Parliamentary Review of Health and Social Care Wales

Summary analysis of written evidence

May/June 2017

Dr Julia Simon—Thesis 11 Ltd

Introduction

The Review has been commissioned by the Welsh Government to develop recommendations for the future delivery of health and social care services. To that end, it put out a call for evidence in March 2017. The call received a total of 81 responses: 79 from public, private and third sector bodies and organisations, and two from private individuals. In total, there were about 2,310 pages of evidence and supplementary materials submitted; for a full list of contributors, please see annex A.

Submitted views ranged from highly specific recommendations for ailments, patient pathways or age groups, to broader comments on sectors of care (e.g., primary, community or acute care), to generally applicable insights and recommendations concerning the overall shape and future direction of health and care services in Wales. Some submissions set out to answer some or all of the questions specifically posed by the Review's call for evidence, others focused their remarks on their individual areas of concern and expertise. In the interest of time and usability, this summary analysis has focused on the bigger, strategic picture and has drawn out the key themes that have emerged across all the submitted evidence.

Although originating in many and varied sources, the submissions exhibited an unanticipated level of consensus and cohesion, both regarding the nature of the case for change, and regarding the right direction of travel; there was nearly universal agreement that health and care need to move forward in a much more integrated way, with care increasingly delivered outside the hospital, and with strong emphasis on primary care and services focussed on prevention and wellbeing. The one partially dissenting voice came from the BMA, which, although in favour of greater investment and access to primary and social care, argued that Wales needs more hospital beds and greater theatre capacity to reduce the pressures on secondary care.

A strong majority of all submissions emphasised the importance of a new national conversation with the public to raise awareness of what everyone can all do maintain and protect their own health and wellbeing. Likewise, most respondents highlighted the need for the right kind of workforce planning and development, and for the need to significantly scale up IT and the digital offer in health and care.

The topic of quality was almost absent in the submissions, as was any mention of leadership. Clinical leadership and its importance was mentioned once or twice.

Areas of disagreement between the submissions primarily concerned clinical priorities, with different advocacy groups putting forward arguments in favour of the priority and primacy of their own clinical condition or disease area. There was also split views regarding what would constitute the best organisational architecture for Wales, with some arguing that Wales now needs an overhaul of organisational, reporting and governance structures, and others stating that on the contrary, by building on the current Health Boards, Wales would be ideally positioned to take a holistic and integrated approach to health and care. Some expressed the view that Wales needs to re-introduce a commissioning role in the NHS to strengthen accountability and patient advocacy, whilst others thought not.

The case for change

General

- Like the rest of the UK, the Welsh health and social care system is facing a series of challenges: an ageing population with increasing and multiple long-term conditions; globalisation; lifestyle diseases; economic austerity and tighter public budgets; global security threats; poverty and persistent health inequalities; and growing demand for health and care, with the expectation that it will be high quality, efficient, and digitally enabled.
- Wales has the highest rates of long-term limiting illness in the UK, and this is expected to rise further in e.g. cancer, dementia and diabetes.
- Wales also has high levels of obesity, drinking, and smoking and poor levels of physical activity, all of which suggests that Wales needs an "industrial scale. change" in its services towards upstream interventions and a shift in funding to support people to make and maintain healthier lifestyle choices.
- Public Health England estimates that 40% of NHS expenditure is for the treatment of illnesses caused by preventable factors (poor diet, alcohol, lack of exercise), which lends further urgency to the focus on health promotion, prevention and upstream services.
- There is also a pressing need for a dialogue with the public about health and healthcare, including what is wanted and what can realistically be delivered through public funding.
- Waiting times are a growing problem, with patients waiting 36 weeks or longer for routine appointments in e.g., orthopaedics, urology, dermatology, cardiology and general medicine.
- Alongside this, Wales is experiencing a level of public finance austerity not seen since the financial markets crash ten years ago.
- Simply working 'more efficiently' will not be enough to address or even mitigate the financial situation in health and care—a much larger, system-wide set of changes are required.

- There are both clinical capacity and capability shortages—specific areas flagged as needing improvement include mental health services, services for children and young people and an acute trauma centre for Wales.
- In light of fiscal constraints, Wales should identify a limited number of key health priorities and focus on these to make genuine progress in priority areas (these priority areas should include cancer: achieving an earlier diagnosis in cancer should be a national priority).

Mental health

- The current ringfencing arrangements for mental health spending is not effective in delivering a focus on prevention and early intervention
- Parity of esteem between mental health and physical health should be an urgent priority; and more integrated approached across mental health and physical health services are needed.
- At present, there is a lack of meaningful success indicators and metrics in mental health, meaning it is not known whether mental health services are getting better or not, or how many people are benefitting from their treatment.
- We need a different interface between policing services and health and social care to support people at risk and people with mental health problems.

Workforce

- There is a shortfall in both clinical and non-clinical staff (doctors in e.g. general practice, emergency medicine and clinical radiology, nurses, care workers) which is expected to get worse.
- We are currently not training sufficient numbers to fill current and future gaps
- Brexit is likely to exacerbate the situation, with EU staff returning to their home countries.
- General practice constitutes a specific challenge where the inverse care law is exhibited, as those areas of greatest deprivation also have the highest percentage of GPs retiring in the next ten years.
- In terms of workforce, there is not sufficient capacity or, in some geographical areas and clinical specialties, capability; and there is difficulty recruiting and retaining in many areas, including general practice, nursing and social care.
- The social care market is stretched to breaking point, and the domiciliary and nursing home market is equally frail.
- Too many staff complain of bullying and excessively long workdays—we need a zero tolerance to bullying in the workplace and we should address unnecessarily long hours; even with Brexit, we should keep the 48-hour European Working Time Directive.
- There needs to be an investment in unpaid carers as a major untapped resource for health and care services.
- There is a massive risk that Brexit will cause an exodus of capable and talented staff that Wales can ill afford to lose: it is essential that EU workers in

health and care are protected post-Brexit to prevent a huge destabilisation of the NHS in Wales.

Independent and third sectors

- There remains a prejudice towards the private sector in the provision of health and social care that needs to be eliminated, with providers treated as equals, to optimise integration and patient outcomes.
- A spirit of collaboration, not competition, needs to be created to enable dialogue in developing new types of services across the public, private and third sectors.
- There needs to be consistency across the 22 local authorities and 7 health boards in how they approach commissioning from the independent sector.
- Third sector providers are often struggling to plan their services, innovate, and recruit and retain staff as they have short, one year contracts: this must change if we are to tap into the vast potential of the third sector to support and enable the changes that are necessary.
- To support innovation, improved outcomes and best value in health and social care, the third sector should consistently be included in local strategic relationships, discussions and decision-making.

Information Technology

- IT in health and care are much behind the rest of society—a simple and modern health and care IT system needs to be implemented.
- Many say that older people don't want to use the internet, but on the contrary, older people are more tech enabled than ever and we're not keeping pace with technology as an enabler, or with people's wish and need to use it.
- We should learn from other sectors in terms of technology-driven change, such as the banking sector.

Children and young people

- The role of children's services and youth support services in prevention and early intervention should be recognised, and funding should move away from the short-term to avoid costlier acute interventions further down the line.
- There needs to be a greater investment in building resilience and emotional wellbeing in our young people so they can thrive and become active and economically active citizens.

Rurality

- In rural settings, we need generalist skills in hospitals and enhanced GP skills in community practices.
- We must work across traditional boundaries and make the most of available assets to achieve a patient-centred, whole system approach to high quality care.

- Evidence suggests that medical students from rural areas don't get enough exposure to practicing medicine in rural areas, so they tend not to return on completion of their studies. If they get exposure early on in their training, through placements, this is less likely to be the case.
- The majority of the population in rural West Mid Wales are elderly with multiple chronic conditions, meaning that the nature of the health and social acre now needed is very different from 20 years ago.
- There needs to be an increase in primary, community and social care as close to home as possible.
- West Mid Wales sits across three Health Boards; as a consequence, care pathways are not patient centred and often patients can't go to the nearest, most convenient hospital, but are sent to a more distant hospital which is in the same Health Board area. This needs to change: there should be one overarching organisation in charge of health and care for West Mid Wales.
- Regional networks need to be developed to cross current organisational boundaries; and GP clusters need to be empowered to make decisions about developing services based on local population need.
- General practice needs to develop networked models of care to increase its sustainability, either through the development of the current cluster model, or through the development of GP federations.
- Technology (telemedicine, telecare and telehealth) should be part of the norm, rather than the exception to best serve a dispersed population.

Welsh language

- Currently not enough is being done to ensure that patients can be seen by clinicians and staff who speak their language, yet there is international evidence for the importance of being able to speak your first language in communicating with a clinician. This is especially true for the elderly, people with dementia or stroke, or young children who may only speak Welsh.
- NHS Wales and social services have a responsibility to deliver the actions set out in Welsh Government's strategic framework for Welsh language services in health, social services and social care, *More than just words*.
- A key principle of the framework is "the active offer", i.e., providing a service in Welsh without someone having to ask for it. There is much work to be done to make the active offer a reality across Wales as the evidence available indicate inconsistencies in terms of the availability and standard of Welsh language services in health and social care.
- To rectify this, Welsh language services need to be mainstreamed as an integral part of planning for the future, in both health and social care.
- Much more also needs to be done to actively recruit Welsh speaking staff by making Welsh language skills a requirement for employment. Employers also need to provide Welsh language learning opportunities to upskill current staff.

- It's difficult to see how Welsh language standards can be met with the reliance on overseas recruitment within Welsh health and social care.
- Local Health Boards must map the Welsh language capacity of their workforce and plan accordingly on how to increase Welsh language proficiency.

System architecture

- Wales needs a long-term strategy for health and social care—25 years, rather than the proposed 5-10 years forward view. This needs to be accompanied by a 5-10-year integrated financial strategy across health and social care: both need cross-party political backing.
- Wales needs a national set of standards (e.g., in the provision of child and adolescent mental health services between Health Boards) whilst allowing for local and regional innovation and difference of approach. Standards are not the same as standardisation—the achievement of standards can be universal, whilst leaving room for local innovation. We must beware a 'one size fits all' approach and recognise that delivery options will and should vary, dependent on local context and circumstances.
- The divide between health and social care, with their different means of funding and two separate inspectorates, makes for a disjointed, hard-to-access and navigate health and care system.
- Health and social care organisational landscapes are crowded and inconsistent; for instance, boundaries between Health Boards, Local Authorities and other non-statutory arrangements may differ and sometimes overlap.
- The marketisation of social care has failed: outsourced health and social care services should be brought back under public control to provide the right quality of services and the right treatment of staff.
- The time might be right to consider the transfer of the public health improvement role fully into local government, to give local authorities a more joined up approach to the broader determinants of health: the local environment; housing; leisure; transport; employment; and social interaction
- The current performance regime measures what can easily be counted (time), but not what really matters (outcomes)—it needs an overhaul.
- Further, our current regime focuses on targets and performance measures, not prevention or empowerment.
- Current governance and reporting arrangements within NHS Wales are very complex, with no underpinning logic or structure, requiring various 'work around' solutions. Most likely, legislative change will be required to fix this.
- It is time to move to one inspectorate or regulator for health and social care: having two is costly, inefficient, confusing and constitutes a regulatory obstacle to genuine integration [this is countered by the view that]:

- There should be separate lines of accountability for health (the NHS) and social care (local government), but seamless provision.
- We need to adequately resource health and care regulation—the Health Inspectorate Wales' budget is currently significantly lower than other inspection bodies in Wales.
- The Welsh healthcare system is lacking in accountability: it needs a commissioner or payor to hold providers to account and act on behalf of patients. Commissioning can be a highly effective system lever.

How can change be achieved?

Culture and approach

- There needs to be a long-term focus that avoids short termism regarding change, and this needs to include a clear prioritisation of joined-up investments.
- There needs to be a massive culture change towards working across organisational boundaries—and this subsequently needs to be supported by a change to regulation and incentives structures.
- Equally, we need a whole system approach towards the shifting of care from reaction to prevention: this must be based on changing cultures and behaviours within both health and social care, and by affecting a change in societal attitudes.
- The focus on culture and behaviours must come first: form must follow function, so we must first change the culture and how things are done, and then attend to organisational form.
- We need a major shift in culture and behaviour to focus on localities as the locus of service delivery, and where all local system partners contribute to maintaining and improving services.

Integration

- Integration is a means to an end: it needs to take place across health and social care, primary and secondary care, and physical and mental health, to enable a better patient experience, better outcomes, and more cost-effective intervention further upstream.
- Health and social care should be viewed as one, with a single approach to clinical pathways—financial flows and regulation should then follow suit.
- Integration also needs to extend to an integrated approach with housing, education, community support and the wider social determinants of health.
- We must avoid a preoccupation with organisational integration and focus on what needs to be delivered for patients and citizens at a local community level: form should follow function.
- Services should be designed around the patient, achieving seamless services spanning public, private and third sector providers.

- Organisations should share a collective responsibility for securing a seamless pathway across primary, secondary and tertiary care, in and out of hospital, and across geographical boundaries.
- All parts of the urgent and emergency care system need to work as part of a single system: A&E, minor injury units, GPs, pharmacies, the ambulance service, and the developing NHS111 service.
- We need to push through structural integration of backroom processes and service improvement activities across health and social care.

Clinical models

- A paradigm shift is required, whereby care is shifted out of hospital. Instead a system needs to be created that is founded on primary and community care and which is resourced to keep people fit and well.
- This will require a radical upgrade in prevention and public health. There should be a 'physical activity champion' in each Health Board to lead an integrated team and influence local and national policy-making bodies.
- We need to work with partners in education, transport, the environment, workplace settings, sport, leisure and active recreation, as well as in health and social care.
- The importance of continued physical activity must be fully embedded in primary, community, secondary and social care.
- All services need to be redesigned around patient needs, including hospital that would be better organised in managed clinical networks.
- A strong primary care platform must be created where community services, mental health and social care are wrapped around groups of practices, where those practices are given access to specialists and diagnostics and are working on more systematic approaches to collaborative working.
- We need to develop multi-disciplinary teams that work across health and care, and across the public, private and third sectors.
- One suggestion is the development of an 'intermediate' service in the community by strengthening skills and capabilities through the shifting of some hospital staff into a community service. This service would support the care of complex cases and develop substitutional services as a more appropriate alternative to hospital referral.
- Another suggestion is to create locally based multi-agency teams or hubs that take a place-based approach to care. This would mean health and social care coming together under a single integrated management with genuinely pooled budgets and close working across health, social care, housing, education, leisure, transport providers and the third sector.
- Clinical standards and protocols across the seven Health Boards need to be standardised, e.g., admission directly to a specialist mental health unit is a better solution for patients in mental distress than admission to a busy emergency unit.

- Ambulance services could take on quite a different role from how they are traditionally conceived. Already the ambulance service is moving away from being a 'transport service' to a clinical service at the forefront of the pre-hospital, unscheduled and planned care systems.
- We need to move from a purely medical model of care: e.g., social prescribing can lead to a range of positive health and wellbeing outcomes and may lead to a reduction of the use of NHS services.
- The health and care system needs streamlining so that it's more easily navigable—a simplification in how and where services are delivered, with genuine, easy access. Telephone and online-based services should be developed to provide a more effective gateway into the non-urgent health and care system.

Prevention

- Prevention services range from voluntary support groups to formal public services that tend to address the root causes of current ill health and health inequalities. We can't rely entirely on unfunded voluntary services: we must reverse the trend of the decline of preventative services such as leisure centres, parks, adult education and community facilities.
- Overall, resources must be redirected away from the acute model and into prevention services based in primary and community settings: a wholesale shift from treatment to prevention.
- We need to strengthen primary care and the links with public health to focus on wellness as much as on illness.
- There should be a focus on early years and the wellbeing of children and families, with attention paid to the mitigation of health inequalities from the very start.
- Wales needs a national child health strategy, with urgent attention on childhood obesity, including breastfeeding and improving mental health and wellbeing.
- Prevention and early intervention, especially in childhood, offer substantial value for money in reducing health burdens and thus costs later in life.
- Welsh Government, Local Health Boards and councils are urged to consider the allocative efficiency of their budget processes to support a preventative model of health and social care.

Mental health

- A whole population assessment of mental health need in Wales is needed to adequately plan and deliver the right services.
- We need to work towards creating a sustainable all-Wales mental health service where funding is transparently and directly linked to outcomes that lead to a reduction in the inequalities currently experienced by people with a range of mental health problems.

- A major drive to tackle inequalities of health and social care outcomes faced by people with mental health issues need to be part of this.
- Data collection and transparency within mental health services are severely lacking, in particular regarding outcomes and how services are improving, and if they are. Addressing this data gap must be a priority.
- All services across the spectrum should be underpinned by a bio-psycho-social perspective to achieve prudent healthcare with "no health without mental health" being core to delivery.
- A holistic approach to metal health services is needed where people with mental health are supported to become and stay economically active with greater opportunities for further education, training, volunteering, peer-mentoring and learning and development.

Prudent Health

- Prudent health is about securing the future sustainability of the NHS.
- It includes doing no harm; making best use of resources; working co-productively with the public as part of a 'new deal' where citizens take a more active role in their treatment and responsibility for their own health and wellbeing.
- Prudent health also means being more imaginative about the way family members are encouraged to be part of the treatment and support for patients, especially in hospitals.

Workforce

- Wales needs a long-term, national workforce strategy for primary, community, secondary and social care as well as pharmacy that will deliver both increased capacity and the right capabilities for the future.
- The strategy needs a four-point focus: sustainable funding; improved workforce planning; investment in education; and action to improve recruitment and retention.
- Fundamentally, this strategy needs to translate into a step change in workforce planning which needs to take a whole-system, multi-sector approach.
- Part of thinking about the workforce of the future must include a national approach to the support and development of carers, and recognition of the fundamental role they play.
- It must strongly value the role of carers, and consider putting further national development and support in place for Wales' many carers.
- The workforce strategy needs to address the disparity in culture and prestige between NHS and care staff and put an end to the current two-tier workforce and raise the generally inferior position of social care working conditions.
- It should consider adopting UNISON's "ethical care charter" as the baseline for the treatment of all care workers—e.g. Southwark and Islington local

authorities, having done so, have seen improvements in staff retention and recruitment.

- A sophisticated workforce planning and modelling for complex system is required, with an assessment of the types of professional roles needed, their skills, competencies and geographical placements across Wales.
- In other words, planning needs to anticipate future needs, based on the overarching health and care system we're trying to create. It needs to develop a resilient, well-trained, flexible and adaptable workforce, better able to adopt to a changing future.
- The approach needs to be joined up, transparent and evidence-based, and critically, must come with funding for education and training that's in line with the strategic vision.
- It needs to entail a shift towards rebalancing the emphasis of training and education towards primary and community based care.
- A move away from an expensive GP-based model of primary care is required, to one where a range of clinicians and social care professionals are working together.
- Creative thought needs to be given to the development of new roles.
- Healthcare and social care workers across the board should be registered: this will bring transparent professional standards, clear role definitions and expectations, strong links to qualifications, and a better-defined career structure. This will also raise status and morale and aid recruitment and retention.
- Alongside a new strategy for the future, a large-scale skills mapping of our current workforce needs to be undertaken, alongside support of them to upskill.
- We need to make better use of under-used staff groups, such as occupational therapists who could play an even bigger role for recovery, wellness and admission avoidance. All staff should be encouraged, supported and enabled to work at the top of their licence: this will enable everyone to make the greatest possible contribution, and free others to focus on work that truly only they are licensed to do. Pharmacists can play a stronger role e.g., in the management of LTCs and in the medicine reviews in care homes; and speech and language therapists can help shift care from hospitals to community settings.
- An asset-based approach should be taken to staff across public services in Wales: they often have many of the answers to entrenched problems, but need to be much more meaningfully engaged.
- Domiciliary care workers, if better valued and respected and included at all levels of care planning, could realise their potential and deliver at a much higher level.
- We need to develop a workforce in primary and social care with the right skills mix for effective multi-disciplinary team working, and with a deep

understanding of the wider determinants of health, e.g., social, economic and environmental.

- Overall, public sector staff needs to be upskilled to work with people and communities in a way that recognises them as assets to build on, rather than as problems to be solved.
- The provision of high quality undergraduate medical education, postgraduate training and continuing professional development must be prioritised—general practice poses a specific challenge here.
- A focus is needed on the development of generalists to match the demography of the Welsh population—older, with multiple long-term conditions.
- More integrated training needs to be offered as a matter of priority to promote future multi-disciplinary, multi-sector working.
- To address the shortage of GPs and the difficulty in recruiting to those training posts, current GMS and GDS contractual arrangements and regulatory frameworks should be reviewed to promote greater flexibility and support for innovative ways of working. This will be especially important for millennials, who value a different type of work-life balance and who, evidence suggests, may be less interested in pursuing full-time partnerships.
- In general, new contracts of employment may be needed, for instance given changes in pension thresholds where there's a potential for a huge loss of talent and expertise.
- Overall, to address recruitment, a drive to reach school children and young people early on in their education is required, to bring about awareness of the many different roles and careers that exist in the health and care sectors, and the rewards that they bring.
- Wales needs a widening access scheme to medical education—more must be done to reach those groups that are underrepresented in medical schools, and more must be done to recruit and retain graduated clinicians in NHS Wales.
- Older people should be seen as an asset, and more needs to be done to support retired medical and non-medical staff back into work.
- A post-graduate qualification needs to be developed for all healthcare professionals which recognises expertise in the provision of care in rural areas.
- To mitigate the insufficient number of training places, consideration should be given to whether students should be allowed to self-fund their training—whilst maintaining bursaries for those less well off.

System architecture and principles

- Given the move towards Wales having revenue raising powers under the Wales Bill, consideration should be given to hypothecating revenue raised in

Wales to the NHS and social care, ensuring people see the benefit of a devolved tax regime.

- Wales needs to bring healthcare funding levels up to European levels to make the health and care system viable, and the Welsh Government should consider increasing taxation to pay for this.
- It is now time to consider alternative funding models for the health and social care sector, including increasing taxes; paying for specific services; rationing some services.
- The Welsh Government needs to become more prescriptive regarding expectations on bodies and organisations, notably the Health Boards: these organisations should be aiming to enable and empower the frontline.
- The leadership of health in Wales in too thinly spread: it is time to split the role of NHS CEO and Director General.
- There needs to be a vehicle for all-Wales planning and decision-making in health and social care.
- The Welsh Government should fund and implement a national public communication and engagement strategy for prudent healthcare
- Wales needs a financial and capital investment strategy based on clear national and regional priorities.
- In all that the Government does, it must ensure that the focus remains on those with greatest needs, not loudest voice.
- There should be a single, national process and standard for managing concerns and complaints with a focus on “do it once, do it well” and a whole systems approach to learning from mistakes and feedback.
- Removing the barriers to the sharing, dissemination and adoption of good practice across health and social care should be a national priority for Wales.
- In thinking through system-wide integration, we should not miss the opportunity to experiment with new organisational models for integration such as the ones being tried out through ‘Devo Manc’ and ‘Devo Cornwall.’
- Health inspection in Wales seems much more low key than the inspection of social services, and does not seem to trigger the same improvement journey—this could be strengthened for the benefit of patients and the public.
- Wales could learn from Scotland’s experience of a national performance framework focussed well-being outcomes and the shared pillars of prevention, partnerships, participation and performance as way of working across all public bodies

Technology and IT

- Wales needs to firmly commit to the spread and development of hyper fast broadband and advances in digital technology such as telehealth, telecare and use of data for whole system management.
- The future will see genome-based diagnoses and therapies and related technologies, and Wales should be an early adopter.

- We need to develop monitoring and wearable technology, on-line triage, information and advice services, appointments and transactional services
- Public services need to engage more closely with citizens and patients using social media, apps and interactive technologies to support self-care and the management of long term conditions.
- As a strategic tool, digital technology can help transform the operating model of an organisation.

A new dialogue with the public

- There is an urgent need for a meaningful, mature dialogue and an open and honest conversation with the public about the future of public services, their own expectations and what services the NHS should and could provide.
- The public needs to be activated into a live engagement with their own health and care, including understanding the impact of their behaviours on their health.
- To do this we need to work with local communities to positively shift the nature of the centre's relationship with them: we need to move away from a culture of expectation that statutory services will step in, to a system that better supports communities and individuals to engage positively in protecting their own health and wellbeing.
- The focus needs to shift to health and wellbeing, resilience and community first.
- The time may now be right for a re-think about the role of the state in family life.
- Patients need to become partners in managing and improving their own health, rather than passive recipients of services.
- The NHS needs to help manage expectations and help patients understand exactly which services the NHS can provide.
- We need a national approach to public awareness and engagement: this should be framed positively around the need for change to improve health and wellbeing, rather than around the need to save money.
- We need a positive and accessible narrative for this, and the development of this narrative should be an early priority.
- We need to pro-actively work with social movements and through social media.
- Patient leadership programmes and self-management tools enable patient empowerment which is key to this transformation.