Dear Colleague,

*Improving Health in Wales – A Plan for the NHS with its partners* signals the renewal of NHS Wales and sets out an ambitious agenda for change and improvement. The Plan presents challenges that will demand new approaches. These will be based on new and dynamic partnerships within the NHS and between NHS Wales, local government, the voluntary and independent sectors and the communities they serve. They will need strong leadership and clear accountabilities at all levels.

The prime aim of the Plan is to achieve wide scale improvements in patients services and the quality of care. To achieve these, fundamental structural changes are required to deliver a people-centred and participative health service which is designed to be:

- *simpler* for patients to understand;
- *accountable* for the actions it takes and the services it delivers; and
- have a stronger *democratic* voice in the way it is governed.

I am therefore pleased to enclose a consultation document “*Structural Change in the NHS in Wales*” which sets out proposals for structural change that aim to provide the means to take the NHS forward and to meet the challenges it faces. This document has been produced as part of the implementation of the Plan by the Structures Task and Finish Group, which is chaired by the Director of NHS Wales.
While structures will alter, the role and involvement of staff with the development of our services and systems remains of vital importance. The new ways of organising services in Wales will require the talents of people currently employed at all levels in the NHS in Wales, in helping to strengthen Local Health Boards, in public health and in the new strategic role of the Assembly. There are vitally important jobs to be done. The experience, skills and dedication of the health workforce will remain an essential pool, which we will need to draw upon for the future.

I appreciate that all staff affected by these changes will wish to know as quickly as possible the shape of the new structures and the opportunities they present. In recognition of this I intend to announce my decision following the outcome of consultation in November 2001.

Your comments about the proposals contained within the document will be vital in determining the shape of the NHS for the people of Wales. I urge you to share the document as widely as you possibly can and encourage others to comment likewise.

Yours Sincerely,

Jane Hutt
Minister for Health & Social Services

Please address your comments about this document no later than 19 October 2001 to:

Jackie Oakley
Health and Well Being Strategy and Planning Team
National Assembly for Wales
Cathays Park
Cardiff
CF10 3NQ

Email: jackie.oakley@wales.gsi.gov.uk
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IMPROVING HEALTH IN WALES - STRUCTURAL CHANGE IN THE NHS IN WALES

INTRODUCTION

The purpose of this paper is to outline the structural changes needed to achieve the objectives set out in Improving Health in Wales - A Plan for the NHS with its Partners (The Plan). The Structures Task and Finish Group has prepared a range of proposals, which are discussed in this document upon which comments and views are requested.

SUMMARY

The Plan signals the renewal of the NHS in Wales and sets out an ambitious agenda for change and improvement. It presents challenges that will provide new and dynamic partnerships between NHS Wales, local government, the voluntary sector, the independent sector and the communities they serve. These challenges will need strong and cohesive leadership with clear accountabilities for services and partnership at all levels.

In order for the Plan’s objectives to be implemented successfully the structure, through which care and partnership is delivered, must be strengthened at two levels:

At local level Local Health Groups will be developed into Local Health Boards and their role strengthened. They will take on new responsibilities for commissioning, securing and delivering healthcare in their localities. They will be held to account by their local population and formally by the Director of the NHS Directorate (NHSD) and the Minister for Health and Social Services for accessibility to high quality health services.

The new structure will strengthen the democratic voice in Wales locally by enhancing the role of local government in health. Membership of the Local Health Boards will be extended to include representation from Local Authority Members and the local population. The new responsibilities of the Local Health Boards bring a need for improved systems of management, financial control and probity as well as clear accountabilities.

Local government will have a key role in developing and implementing a Strategy for Health and Well-being, working in consultation with a broadly based local Strategic Partnership.

NHS Trusts’ main functions will remain unchanged as will their statutory position, but their responsibilities will be discharged via new lines of accountability.

At the same time at the national level, to achieve a corporate Welsh NHS that tackles inequalities and provides the best possible service reflecting the needs of local populations, the National Assembly will be strengthened to provide a new sense of leadership, direction and oversight to hold both Local Health Boards and NHS Trusts fully accountable for their actions and the services they provide and commission. The Plan involves a new assertion of the National Assembly's direct democratic control of its health responsibilities. Part of this strengthening will include a dimension based on health economics for the implementation of nationally agreed strategic priorities.

At both national and local levels new ways of achieving health gain through public health measures are required. A review of public health provision is taking place and the service will be developed to meet the health and well-being challenges of the 21st Century. Public health will form an integral part of the agenda for public protection, health promotion and preventative health, set out in Improving Health in Wales.
Taken together, all this removes the necessity for Health Authorities in Wales, abolishing a tier in the current hierarchy between the Assembly and patient. The establishment of Local Health Boards will enhance the direct relationship of the National Assembly with their local populations.

The Assembly's statutory responsibilities will be supported by a newly created and inclusive Health and Well-being Partnership Council chaired by the Minister for Health and Social Services. This will make tangible the Assembly's responsibilities for improving health services and engaging the full range of stakeholders.

By stripping out a level of administration and strengthening the local and central organisations, the new NHS will be shaped by three key characteristics:

- It will be **simpler** for patients to understand.
- It will be **accountable** for the actions it takes and the services it delivers.
- It will have a stronger **democratic voice** in the way it is governed.

The Assembly will reinvigorate mechanisms to make heard the voice of the professions and local people. In new partnerships it will draw on the views and experience of those who are involved in the delivery and receipt of health care to develop and deliver high quality services for local people.

In addition to reducing bureaucracy and making accountabilities clearer, the new arrangements will strengthen strategic decision making at national level while moving service planning, design, delivery and accountability closer to communities and patients.

**IMPLEMENTATION OF THE PLAN**

**The Implementation Framework**

To ensure a cohesive approach to achieving the objectives of the Plan an implementation structure has been put into place. A national Steering Group chaired by the Minister for Health and Social Services oversees the process of implementation and advises the Minister on policies emanating from the work. The Implementation Group chaired by the Director of NHS Wales oversees the management of the implementation and works in close partnership with the Task and Finish Groups. There are nine Task and Finish Groups which are looking at their subject areas with the first priority of scoping the activity needed to implement the Plan and identifying and prioritising the objectives that need to be set for achievement in the short, medium and long term. The Task and Finish Groups include Structures; Public Health; Service Development; Health Challenges; Patient Focus/Public Engagement; Joint Working; Workforce Development; Finance and Assets; and Performance Management.

**The Structures Task and Finish Group**

The remit of the Structures Task and Finish Group is to:

- Identify and evaluate the statutory implications and needs regarding the abolition of Health Authorities, the available options for the establishment of alternative corporate/statutory bodies and/or the transfer of powers appropriate to the structural change;
- Agree the necessary structural and organisational changes and the respective new roles of the National Assembly, Local Health Groups and NHS Trusts;
- Design an accountability framework appropriate to the new arrangements;
- Consider new professional and staff advisory machinery;
- Identify necessary process changes in the planning, delivery and review of services;
• Consider the role, constitution and powers of the National Health and Well-being Council, and similar bodies at regional and local levels;
• Draw up the personnel processes to be used in managing the change process.

The Structures Task and Finish Group has made good progress with its work. While its immediate priority was to put forward options and proposals for general structural change, it has also undertaken detailed work on a range of issues that have influenced the proposals in this document, as follows:

i. Professional Advisory Arrangements – Professional advice at all levels within the renewed NHS in Wales will be of key importance in the decision making process. In the new organisational environment it is essential that health professionals and their representatives have every opportunity to influence the management and development of health services. A review of the current arrangements and the options for building on this process for the future is underway. The National Assembly intends to confirm and clarify the statutory functions of professional advisory bodies following the abolition of Health Authorities. Non statutory professional bodies will also be aligned to the new NHS structure in Wales and, where appropriate, their relationships will be strengthened and clarified. The guiding principle of the review is to ensure high quality comprehensive advice is available through recognised mechanisms to inform decision-making processes at all levels. Consultation with the professions and other interested parties will take place later this year.

ii. Re-allocation of Health Authority Functions – all Health Authority functions have been reviewed and have been categorised for transfer, as appropriate, to the National Assembly, Local Health Boards or NHS Trusts. Descriptions of the new roles and responsibilities and arrangements for their smooth and effective transfer will be included in the organisation development plan now being developed to take effect in April 2003 following the abolition of health Authorities.

iii. Commissioning and Planning Processes – both processes have been examined in detail to assess the appropriate responsibilities and approaches for commissioning and planning health services. The requirements for a new strategic and operational planning process have been assessed and guidance on this will be issued in October 2001.

iv. Organisation Development – a detailed assessment of the organisation development needs for the new organisations has been undertaken. An organisation development plan is nearing completion for implementation in the Autumn 2001 so that preparation for change can begin in good time.

v. Personnel Processes for Managing Change – the principles have been agreed and detailed policies are now being prepared and will be put out for consultation with the staff in the Autumn 2001.

vi. Accountability Frameworks – these are being developed in parallel with the work of the Performance Management Task and Finish Group and will be finalised early in December 2001

**Principles guiding change**
In addition to the guiding principles in the NHS Plan of simplicity, accountability and the strengthening of a local democratic voice, the Structures Task and Finish Group proposed that the following criteria be adopted in assessing the options for the new structures:

- Benefit patients and assist in the improvement of their health;
- Taking decisions at the lowest level possible;
- Capable of providing National standards for health and social care (whilst recognising that social care is not necessarily a “national” service in the way the term applies to the NHS);
- Securing demonstrable health improvement through effective public health services;
- Promoting joint working;
- Evidence based and effective;
- Promoting equity of access to services for patients;
- Provides flexibility in local delivery whilst ensuring high/measurable standards;
- Allows for clear account of organisation objectives;
- Provides value for money.

Other desirable characteristics were also considered in determining the options for new structures:

- That there be two formal tiers of management and organisation – local and national. The design of roles and accountabilities has been predicated by the principle that as much as possible be undertaken locally by and through the Local Health Group successor bodies unless other approaches have demonstrable benefits in terms of effectiveness and value for money;
- The development of a health economy focus for planning, management and monitoring purposes;
- The introduction of new, effective and unambiguous lines of accountability between the National Assembly, Local Health Groups and NHS Trusts;
- The need to create appropriate new arrangements for public health leadership and support services;
- The need to bring professional, technical and administrative support services together in new groupings both at local and national levels to obtain optimal critical mass, effectiveness and value for money, e.g. information management, estates etc;
- The need to ensure a high profile for primary health care and contractor services in the structural arrangements at the national level.
- The NHS in Wales has an important role to play in promoting community safety, in partnership with the police and with local authorities. The Crime and Disorder Act 1998 places a specific duty on Health Authorities to co-operate with the police and local authorities in crime and disorder strategies. The National Assembly for Wales will take the necessary steps to ensure, following the abolition of health authorities, that the Welsh NHS at all levels will co-operate positively in crime and disorder partnerships and all other partnerships in which it has a role to play.

Additionally at national level the following must be considered:

- The need for clarity in the relationship and complementarity of the NHS Directorate, the Nursing Division and the Health Protection and Improvement Directorate in the new arrangements;
- The need for clarity in the inter-relationships between the Social Care Group, the Chief Social Services Inspector, the Local Government Group, the two Health Directorates and the Nursing Division in the light of the development of the unfolding Health and Well-being agenda.
LOCAL HEALTH GROUPS

Title

It is proposed that Local Health Groups should from 2003 onwards be known as Local Health Boards to reflect their changed functions and responsibilities.

Do you have any other suggestions for a title?

Corporate Status

It is proposed that Local Health Boards become statutory bodies and as such will be given powers, duties and obligations consistent with their role as commissioners and providers of health services. On this basis management arrangements would need to be put in place that are geared to meet the requirements and standards of regularity and propriety in public bodies and offer demonstrable value for money. They would be required to prepare and publish audited sets of accounts and Annual Reports. The Boards will extend the remit of the National Assembly to be accountable at a local level for the delivery of care for local people.

The developing role of Local Health Boards

The proposals in the Plan for renewing NHS Wales include two sets of key objectives: to shift the emphasis from treating disease to improving health, and to increase the quality, effectiveness and efficiency of the health care system. Local Health Boards are pivotal in achieving these objectives and must be empowered to address them.

Success will depend on:

- Improved access to patient centred primary health services;
- Improved support for community health development;
- Improved community health and intermediate care services;
- Increased support for family-based care;
- Stronger health protection programmes;
- Increased support for informed community participation.

It is recognised that a distinct approach in Wales needs to be developed based on partnership and community health development. Coterminosity with Local Authority areas provides Local Health Boards with the ability to take forward and develop the health and social agenda in a way that is unique and can be responsive to local needs. This will enable them to recognise and respond to disparities of scale, health status, and inequalities in health and local working arrangements. The establishment of local solutions to local issues is one of the strengths of Local Health Boards. Any model for the future must empower them to build on these benefits.

Specialist public health skills will be of key importance to LHBs in addressing the health care needs and health inequalities of local populations

The LHBs relationship with the voluntary sector and independent sectors as partners in service provision is significantly important and must be based on local compacts, which will need to be put in place.

The key accountabilities identified for Local Health Boards are seen as being:
Assessing the health needs of their area and the effectiveness of their local health system through locally acquired information to support this process.

Representing and meeting those needs by
(a) Securing and providing primary health care services
(b) Securing community and intermediate care services (including locally organised mental health services)
(c) Securing secondary care services (including mental health)

Holding the budget for primary, community, intermediate and secondary care services.

Providing advice on the provision of tertiary services for their population

Developing local health services that are responsive to the health needs of the local population and which comply with the views of the user.

Ensuring the delivery of primary care, community health services, intermediate care and community mental health services to their local area.

Addressing inequalities in health in their communities.

Achieving good quality health outcomes within an all Wales performance management framework.

Do you think the above accountabilities are appropriate for the new Local Health Boards?

Local Health Boards as providers of community health services

A major issue arising from discussion on the role of Local Health Boards has been their potential for taking on the role of provider of community health services. It is clear that they should have the responsibility and accountability for securing and funding community services for their populations. At a strategic partnership level, along with their local authority, NHS Trust, voluntary and independent sector partners they will be accountable for contributing to the provision of seamless, flexible and responsive health services.

The discussion so far about a possible shift of responsibility for providing community health services has revealed mixed views. The current model of integrated NHS Trusts has only recently been implemented and was designed to bridge the gap between community and secondary health care facilities. Some see this as a model that should continue and believe there is evidence of it being successful in bringing benefits in the quality and continuity of care for patients. Others see a new opportunity to integrate primary health care and community health services. They see Local Health Boards being empowered to be flexible and responsive to local needs to mould services more effectively to local circumstances. They consider that Local Health Boards would be well placed to integrate primary care and community health services and provide the bridge necessary to bring health and social services closer together at the point of organisation and delivery.

It could be perceived that limiting the role of Local Health Boards to that of securing community health services only would not provide the levers for change needed to achieve the strategic aim of integration and improvement. It could also make customisation and reshaping of services cumbersome without the force of direct management control. On the other hand commissioning backed by resources can be an effective change management tool. In this context it would need to be reinforced and underpinned through the new frameworks for accountabilities and performance management.
There are obvious risks in the manageability of further and significant organisational change at a time when the main focus on all service providers and commissioners must be to reshape structures and services to deal with the transferred responsibilities of health authorities and to secure improved services for people. The implications of major service shifts on the current NHS Trust configuration both from a service quality and organisational perspective need to be carefully and accurately assessed. However, if a transfer of responsibility for providing community services were to take place, then the risks associated with drawn out organisational change and its impact on staff morale and patient services also need careful assessment.

There are advantages and disadvantages in either restricting Local Health Boards to commissioning community services or extending their responsibility to service provision. These are summarised as:

A: Exclusive Commissioner Role

**ADVANTAGES**
- Builds on existing roles;
- Maintains distinction of purchaser and provider roles;
- Enables a focus on major change issues not tied into operational delivery of functions.

**DISADVANTAGES**
- Inadequate levers for change;
- Trusts remain as monopoly suppliers (managerially and financially);
- No champion for community services and integrated care at local level;
- Split of primary & community services.

B: Provider Role

**ADVANTAGES**
- Direct management of services - immediate control;
- Directly links primary & community care;
- Responsiveness;
- Interface with social care.

**DISADVANTAGES**
- Diversion of management and infrastructure issues;
- Huge organisational change across whole NHS System;
- Viability of some NHS Trusts affected as a result;
- Cost – financially and organisationally;
- Diversion from primary care agenda;
- Mixes provision and commissioning;
- Reduced co-ordination at discharge (seen as one of the main benefits of integrated Trusts);
- Skills and competence.

In considering the arguments three options have emerged at the Structures Task & Finish Group:
Option One – Local Health Boards should continue to be responsible for assessing local health needs, nurturing and developing primary care services and for securing community health, intermediate and secondary care services. NHS Trusts would continue to be the main providers of community health care services.

Option Two - In addition to their responsibilities as in Option One above and, as soon as legislation can be put in place, all Local Health Boards should become accountable for providing community health and intermediate care services either by directly managing services or through arrangements with other providers.

Option Three – To assess the current strengths and weaknesses of the integrated Trust model and to set up a number of action research projects to assess the implications and viability of the transfer of the community health service provider function to Local Health Boards.

It is felt that the concept of transferring responsibility of community health services from Trusts to LHBs has merit and needs further consideration. Similarly we need an accurate picture of the strengths and weaknesses of the existing organisation and delivery of community health services by NHS Trusts. It is proposed that:

I. Local Health Boards become accountable for commissioning community health services immediately upon their establishment.

II. In 2002 – 2003 Powys and a number of other selected Local Health Boards with differing health challenges and representing North and South Wales, become pathfinder Local Health Boards to develop their new role including responsibility for providing community health services and to guide the development of the others as part of an Action Research Project. The Powys NHS Trust and the LHG for Powys will be abolished as a result of this. LHBs and NHS Trusts will be invited to put forward proposals for setting up pathfinder projects. Guidelines for applications will be issued in Autumn 2001;

III. An evaluation of the present arrangements for organising and delivering community services within the existing organisations in Wales be undertaken immediately;

IV. In April 2003 the pathfinders go live;

V. At the end of 2003/4 the research team report their findings and a decision made on way forward for Local Health Board's in respect to their role in providing additional local services.

The future commissioning arrangements for mental health services must be addressed as a priority with the implementation of the Assembly's Mental Health Strategy and the forthcoming National Service Framework. An Implementation and Action Team will implement this work. Further guidance will be available for consultation in March 2002.

What is your view about the role of LHBs in the provision of community health services?

What is your view about the commissioning and provision of mental health services at local level?

STRATEGIC PARTNERSHIPS FOR HEALTH AND WELL BEING
The success of the new NHS structures, and their service planning and delivery responsibilities, will depend to a large extent on building effective partnerships at the local and national levels. At National level, the Health and Well Being Partnership Council, chaired by the Minister, will bring together key players from the NHS, from Local Government, and from the voluntary and independent sectors, together with staff, professional interests and patients representatives to ensure the overall direction and leadership of the new agenda for health and well-being.

At the local level, similar partnerships and leadership will be required to ensure that service planning, commissioning and delivery contributes directly to the achievement of community strategies for the development of the whole area. Strategic partnership for health and well being must embrace the crucially important interface between health and social care services. It must also bring together the other vital elements necessary to promote the wider health and well being of everyone in the local area. This includes a wide range of local government, public health, housing, social care and community services and voluntary and independent sector providers, working alongside the whole range of NHS services. In this way, Strategic Partnerships for Health and Well-being will engage all sectors with a contribution to make.

Local Health Alliances have, in many places, established innovative and strong relationships with a wide range of service interests in the broader health and well being agenda. The Strategic Partnerships will require an extensive network of local players to ensure that the strategies are comprehensive, inclusive and responsive to local needs. The Health Alliance will provide the vehicle through which such wider referencing can take place.

What functions will Strategic Partnerships Perform?

The NHS Plan set out an initial commitment to create Strategic Partnerships for health and well being. The Implementation Group has taken this concept forwards, and proposes that there should be a new statutory duty on each Local Authority and Local Health Board, to come together to develop and implement a Strategy for Health and Well-being in their area. They will be required to co-operate with each other, and to work in consultation with a wide range of local interests. These should include the relevant NHS trusts, and service providers in the independent and voluntary sectors; patient, user and carer groups; the voluntary sector; and a wide range of related service interests including housing, education and community development. Specialist public health involvement will be essential to this process. The Assembly intends that the establishment of Strategic Partnerships should be formalised in the new Health Bill. More detailed work will be required, over the coming months, to develop detailed guidance on membership, remit and consultation requirements. Further work is also required to specify the relationship between Strategies for Health and Well-being and the various planning requirements for health and social care and other related local government functions, which are themselves subject to review and rationalisation. This work will be completed later in the year.

What is quite clear, however, is that each local Strategy for Health and Well-being will have a direct relationship with the local Community Strategy required under the 2000 Local Government Act. The Strategy for Health and Well-being (for example social care plans) will in turn provide a framework within which more detailed service delivery and operational plans can be taken forward by all partners. The strategy should therefore come to replace the strategic elements of the Health Improvement Plan, and contribute to the health-related elements of the local Community Strategy. An analogy may help to explain the relationships between the different layers of local strategic planning. If the community strategy is the bookcase for local strategic and service planning, then the Strategy for Health and Well-being is one of the books on the shelves; and the various service-specific and operational plans will be the chapters within the book. Parallel strategies – for example for crime reduction, for children and young people, or for economic development – may be other books on the shelf, and some of their chapters will inter-relate where service delivery plans overlap or complement each other.
The role of local authorities will be crucial in leading, with the LHB, the development and implementation of Strategic Partnerships for Health and Well Being. This is in line with their responsibilities for leading the development and implementation of local Community Strategies, and other cross-cutting strategies such as that for Crime Reduction, as required under the 1998 Crime and Disorder Act, and their power to promote social, economic and environmental well-being under the Local Government Act 2000.

How do you think the strategic partnerships should be structured?

**Local Health Boards as commissioners of secondary care services**

It is clear that Local Health Boards should be responsible for specifying the level and range of the secondary and tertiary care services required by their catchment population. This work must be dealt with at a level where there is sufficient critical mass and expertise to ensure effective and equitable service provision, consistent and high standards of care and value for money. This work would ideally take place at health economy level, either through the Assembly’s NHS Directorate or through groups of Local Health Boards working together.

To reflect the primacy of Local Health Boards in the assessment of health need and for securing health care for their populations, it is proposed that Local Health Boards should join together as consortia, based on the three health economy areas, to develop joint service plans and service level agreements for secondary care services. They should also prepare combined assessments for the more specialised tertiary services, which would continue to be secured through nationally agreed service level agreements.

On the basis that the aggregation of service needs for secondary care and more specialist care at a health economy level would provide the optimum critical mass for effective commissioning, it is proposed that LHB consortia should be set up to cover North, Mid/West and South/East Wales. Each consortia would put in place a range of shared supporting services that would be best organised, managed and delivered at a supra LHB level. This would ensure value for money, affordable high quality support that would not be viable or sustainable at individual LHB level. Consortia would also provide a good focus for the NHS Directorate’s interface with its NHS partners for planning and monitoring at a strategic level.

Additionally, in order to ensure that LHBs have good access to scarce specialist advice and services while ensuring value for money, it is envisaged that they would share services at consortia level in the following disciplines:

- Financial Support Services
- Planning (strategic);
- Information Services;
- Public Health;
- Professional Advisers;
- Corporate Support;
- Human Resources.
- Estate Management

One LHB in each consortium would be responsible for managing shared services on behalf of all LHBs in the consortium. These services, however, would be an asset shared equally by all the constituent LHBs.
The LHBs forming the consortium would have two main areas of collective business. First, they would oversee the joint corporate business of managing shared services and dealing with matters of common interest. Second, they would need to meet regularly with their professional advisors, their partner NHS Trusts and other providers to discuss and formulate service plans and service level agreements, to negotiate and determine clinical services and wider workforce planning issues. In this role LHBs would be joined by their partners from local government and the voluntary and independent sector. For this purpose NHS Trusts will be required to enter partnerships with LHBs and other service providers.

The constituent Local Health Boards would continue to be individually responsible for assessing local needs and securing primary care, community health and intermediate care services in their population. Each LHB will monitor the delivery of services and the quality of care provided to people within their catchment area.

This model assumes that:

- LHBs will be accountable for assessing local needs and securing primary care, community health and intermediate care services.
- LHBs will be required to work in partnership as consortia to provide a mutually supportive way of sharing services that makes effective use of resources and provides value for money.
- LHBs acting within the consortia arrangements will be accountable for securing secondary care services.
- The Assembly’s NHS Directorate will be accountable for securing and funding tertiary care services.
- LHBs will have a General Manager as Accountable Officer appropriately supported by a Finance Officer.
- The consortium will provide comprehensive technical financial and audit services to all its stakeholders;
- One LHB and its General Manager will take the lead on securing and/or managing shared services which will include professional advice and public health support and will be accountable to the constituent LHBs for the effectiveness of these services.
- Health Economy Offices within the NHS Directorate will, on behalf of the Director NHS Wales, oversee the strategic and commissioning work undertaken by the consortium and work closely with the individual constituent organisations to monitor their performance. This will be in support of the direct line of accountability between General Managers/Chief Executives and the Director of NHS Wales.

Do you have views on the commissioning of secondary care services by LHBs?

Do you have views on the proposed consortia arrangements and the arrangements for securing high quality support services for LHBs?

Local Health Boards as Providers of some Public Health Services

Accountability for health must be designated at the local authority population level and be the responsibility of an appropriately qualified public health specialist.
Local Health Boards together with Local Authorities need to develop their distinct, complementary roles in health and fulfil statutory and formal obligations; both need access to specialist public health skills - communicable disease, health promotion, child protection, epidemiology, health needs assessment, health/environmental/social science etc. NHS Trusts and others may also require public health expertise.

Public health specialists working at this level must not be isolated from their peers; critical mass is a concern where there are relatively scarce professional resources; individuals may have to provide services to a number of different local organisations.

The anticipated accreditation of non-medical public health specialist training will enable a much wider range of individuals to play a key role in future.

The accountable public health specialist must be a member of the Local Health Board, be a key player in the Local Strategic Partnership and have full credibility with the Local Authority. There may be scope for joint or shared appointments encompassing relevant Proper Office functions.

All public health specialist and support staff must be brought together across Wales through a public health service network, co-ordinated and managed by a public health director in each of the three Consortia who will be responsible for deploying public health resources to fulfil the full range of statutory and other functions across the health economy.

The three directors will have a line of accountability to the Chief Medical Officer.

**Governance**

**Transitional Arrangements**

The existing LHG Chairs and members have been asked if they would agree to an extension of their tenure until the end of March 2003. The new Boards will be established in shadow form in Autumn 2002 to prepare for their formal establishment in April 2003.

**The New Arrangements**

The Plan requires new models of participation and involvement, openness in the policy process and greater transparency in local decision making. The Nolan Committee has laid down clear principles for the governance of public bodies and which it will be important to respect in the creation of the Local Health Boards. It is envisaged that by comparison with current Local Health Groups, Local Health Boards will have:

- Greater democratic involvement to address democratic deficit;
- Greater accountability to communities;
- Greater visibility and openness.

Accountability to the community and the Nolan principles require that the Board should not be dominated by those with a financial or other direct interest in the decisions which it takes. In view of the particular need to ensure the independence of the Chair this will be a public appointment made by the National Assembly for Wales subject to the Nolan principles. It is envisaged that the Chair would need to live and/or work locally.

A key issue for the success of Local Health Boards will be securing the right balance of representation between the health professions, local government, the voluntary sector, and the
public. It will be equally important to ensure that the Board does not become so large as to be unwieldy and incapable of effective decision-making.

Local Health Boards will be statutory NHS bodies, and as such it will be in accordance with normal practice for Board membership to include both the General Manager and the Finance Officer.

It is clear that the expertise of the full range of health professions involved in primary and community care should be available to Local Health Boards, and accordingly all disciplines - doctors, nurses, optometrists, pharmacists, dentists, Professions Allied to Medicine and public health professionals - should be eligible for professional membership of Boards. The need to have a proper balance of professional and non-professional interests on the Board, coupled with the need to keep Board membership to a realistic size for effective working, means however that it is likely that not every discipline can be represented on every Board. Effective mechanisms will need to be put in place to ensure that Boards can and do co-opt expertise from disciplines not represented on the Board as and when necessary and ensure robust liaison with Trusts and other advisory relationships.

The health professional membership should be elected in accordance with a protocol to be agreed with their representative bodies. This will set in place a transparent process for the selection of appropriately qualified people at the local level.

The NHS Plan highlighted the need for effective local government representation on Local Health Boards and announced that it would include elected members. The WLGA will be consulted about a protocol for the appointment of local authority representatives based upon local authority principles of openness and accountability.

The voluntary sector is also an important partner in community health services and must be represented. Similarly with the voluntary sector, the Wales Council for Voluntary Action will be asked to advise on the election of voluntary sector representations.

The Plan also lays great emphasis on the importance of the patient and public perspective in the health planning and decision making processes and representatives of the public should, on this basis, have places on the Board. The means of selection of lay representatives needs careful consideration to ensure they are effectively accountable to the populations they represent. It is proposed that the Welsh Association of Community Health Councils be asked to advise on practical ways of achieving such public representation on LHBs.

An accountability agreement based on role specification will be developed for each Board member detailing the responsibility and contribution expected from them. It will make explicit that it is the role of all Board members, irrespective of their background, constructively to promote the health interests of local people in relation to planning and delivery of services and that personal and sectional interests have no part to play.

What would you suggest as the upper limit on the number of Board members if Boards are to function effectively?

What would you suggest as a balanced and appropriate membership for Local Health Boards?
THE NATIONAL ASSEMBLY

The role of the NHS Directorate

The NHS Directorate has an important role in the provision of strategic leadership to the NHS in Wales and is responsible for implementing the Assembly’s policies and strategies for the management and development of the NHS. In summary its role can be described as:

- Providing leadership to the NHS and its partners;
- Setting strategic direction;
- Developing, implementing and reviewing policies and plans;
- Advising the Minister for Health and Social Services on securing and allocating health resources;
- Driving whole system change;
- Agreeing priorities and resources for service development;
- Setting clear accountabilities for implementation and delivery;
- Creating optimum size and capacity within the Assembly and the service to deliver high quality care and services to patients and the community;
- Creating, implementing and reviewing corporate standards;
- Reviewing progress/achievement and disseminating good practice;
- Public engagement and effective communication with the service;
- Ensuring a strong voice for the voluntary sector at all levels;
- Ensuring that there are effective relationships with voluntary and independent sector as partners in service provision

This will involve:

- Managing risks;
- Managing the short, medium and long term change process;
- Addressing the wider agenda of health improvement;
- Ensuring best practice;
- Speaking with one voice for coherent and consistent approaches;
- Working through the discipline of project management.

Policies and plans must be set in the context of health and well-being and will involve:

- Specifying required levels of activity and accountability;
- Addressing the full range, quality and effectiveness of services;
- Directly linking organisational objectives with personal accountabilities and objectives;
- Addressing inequalities both in health improvement and access to health services dealing with range and quality.

The principles for the NHS Directorate should include:

- Working in partnership;
- Clear accountabilities for all;
• The Directorate becoming the employer of choice;
• Balanced mix of skill, experience and competencies to fit the job;
• Providing demonstrable added value;
• Enjoying the confidence of Ministers, politicians, the public, professionals and partners;
• Evidence based policies, programmes and method;
• Transparency;
• Based on the cultures of learning, teaching and sharing;
• Results and outcome based;
• User and partner focused;
• Responsive;
• Outward looking and developmental;
• Efficient and effective.

The Director needs a strong supporting team to help provide the leadership and direction needed by the NHS across Wales. The range of functions forming the new NHSD would include:

• A Renewal Team which would drive improvements, develop good practice and oversee the research and development programme;
• A policy, planning and implementation team that would develop national policy strategies and plans and ensure their implementation through a new process of project management. This Team would be structured to include functional teams dealing with primary and community care, secondary care and tertiary care. Responsibility for commissioning tertiary care services and possibly emergency ambulance services would lie here;
• A Finance Team that would prepare the overall financial strategy for the NHS, manage the resource allocation process, provide financial information and take a lead in value for money work;
• A quality, performance management and review team to maintain, develop and implement the performance management process to liaise with and implement the proposals of CHI and NICE including overseeing the clinical governance process and reviewing the success and outcome of policy and planning implementation;
• A Human Resource Team providing a national perspective on pay and reward systems, training and education, workforce planning, leadership and management development, and workplace health;
• A management team for facilities including Estates and Information and Information Technology to co-ordinate policy and develop services in Wales.

These functional teams would support the Health Economy Teams in providing the technical support needed to deal with issues or contribute to projects as they occur.

The organisational relationship between the Assembly’s NHS Directorate, Local Health Boards and Trusts

The Plan proposes a direct line of accountability between the Assembly and the Local Health Boards and NHS Trusts. This will include a direct relationship between the Director of NHS Wales and the Chief Executives of Trusts and the General Managers of Local Health Boards.

This span of control between the Director and the 37 senior managers in NHS Wales is hardly practical. While the line of accountability between each LHB General Manager and between each NHS Trust Chief Executive must ultimately lead to the Director, support will be needed to ensure effective oversight of the day to day performance of all organisations.
The health economy model on which the collective activity that LHB Consortia could be based would provide an equally useful focus on which to build the operational arm now needed in the NHS Directorate.

It is proposed that three Health Economy Teams be established in the NHS Directorate. Each would be led by a director and the function of the team would be to link with the Consortium and its constituent Local Health Boards and Trusts (i.e. North Wales, South and East Wales, and Mid and West Wales).

The HET Directors would be an integral part of the NHS Directorate but would also have bases with which to spend time working in the health economies for which they are responsible. HETs would form an important interface in the implementation, monitoring and review of plans and policies. They would underpin the performance management framework and would facilitate the ‘top down, bottom up processes’ envisaged as part of the new partnership between the Assembly and the NHS.

The role of the three Health Economy Teams would include:

- Day to day contact with Local Health Boards and NHS Trusts to include performance management, implementation of plans and financial review;
- The development of clinical networks and health economies in liaison with Local Health Boards and NHS Trusts;
- Co-ordinating with LHBs and Trusts the specification for tertiary services;
- Provide a population health perspective for the health economy;
- The preparation and implementation of strategies and plans for health economies to guide LHB and Trust plans and to contribute to national plans and priorities;
- Arbitrating in disputes between the members of the Consortia in the content range and resourcing of service level agreements and in disputes between the Consortia and their providers;
- Monitor the arrangements for implementing the voluntary sector scheme across the health economy.

The Specialised Health Service Commission for Wales will be transferred into the National Assembly carry out its all-Wales functions as part of the new Policy, Planning and Implementation Team.

Do you have views or suggestions on the role and organisation of the NHS Directorate and its relationships with LHBs and NHS Trusts?

Public Health at the National Level

Increased capacity is needed within the National Assembly for public health policy, advice and for holding service providers to account. This will need to continue to operate across Assembly business and it is proposed that the Chief Medical Officer organise the National Assembly’s public health team on a health economy basis similar to that proposed for the NHS Directorate. This will facilitate further sharing of services such as information across the NHS, health and social care groups within the Assembly.

A national body is needed to support public health practice, wherever it is undertaken, to promote advocacy, to provide public health leadership and act as a hub for public health professional networking nationally and internationally. This should have a key role in promoting multi professional training/working, collating evidence from research and information sources and
incorporate within its functions those of the new Health Observatories in England. The “Wales Centre for Health” is being established to undertake this role.

A strong national focus is needed for national programs requiring substantial public health input, including all Wales Screening services and these should be located within an existing Trust. This is being considered as part of the organisation development plan referred to above.

A strong role in management of data and intelligence sources is required and public health cross membership of the proposed Information Services Agency (or its equivalent) and WCH at board level and operational input will be essential.

Inter professional accredited specialist public health training in Wales needs to be expedited. Generic skills must be developed in other professional groups e.g. those in primary health and social care.

**Primary Care and the NHS Directorate**

A new primary care policy division will be established within the NHS Directorate to focus attention on this important service.

The strengthening and development of Primary care health services is a central priority in implementing the Plan. As such the NHS Directorate must have the capacity, skills and experience to ensure that primary health care issues are handled well. Each of the functional teams within the Directorate will have specialist primary care staff that will be responsible for ensuring every aspect of work is given detailed attention and high profile. This will ensure that the Directorate will have a high level of primary care expertise across the range of functions aimed at radically strengthening its ability to provide the leadership and support now needed to take this vital area of work.

**INFORMATION SERVICES**

All organisations in the renewed NHS will need access to timely, accurate and relevant information. ‘Better Information, Better Health’ is being reviewed currently and a National IM&T Development Plan is expected in December 2001. The new Resource Allocation formula for the NHS, to be introduced from 2003 onwards will also need to be underpinned by a robust information system.

At national level, the information function in the NHS Directorate will set strategic IM&T policy direction, lead on standards for information sharing and ensure the information requirements of the National Assembly itself and the NHS are met.

At local level, Local Health Boards and NHS Trusts will need access to robust clinical and corporate information, to discharge effectively their responsibilities for delivering ‘Improving Health in Wales’. LHB consortia will also need information and IM&T support.

To support the requirements at both national and local level, there is a role for an all Wales information services function, which should include:

- National Databases and Data Warehouses
- NHS Wales Clearing Service
- Production of basic statistics and data sets
- HOWIS
- Corporate Information Infrastructure
- Technical support and responsibility for managing the IT infrastructure for the Exeter System
It is proposed that the functions of Health Solutions Wales will be integrated within the all-Wales function. This will complement the health intelligence, interpretation and information analysis function of the Wales Centre for Health.

These all-Wales information services and their circa 400 staff could be attached to existing all Wales services managed by NHS Trusts.

**PRIMARY CARE CONTRACTOR PAYMENTS**

LHBs will be accountable for securing and providing primary care services. The LHBs will need access to the range of information currently provided as a by-product of the ‘Exeter’ system and other independent contractor support systems.

The ‘payment’ mechanisms for the contractor professions are best managed on an ‘aggregated’ basis and aligned with LHB consortia pending the replacement of the Exeter System when the scope for further rationalisation will be considered. This will optimise the skills associated with prompt and accurate contractor payments, minimise the risk of system destabilisation and continue local access for individual contractors. The technical support and the management of the system infrastructure will be provided from the all-Wales information services agency.

**THE NEXT STEPS**

The strategic change needed to deliver the agenda set out in “Improving Health in Wales” is significant and fundamental in nature. It requires a paradigm shift in the way people and organisations think and behave, as well as new ways of working and different approaches.

In this context the Structures Task and Finish Group has recognised that organisational development would need to be considered at two levels:

- **First**, the short term OD required to facilitate the change in organisational functions and form that needs to take place by April 2003.

- **Second**, the longer term OD agenda required to ensure that these organisations deliver the various policy objectives and targets outlined in “Improving Health in Wales”, that they are aligned to the vision for the NHS in Wales and that they are attuned to working together to achieve this.

The following action is now taking forward the organisation development agenda:

- An All Wales group has been established to oversee implementation of the immediate OD agenda, and to take forward the longer term OD planning that is required to meet the broader policy agenda.

- Close links are being put in place between the group and other modernisation/strategic change initiatives such as Innovations in Care, and the Centre for Health Leadership, to ensure that the longer term OD agenda directly supports service improvement.

- “Local Development Teams” (based on the Scottish model), will be established and based on Health Economy areas, to deliver the strategic change agenda, of which the OD programme is a crucial part. Teams are responsible for producing Local Development Plans setting out how change is going to be implemented and are constituted from the relevant local partners. These need to be put in place immediately, in advance of the structural changes. (However, this may be difficult in view of the time commitments for other Task and Finish/Sub Groups)
• Chief Executives will be involved in the Local Development Teams and will be expected to champion the strategic change

• Resources have been set aside to implement the OD plan so that there are clear expectations about what can be delivered. These resources will be targeted at achieving specific outcomes.

• A comprehensive assessment of OD requirements at organisational level, and for individual Board members will take place over the next three months.

• A network of “OD providers” will be established, including the Centre for Health Leadership, to ensure that there is a range of options available to meet OD requirements. Further work will be undertaken regarding the potential contribution of other providers, and this needs to include academic centres.

• A “modernisation network” will be established with England, Scotland and Ireland to share best practice and where appropriate pool resources.

• Research into existing OD approaches in international health systems will be commissioned.

• Effective communication about the implementation of the Plan and the OD programme will continue to be developed to ensure that there is equal access to opportunities.

What are your views on the organisation development programme and the issues it should address?

CONCLUSION

Improving Health in Wales – A Plan for the NHS with its partners signals the renewal of NHS Wales and sets out an ambitious agenda for change and improvement. The Plan presents challenges that will demand new approaches. These will be based on new and dynamic partnerships within the NHS and between NHS Wales, local government, the voluntary and independent sectors and the communities they serve. They will need strong leadership and clear accountabilities at all levels. This consultative document sets out proposals for structural change that aim to provide the means to take the NHS forward and to meet the challenges it faces.

Please send your views and comments on these proposals by 19th October to:

Jackie Oakley
Health and Well-being Strategy & Planning Team
National Assembly for Wales
Cathays Park
Cardiff
CF10 3NQ

Email: jackie.oakley@wales.gsi.gov.uk