Health, Wellbeing and Local Government Committee

Inquiry into the Assembly Government's Consultation Proposals on the Structure of the National Health Service in Wales

June 2008

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Contents **Page**

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1. Background

1.1 On 2 April the Minister for Health and Social Services, Edwina Hart AM announced a three month consultation on proposals for major changes to the NHS structure in Wales.

1.2 The proposals included:

- Abolishing the internal market in Wales by providing funding from the Welsh Assembly Government or an NHS Board for Wales directly to NHS Trusts and Local Health Boards (LHBs);
- Three options for establishing a Board for Wales - a Special Health Authority, a Civil Service Board, or an Advisory Board supporting an Assembly Government NHS Chief Executive; and,
- LHBs reduced from 22 to eight, including Powys LHB.

It also included proposals:

- To transfer the management and provision of Community Services from NHS Trusts to Local Health Boards.
- On the constitution and membership of the new Local Health Boards in Wales and of NHS Trusts in Wales.
- For a possible revised model for providing shared services, such as procurement, certain legal services and estates advice across Wales.

Given their significance, we agreed at our meeting on 9 April to conduct a short scrutiny Inquiry into the proposals in the Assembly Government's consultation paper.

2. Terms of Reference

2.1 We agreed the following terms of reference for the Inquiry:

To examine the Assembly Government's consultation proposals for changes to the structure of the NHS in Wales in order to:

- *Gain a clearer understanding of the proposals and the process for considering and implementing them;*
- *Identify and highlight any particularly significant issues;*
- *If appropriate, make recommendations to the Assembly on the various alternatives proposed.*

3. Witnesses and Evidence

3.1 We agreed that oral witnesses should be limited to representatives of the main NHS institutions likely to be directly affected by the proposed changes (i.e. the Assembly Government, NHS Trusts, LHBs and Community Health Councils).

Given the consultation status of the proposals we also agreed not to issue any general call for written evidence on this occasion although those giving oral evidence were asked to provide a written Memorandum, copies of which are included in the Annexes to this report.

3.2 In the light of this we took evidence from:

• Assembly Government	-	Ann Lloyd, NHS Chief Executive
• Board of Community Health Councils	-	Carol Lamyman-Jones, Director
• NHS Confederation Wales	-	Mike Ponton, Director Jonathan Davies, Policy & Political Manager

3.3 The evidence from the NHS Confederation helped us understand the perspectives of both NHS Trusts and LHBs on the proposals.

3.4 We would like to record our appreciation for the frank and open way in which witnesses presented their evidence.

4. Recommendations

4.1 We do not feel it is appropriate at this stage to make recommendations on the merits or otherwise of specific proposals. We agreed that the Minister does need to consider a range of issues carefully when deciding on her final proposals. These issues are highlighted in Section 5 of this report.

We recommend that the Minister for Health and Social Services takes account of the specific issues highlighted in this report and responds to them within 6 weeks of the publication of the report or when announcing her final proposals, if this is earlier.

5. Specific Issues

Model for National Board

5.1 The consultation outlines three options for establishing a National Board to oversee the NHS in Wales and be responsible for advising on or agreeing the funding and planning of the work that NHS Trusts and LHBs are to carry out. These are:

- A Special Health Authority
- A Civil Service Board
- An Advisory Board supporting an Assembly Government Chief Executive.

5.2 We take no view at this stage on merits or otherwise of the three options outlined. However, whatever model is adopted it will be important that the role and responsibilities of Board Members and of the Chief Executive are very clearly defined.

5.3 In particular, clarity is needed on whether Board Members' roles should be primarily advisory or executive; on the extent to which they should have a representative role in relation to particular interest groups; or are appointed for their technical expertise or knowledge. There may be a case for some to have an executive function while others are non-executive but the rationale and responsibilities of these roles needs to be clearly spelled out. Under whatever model is adopted, the need for patients' voices to be clearly heard in the new national structure is of considerable importance.

Accountability of Ministers

5.5 The interface between the accountability of the National Board, the Chief Executive and Ministers also needs to be made very clear. It is important that the new arrangements maximise public accountability and limit the scope for finger pointing or shifting of blame. Ministers need to continue to be clearly accountable for their decisions, including through the political process, while operational decisions must also be transparent and open to public scrutiny.

Local Health Boards

Localism

5.6 One of the more successful features of Local Health Boards is that they are rooted in the areas they serve and can be made responsive to local concerns and needs. It will be important to ensure that if there is a move to fewer LHBs that the new organisations maintain a strong community focus and are able to link effectively with the communities they serve.

Joint Working with Local Authorities

5.7 A reduction in the number of LHBs means that it will not be possible to maintain coterminosity with individual local authorities. This will have consequences for how NHS bodies work with local authorities in future, for instance through Health, Social Care and Well-being (HSCWB) Partnerships, but also more generally. It is very important that these consequences are fully considered so that the impetus toward improved partnership working between the Health Service and local authorities is not adversely affected.

Membership of LHBs

5.8 Members of Local Health Boards currently have a strong representative or stakeholder role. It may be that with fewer LHBs, their members need to have a stronger independent focus, more akin to the role of NHS Trust members. In our view the balance between these two roles needs to be very carefully considered, not least because of the need to maintain strong local and community roots and strong links with local authorities.

5.9 Local elected members should continue to be directly involved in LHBs' work. How this can be achieved without creating unwieldy working arrangements also needs careful consideration.

Management of Community Health Services

5.10 The consultation paper asks whether responsibility for managing and providing community services should be transferred from NHS Trusts to LHBs. For the purposes of the consultation, it defines Community Services as:

> *"'Services in the community that enable people to live healthy, fulfilled and independent lives. It includes services that are familiar, such as:*
> *• …generic community services such as the district nurse, health visitor, community midwife, community psychiatric nurse, school nurse, and community therapy services;*
> *• specialist clinical or [NHS] outreach services;*
> *• …respite care, …and nursing home services…'*
> *and also includes the management and provision of Community Hospitals."*

5.11 We note that transferring responsibility for Community Services to Local Health Boards represents a considerable change in their role and responsibilities. Coming alongside the proposed reconfiguration this is likely to present them with a range of new and significant management challenges. If this change goes ahead it will be important to ensure that the reconfigured LHBs have the management expertise and central support they need to make the changes a success.

5.12 One of the supporting papers to the consultation[1] notes that *"…there are strong links between community services and the provision of professional secondary services at the moment."* It goes on to note that there *"will continue* [to be a need] *for seamless working between community services, secondary services, primary care and social services."*

We agree with this assessment and would need to be reassured that there will be a very careful evaluation of the likely impact on care pathways of a transfer of responsibility before any change is introduced.

[1] Governance in Health (para 20)

5.13 On specific aspects of community services, while we note the working definition of these services set out above, we would want to see a much clearer definition of precisely which services would be transferred. In particular, as noted above, there are a number of services where a clear divide between community and secondary services is either not straightforward or may even be undesirable. The implications for areas such as mental health services and maternity services in particular will need to be thought through carefully. The impact of any changes on currently integrated acute and community services also need to be considered carefully.

5.14 In some parts of the country Community Hospitals may be providing services that blur the distinction between community and secondary services. The ability and experience of the relevant LHBs to run these hospitals effectively will need careful assessment.

Community Health Councils and the Patient's Voice

5.15 Our working assumption is that there will be no fundamental changes to the role and responsibilities of Community Health Councils and the Board of Community Health Councils as a result of this consultation, although the consultation document *Governance in Health* states that the role of CHCs in reflecting the needs of communities "needs to be enhanced". However, the consultation documents are lacking in detail on these points and there is a need for much greater clarity and detail on the impact of any changes on these organisations.

5.16 Whatever future arrangements may be, the views of Community Health Councils and of patients need to be clearly heard and understood in reaching decisions following the consultation.

5.17 The patient voice is not solely expressed through Community Health Councils. The Voluntary sector also has an important role to play in this area and the Government needs to pay particular attention to voluntary sector responses to the consultation. It also needs to consider how best the input of voluntary organisations, who in many cases will have considerable service user expertise, can best be used to ensure responsive and appropriate organisational structures and services.

Shared Common Services Body

5.18 There is a range of shared common services that are currently managed by a number of NHS Trusts. One of the consultation proposals is that a single organisation should become responsible for managing and delivering these services. The current patchwork of responsibilities may be confusing and there may well be better ways of organising these services in future. However, the

point was made to us that what is now suggested looks very similar to the old Welsh Health Common Services Authority (WHCSA).

5.21 It was put to us by the NHS Confederation that part of the reason for disposing of WHCSA and moving to a different model for shared services was the perception at the time of an organisation that was remote and self promoting. Conversely, the point was also made that many Trust Chief Executives feel little ownership of common services under the current arrangements. Whatever arrangements are made for the future it is important that they are accessible and responsive with a clear local and service focus.

Integration of Health and Social Care Services

5.22 It was put to us that the current reorganisation may be an opportune time to consider whether social care services should be integrated with healthcare services. We are not convinced that now is the time, or that this consultation is the right vehicle, to consider this issue in any detail. Neither are we convinced that such a change is necessarily desirable.

5.23 However, we are also firmly of the view this is an issue that does merit serious consideration in the not too distant future. Therefore, in taking decisions on this consultation, the Minister may wish to consider how best health and social care services can be delivered seamlessly in future, including the possibility of further work on bringing health and social care services organisationally closer together.

Stability of Service Delivery

5.24 Any reorganisation or reconfiguration is inevitably disruptive to some extent. If it is not managed properly this can cause considerable delays in service improvements and, in the worst case, a deterioration of service delivery. This reorganisation must not be a distraction from continuing the drive for improved services for patients.

5.25 We call on Ministers to spell out very clearly how they will ensure the stability of both service delivery and the drive for improved services. We also call on Ministers to detail the steps they will take to ensure that there is sufficient capacity, expertise and resources available within the NHS to manage any changes in a way that does not adversely affect services to patients.

5.26 Following any changes, we recognise that there will be a need for a period of stability to allow the changes to bed down and for their success to be carefully evaluated.

Removing the Internal Market

5.27 In her foreword to the consultation, the Minister makes it clear that one of her primary motivations is to end the internal market in the NHS and to make co-operation rather than competition the main factor in the organisation of the NHS in Wales. There are differing views within the Committee on the extent to which competition continues to play a significant role in the running of the NHS in Wales.

5.28 However, the Committee is agreed that there remains little point in maintaining structures created to service an internal market mechanism when the Government has decided to pursue a different model of service delivery.

Timing

5.29 The Government's consultation closes on 25 June. We understand that the aim is for any changes to be implemented by April 2009. This is primarily a matter for Ministers to consider but we do want to note that this appears to be a very ambitious timetable. If it is not possible to meet this timetable, Ministers will need to consider what the risks are in implementing changes part way through a financial year.

6. Conclusion

6.1 Although the Minister for Health and Social Services says in her foreword to the consultation that any changes flowing from the consultation are meant to be evolutionary rather than a radically new direction or reorganisation, we have little doubt that many of the changes proposed are very significant and will have far reaching implications for the Health Service in Wales.

6.2 We look forward to the Assembly having the opportunity to debate and scrutinise the Minister's final decisions in detail to ensure that they are as clear, robust and forward looking as they need to be to ensure that the NHS in Wales is well equipped to meet the challenges of delivering modern, effective health services to the people of Wales.

Health, Wellbeing and Local Government Committee June 2008