provides a pension and offers continuous secure employment in a deindustrialised country of low wages and precarious employment. These wages are distributed evenly across Wales according to population, not concentrated in the higher income areas in the Cardiff/ Newport and the Wrexham Flint corridors.

On numbers employed, according to the latest NHS Wales' Workforce Trends[14], in 2021 NHS Wales employed 88,746 FTEs - an increase of 21% since 2015 and 59% since 2000 - at a cost of £4.8bn for the year 2020/21. This data covers only directly employed staff and therefore excludes staff employed in primary care and in residential care organisations. GPs and their practice staff, totalling more than 10,000, are not included in official data reported by HEIW or StatsWales, even though primary care is an important part of healthcare provision: RCN Wales notes that there were 1,368 registered nurses working for GPs in 2020 and 1,438 in the care home sector in 2019.

As exhibit 1.2 shows, the seven area-based local health boards have similar composition of costs, with labour as 69-75% of total costs. Velindre University Health Trust has a different activity mix because it provides specialist cancer and blood services and hosts NHS Wales shared services. The average total per employee costs in the seven health boards ranges from £48-54k in 2020-21, with the average for NHS Wales as a whole of £53,000 (exhibit 1.3).

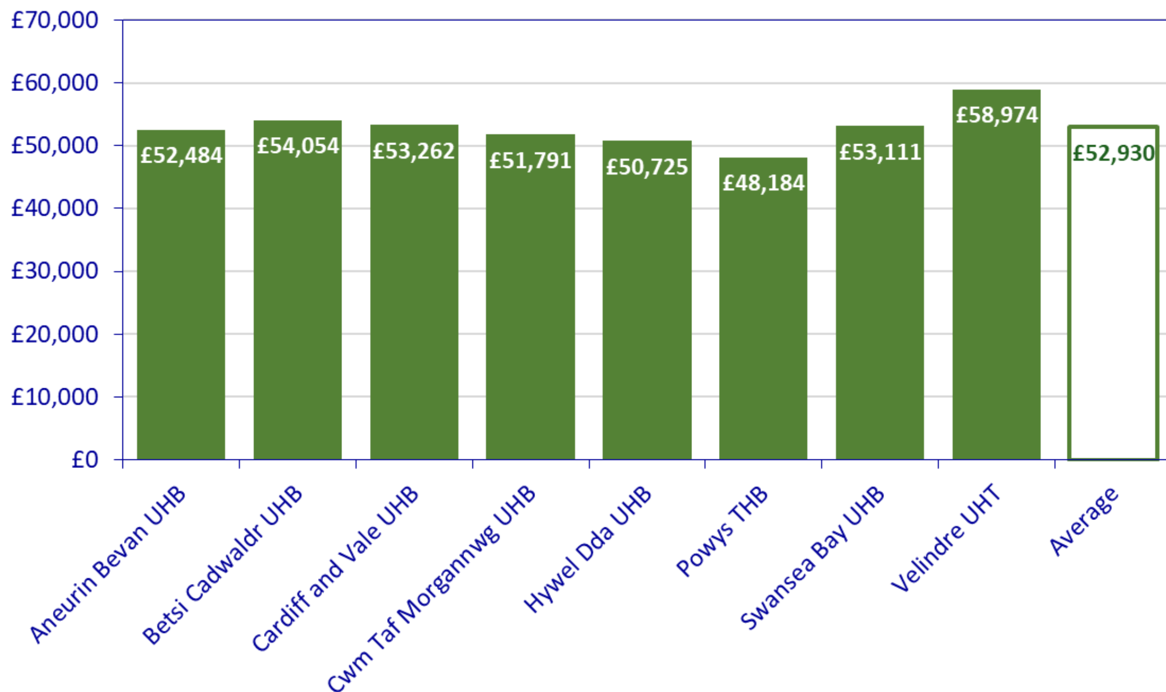
[14] NHS Wales Workforce Trends (as at 31 March 2021) - Final (1).docx (live.com)

Exhibit 1.2: Cost structure for NHS Wales (year ended March 2021)[15]



[15] Sources: https://abuhb.nhs.wales/files/key-documents/annual-accounts/abuhb-2020-21-final-annual-accounts-pdf/ 2. https://bcuhb.nhs.wales/about-us/governance-and-assurance/annual-report-and-accounts/annual-reports-and-accounts/annual-report-amp-accounts-2020-21-nbsp/ 3. https://cavuhb.nhs.wales/files/board-and-committees/annual-reports/annual-reports-committees-2020-21/cardiff-and-vale-uhb-annual-report-2020-21/ 4. https://senedd.wales/media/bq2ab52e/agr-ld14372-e.pdf 5. https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/annual-general-meeting-agenda-and-papers-29-july-2021/agm-papers-29-july-2021/item-4-hdduhb-annual-report-and-accounts-2021-21-bilingual/#page=81 6. https://pthb.nhs.wales/about-us/key-documents/annual-reports-annual-accounts-and-annual-quality-statements/powys-teaching-health-board-annual-report-2020-21/ 7. https://senedd.wales/media/qugfmsx1/agr-ld14371-e.pdf 8. https://senedd.wales/media/jwuke4en/agr-ld14381-e.pdf
Note: The total expenditures are for Hospital, Community Health Services and Special Health Authorities and exclude primary care and some other expenditure fund transfers for which the employee costs, depreciation and purchases are not disclosed. Velindre operating costs reflect the provision of specialist services to the people of Wales, specifically the operational delivery specialist of Cancer Services and the Welsh Blood Service.

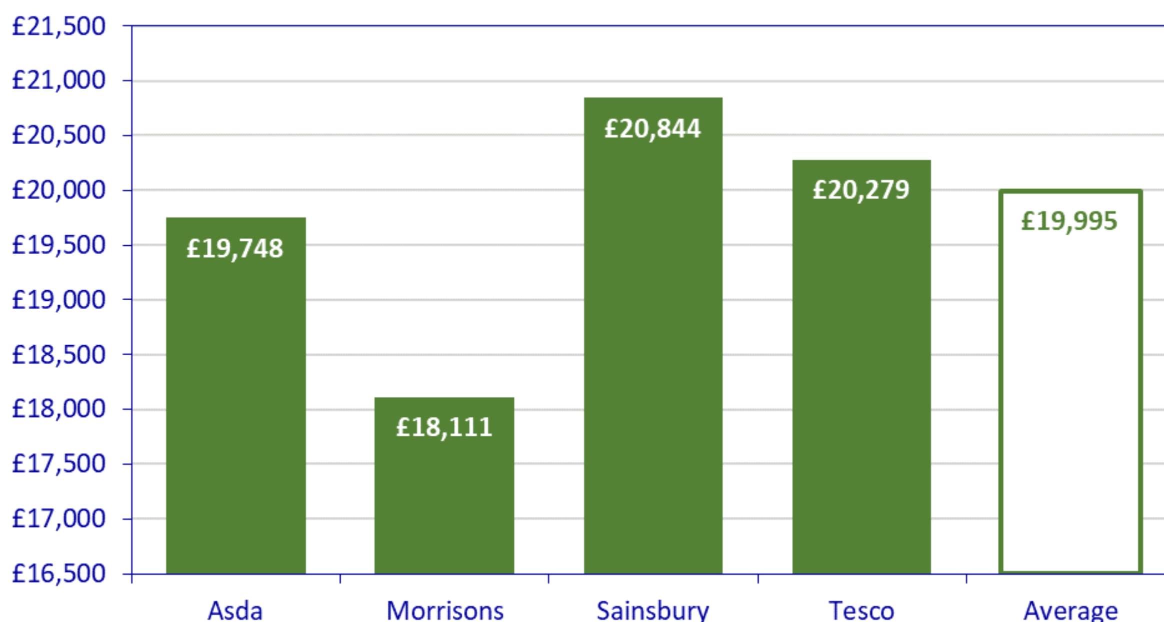
Exhibit 1.3: NHS Wales: average employment costs per employee[16]



Any comparison of pay between NHS Wales and supermarkets is complicated by the extent of part-time work. Our average employment cost figures for health and supermarkets are based on total head count not full-time equivalents: on this basis, the mean total average employment cost per employee in the old 'big four' supermarket chains (Asda, Morrisons, Sainsbury and Tesco) is £18-21k per annum (exhibit 1.4). Even allowing for significantly more part-time workers in food retailing, compared with healthcare, the full-time wage in Welsh supermarkets cannot be much more than half that paid by NHS Wales.

[16] Source: Annual report and accounts
Note: Calculation uses average number of employees employed during year (these are not FTE adjusted).
Tesco year end 27 Feb 2021, Sainsbury 6 March 2021, Morrisons, 31 Jan 2021 and Asda Dec 31 2020.
For reference, the gross weekly average earnings for full-time employees on adult rates in Wales was £29.3K per annum as at 2021.

Exhibit 1.4: Large supermarkets in Wales, average total employment cost per employee, 2020/2021[17]



The high average employment costs paid by NHS Wales reflects the range of occupations and diversity of households supported. The social value of the NHS Wales expenditure on wages and salaries covers the full range of salaries from porters and cleaners to consultants and senior managers, with many of these workers protected by extensive union organisation. The largest group of employees is registered nurses (exhibit 1.5) which helps to sustain a relatively high average wage.

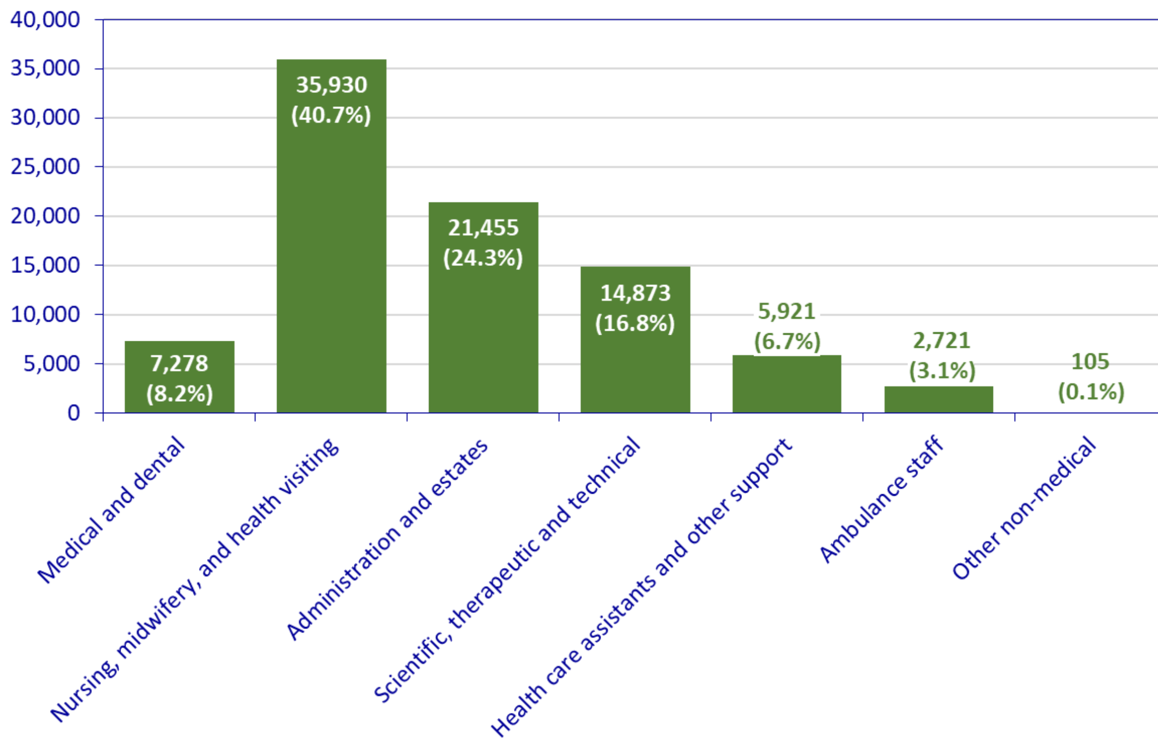
The contrast between health and the related activity of care is again notable. In care, the distribution of wages is bottom heavy and biased towards the uncertificated care worker earning minimum wages in a disorganised activity with a high degree of labour churn. In a recent report published by Skills for Care, the FTE equivalent mean annual pay for a registered nurse is given as £33,600. For a care worker, full-time equivalent mean annual pay ranges from £17,900 (independent provider) to £20,700 (local authority); for a senior care worker the range is £19,200 (independent provider) to £25,700 (local authority).[18]

In 2021, NHS Wales directly employed 88,283 FTE staff in medical/ nursing and non-medical roles. In the medical/ nursing category, 7,278 doctors and 35,930 nurses account for just under half the workforce. The non-medical workforce is substantial and includes 21,455 administration & estates staff 14,873 scientific, therapeutic and technical staff and 5,921 healthcare assistants and other support staff.[19] Appendix 1.1 shows the trends in staff numbers since 2009: in three groups – medical & dental, administrative & estates and

[17] Sources: see previous note for exhibit 1.3
[18] https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-State-of-the-Adult-Social-Care-Sector-and-Workforce-2021.pdf
[19] Source: NHS Wales, personal communication

scientific, therapeutic and technical - staff numbers have increased by around 30% over this period. The growth in number of nurses is lower at 15%, while numbers of healthcare assistants and other support staff fell by 9% over this whole period.

Exhibit 1.5: Directly employed NHS Wales staff, by staff group, 2021[20]



By weight of numbers and their graduate status, exhibit 1.6 shows that nursing salaries claim the largest share of the pay bill (27.8%); and the much smaller number of more highly paid doctors claim another 23.6%. But the assorted non-medical staff in the three categories of administrative and clerical, scientific and technical, estates and ancillary together claim 25.6% of the total pay bill, underlining the importance of the diversity of employment in NHS Wales.

[20] Source: NHS Wales, personal communication
Note: Data is FTE (full-time equivalents), includes those on short and fixed term contracts and excludes GPs and dentists. See Appendix 1.1 for the trends in NHS Wales staffing.

Exhibit 1.6: Share of total pay and employment, by staff groups, 2020-21[21]

	Share of pay expenditure %	Share of employment %
Administrative, Clerical & Board Members	16.9%	21.9%
Medical & Dental	23.6%	8.7%
Nursing & Midwifery Registered	27.8%	27.2%
Prof Scientific & Technical	3.7%	3.6%
Additional Clinical Services	13.4%	21.1%
Allied Health Professionals	6.9%	7.0%
Healthcare Scientists	2.6%	2.4%
Estates & Ancillary	5.1%	8.2%
Students	0.0%	0.0%
TOTAL	100.0%	100.0%

The value distribution analysis so far shows that NHS Wales distributes a large proportion of its revenues to labour, which benefits Welsh households by putting substantial salaries into a large number of households. However, the comparision with supermarkets raises as many questions as it answers: to what extent is NHS Wales an outlier and, if we shift to the micro level and examine diverse firms and organisations, what do we find?

C. The unique value of the health boards in distributing value

The unique foundational economic value of NHS Wales is brought out by the quadrant diagram in exhibit 1.7. This allows us to compare value contributions via employment to the Welsh economy by the health boards and by Welsh headquartered public organisations and private firms across a variety of activities It also allows us to compare whole activities or sectors like healthcare and food distribution, as well as individual firms and organisations.

To measure scale we use cumulative turnover, adding up the most recent five years of revenue for each enterprise. Value retention can be considered as the extent of wage support provided to households in Wales and is captured by a proxy: the ratio of total employment costs to revenues in the enterprise. The diagram has a horizontal 5-year cumulative revenue axis, which runs from zero to £40 billion, and a vertical labour/ employment cost ratio axis, which runs from zero to 100%. These axes bisect to give four quadrants. The top right-hand quadrant is the most desirable from the household support point of view because it combines

[21] Source: NHS Wales, personal communication
Note: Pay expenditure is based on the spend for the 9 months of 2021-22 financial year.

large scale activity and high distribution to labour, while the top left-hand quadrant is the second most desirable because it combines modest scale and high relative distribution to labour.

To begin with, the activity comparison of health services and retail food distribution can be fitted into the diagram. NHS Wales at a consolidated level is in a class of its own, due to its scale and composition of costs, which gets it into the top right-hand quadrant. Over the most recent five years available it has a huge cumulative revenue volume of £27.6 billion and a high labour share of 69 percent of those revenues: a remarkable 69p in every pound of NHS revenue goes directly into household support via employment. In retail food distribution, we can obtain turnover and distribution/ employee costs for 'non specialist stores' in Wales which includes convenience stores and supermarkets.[22] This sector also has a huge turnover at nearly £40 billion over five years, but a labour share of only around 10% of those revenues keeps the activity in the bottom half of the diagram.

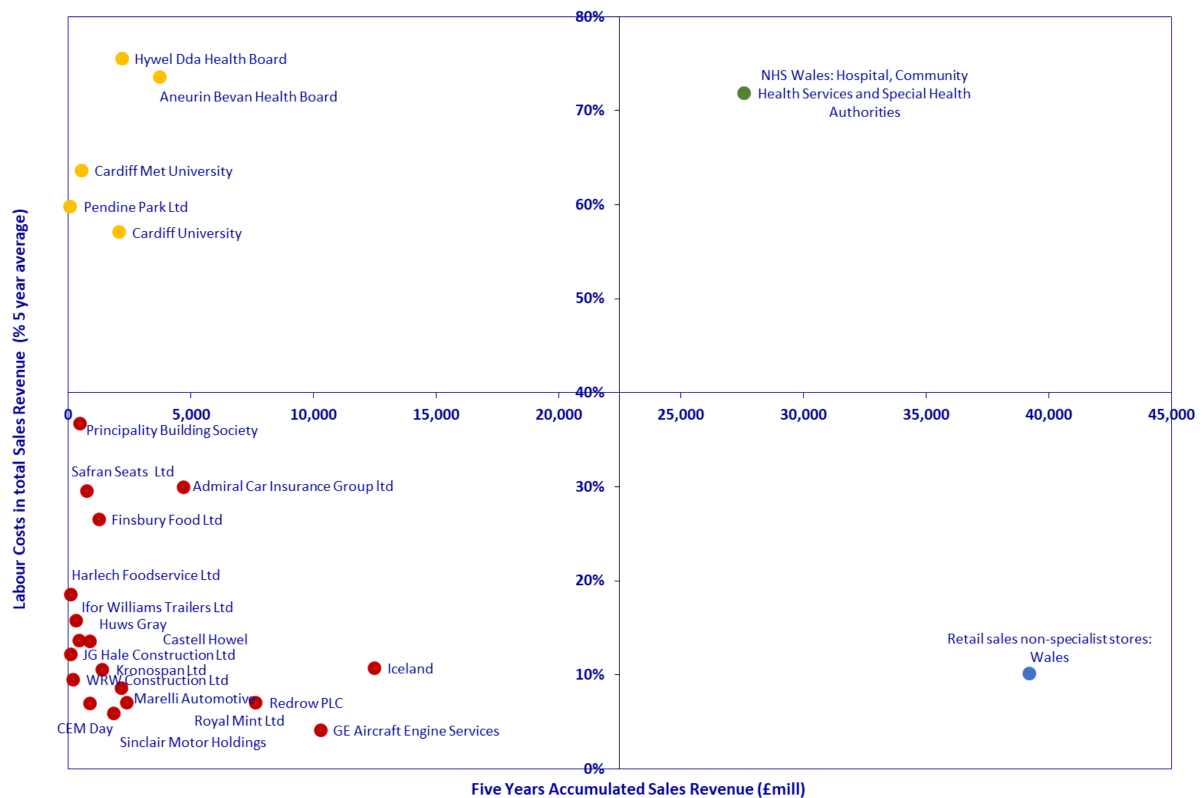
So far so predictable, given the activity contrast between health and food distribution in the previous section, but what do we find if we compare single Welsh headquartered organisations and firms across a diverse range of activities?

The seven area-based health boards are effectively the major operating units of NHS Wales and they all get into the second best, top left-hand quadrant because they distribute a large share of their revenues as employment costs and have substantial revenue volume. This quadrant includes not just the health boards but other large public sector organisations and not-for-profits like universities, which also deliver labour-intensive services. Only a couple of Welsh headquartered private providers of labour-intensive services, like Pendine Park, a care homes provider, have the combination of scale plus relatively high labour cost share of more than 50%, which is required to get into the top left-hand quadrant.

A characteristic of the Welsh economy is that it has too many small Welsh head quartered firms with low revenues and relatively low distribution to labour; these are all clustered in the bottom left-hand corner of the bottom left-hand quadrant. We would of course expect that with the Iceland supermarket chain or Castell Howell and Harlech Foods in food service distribution, or car dealership groups like CEM Day or Sinclair Motor Holdings or Huws Gray Builders merchant. That lower left-hand position is inevitable in all these distribution activities where external purchases dominate costs. Though the cluster of so many Welsh household-name SMEs in this group does underline the precarity of the Welsh economy as one where distribution with limited retention has expanded at the expense of production.

[22] For the Welsh economy we have used Annual Business Survey (ABS) data published by the ONS which provides data on total revenues and total employment costs by country and region and by Standard Industrial Trade Classification (SITC): section/division. In this case Division 47.1 'non-specialist retail stores for Wales is used which includes food supermarkets, hypermarkets and also convenience stores.

Exhibit 1.7: Scale of activity and significance of employment costs in Welsh firms and organisations[23]



The location of manufacturing firms like Safran Seats, Ifor Williams and Kronospan in the bottom left-hand corner is more troubling because it reveals that much of Welsh manufacturing adds relatively little value to inputs. Before we looked in detail at the accounts of Welsh manufacturing firms, we had expected manufacturers to have purchase to sales ratio of 65% or lower on the assumption that manufacturing would add more value to output; and this would be reflected in a higher employment share in costs. But firm level accounts show surprisingly little difference between the two activities of distribution and manufacturing because the commodity input is the major part of costs in low value-added processing activities. Castell Howell and Harlech Foods in food service distribution have purchase to sales ratios of 82%; whereas a sample of more than 20 Welsh food processing companies shows them to have purchase to sales ratios not much lower at 79%.[24]

Exhibit 1.8 shows the relative size of external purchases, employee costs and operating surplus measured as earnings before interest, tax, depreciation and amortisation (EBITDA) for all the Welsh organisations and companies we have so far been considering. As we move up the rows, the blue segment - representing purchase costs as a proportion of total revenue – contracts and the red segment - representing share of employee costs in total revenues - generally expands. More unsteadily, as we move up the rows, the relative size of the financial

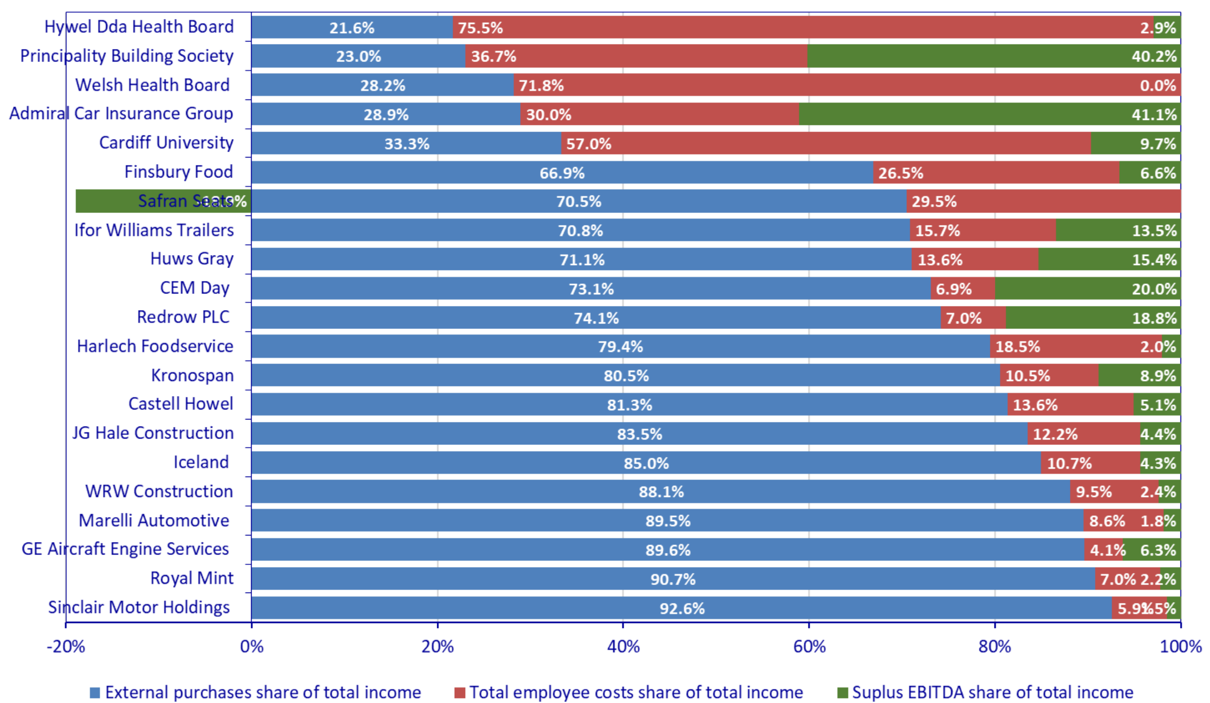
[23] Sources: Company annual report and accounts, and financial statements.
[24] *Welsh Food SMEs Report* (2021) https://foundationaleconomycom.files.wordpress.com/2022/01/smes-in-the-welsh-food-system-final.pdf.

surplus (after purchases and labour costs) also increases as is clear from the green segment in the bars of the chart.

The general problem of low distribution to labour arising from high purchases is immediately apparent. Almost half the firms in the sample have external purchases equivalent to 75% or more of sales revenues and it is easy to see how this compresses the head room for paying wages and salaries. But in the right-hand side of exhibit 1.8, the compression also comes from the claims of capital. As we can see if we consider the five organisations on the right-hand side of the bar chart which all represent labour intensive services with a high labour share but with variable surpluses for capital. Hywel Dda makes a small loss while Cardiff University may be not for profit, but (like other corporatised universities) pursues a surplus for paying interest on debt and for its reinvestment strategy.

The bottom line is simply that through the health boards, NHS Wales is uniquely valuable as a machine for retaining value and distributing it in the form of decent wages to support Welsh households.

Exhibit 1.8: Welsh companies ranked by their purchases and total employment costs to sales ratios (based on averages from the most recent five-year accounts)[25]



25 Sources: Annual report and accounts, Companies House.

Appendix 1.1

Table 1: NHS directly employed staff, by staff group, 2009-2021

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Change in staff numbers 2009-21	Change 2018-21
Medical and dental	5,637	5,731	5,851	5,917	6,083	6,028	6,136	6,249	6,383	6,539	6,693	7,211	7,278	29.1	11.3
Nursing, midwifery and health visiting	31,159	31,274	31,041	31,176	31,366	31,386	31,912	32,713	32,974	32,927	33,301	34,762	35,930	15.3	9.1
Admin and estates	16,068	15,472	15,192	15,039	15,120	15,172	15,757	16,580	17,384	17,895	18,687	19,722	21,455	33.5	19.9
Scientific, therapeutic and technical	11,265	11,507	11,472	11,549	11,616	11,671	11,971	12,429	12,799	13,206	13,777	14,512	14,873	32.0	12.6
Health care assistants and other support	6,500	6,485	6,242	6,259	6,169	6,161	6,090	6,199	6,254	6,294	6,071	6,174	5,921	-8.9	-5.9
Ambulance staff	1,855	1,859	1,873	1,937	1,918	1,947	1,998	2,045	2,084	2,095	2,431	2,670	2,721	46.7	29.9
Other non-medical	213	161	158	124	118	104	106	86	92	98	86	94	105	-51.0	6.4
All staff	72,698	72,488	71,828	72,002	72,390	72,470	73,971	76,301	77,971	79,054	81,044	85,145	88,283	21.4	11.7

Source: Extracted from the NHS Electronic Staff Record system. Staff groups and areas of work are determined from NHS occupational codes.
Notes: 1. All data refers to September, except 2021 which is for June
2. Numbers are full time equivalents, rounded to 1 decimal place

3. Most of the staff groups include staff on short term or fixed contracts – these include health professional students and recently retired staff brought in to help during the COVID-19 pandemic.
4. General Medical and Dental Practitioners are excluded as they are independent NHS contractors.
5. Various changes have been made to the occupational codes over this period. For example, changes to the ambulance section of the NHS occupation codes in April 2019. During 2018 Betsi Cadwaladr and Cwm Taf Health Boards recoded many of their former Health Care Assistants (HCAs) (occupation code H1) as Nursing Assistants / Auxiliaries (N9) bringing them in line with most of the other Health Boards. To show as comparable a position as possible over time, HCAs in previous years are now included within the nursing, midwifery and health visiting group.

2. Workforce development as a lever for Welsh household support

Given the composition of costs and the distribution of value to Welsh households, local workforce development should be a major issue, even *the* major issue in NHS Wales foundational policy. In practice, this has not been the case. Local purchasing for economic value is a long-standing preoccupation inside and outside NHS Wales but local employment for economic value is a minor theme and, as we shall see, a recent discovery. Even now, radical 'grow your own' local talent policies figure on the edge of existing recruitment practice in an organisation which mostly works by recruiting the appropriately certificated for specific roles and then makes up any deficit by importing 'readymade' workers.

In thinking about workforce development, the first prerequisite is to clear away the confusion and noise around staff shortages caused by political fixation on the use of agency staff and the technocratic response of workforce planning. When that is done, we can highlight 'grow your own' workforce development and commend the innovative policies which in some health boards are already opening up career progression opportunities for those with ability but without many certificates. If we recall our analysis of how NHS Wales distributes value in the last chapter, spreading 'grow your own' so that it delivers much wider benefits must be a high priority.

A. Confusion and noise: agency staff and the aim of workforce planning

Political debate often simplifies and confuses. So, it is when the NHS Wales patient experience is summed up in waiting times or when NHS workforce issues figure through political criticism of the use of agency workers. Too much attention on this one number is not helpful, but it is a crude indicator of a complex and ongoing problem about staff shortages which have motivated NHS Wales policy makers to call repeatedly for workforce planning.

Agency work can be more attractive to staff because it offers more flexibility and higher pay but pushes up employer payroll costs. There is general agreement that use of agency staffing should be reduced, though it is less clear how this will be done through a combination of targeting recruitment and/ or retention[26]. Various initiatives have sought to reduce use of agency staff, though few appear to have been evaluated[27].

An Audit Wales report on agency staff in NHS Wales in 2019[28] reported that, since 2010, staff costs have risen more quickly than staff numbers, as a consequence of greater reliance on agency staff, not higher pay. But, at the same time the agency and locum share of total staff costs is relatively small: pre-Covid, agency costs were always less than 5% of total costs. In the 2010s they rose rapidly from under 2% to a peak of 4.5% in 2016-17,[29] but were then reduced

[26] *A Healthier Wales. Our Workforce Strategy for Health and Social Care* (2020) A healthier Wales (nhs.wales)
[27] Expenditure on agency staff by NHS Wales | Audit Wales These initiatives are listed on pp.13-16 but they are not evaluated.
[28] Audit Wales (2019) *Expenditure on agency staff by NHS Wales* https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales-0
[29] Expenditure on agency staff by NHS Wales | Audit Wales

in the next two years to well under 4% before rising to 5.23 % of total costs in 2021-2 under pandemic pressures[30].

Use of agency staff beyond a minimum level does reflect an inability to fill vacancies. The Wales Audit Office (2019) reported that (pre-pandemic) around 80% of agency expenditure was to provide cover for vacant positions; it is also noted that there was no central data on how many positions are being covered, as the health boards and trusts do not collect vacancies data in a consistent way, nor do they share the data. Data for the most recent year (2021-22) shows that, under pressure of the Covid pandemic, the proportion of agency spend used to cover vacancies had fallen to 64% because of higher levels of sickness and the need for greater staff numbers[31].

Greater spending on agency staff in some categories and areas does indicate the pinch points and the areas of difficulty in recruitment and retention. Around 80% of agency staff costs are for two groups – medical & dental and nursing & midwifery - with nursing and midwifery's share of the whole bill rising from 33% to 50% between 2016-7 and 2021-2.

There are also significant differences between spend by health board, with the most urban and eastern of the Welsh health boards consistently spending less on agency staff than those in more rural and western regions. Cardiff & Vale still spends relatively less in 2021/22 (2.72%) than any of the other health boards before the pandemic. Hywel Dda had managed to reduce agency costs by half (from 10.1 to 4.95%) between 2016/17 and 2018/19, but in 2021/22 there was an increase to a fairly typical 7.28%

At the same time, there is the issue of overtime and bank staff who are already employed by a health board but working extra paid hours for their own or another board. Neither of these is included in the 'agency/locum' category. This means that the agency costs do not fully capture the extent to which health boards are paying for additional staff time above and beyond contracted hours worked by their regular workforce. A 2015 report by NHS Professional notes that 'Historically, as much as 29% of total workforce cost may be spent on temporary and flexible working, including overtime, bank staff and expensive agency workers (NAO, 2006).'[32]

There has been pressure in Wales and in England to switch from agency to bank staffing to meet additional short-term needs as bank staff are cheaper pro rata. There is little published information on the cost of bank staff but an FOI request in 2021 found that (based on incomplete data) between 2016/17 and 2021-22, Welsh local health boards spent a total of £837m on agency staff and £502m on bank staff.[33]

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[30] NHS Wales, personal communication
[31] NHS Wales, personal communication
[32] NHS Professional (2015) *Exposing the true cost of managing a temporary workforce.* P.6 Available at: D6D9A6AED54742769E12231EAC9D4B6D.ashx (nhsprofessionals.nhs.uk)
[33] https://www.walesonline.co.uk/news/health/huge-amount-money-spent-agency-21199623 The data is incomplete because not all health boards provided data.

The use of agency and bank staff is not so much the problem as an indicator of ongoing stress about vacancies. In successive reports of the 2010s[34] the technocratic response of Welsh health policy makers was to call repeatedly for workforce planning. This is an ambiguous concept which in its simplest sense means managing the training, recruitment and retention of enough staff in each category so as to balance worker supply and demand and avoid the embarrassment of skills shortage or temporary over supply.

The current phase of Welsh health policy begins in 2018 with the review chaired by Ruth Hussey, *A Revolution from Within: Transforming Health and Care in Wales.*[35] This called for 'joint workforce planning at regional (Health Board boundary) level supported by Social Care Wales (SCW), Health Education and Improvement Wales (HEIW) and academia, with an emphasis on expanding generalist skills and new ways of working that enable staff to work at the top of their skill set and across professional boundaries' (p.21).

In response to the Hussey review in 2018, *A Healthier Wales. Our plan for health and social care*[36] promised that 'the Welsh Government will commission Health Education and Improvement Wales (HEIW) and Social Care Wales (SCW) to develop a long-term workforce strategy'.[37] In 2020 these bodies published *A Healthier Wales: our workforce strategy for health and social care*, which set out a 'journey' over 10 years to deliver 'a motivated, engaged and valued, health and social care workforce'[38] with a more planned approach to recruitment and retention and annual reports to update on delivery actions.

The 2020 version of workforce planning does recognise the practical importance of engaging with, and recruiting from, the local population through developing 'a range of opportunities to promote and achieve the "Made in Wales" ethos for careers in health and care', which 'includes supporting our local learners into employment through our streamlining approach'.[39] This recognises the need for flexible entry points appropriate for people from a range of backgrounds and career pathways which allow transfer across roles and staff development. And deliverables for this objective in 2021-22 including the formation of a Made in Wales team to establish a programme of work, create and launch the programme.

But the supporting argument about the economic value of NHS Wales workforce is only belatedly being recognised within this workforce planning frame. The 2020 workforce strategy acknowledges the wider 'context of a prosperous Wales' and observes in a rather abstract macroeconomic way that the health and care workforce 'as members of local communities… contribute greatly to the wider socio-economic prosperity and sustainability of Wales'.[40] This recognises that recruitment has an explicitly local economic dimension:

[34] Reconverted NHS Wales Key Themes Jan 2015.pdf
[35] Parliamentary Review of Health and Social Care in Wales Final Report (gov.wales)
[36] A healthier Wales: long term plan for health and social care | GOV.WALES
[37] A healthier Wales: long term plan for health and social care | GOV.WALES p.32
[38] A healthier Wales: long term plan for health and social care | GOV.WALES p.11
[39] A healthier Wales: long term plan for health and social care | GOV.WALES pp.31, 9.
[40] A healthier Wales (nhs.wales) pp.3, 2.

> The NHS and local authorities are the two largest employers. To make the most of these benefits, health boards and local authorities will need to work together with local providers to establish joint campaigns, make best use of resources and recruit the best people. In doing so they will need to identify shared recruitment and staffing needs and develop attractive employment packages which can help entice individuals and families to train, work and live in Welsh communities.[41]

This direction is important and encouraging. Nevertheless, within the workforce planning framework, local economic value is a recently discovered objective without any empirics on the value delivered or any sustained attention as to what needs to change if health and care are to deliver more economic value.

B. Filling the staffing gaps by importing 'readymades'

In Wales there is often a gap between ambitious objectives and modest, fitful delivery. So far, this is certainly the case with NHS workforce planning. As we have noted, for more than a decade, policy makers have called for workforce planning in health and care and 'Made in Wales' does represent recent progress. However, workforce planning cannot be delivered at a system wide level as long as NHS Wales does not have the basic data which is prerequisite for any kind of planning.

There was a short-lived attempt to collect vacancy data in 2010 and 2011 but it was then discontinued. Since then, system-wide data on NHS Wales recruitment, retention and vacancies has not been collected and published[42]. When RCN Wales estimated nursing vacancies in 2021, it complained about incomplete and inconsistent data from the health boards and then produced estimates by working from advertised vacancies.[43] This probably under-represents the size of the staffing shortfall given the extent of overtime and bank working worked by established staff.

Like other UK health organisations, Welsh health boards have relied on recruiting 'readymade' qualified international workers from lower income countries to fill the gaps left by a UK training system and poor retention rates. Hence the recruiter trips to the Philippines and India and the result that one quarter of Welsh doctors are not of British or Irish origin. This source should not be relied upon over the medium to long term because the WHO projects an 18 million global shortage of health care workers by 2030, particularly in low- and medium-income countries[44].

But here and now in Wales, staff shortages (especially of doctors) have led to public criticism by opposition parties and medical unions. Thus, in December 2021, the Conservatives in the

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[41] A healthier Wales (nhs.wales) p.31

[42] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/Vacancies/Vacancies-by-AreaOfWork-Date

[43] https://www.nursinginpractice.com/latest-news/rcn-wales-calls-on-government-to-publish-nursing-vacancy-data/#:~:text=The%20RCN%20Wales%20workforce%20report,on%20incomplete%20and%20inconsistent%20data. RCN Wales (2021) *Nursing in Numbers 2021. An overview of the nursing workforce in Wales* p.9.

[44] https://www.who.int/health-topics/health-workforce#tab=tab_1

Welsh Assembly complained that an FOI request had disclosed that A and E departments in every major Welsh hospital were below the recommended 'baseline' level of consultant staffing.[45] A couple of months previously, a Royal College of Physicians report had documented under staffing at the newly opened Grange hospital with trainee doctors 'scared to come to work' because they were being asked to cover too many beds[46].

Against this background, the NHS in Wales (as in England) continues to default onto what might be called the UK national quasi-solution of importing migrant labour when domestic training fails to reproduce skills in volume, or when wages and conditions make a job unattractive for natives. Hard working 'readymades' in health, as in other activities, of course do solve the immediate problem of service provision. But this is only a quasi-solution because the import of trained staff encourages tolerance of training system deficiencies and acceptance of poor wages and conditions in some sectors.

As a 2020 report by the Wales Public Policy Centre (WPPC) notes,[47] Brexit has disrupted established health and care patterns of importing migrant labour from the EU. But there is no sign yet of a major paradigm shift towards NHS reliance on the domestic workforce which would require major investment in training and upgrading of wages and conditions. And without such a paradigm shift it is harder to raise the question of what kinds of changes in training are necessary to maximise the economic added value from local recruitment.

All this needs to be kept in perspective. Overall, the number of non-UK migrant staff working for Wales NHS is not very large and has fallen over the past decade. In 2020, 8% of NHS Wales staff with an identifiable nationality were non-British/Irish (5% EU, 3% non-EU); this is much lower than the equivalent in England with 14% (8.5% EU, 5.5% non-EU)[48]. Reliance on non-UK nationals in Wales has fallen - in 2010 14% of the staff with identified nationality were migrants (10% EU, 4% non-EU) - though the WPPC report notes that this may be partly due to staff acquiring British nationality over time.

However, reliance on migrant workers varies significantly across staffing categories and is relatively high at both the top and bottom of the pay scales.

- At the top end, non-British/Irish doctors were 26% of the total in 2020, with Wales having a relatively much larger number of non-EU doctors (mostly Indian), compared with England (pp.11-13).[49] This dependence may be worsening with 27% of training grade medic positions filled by non-British/Irish, possibly encouraged by a loosening of visa rules which removed the cap on non-EU migrants for NHS workers.

[45] https://www.itv.com/news/wales/2021-12-21/staff-shortages-main-reason-for-a-and-e-department-crisis-say-welsh-conservatives
[46] https://www.bbc.co.uk/news/uk-wales-58967159
[47] Portes, J., Oommen, E. and Johnson, C. (2020) *UK migration policy and the Welsh NHS and social care workforce.* Available at: https://www.wcpp.org.uk/publication/uk-migration-policy-and-the-welsh-nhs-and-social-care-workforce/
[48] Portes et al (p.9)
[49] https://gov.wales/recruitment-boost-nhs-wales-home-and-abroad

- At the lower end, estates and ancillary staffing has a higher-than-average dependence on migrant workers (mostly EU nationals) (p.13). As the WPCC report notes, post-Brexit visa rules make it relatively harder to rely on EU migrants at lower pay level especially in the 'additional clinical services' of auxiliary workers. It is not clear how these gaps in lower pay roles will be filled.

The WPPC report reflects the pre-pandemic situation. More recent data on nurses shows that pandemic travel restrictions have significantly reduced international mobility at least in the short term.[50] Reports by other organisations, such as the Kings Fund, have highlighted the scale of the UK's dependence on recruiting internationally-trained nurses.[51] While Wales may be relatively less dependent on such international recruitment in some staffing categories, it will still need to address the short and long term issue of nurse recruitment and the reluctance of UK-trained doctors to work in the unglamorous parts of Wales.

Firefighting import of readymade workers is quite properly part of managing current problems but there are major policy issues about the balance between importing readymade workers and 'grow your own' workforce development. At the very least, in the medium term, imports of trained staff need to be systematically twin tracked with grow your own work force development which will increase the economic value of what NHS Wales contributes to Welsh communities. And that requires a new approach to training.

C. Reframing the problem as the opportunity to 'grow your own'

The largest policy opportunity in Wales in the 2020s is to press NHS strategies of workforce development which both recruit more Welsh workers and break with the narrow definition of training. It is important to recognise that the issue here is not about quotas for the Welsh but about rethinking the whole system of training and ending the disconnects between different career paths. The current problem is that entrants require the appropriate exam certification to get onto a standard training pathway connected to one career ladder, which is disconnected from other career ladders.

The corollary of the import of readymades, especially in nursing and doctoring, has been an acceptance of narrow and socially selective training systems based on entry certification. The medical schools are disproportionately reservations for the upper middle class with very good A levels; Welsh medical schools require 3 A grades at Advanced level; nursing as a graduate profession restricts entrance to those with good 18-year-old leaver qualifications (for example, the University of South Wales requires 3 B grades at Advanced level). Only in the case of health care support workers are there flexible school/ college qualification requirements.

Entry certification and training gets each group onto a separate short career ladder and most of the ladders are not strongly connected to wider Welsh social characteristics and needs, nor

[50] https://www.health.org.uk/news-and-comment/charts-and-infographics/thinking-local-and-global-exploring-the-uks-reliance-on-international-nurses
[51] https://www.kingsfund.org.uk/publications/articles/brexit-end-of-transition-period-impact-health-care-system#people

do they compensate for disadvantage. For example, Wales has quite remarkably only just started training nurses through the medium of Welsh, even though more than 20% of the population speak and use the language. Equally, there is no recognition that many potential Welsh applicants for medical school are disadvantaged in that they come from schools which do not routinely send sixth formers to medical schools and do not prepare students for that destination.

The practices of established training systems are questioned and reformed by a 'grow your own' approach. This alternative recognises that what is needed in the care and health workforce is not entrance by certification and knowledge cramming, but the two prior human qualities of responsibility and empathy (backed by the necessary technical knowledge and experience to ground judgement and make good decisions under pressure). The aim of workforce development should be to develop capability and ambition amongst those who have the basic qualities and then to broaden the definition of training so that it develops clusters of skills, with possibilities of movement horizontally between ladders and vertically from the top of one ladder to the bottom of the next.

Many potential recruits will not have the qualifications required to enter and progress on standard training routes because prior educational certification is both a principle of qualification and exclusion. Grow your own must therefore be an adaptive response which creates pathways that can credentialise experience (as an alternative to certificates) and set up training pathways which are accessible to those who have family responsibilities and need to earn while learning. This can encompass both new entrants to the NHS and existing staff who are willing to be trained for more responsible roles through new career pathways that have not previously existed. This could mean, for example, that a facilities worker could become a healthcare support worker, or a healthcare support worker become a registered nurse.

This is the model of vocational training advocated by Professor John Buchanan in New South Wales and articulated in a 2020 report to Colegau Cymru and the further education colleges[52]. As part of this broadening of qualification and training, we should accept that many of those trained for health and care will over a life course shift into other activities and vice versa. This should be regarded as a social benefit. We advocate broad vocational training which would equip Welsh health workers to move sideways into other client facing activities requiring empathy and the exercise of judgement after reading situations and eliciting a narrative from a subject. Correspondingly, there would be opportunities for workers from other sectors to move into NHS Wales as a second or third career.

If the 'grow your own' approach were widely adopted, we would expect it to ease recruitment problems particularly in West Wales, the region furthest from the cross-border labour markets in south east and north east Wales. And local recruitment and progression of older workers should everywhere improve retention because such staff are already residents.

[52] Report by John Buchanan et al for Colegau Cymru (2020) *Enabling Renewal. Further Education and Building Better Citizenship, Occupations and Business Communities in Wales.* Enabling Renewal - FE.pdf (colegau.cymru)

Imported workers may be more likely to move on from NHS Wales as nurses try life in a big city and doctors choose leafy suburbs.

The 'Made in Wales' approach begins to set out the right ambitions, with flexible entry points appropriate for local people and career pathways which allow transfer across roles and staff development. But there is not yet an NHS Wales set of programmes and actions in place to deliver this. Instead, at the individual health board level there have been grow your own experiments where developments at Aneurin Bevan and Hywel Dda Health Boards indicate the potential of this new imaginative approach (see appendix 2.1 for details), as well as highlighting obstacles to its scaling and development.

All the health boards provide large amounts of on the job/ career training for existing staff so that, for example, more than 650 employees at ABUHB and more than 350 employees at Hywel Dda are currently engaged in levels 2 to 5 development across a range of specialisms. All the health boards also have employability programmes, especially targeted at widening participation and careers awareness, including work experience schemes and volunteering.

But some new and promising experiments in grow your own at Aneurin Bevan and Hywel Dda show a more ambitious way forward so that someone without standard entry qualifications could not only enter the health service but have a long-term career which involved progression through a series of increasingly responsible roles.

- At the entry level for school leavers. Aneurin Bevan and Hywel Dda are expanding programmes which provide what one workforce director described as 'genuine apprenticeships'. These are programmes which, on the basis of attitude and skills, select absolute beginners to earn and learn (as distinct from providing in-service training for those who have been recruited because they meet standard academic entrance requirements). Since 2019, Hywel Dda has recruited 132 of these apprentices under its Apprenticeship Academy programme which is currently being expanded; under a similar scheme in 2021 Aneurin Bevan recruited a first cohort of 40 students for level 2 apprenticeships. In both cases, the initial focus has been on apprenticeships in health care support, but both boards are actively planning to widen the scope of these schemes and open more routes to various craft and professional skills from carpentry to recruitment.

- Equally important is long-term career progression along pathways that allow individuals to move upwards into more responsible roles. These are practically closed off by standard training systems for more senior roles which recruit young school leavers for full time training and do not allow for the needs of older workers who have to balance paid work, family responsibilities and training. Since 2017, both Aneurin Bevan and Hywel Dda have operated a Flexible Nursing Programme which enables an in-post health care support worker to become a qualified nurse within four years. The first cohorts are now coming through and, by autumn 2022, 77 support workers at the two boards will have qualified as nurses; a further 142 support workers at the two boards are enrolled in the programme and due to qualify from autumn 2023 onwards. Encouraged by this success, Aneurin Bevan is supporting a pilot that provides an opportunity for facilities operatives to move

into a HCSW role and five facilities operatives have so far transferred; while Hywel Dda is working towards creating career pathway support programmes.

The lesson from these innovations is that it is possible for health boards to develop training routes that open access to previously excluded entrants and provide opportunities for existing staff to progress to more responsible and better paid roles which have been out of reach. At both Boards, over eight years, a recruit could complete an 18-month apprenticeship as a health and care support worker (HCSW), work at this level for two years, then subsequently train for a further four years to become a registered nurse If such programmes can be expanded this has the potential to address some of the long-term staffing issues in NHS Wales, while also providing good quality employment to local people, especially those beyond the school/ college leaver stage. This is a way of increasing economic value and at the same time strengthening its distribution to disadvantaged households and communities across Wales.

D. Addressing the challenges

Mainstreaming 'grow your own' initiatives will depend on internal support and resourcing, as well as a good deal of collaboration and co-operation inside NHS Wales and with external partners.

i. The development of the pilot schemes in ABUHB and HDUHB are significant achievements: they require an alliance for change that brings together the health boards that recruit and employ staff, the HEIW, professional associations that govern entry qualifications and training requirements within professions, as well as the training providers in higher and further education. The innovative Flexible Nursing Programmes at Aneurin Bevan and Hywel Dda are the result of collaboration between the two Boards and three Universities (Swansea university, University of South Wales and the Open University. Further development of new and expanded pathways into and within NHS Wales will require commitment and cooperation from the professional and training organisations, particularly to find new routes for those who do not meet traditional entry requirements. This challenge is relevant for doctors, as well as for nursing and allied healthcare professions.

ii. Communication, sharing and co-operation between health boards and trusts will be important in doing more 'grow your own'. A workforce recruitment and development community of practice would allow innovations – both successful and otherwise - within individual health boards to be shared and developed in others, as appropriate. While there are differences between health boards in terms of the local labour market and particular areas of shortage, the areas of commonality will also be significant. Sharing learnings from pilots will allow other health boards to benefit from and encourage further experimentation including collaborative projects. A shared agenda from the health boards to develop further 'grow your own' schemes will also provide constructive pressure on training partners to collaborate to develop new entry and progression routes.

iii. Prioritisation and resourcing for 'grow your own' is essential to make this approach sustainable. Developing and operating entry level and workforce development routes requires dedicated staff. While pilots are the result of individual imagination and commitment by staff, scaling up initiatives requires sufficient, continuous and dedicated resource, with sustained focus and commitment from health board leaders. Committed staff members whose role is to take creative approaches to recruitment and workforce development will be able to co-operate, create networks and work across health boards to remove obstacles.

iv. The role of Welsh Government is important in promoting collaboration across NHS Wales and with external partners. The 2022 employability and skills plan, *Stronger, fairer, greener Wales*,[53] highlights the importance of NHS Wales as employer across communities in Wales, though it does not contain concrete actions that can realise the potential of expanding employment through 'grow your own'. In developing the plan, Welsh Government can provide both a high-level steer and practical support in creating new career routes, including drawing on regional skills partnerships to contribute to workforce and skills development and to connect up general targets for skills with the specific opportunities for place-based recruitment.

v. The development of new entry routes and career pathways should also be on a co-operative and co-ordinated basis with social care (to avoid dysfunctional poaching or competition) while working to expand the overall number and range of local employment opportunities across health and care.

vi. A better understanding of the wider benefits of grow your own approaches to NHS Wales (through data on, for example, recruitment, attrition, staff satisfaction) and to individuals and communities (through wages and security) will be invaluable. Place based studies will also be helpful in understanding both the opportunity for 'grow your own' policies in specific places as well as tracking the outcomes.

[53] Stronger, fairer, greener Wales: a plan for employability and skills | GOV.WALES

Appendix 2.1: Training provision in Aneurin Bevan and Hywel Dda Health Boards

Scheme	Aneurin Bevan (ABUHB) schemes	Hywel Dda (HDUHB) schemes
Apprenticeships	40 apprentices recruited under a scheme owned by the HB First cohort advertised September 2021 Each apprentice will be required to complete a level 2 apprenticeship qualification specific to their role over 18 months. 3 different routes (numbers in the first cohort): • HCSW's supporting nursing - **25** • Administration – **13** (including professional routes such as IT/HR/Data Analysis) • Facilities – **2** The HB have agreed to recruit 2 cohorts of a minimum of 10 apprenticeships every 6 months. The plan for 2022/23 is to widen apprenticeship routes to more professional fields	132 Apprentices recruited as part of the Apprenticeship Academy programme. First cohort started in Sept 2019, which were primarily Health Care Apprentices and 4 x Patient Experience. Due to the pandemic, no recruitment took place in 2020. In 2021, the main recruitment drive was again Health Care Apprentices, however, the offer was increased to the following apprenticeship routes • 57 x Health Care • 3 x Patient Experience (customer Service) • 1 x Patient Experience (Digital) • 3 x Digital Services • 2 x Corporate Governance • 1 x Workforce • 3 x Mechanical Engineering • 3 x Electrical engineering. • 1 x Plumbing Recruitment is once a year, where the current priority is 100 Health Care Apprenticeship and 15 Joint Health and Social Care apprentices.

		With the Grow Your Own philosophy, the HB are increasing routes available, dependant on service requirements. This will include carpentry, recruitment and painting and decorating.
Finance Academy Apprentice	A 3-year apprenticeship owned by the Finance Academy and hosted by ABUHB First cohort started in September 2021 (one accountancy apprentice hosted by ABUHB; 5 supported in total)	One apprenticeship in the September 2020 intake; currently assessing the success of this new scheme. The HB will review whether to support a national or a more local approach to ensure a pipeline remains within West Wales.
Network 75 Scheme	A 5-year scheme leading to an Accountancy & Finance degree. Currently 4 apprenticeships in ABUHB	Currently HDdUHB are not accessing Network 75

a) Development Opportunities for Existing Employees

Scheme	Aneurin Bevan (ABUHB) schemes	Hywel Dda (HDUHB) schemes
Internal apprenticeship qualifications to enhance skills and knowledge	A range of modern apprenticeship qualifications (15–18-month durations) are offered to existing staff members to support career progression. The HB works with external accredited training providers. Currently supporting **655 staff** to undertake level 2-5 qualifications. This includes: • Business Administration (Level 2, 3 and 4) • Leadership and Management (Level 4 and 5) • Clinical Healthcare Support (Level 2 and 3)	Working with a range of external training providers, **363 staff** in Hywel Dda are actively enrolled for the following level 2-5 qualifications provided through apprenticeship funding. • Business Administration (Level 2,3 & 4) • ILM Management qualifications (Level 2,3,4&5) • Clinical Healthcare Support (Level 2 & 3) • Health & Social Care Practice (Level 2&3) Adult) • Health & Social Care Practice (Level 2&3)

	• Primary Health Care Support (level 2) • Certificate in Facilities Management • Extended certificate in Health Informatics • Diploma in Management (Level 3, 4) • Clinical Health Care Support services (level 2 certificate) • Health & Social Care Practice (Adult) • Health & Social Care (Children and Young People)	Children and Young People) • Project management (Level 4) • Cleaning & support services (Level 2) • Cleaning Supervision skills (Level 3) • Food production & cookery (Level 2) • Professional cookery (Level 2 & 3) • Hospitality Services (Level 2) • Hospitality supervision & leadership (Level 3&4) • Certificate in Facilities Management (Level 2) • Physiotherapy Support (Level 3) • Perioperative Care (Leve 3) • Occupational Therapy Support (Level 3) • Rehabilitation Support (Level 3) • Speech and Language Therapy Support (Level 3)
Enabling facilities operatives move to HCSW roles	The HB is supporting a pilot that provides the opportunity for facilities operatives to move into a HCSW role, either via a formal apprenticeship or via a part time/bank arrangement whilst studying an NVQ 2 qualification. So far, **5** facilities operatives have transferred into HCSW roles.	The HB are working towards creating career pathway support programmes to support facilities employees with employability skills, supporting with interviews and the application process. It is also important to recognise the development of the facilities profession too, with the new facilities qualifications, which we are in discussions with the local colleges/training providers to deliver.

4-year Flexible Nursing Programme commenced in 2017 in University of South Wales (USW) and Open University (OU) in 2018	The HB with USW (since 2017) and OU (since 2018) have run a flexible nursing programme since 2018 which enable HCSW staff to become qualified nurses over 4 years. So far, **9** HCSWs have become Registered Nurses with a further **13** USW flexible Nursing students are due to complete in September 2022. On the OU programme, 7 Flexible Nursing students are due to complete in September 2022. There are a further 94 students currently on the programme and completing from 2023 onwards: 57 with USW and 37 with OU.	The HB has been with Swansea University (since 2017) and OU (since Feb 2019). The flexible programmes have enabled our HCSW to become qualified nurses over 3 or 4 years depending on prior qualifications So far **13** HCSW have become registered Nurses through 4yr part time programme and **15** from full time programme in 2015 & 2016 (sponsored by HB), with 20 students undertaking and due to qualify in 2022; and 48 are undertaking the OU programme are due to complete in 2023-27.
Band 4 Nurse Practitioner	The role of the band 4 Nurse Practitioner has been successful in support nursing teams and this has been implemented across acute care, community settings and CHC.	The role of the band 4 Practitioner has been embedded into nursing support teams across acute, community, learning and development, paediatric and theatres. There are more roles planned for mental health, critical care There are other band 4 roles in therapies, with practitioners working towards level 4 qualifications.

3. Revenue and capital spend for Welsh firm support

A. Confusion and noise

When public sector purchasing figures in Welsh political debate it is usually to promote or applaud the objective of localising final purchases and switching suppliers to stop leakage from the Welsh economy. This has had uncontroversial, cross-party appeal in Wales across the whole political class for more than a decade. In 2012-13, when the Labour Government celebrated a rise in the percentage of pubic purchases made locally, Plaid, Conservatives, Liberal Democrats, CBI Wales and FSB Wales united to ask for more of this good thing[54].

The objective was institutionally supported by the creation of the Atamis database which classifies all Welsh public sector invoices by postcode so that Welsh and non-Welsh invoices can be counted. And the approach was intellectually legitimated by the adoption of Community Wealth Building and its municipalisation in Preston. Invoice counting for localisation of final sales became a consultancy product sold to other municipalities and, in due course, to Welsh Government, which hired CLES to work with the Public Service Boards.

There has been a separate stream of interest in adding social conditions to contracts and other ways of supplementing price as the decision principle in contracts with suppliers. This was pioneered in Wales with the *Can Do* tool kits[55] used by social housing providers. Since then, there has been a proliferation of methods for producing add-on social calculations or for incorporating social value weightings in contracts.

The WLGA has worked with the Social Value Portal to produce a Welsh national TOMS which assigns monetary values to social benefits, from environmental goods to hours of volunteering. This means that for each contract it is possible to produce an add-on financial measure of the social value offered. Separately, NHS Wales has adopted the simpler approach of introducing a 15% weighting of contracts for social criteria, including 5% for the foundational economy.

Against this confusing background, two numbers stand out in public debate: first, the large £6 billion plus total of Welsh public procurement is used to represent a glittering opportunity; and, second, millions of final sales switched to local suppliers is used as a measure of achievement, as in the case of NHS Wales which has recently moved £38 million of sales to local Welsh suppliers[56]. The rest of the discourse about public procurement lacks numbers about magnitudes and leverage. Thus, the Future Generations Commissioner Section 20 Report into Welsh public procurement recommends major institutional innovation in the form of a national Procurement Centre of Excellence and does so on the basis of 'case study'

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[54] See *What Wales Could Be* (2014) pp 45-51on the Welsh political chorus in 2012-13 for localising purchases with no questioning of economic results.
https://foundationaleconomycom.files.wordpress.com/2017/01/what-wales-could-be.pdf
[55] https://www.candotoolkits.com/resources
[56] Personal communication

vignettes that include no analysis of supply systems with numbers on purchased throughput volumes or supplier business models.

Given the largely rhetorical use of numbers to talk up opportunity and achievement, it is perhaps not surprising that the policy literature completely fails to distinguish between socio-cultural and volume effects of purchasing. Of course, the socio-cultural matters because not everything important has or requires a big economic number attached to it; and the socio-cultural and the volume economic benefits are intertwined in many cases. But, given the Welsh problems about underperformance against many economic and social objectives, we need to ask the question of whether and how purchasing policies have direct volume economic effects or strategically build Welsh resource and capability.

If we consider the relevant numbers on NHS purchasing it quickly becomes clear there is a volume leverage issue. The small size of the overall spend with external supplier firms limits the possibilities for value creation, and this is further damped by the way in which many external supplier firms retain little of the value of the final sale they make to the NHS, because they are intermediaries, not producers. These problems about limited value creation and retention by external suppliers are not peculiar to NHS Wales but are typical of public procurement outside the labour-intensive area of adult care. The great exception is care where the 22 local authorities are effectively large, monopsonistic purchasers. But paradoxically, where it has power, the public sector has generally not used that power to shape the local supplier base and to create value in care.

The publicly available numbers on NHS Wales purchases are limited and ambiguous. Working from the consolidated NHS accounts and subtracting labour and capital costs from revenues, produces an estimate of just over £2.2 billion (see exhibit 1.1). But this headline figure conceals as much as it reveals because purchases, on this measure from the consolidated accounts, includes not only NHS external purchasing from private firms but also all NHS purchases from other public organisations including NHS Wales Shared Services. Our primary concern is not public sector churn but the scale of external purchasing from commercial enterprises.

To get better insights into the composition of purchasing expenditure, we turned to the NHS Wales e-procurement dataset[57] and requested data on the top five supplier organisations by contract value within each of the 23 procurement e-class codes. This data is based on classification of invoices and therefore provides insights into the scale and pattern of external expenditure on different kinds of goods and services. The immediate finding is that only a small fraction of health boards and trusts' external purchases are from private firms. As exhibit 3.1 shows, the value of purchases from the top 5 suppliers across 23 category codes totalled £961 million in 2019/20 but only around a third, £311 million, of that was external purchases from private firms. Our sample covers £961 million from the just over £2.2 billion total of NHS Wales purchases in the consolidated accounts total, so (on a pro rata basis) all NHS Wales external revenue purchases from private companies probably account for under

[57] NHS Wales Spend by eClass for year period 2019/2020

£700 million. To that sum we could add most of the £350-450 million of annual capital spend. Our estimate is then that total NHS Wales external purchases from private firms account for approximately £1 billion.

Exhibit 3.1: Purchases by NHS Health Boards and Trusts from the top 5 suppliers in each category[58]

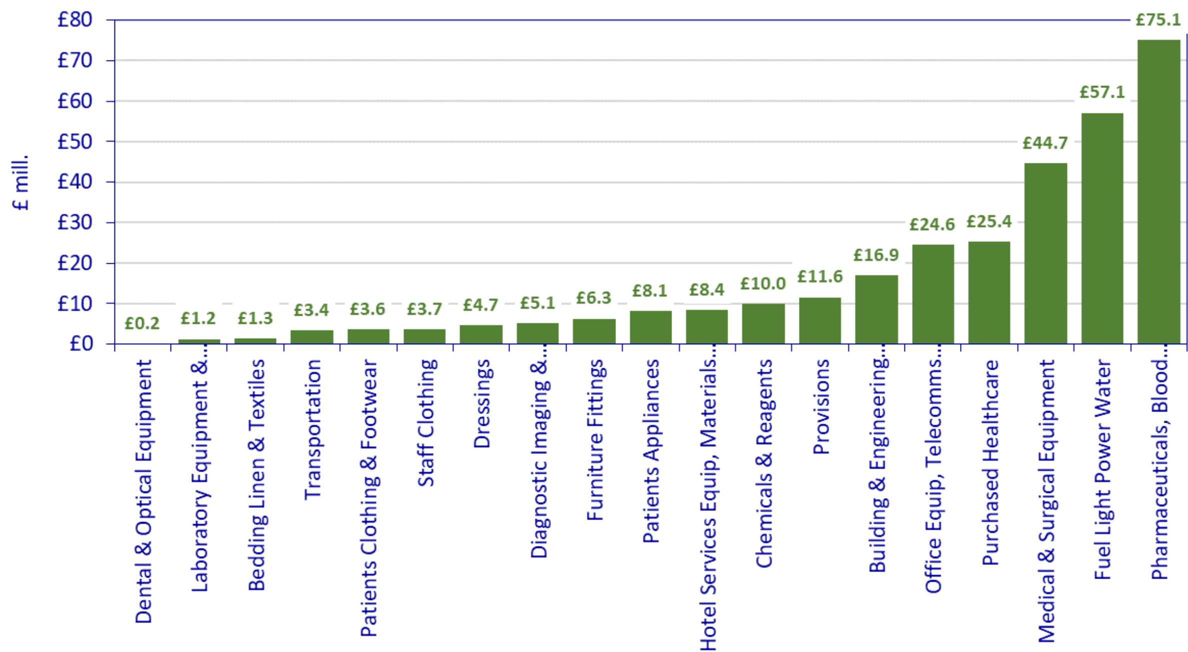
	£mill
Total value of purchases from top 5 suppliers	961.0
Of which: Non-private company organisations Private companies	 649.8 311.2
Non-private organisations: NHS supply-chain, County Councils, Universities, Health Trusts outside of Wales. Welsh Health Specialised Services.	

Around £1 billion of purchases sounds like a substantial sum but the impact on value creation and retention is limited in two ways. First, the NHS Wales spend with external private suppliers is divided between many categories and many firms; and, second, in most of the larger categories only a small portion of the value of the revenue from these contracts is retained by the supplier that issues the invoice because suppliers are typically distributors or retailers, not manufacturers making a relatively larger distribution to employment costs. Exhibit 3.2 shows the distribution of NHS Wales purchases from private firms by category and the value of the spend with the top five companies in each category.

In five most important categories by value, the top five private firms share procurement spend of between £25 and £75 million. However, in four of these five categories (pharmaceuticals, utilities, medical equipment and office equipment) the final supplier is in effect a distributor or retailer of a product or service, where the value is mostly added elsewhere. Local supply mostly means a local warehouse or distribution centre with relatively few employees. The (better paid) employment associated with production is generally further down the supply chain (and mostly outside Wales).

[58] Note: Data run from NHS e-procurement dataset which extracted data for top 5 organisations within each procurement category. NWSSP Procurement Services 20 Jan 2022.

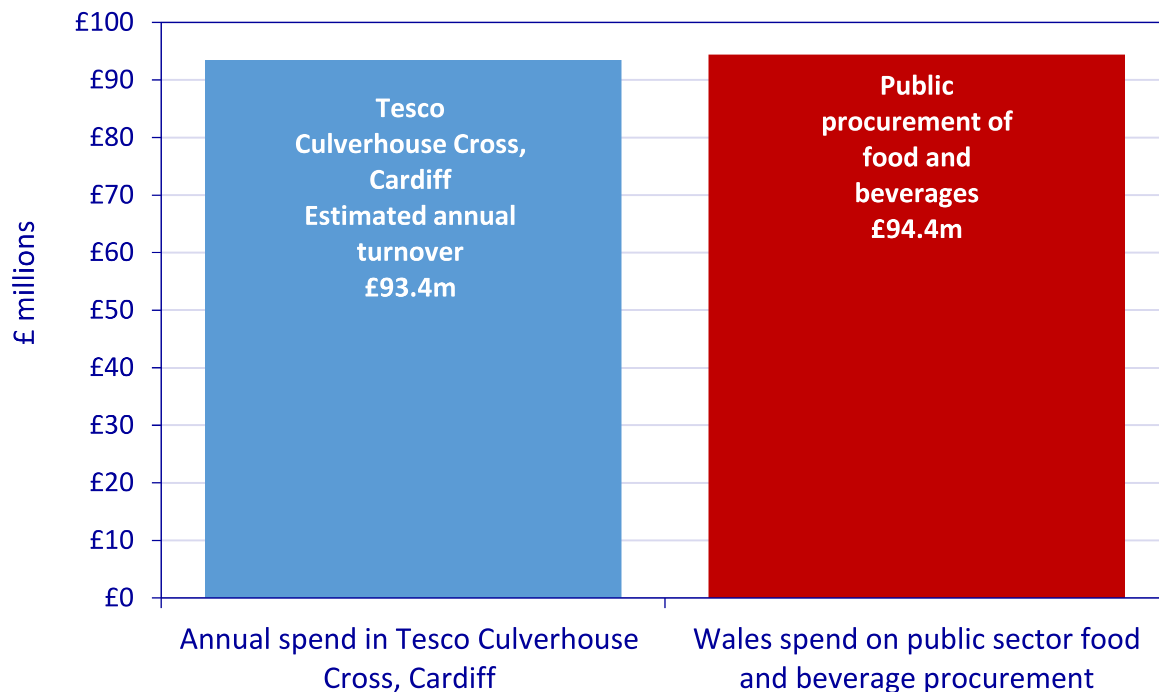
Exhibit 3.2: NHS Wales purchases from the top 5 suppliers in each category in 2019/20 £mill[59]



It is only when we reach categories 6 and 7 by value (Buildings and Engineering Products & Services and Provisions) that we reach categories where much value could be added locally. On an invoice basis, the top five firms in these categories claim a collective spend of £17 million and £12 million respectively from NHS Wales. The amounts available to individual firms (on average £3.4 and £2.4 million per firm in these two categories) are therefore typically too small to provide a substantial chunk of turnover whose value could sustain a local SME firm, though NHS Wales is no doubt a significant customer for some of these firms. And, even if we aggregate the NHS with the rest of Welsh public sector's demand for food and catering, the total value is relatively small. Using the Atamis database (in the year before Covid-19), the total public sector demand for food and drink of just over £90 million is no more than the turnover of the one Tesco superstore (Exhibit 3.3).

[59] Note: Data run from NHS e-procurement dataset which extracted data for top 5 organisations within each procurement category. NWSSP Procurement Services provided the data on 20 Jan 2022.

Exhibit 3.3: Comparison of estimated turnover of one Tesco store in Cardiff against Wales total public sector procurement spend on food and beverages, 2018-19[60]



Limited local value creation and retention is what we would expect when Wales is a small country with just over 3 million population, and an area of just over 8,000 square miles which includes much inhospitable upland. Almost half - 48% - of the Welsh population live within 25 miles of the border and 4.9 million of the English live within a similar distance on the other side of the border[61]. This kind of small country will have a high propensity to import and export and both flows are equally necessary. The purchasing literature preoccupation with localisation is in this case fundamentally unbalanced because Welsh economy and society needs value capture through exports from Wales to compensate for value leakage through imports from England and elsewhere.

The localisation agenda emphasis on stopping demand leakage from Wales might be justified if at macro level Wales had a balance of trade problem with England and the rest of the world and reducing import values was desirable. Welsh intra-national trade with the rest of the UK is much larger than Welsh international trade. The evidence on Welsh intra-national trade balance is contradictory. Working from published data and studies, the Office for the Internal Market guesstimates a modest Welsh deficit of £ 1 billion on intra national trade[62] . But, using input output tables, the most recent and robust academic study from the University of

[60] Sources: Tesco annual report 2020, https://www.tescoplc.com/media/755761/tes006_ar2020_web_updated_200505.pdf and Wales Online, https://www.walesonline.co.uk/news/wales-news/triple-sized-store-set-create-300-2182492
Note: Fuel turnover is excluded.
[61] Ifan and Poole https://www.wcpp.org.uk/wp-content/uploads/2018/07/The-Welsh-Tax-Base-_WCPP-Final-180627.pdf
[62] https://www.gov.uk/government/publications/overview-of-the-uk-internal-market-report/overview-of-the-uk-internal-market

Strathclyde estimates that in 2015 Welsh intra-national exports in all goods and services account for a massive 67% of Welsh GDP and are substantially larger than Welsh intra-national imports, so that Wales has a trade surplus of £5.3 billion or 7.9% of GDP on intra-national trade with the other three nations of the UK (exhibit 3.4).

Exhibit 3.4: Hypothetical Welsh Inter-regional Trading Position, 2015[63]

	Exports £m	**Imports £m**	**Net balance £m**
Agriculture	1,119	666	453
Other primary	123	376	-253
Manufactures	25,731	17,256	8,475
Utilities	1,389	1,093	296
Construction	1,628	1,925	-297
Retail	3,107	1,581	1,526
Communications	2,159	2,929	-770
Business & computing	2,490	6,249	-3,759
Financial	4,962	4,087	875
Public	1,829	3,065	-1,236
Recreational	1,080	1,062	18
Total trade	**45,617**	**40,289**	**5,328**
Wales GDP (2015)	67,863	67,863	
Trade as % of GDP and Trade	40.2%	37.3%	7.9%

So far, we have argued that NHS Wales external purchasing from private firms at micro level offers limited leverage over volume, while there is no significant macro problem about demand leakage from the Welsh economy. Our reservations about localisation are increased if we consider how localisation of final sales impacts on the stock of Welsh private firms: as outlined below, public procurement cannot solve problems about large firm retreat and a missing middle, and may even make things worse by increasing the number of low capability micro firms.

The distribution of firms by size in 2019 is summarised in exhibit 3.5. Wales has a substantial and high performing large firm sector which accounts for 38% of employment and 62% of

[63] Source: UK Interregional Trade Estimation: Estimates of trade between Northern Ireland, Scotland, Wales and England Alastair Greig, Mairi Spowage and Graeme Roy ESCoE Discussion Paper 2020-09 https://escoe-website.s3.amazonaws.com/wp-content/uploads/2020/07/16103450/ESCoE-DP-2020-09.pdf, p.31.

turnover. It also has a weaker 'missing middle' of small and medium sized firms which together account for 28% of employment and 25% of turnover. In contrast, there is a large micro firm sector with weak performance, indicated by the disparity between its 35% share of employment and 13% share of turnover. The average Welsh micro firm employs 1.6 people and is not so much a firm as a skilled worker plus helpers.

Exhibit 3.5: Welsh private business structure: number of enterprises and share of employment and turnover by size band in 2019[64]

	Enterprises No.	Employment Share %	Turnover Share %
Micro (0 - 9)	253,640	34.9%	13.0
Small (10 - 49)	9,485	15.2%	11.1
Medium (50 - 249)	2,215	12.4%	13.7
Large (250 +)	1,705	37.6%	62.1
Totals	267,045	100.0%	100.0%

The small and medium sector has held but not increased its share of employment over the past twenty years. The main changes in the distribution of employment from 2003-19 were a decline in the share of large firm employment which fell from 42% to 36% from 2003-19, while there was a roughly corresponding rise in the share of micro firms from 31% to 35%. As in the rest of the UK but rather more sharply, Welsh employment is being decanted into the micro sector which generally has lower wages. If NHS Wales or public procurement more generally assists that process by increasing the number of micro firms rather than helping small firms to grow, it is less a solution and may represent part of an embedded problem.

If we turn from revenue to capital spending, there has been a public sector effort to extract social value through the attachment of social conditions to construction contracts. The results in construction have been very mixed because they have favoured a few medium sized local SMEs and larger firms from outside Wales. These firms have two core competencies: the ability to manage delivery through organising subcontract and the ability to write bids including social value benefits. In effect, the system is being gamed by such firms which can offer to deliver whatever is required, such as employment of NEETS, while also organising

[64] Source: 'Business structure in Wales by size-band and measure', StatsWales. https://statswales.gov.wales/Catalogue/Business-Economy-and-Labour-Market/Businesses/Business-Structure/Headline-Data/latestbusinessstructureinwales-by-sizeband-measure
Note: The classification of firms by numbers employed is straightforward for micro, small and medium firms which most probably have a single establishment or a few establishments within the region. But it is more complicated in the case of multi-site large firms. In this series, 'large' means firms employing more than 250 workers on all sites inside and outside Wales. These firms may employ less than 250 in their Welsh branch establishments.

specialised sub-contractors in a narrow margin system which does not easily sustain craft training.[65]

More broadly, NHS major capital spend on hospitals is large but lumpy so that it cannot easily sustain a steady flow of Welsh work for one or two major firms. At Cwmbran, the new 471-bed Grange Hospital cost £350 million.[66] Hywel Dda Health Board now proposes a new hospital between Narberth and St Clears and refurbishment of existing hospitals, at a total cost of £1.3 - 1.7 billion.[67] This cannot happen quickly because expenditure on this scale is beyond health budget capital resources, and it is not clear whether and how NHS Wales can tap private finance to fill the funding gap.

Plans for the rebuilding of the primary care estate are more immediately relevant as they are less costly, less specialised and strategically necessary as part of a shift to community based and person-centred health care. Here the aim should be to co-locate new health and wellbeing centres and NHS staff accommodation along with other public services in town centres as part of broader strategies of urban regeneration. This would be coherent with Welsh Government's Town Centres First principle, which should apply to all public sector bodies.

This is happening in one or two places like Newtown where suitable sites and premises for co-location become available. The planned North Powys health and care facilities at Newtown indicate the potential for co-operation in the funding of facilities and co-location of services. But there must be some doubts about whether NHS Wales has the strategic focus, directive capacity and financial resource to deliver this result more widely across the nation.

From interviews we understand that NHS Wales has long operated an unplanned push system for approving capital project applications brought forward on the initiative of individual health boards. This is now being replaced by a system of 10-year plans for capital spend. While planning of capital expenditure in relation to needs over the longer term will offer benefits, there are uncertainties about whether health board plans for primary care new build will be in line with the Town Centres First policy.

Central direction is incoherent. The 2021 Archus Report on the primary care estate provides some overall direction with a nod towards the location of new facilities 'in the high street and repurposed department stores', while at the same accepting that the public wants convenient car parking, which is most easily offered on the edge of town.[68] It is not clear how the conflict between town centre needs and car using public wants will be resolved.

Co-location of services in any case requires NHS Wales to cooperate with other actors and agencies engaged in providing services. But here there are practical difficulties about blending

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[65] Report by John Buchanan et al for Colegau Cymru (2020) *Enabling Renewal. Further Education and Building Better Citizenship, Occupations and Business Communities in Wales.* Enabling Renewal - FE.pdf (colegau.cymru)
[66] https://www.bbc.co.uk/news/uk-wales-53936814
[67] HDUHB (2021) Programme Business Case, https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/healthier-mid-and-west-wales-folder/documents/hywel-dda-programme-business-case/
[68] Archus (2021 final report) Future Approach to Planning Primary Care Premises in Wales

different sources of capital and revenue funding when different organisations like local authorities, housing associations and health boards all operate under different budgetary rules. For these reasons, for example, it has been difficult to line up capital and revenue funding to build and operate a new residential home at the Penrhos Polish Care Home on Lleyn.[69]

Budgetary rule differences become major obstacles because many health boards do not have close working relations with other bodies. In interviews with these bodies, we heard RSL complaints that some health boards had 'nobody who could take a decision' on relatively small amounts of capital spend, and in one case a Welsh Government regeneration team told us they did not know who to talk to in a health board about planned capital projects. Only exceptionally do health boards follow standard commercial practice by designating a senior figure as project manager with responsibility to progress the project and executive authority within budgetary limits.

B. Reframing the issue

The starting point for reframing the potential of NHS Wales expenditure is not to assume that switching final suppliers (according to invoice postcode or corporate HQ) delivers significant economic or social value, nor that the role of NHS Wales is or should be to organise a kind of social value beauty contest by adding supplementary criteria so that the contract goes to the most socially worthy of the bidders.

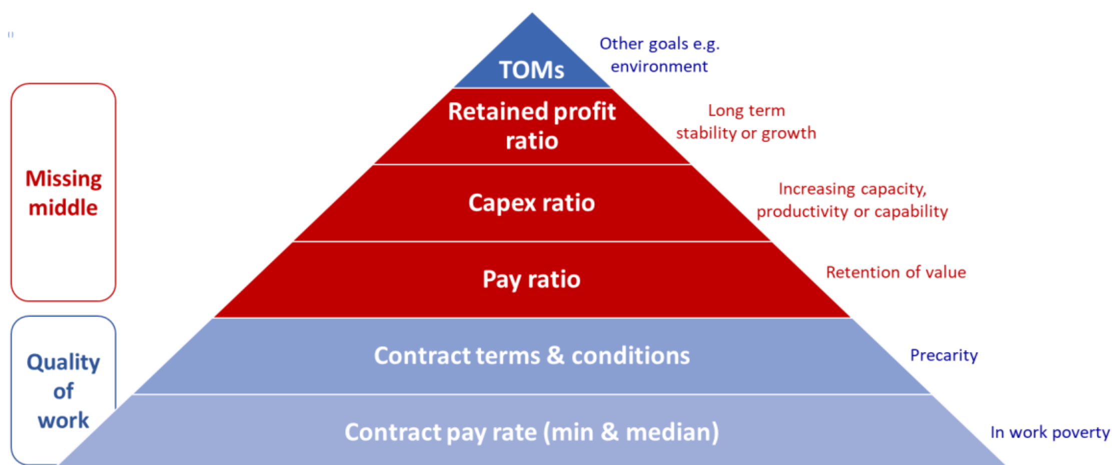
The first most general obligation in procurement for the NHS and other public services is to behave in an economically responsible way towards all those who bid for public contracts by helping to create and maintain a sustainable supplier base inside and outside Wales. A sustainable supplier base consists of firms which are: (a) making adequate returns so that they can reinvest, and are doing so, while (b) offering regular employment with good wages and conditions.

When this basis of economic value has been secured, it is possible to push towards social value goals and set social value priorities in the knowledge that the supplier base can deliver on those social goals. From this point of view any kind of social value is a second order objective to be specified and pursued after securing economic value in the form of a sustainable population of firms in the supplier base (exhibit 3.6). The pursuit of non-economic 'social value' objectives (like the goals of the Well-Being of Future Generations Act) will provide only superficial and fleeting gains if the foundations of economic value retention and distribution have not been established.

Supplier sustainability is about combining the basic requirements of financial stability with the capacity to offer decent pay and conditions, and it can be broken down into the elements below which are then brought together into a framework which is represented in the pyramid diagram in exhibit 3.6. The rationale for, and assumptions behind the different elements is explained in the text below.

[69] https://www.clwydalyn.co.uk/developments/penrhos-polish-village-penrhos-gwynedd.html

Exhibit 3.6: Social value on a base of economic value from a sustainable supplier base



- *Contract pay rate:* individuals (and their households) generate immediate benefit from a contract pay rate that is above the national minimum wage, this impact extends to the differentials between the pay grades that affect the median pay rate. This supports a policy focus on reducing in-work poverty.
- *Contract terms and conditions:* individuals gain economic and social value from terms and conditions that are above the statutory minimum. Sick pay and holiday entitlement supports improved wellbeing and productivity, whilst a meaningful employer contribution to a pension scheme impacts wellbeing in retirement. The additional provision of clarity regarding contract length, hours and shift patterns addresses the precarity individuals and households can face in low paid jobs. This supports a policy focus on the improving the quality of work.
- *Pay ratio:* a higher ratio of pay to revenue, indicates a business that invests more in staff compensation and/or levels of employment. Regardless of what this suggests about management inefficiency or social responsibility, a high ratio indicates the potential for more of the contract value to be retained within local communities through pay and conditions.
- *Capital expenditure ratio:* a good ratio of capex to revenue, relative to activity competitors, indicates a company that is investing in improving its capacity, productivity or capability. Companies cannot be sustainable without capital expenditure.
- *Retained profit ratio:* a high ratio of retained profit to revenue, relative to activity competitors, indicates a company that has used a profitable trading history to build a stronger balance sheet. This provides stability, ability to borrow and a potential for investment in long term growth.

The basic accounting information on the relevant points can and should be easily provided by supplier firms of all sizes that tender for public contracts. Pay rates and terms and conditions are already required responses in many tenders and the ratio information is easily accessible from the statutory annual accounts of a business. Or, in the case of micro firms, the

information should still be readily accessible in reports from their accountants or accounting software.[70]

The aim then would not be to use this information as a way of preferring the most sustainable supplier. But to use this information as a screening criterion to identify a subset of bidders who meet the sustainability criteria, after which price and social value can be the decision principle. If all or most of the bidders do not meet sustainability criteria, then the onus is on NHS Wales to reflect on the terms and conditions of its contracts and the need to change its own practices and on Welsh Government to reflect on how it can otherwise support building a stock of capable firms.

If most bidders do meet sustainability criteria, then it is possible (even desirable) to ask suppliers to meet social value criteria (including criteria which add cost for the supplier). On top of the lower-level achievement of a robust and sustainable supplier base, social value objectives and calculations are a super structure. And here is the place and a proper role for a social value framework like TOMS, which allows calculation of financial benefits from non-financial activities that aim to deliver social value. These range from environmental improvements to volunteering with the community.

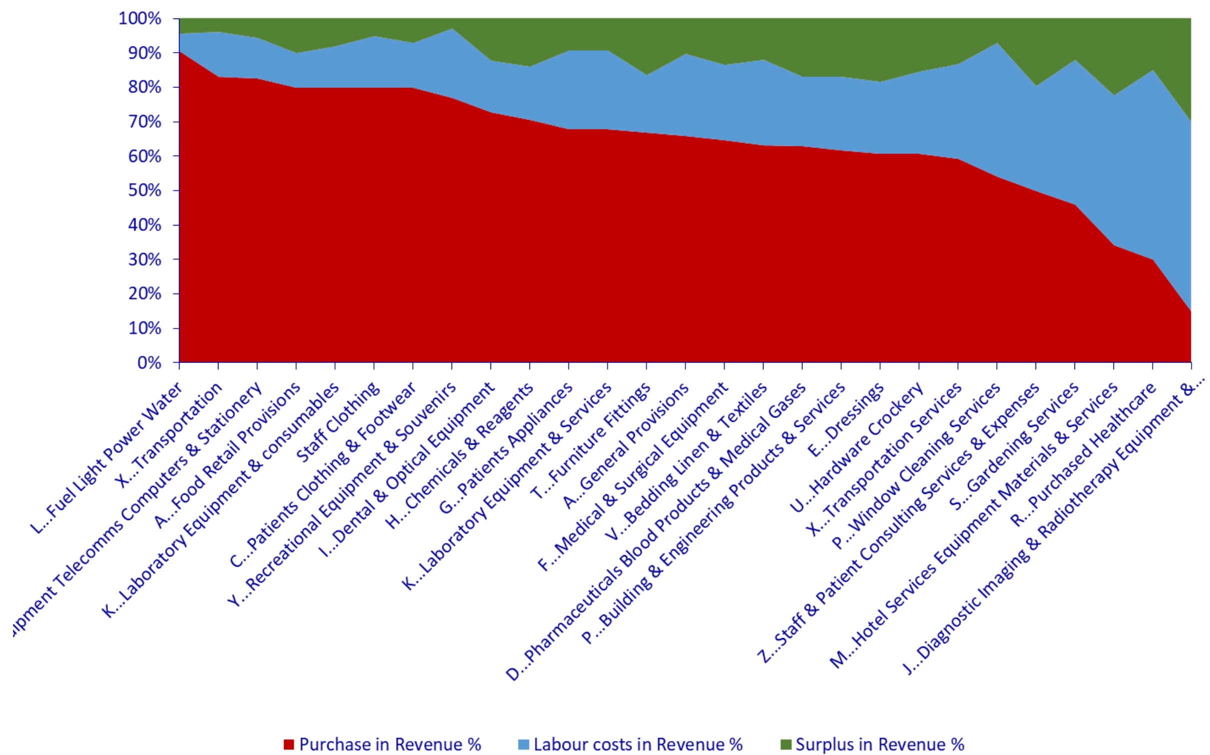
Beyond this there is scope for imaginative, focused interventions to change the behaviour of supplier firms so that more economic value is generated in Wales and captured from outside Wales. Selective intervention should be guided by value retention and capture calculations. As we have seen, the composition of costs and therefore value retention varies by activity.

In exhibit 3.7, the NHS purchase categories[71] have been mapped very roughly onto the composition of costs derived from the Cardiff University input output tables for 88 Welsh industry sector activities. The categories have been ranked from highest purchasing costs in relation to revenues (i.e., fuel, light, power & water at around 90%) to lowest (i.e., diagnostic imaging and radiotherapy equipment & services, where purchases are around 20% and labour costs are around 50% because of the reliance on highly skilled staff). The fit is only approximate because the purchase categories are narrow and the input output categories at SIC 2-digit level are rather broad. However, this mapping does reveal the extent to which NHS procurement categories are located within activities with a low or high value retention.

[70] It may also be desirable over time to introduce some criteria for financial reporting to improve transparency. For example, this could include: all companies supplying NHS Wales (over a certain threshold) must file full (not abbreviated) set of accounts within 6 months of year end; the use of management charges in the accounts and high interest loans should be explained; residence for tax should be revealed so that the NHS can decide whether they wish to deal with suppliers who have off-shore or tax haven registration for tax; an HR table could be introduced stating the use and level of apprenticeships.

[71] http://www.nhseclass.nhs.uk/browser/browse.mth

Exhibit 3.7: Welsh industry operating ratios mapped on to NHS procurement spend categories[72]



If the objective is to retain and capture value, the biggest leverage comes from services that generally fall into high labour share categories at the bottom of figure 3.7. Many depend on locally supplied labour and that is where value capture and retention opportunities are concentrated. Activity related and territorially relevant interventions should then ideally meet four desiderata.

1. Volume sales with NHS Wales i.e., a large sales base for value retention, which can be influenced by NHS Wales' leverage as important customer.
2. High value retention to sales ratio i.e., low leakage from purchases means value retention and total employee compensation from every £ of sales is higher.
3. Short backward system linkages through a supply chain which is, or could be, in Wales.
4. Potential for value capture through building the capability of Welsh based firms at first or second tier to sell into England and beyond.

In principle, it should be a priority to look for a small group of firms in a few activities/ purchase categories which met all four desiderata because then we could concentrate effort to increase value retention and capture on that group. But the empirics show that in practice this is difficult. Therefore, for volume economic effects we need to focus on diverse

[72] Source: Cardiff University input-output data tables
https://www.cardiff.ac.uk/__data/assets/pdf_file/0010/698869/input-output-tables-2007-final-30-6.pdf

interventions in different firms and across various categories, while bearing in mind the importance of high value retention services and value capture through exports to England.

Amongst NHS Wales' largest suppliers are firms like Castell Howell Foods in food service distribution and Siemens medical equipment in supply, consumables and service for diagnostic imaging. Why not use 'something for something' contracts for firms of these kinds which, for example, incentivise Castell Howell to stock more Welsh food lines (to also sell to its private customers) and incentivise Siemens to manage more service and maintenance operations from Wales.

And there is scope for aiming to build new, professionally managed, not-for-profit competitive firms in labour-based services. There are already some firms with the capability to challenge the outsourcing conglomerates like Serco or Sodexho in catering, cleaning and waste disposal. For example, Norfolk Norse already has a foothold in providing Newport's local authority services and there may be opportunities for Welsh firms to develop through providing support services in England as well as locally.

There are also more entrepreneurial opportunities to open new markets and support innovative processes like providing and laundering reusable scrubs for a wider UK marker. Post Covid, NHS Wales has chosen to retain some social enterprises producing higher cost disposable PPE items for Welsh use. But that is a social policy special case decision to subvent Welsh client firms which have no export potential to England; and this should be separated from the economic policy of finding firms with service offerings that can expand outside Wales as a route to wider volume sales.

This is the nub of the issue and the choice about public purchasing policy. Should we be confused by special cases and, following the traditional anchor approach, promote the objective of localisation? This will undoubtedly result in the support of client firms which are not competitive enough to expand and some of which will quickly fail without public orders. Or, should we adopt the evidence-based driver approach to value retention and capture? This suggests focused effort in specific categories where the aim is to build firm capability, ambition and competitiveness to tackle markets in and beyond Wales.

As for capital projects, leaving aside the question of sources of funding, these projects need to be set in a territorial frame so that NHS Wales can be clear about where and how projects like the rebuilding of primary care and the relocation of NHS accommodation fit into local urban renewal and travel strategies. This requires closer relations, more sharing of plans and coordination with other local organisations where the first step is to designate a project manager, as Betsi Cadwaladr Health Board has done on a staff accommodation project in Bangor. This can help to ensure that local organisations work co-operatively and openly with each other towards local objectives, as well as developing opportunities to share sites and co-fund capital projects, including back-office facilities and public facing service operations.

4. In conclusion: rethinking NHS Wales as a driver institution

It is time to move beyond the concept of 'anchor institution' which comes out of the US Community Wealth Building response to big city deindustrialisation in the 2000s. This concept is based on the idea that public service anchors have common characteristics and should distribute their largesse in the form of contracts for goods and services to local firms, with a bias towards cooperatives[73]. Success will be measured by counting local invoices which indicate the large scale switching of final sales but do not have a significant impact on employment nor firm capability. This approach overlooks the need for internal reform of anchor institutions and for the promotion of different ways of thinking and doing which find meaningful volume levers.

What Wales needs is not anchors but driver institutions. The size and composition of costs in NHS Wales put it in a class of its own as a driver institution which delivers economic value. It primarily delivers that value through wage support for households (not purchases from supplier firms) and NHS Wales can do much more if it adopts 'grow your own' workforce development which requires a comprehensive reform of training and career pathways. But that requires a capacity for focused, system-wide reform of employment practice which has previously been beyond NHS Wales as it defaults onto importing 'readymades'. The first message of this report for NHS Wales is that it needs to rethink its approach to local recruitment and workforce development.

More broadly, NHS Wales can take the lead in shifting public procurement away from localisation and social value defined on a contract-by-contract basis as price and quality, qualified by social add-ons. Instead, NHS Wales can lead through the necessary preliminary aim of securing economic value by ensuring the sustainability of firms in the NHS Wales supplier base. Under the aegis of Welsh Government, NHS Wales should accept that responsible public procurement from a sustainable supplier base is only possible if it has more hard accounting information about all its suppliers. When this information has been obtained, NHS Wales may need to reconsider terms and conditions across a range of contracts where it is not a model purchaser.

On the basis of a sustainable supplier base, it is then possible and desirable to specify social value priorities like environmental goals which can only be securely delivered. From that base, we can also start to think about economic value generation and capture which requires more innovative and capable Welsh based firms. Here, as we have argued, there is scope for NHS Wales procurement to adopt a 'do more from less' approach which focuses on the imaginative and focused use of a few procurement contracts to increase the economic value generated in

[73] Private service provision takes many different forms so that a mom-and-pop owned care home is very different from a private equity owned chain. In this case it would be more sensible to encourage all those providers who share social values rather than to start by privileging some forms of organisations like co-operatives which are assumed to embody those values. This point is well made in Wales Coop Centre (2020) *Supporting Care Commissioners and Providers to Promote Social Value Models of Delivery* Supporting Care Commissioners and Procurers to Promote Social Value Models | Wales Co-operative Centre

and captured from Wales. Whether it is Castell Howell in food service or a contract for reusable scrubs, the approach needs to be more entrepreneurial and less mechanical.

The shift to an entrepreneurial policy approach will take policy out of the comfort zone of localism and invoice counting. This is a task that will require political sponsorship and leadership in Welsh Government because dealing with Siemens or Castell Howell is something where the NHS procurement officer's role should be to support a Minister who takes the lead. Much the same can be said about the reform of training pathways and qualification requirements which would be facilitated by national political sponsorship to overcome the many obstacles created by inertia and corporatised vested interests.

On capital projects, local relations are critical because many projects require blended funding; while individual renewal projects in town centres arising from the actions of various organisations need to be coordinated on a cluster or corridor basis. The second message of this report for NHS Wales is to connect with other actors because such relations are the prerequisite of effectiveness. One of the most urgent needs is for the health boards to build good working relations around shared understanding of capital projects, especially with local authorities and housing associations.

Devolved Welsh Government does have limited power and resources. But it has, along with its satellite institutions like NHS Wales, often avoided hard analysis, stayed within its comfort zone and not used powers in devolved areas for radical, constructive purposes which could deliver substantial economic and social value benefits.

The long-term national aim should be to collaborate more effectively on the development of the health and care workforce with upwards/ sideways mobility available to all who want it and have the qualities of responsibility and empathy. Some parts of the preparation for this are being putting in place by local reformers. For example, the reform of domiciliary care in Gwynedd, where the end of time and task gives more responsibility to the worker; or the move towards the accreditation of caring experience as a qualification which is envisaged by Dr Paul Edwards in Aneurin Bevan.

The integration of health and care is often proposed as a way of stopping the low capacity/ high flow NHS falling over. However, health and care face a common problem of workforce shortages and it is essential to consider both sectors together so that improving recruitment and development in one sector is not at the expense of the other. Beyond this, health and care can both gain through collaboration and co-ordination which addresses and extends recruitment into these sectors and supports new pathways and progression. Taken together, the health and care workforces open onto a huge economic and social value opportunity to put aspiration and a decent income into Welsh households who otherwise have no realistic expectation of a secure living and whose progression would otherwise often be frustrated.

The scale of the opportunity is huge. By the early 2020s, NHS Wales directly employs nearly 90,000 and care provides a similar number of jobs;[74] some 180,000 workers from 1.4 million Welsh households. Allowing for more than one health and care income going into some households, we are talking about the material rewards and symbolic aspirations of at least one in every ten Welsh households. Recognising this as an opportunity is part of the fundamental business of recognising the nature and potential of modern Wales.

We understand our past through a series of cliches and, if we go back to the 1960s, then coal and steel together employed significantly less than health and care now. It is a good time to rethink Wales as the health and care nation which is world leading not only in its service quality but in the drive for economic and social value. And that can lead us towards a future that we shape.

[74] Directly employed NHS Wales employee data from NHS Wales Workforce Trends (as at 31 March 2021) - Final (1).docx (live.com); care data from https://heiw.nhs.wales/files/workforce-strategy/ p.16.