Response to the Welsh Assembly Government's *Proposals to Change the Structure of the NHS in Wales*

Introduction

This paper is the response of Academy Health Wales and the Institute of Welsh Affairs to the Welsh Assembly Government's consultation on proposed changes to the NHS in Wales. The consultation, which closed in mid-June 2008, asked for responses to the following areas:

- Abolishing the Internal Market in Wales, by providing funding from Welsh Ministers or a National Board directly to NHS Trusts and Local Health Boards.

- Three options for establishing a National Health Service Board for Wales: a Special Health Authority, a Civil Service Board, or an Advisory Board supporting an Assembly Government Chief Executive. The National Board/Chief Executive will have oversight of the whole NHS in Wales, and will be responsible for agreeing with NHS Trusts and Local health Boards the work which is to be carried out by them, and the funding which is to be provided in order to allow that work to be carried out.

- A reduction from 22 to eight Local health Boards in Wales (including Powys Local health Board).

- Transferring the management and provision of Community Services from NHS Trusts to Local Health Boards.

- The Constitution and membership of the new Local health Boards in Wales.

- A possible revised model for providing shared services, such as procurement, certain legal services and estates advice across Wales.

We would concur with the response by the Welsh Institute for Heath and Social Care at the University of Glamorgan that NHS restructuring is costly and threatens to divert attention from delivery on the ground.[1] Further, we agree that the priorities for any change should be to tackle the following intractable problems that have dogged NHS Wales over many years:

- How do we respond to the major health challenges we face – poverty, a widening gap in health status between rich and poor and the life-style related problems of obesity, type 2 diabetes, smoking and alcohol and drug misuse?

- How do we consign the inverse care law[2] to the dustbin of history?

- How do we achieve greater fluidity between home, hospital and residential and nursing care so that people are not unnecessarily institutionalised?

- How do we make integrated care a reality especially for people with long-term conditions?

- How do we stop sending people into acute hospitals who do not need acute hospital care?

- How do we make sure that we do not continue to have 600 or so people faced with delayed transfers of care at any ne time?

- How do we tackle the so-called 'crisis of productivity in healthcare?

[1] Welsh Institute for Health and Social Care, *Governance, Incentives and Integration: Beyond Changing Structures*, June 2008 (www.glam.ac.uk/whihsc)

[2] In areas with most sickness and death, general practitioners have more work, larger lists, less hospital support, and inherit more clinically ineffective traditions of consultation, than in the healthiest areas; and hospital doctors shoulder heavier case-loads with less staff and equipment, more obsolete buildings, and suffer recurrent crises in the availability of beds and replacement staff. These trends can be summed up as the inverse care law: that the availability of good medical care tends to vary inversely with the need of the population served.

BACKGROUND ISSUES

1. Abolition of the 'internal market'

As stated in the consultation this is the key objective of the proposed changes. However, a number of questions arise:

- Why still retain eight Local Health Boards? If the logic of 'abolishing the internal market' is to remove the purchase provider split between the LHBs and the Trusts, why be content with reducing the LHBs from 22 to eight? Why not simply merge them with the Trusts?

- What is the evidence base underpinning these proposals for change? How are we to judge in, say, five years time, whether the changes have been a success? For instance, is a cost/benefit analysis envisaged in terms of: (i) financial savings and effectiveness; (ii) quality of service delivery; and (iii) patient access and waiting times.

- In the absence of the internal market what incentives are going to drive the system? There will need to be an alternative structure for measuring progress and achievement: some form of benchmarking involving transparency. This will require the creation of a transparent data-base comparing service provision between Trusts, not just within Wales, but across the UK and Europe. Such a database must be open for all to see and readily understand. If the ultimate purpose is to implement 'the citizen model' in place of the internal market it will require more than structural arrangements to achieve the change needed. We will need a fresh approach to the values, cultures and attitudes that motivate the people involved in the service.

If the central aim of health care is to be safe, effective, timely, efficient, and equitable, then the service needs to become more patient-centred than at present. At all times the priority should be the patient's needs. It is important that the patients should be a source of control and cooperation between specialist and general clinicians at a time when there will be and increasing numbers with chronic conditions and co-morbidities. At the same time it has to be recognised that there are resource implications in moving more in the direction of a patient-centred service. In general a balance needs to be struck with efficiency and effectiveness, with an emphasis placed on the delivery of outcomes rather than process and structures.

2. Service delivery and co-ordination across boundaries: the Beecham agenda

How can changes in the structure of NHS provision be considered in isolation from the delivery of public services by other organisations, especially local

government with its responsibility for social services? After all, this was the motivation of the last NHS reorganisation in 2002 when the 22 Local Health Boards were created to make them coterminous with the 22 local authorities.

Is there an implied message for Welsh local government in these proposals? If so the Assembly Government should make this clear. It should spell out in detail how it envisages local government structures evolving in relation to NHS provision over the next ten to twenty years.

If the Local health Boards are to be reduced to eight, or merged with the eight NHS Trusts, what arrangements will be put in place to ensure appropriate co-ordination with the 22 local authorities, especially so far as linkages between health and social care are concerned? Is the Assembly Government thinking in terms of the 22 local authorities creating eight parallel consortiums and would this not, in effect, be a precursor to a later reorganisation of local government itself?

3. Leadership

The Assembly Government should also be more transparent about what is motivating its reconfiguration proposals. Many of those engaged at senior leadership levels in NHS Wales management believe the proposals are a response to the impact of devolution. Since the establishment of the National Assembly, Scottish Parliament and Northern Ireland Assembly in 1999 there has been a growing divergence of health policy and implementation across the United Kingdom. This has created problems for the recruitment of staff in key leadership management positions. Recruitment for many management positions is now confined to people who already have experience of the Welsh system. In other words we have to rely on home-grown talent. In these circumstances the suspicion is that the 22 Local health Boards have proved to be simply too many to allow us to staff them with the appropriate levels of management expertise.

Therefore, the question arises: is this a major driver behind the Assembly Government current reconfiguration proposals? The background paper to the consultation *Removing the internal market in health in Wales: the justification* suggests that it is, when it refers to the 'more than thirty health bodies operating in Wales' and states:

> "…the number of bodies responsible for different aspects of health care planning and provision has placed a heavy load upon a limited number of experienced clinical and managerial staff such that the capacity for talented leadership has been diluted" (page 5).

If this is a major pressure driving the proposed changes, then the Government should be open about it and explain how the new system it is proposing will tackle the problem.

4. Funding

Finance is not addressed in the consultation. Has any estimate been made of the costs that this further reorganisation will entail? It was claimed at the outset of the last reorganisation in 2002 that it would be 'cost neutral'. In the event this was not the case. Is it believed that in the medium to long-term the proposed changes will result in efficiency gains? What is it anticipated these might be and how will they be measured? In recent years the cost of administration within NHS Wales has doubled. Will the proposed new system assist in re-directing resources to front-line services?

5. Public Accountability

It is not clear in the consultation how the new system is to be publicly accountable in an effective way, apart from formal procedures through the National Assembly. What are the mechanisms to ensure that patients and potential patients – that is to say, the population as a whole – is to be informed of the proposals, future changes, and NHS provision more generally – so they feel involved and engaged? Surely a key lesson for the politicians from the 2007 Assembly elections is that NHS provision, and especially reconfiguration proposals, are certain to excite some vehement public opposition.

The background paper to the consultation Governance in Health acknowledges that there is an issue here when it states:

> "Despite their best endeavours, many NHS Boards have struggled to engage effectively and consistently with their communities and to be responsive to the views and feedback from patients and the public" (page 1).

If many of the 22 NHS Boards have "struggled" in this regard, how can the proposed larger, and inevitably more remote, eight Boards achieve any improvement? It is apparent that few health bodies contain any high level consumer research or public relations expertise which are absolutely necessary to effect timely and constructive engagement with consumers/citizens in the health planning process.

This leads to a further question: what is to be the continued role of the 19 Community Health Councils in relation to the new structure? Any accountability structures need to work at both the national and local levels in Wales.

6. Public Health

There is very little reference to public health in the consultation. Improving the health of the people has been a central mission and statutory duty of NHS bodies. Consideration of the health of the public must lie at the centre of strategic planning for NHS bodies with partners. Public health is critical to local bodies for local needs assessment and planning, in addition to the local delivery of statutory public health protection duties.

Public health is now multidisciplinary. Needs assessments include subjective quality of life measurements and qualitative public participation techniques as well as 'rational' quantitative planning techniques based on the census, disease prevalence measures and evidence of the effectiveness of health service interventions.

A separate review of public health is underway. However, this is focussed entirely on the national level. It ignores the key issue - local public health which should be integral to local bodies. This risk is that we will fall between the crack of a nationally focused public health review and a national and local NHS reorganisation which is not considering public health.

In the present situation, instead of concentrating on the health of the people, local NHS bodies risk being simply 'pay and rations' bodies, the focus for bargaining between élite groups, doctors and managers on the one hand and local politicians on the other.

RECOMMENDATIONS

1. The 'National Board'

The consultation asks whether we should have one National Board responsible for funding and planning services for the eight Local health Boards NHS Trusts. It further asks whether this should be a free-standing authority, an arm of the Assembly Government (that is, contained within the civil service), or merely an advisory board.

This answer to these questions should be an emphatic yes to one National Board, accountable to, but at arms length from the Assembly Government and established as a Special Health Authority.

The Board should be primarily responsible for resource allocation and the administration and direction of the NHS Trusts, acting within the strategic guidelines laid down by the Assembly Government. Further, we agree with the Mansel Aylward Review of Health Commission Wales that the National Board should be established as a Special Health Authority, It would also provide a suitable setting for locating the planning and funding of tertiary and specialised healthcare services.

In addition, there should be created alongside the Board a Welsh Health Planning Forum based on 'Futures Thinking' to assess drivers of change and ways of influencing them. This follows the proposal made in the annex paper to the Consultation, Proposed New Planning System: From a commissioned to a planned system, which state:

> "In order to develop a more coordinated approach at the national level a new strategic planning forum should be developed to translate national policy into action and to develop specific plans for an agreed range of planning areas across the system. This will include the development of a long term strategy for the NHS in Wales for consideration by ministers" (page 3)

We fully support this proposal. The new Forum should be an advisory organisation attached to the National Board. The world of healthcare is about to experience greater complexity at both the individual and wider population levels. For instance there will be new pharmaceuticals, medical devices, biologics, and procedures as well as an increasing role for genetic variation in individual responses to treatment interventions. We are entering the age of personalised medicine. The task of the Welsh Health Planning Forum should be three-fold:

1. To propose initiatives to provide for health gain across NHS Wales.
2. To monitor the effectiveness and efficiency of resource allocation.
3. To promote and monitor the people centredness of NHS Wales.

The creation of a National Health Board as a Special Health Authority will require a strengthened policy development capability within the policy arm for the pursuit of healthy public policy across areas where the Welsh Assembly Government has responsibility. It should also influence 'systems for health care' which are not exclusively within the NHS, including the voluntary sector and health industries, Its aim should be to promote 'systems for health' including the determinants of health, through effective legislation and regulation of the Welsh 'health market place'.

Though the consultation paper identifies the need for refreshing national strategies and to achieve better integration between health systems, social care and public health planning, there is no clarity as to how the current reforms of public health are to be embraced. How will the National Public Health Service, the Wales Centre for Health, and the proposed National Public Health Institute and Observatory integrate with the NHS reform proposals?

2. Local Health Boards

The logic of the Assembly Government's proposals is for the eight proposed Local Health Boards to be merged with the eight Trusts. This will enhance the streamlining of the administration and accountability of provision, which is a major objective of the proposals.

3. Public Accountability

The Assembly Government should acknowledge that its proposed changes to the NHS structure have fundamental implications also for the structure of local government in Wales. In doing so it should lay down a longer-term perspective for the evolution of public service provision and accountability in Wales.

In doing so it should start from the bottom-up, acknowledging the role of the smallest tier of local government, the Community and Town Councils. At present there are some 700 of these Councils across Wales, ranging from relatively large town councils, for places like Barry, Rhyl, and Aberystwyth to relatively large rural councils, with very small populations, some of which are non-functioning. They have very few powers apart from an advisory role to the 22 County Councils.

The Community Councils should be reduced in number so that their boundaries respond to real communities of interest. Some of the existing own councils would be retained, but elsewhere there would need to be a major reconfiguration reducing the number to perhaps around 150. There would be similarities between this new system and the former urban and rural district councils that existed prior to the 1974 local government reorganisation in

Wales. The pattern would correspond as far as possible to major NHS hospital catchment areas, but might relate more closely to the catchment areas of secondary schools, especially in rural areas. In any event, a major function of these new authorities would be as sounding boards for the provision of NHS services in Wales. In the first instance their operation in this area could be co-ordinated by the Community Health Councils and it could be that experience will dictate the desirability of a complete devolution of the Community Health Council role to these new authorities.

As the new authorities bedded down their role in relation to aspects of local government provision could be extended. This would follow the European continental pattern of communes, small authorities but which have relatively wide powers, especially compared with the UK system. In any event, once this smallest level of local government had bedded down and was operating effectively, consideration should then be given to reorganising the County Councils so that they become aligned with the eight NHS Trusts. These changes might be accomplished over a ten-year period, but with changes to NHS reconfiguration preceding them.

4. Shared Services

There are strong reasons to support the drawing together of a range of support services including estates, legal, procurement, information services, as well as those that are announced for separate consultation. All are needed as operational support for the new local health arrangements and the new National Board to function effectively. One centrally located agency will build added value in pace of the present dispersed system.

5. A Public Service College

If we are correct in our assessment that a major driver of the Assembly Government's proposals is the "limited number of experienced clinical and managerial staff" to provide leadership in the system, then a key part of any change should be initiatives to tackle the problem. We suggest that urgent consideration should be given to upgrade the present systems for leadership and management training within the NHS and the wider public service within Wales. A start has been made with the Public Service Management Wales initiative within the Assembly Government. However, this operates as a virtual organisation, and does not have the resources to engage effectively with the large numbers of staff involved or the range of their training needs. The time has come for Public Service Management Wales to be developed substantially. We should create a Public Service College for Wales, linked to, but independent of, the Welsh University system and located outside Cardiff. All public servants seeking to advance beyond middle grades should be required to demonstrate evidence of having attended appropriate courses at this college.

6. Public Health

Consideration should be given in any subsequent consultation stage on the proposals to the detail and nature of the local involvement of public health in local NHS structures, local NHS service planning, local health improvement and health protection duties. It is vital that the Chief Medical Officer's current Unified Public Health Project, aimed at streamlining national public health bodies, is reconciled with the NHS reorganisation. In particular, the role of public health within existing Trusts and the new Local Health Boards, if the decision is to press ahead with them, is clearly defined.