NHS Wales

*Putting Patients First*

Presented to Parliament by the Secretary of State for Wales
by command of Her Majesty January 1998

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Preface by The Prime Minister

Creating the NHS was the greatest act of modernisation ever achieved by a Labour Government. Aneurin Bevan's place in its history gives it special significance in Wales. Its creation banished the fear of becoming ill that had for years blighted the lives of millions of people. But I know that one of the main reasons people elected a new Labour Government on May 1 was their concern that the NHS was failing them and their families. In my contract with the people of Britain I promised that we would rebuild the NHS. We have already made a start. The Government is putting an extra £70 million into the health service in Wales during the course of this year and next. More money is going into improving family doctor and hospital services. The NHS will get better every year so that it once again delivers dependable, high quality care - based on need not ability to pay.

This White Paper marks a turning point for the NHS in Wales. It replaces the internal market. We are saving £50 million of red tape and putting that money into frontline patient care in Wales. For the first time the need to ensure that high quality care is spread throughout the service will be taken seriously. Nationwide standards of care will be guaranteed. There will be easier and swifter access to the NHS when you need it. Our approach combines efficiency and quality with a belief in fairness and partnership.

As we approach the fiftieth anniversary of the NHS in Wales, it is time to reflect on its huge achievements. But in a changing world, no organisation, however great, can stand still.

The NHS needs to modernise in order to meet the demands of today's public. Putting Patients First begins the process of modernisation in Wales. The NHS in Wales will start to provide new and better services to the public. For examples, faster tests and treatment for breast cancer, and better and speedier information from hospitals to GPs about their patients.

In short, I want the NHS in Wales to take a big step forward and become a modern and dependable service that is once more the envy of the world.

Of course, we must get the funding right. The Government has already put large extra sums into the NHS and will raise spending in real terms every year. But with that money comes a responsibility within the service to change. To produce better care. Care when you need it. Care of uniformly high standards.

It is a big challenge but I am confident that, with the support of the public, the dedication of NHS staff and the backing of the Government we can again create an NHS in Wales that puts patients first, an NHS
that is truly a beacon to the world.
The Government was elected on a Manifesto to restore the National Health Service as a genuinely public service of high quality, delivered in co-operation with others to protect and improve health as well as respond to illness and disability. This White Paper, Putting Patients First, sets out our vision for NHS Wales and explains how, working together, we can fulfil these commitments.

None of the values enshrined in the NHS when Aneurin Bevan created it will be lost. The NHS in Wales will continue to be a truly national service available to all on the basis of need. Need alone; not ability to pay; not who your GP is and not where you live. We will back these values by raising spending on the NHS in real terms every year and investing that money in better services for patients.

Our objectives are clear: to help the NHS work collaboratively with all who can improve services for patients; to do away with competition, avoidable bureaucracy and fragmentation; to put quality at the top of everybody's agenda, and to allow decisions to be taken locally. We will meet these objectives by doing away with the internal market which has pitted hospital against hospital. We will put in its place new arrangements which encourage co-operation and drive up performance.

"Putting Patients First" also honours our commitment to enhance the role of primary care. Local Health Groups will open up new opportunities for GPs, nurses, other health care professionals, local authorities and local people to take the lead in organising health services for their communities. Change is essential, but it will be evolutionary and in response to local needs. The Government will give a national lead where this is important; otherwise health authorities, NHS trusts and Local Health Groups will have clear responsibilities to improve the quality and range of services offered to patients.

"Putting Patients First" provides solutions which are right for Wales and it paves the way for the creation of the National Assembly for Wales in 1999. More importantly, it will restore to its people a service which is true to its founding principles, faithful to its ambitions, responsive to its users and confident in its future.
PUTTING PATIENTS FIRST

1. A NEW BEGINNING

The Government was elected to return the NHS to its roots as a service of high quality, delivered in co-operation with others to protect and improve health as well as respond to illness and disability. The internal market's emphasis on competition ran counter to the NHS's long-established philosophy of co-operation and partnership. This White Paper is founded in the belief that reform of the NHS is about more than recreating mechanisms to replace the failed internal market. It is about reaffirming its founding principles and devising new responses to the challenges which face it.

1.1 This year sees the 50th anniversary of the founding of the NHS. Wales made a proud contribution to its creation. In the years since Aneurin Bevan created it, the NHS has developed into one of the nation's most cherished institutions, admired throughout the world as a model of comprehensive and cost-effective health care, made universally available on the basis of need and backed by specialist services and extensive programmes of professional and technical research.

1.2 None of these values will change; the NHS will continue to be a truly national service available to all on the basis of need. It will also be a service rededicated to patients to ensure that they can receive speedy, appropriate and effective care and have a voice in the way services are provided and developed. However, the NHS faces a number of enduring challenges:

. rising demand and expectations by patients, which require that the NHS is managed in ways which retain and enhance the patient focus while using available resources as effectively as possible;

. the impact of medical technology and the growing influence of technological progress (for example, keyhole and transplant surgery, telemedicine, the role of genetic engineering in the production of drugs and vaccines, and the role of genetics in all aspects of health care);

. demographic pressures which, in Wales, will mean that by 2015 8.8% of the population will be over 75. This is 14% higher than is expected to be the case in England and it will have significant implications, for cost as well as care, for the NHS, local government and voluntary agencies;

. best practice in health care needs to become common practice. Identifying good practice and spreading success across organisations whose performance varies widely will be a priority for the new NHS.
1.3 These pressures are real but not insurmountable. There have always been challenges from technology and rising demand. They will continue but do not inevitably point in one direction. New medical treatments and technologies may replace outmoded and more expensive services; efficiencies can come from making better use of existing resources and also from shaping services in the light of new evidence on clinical cost effectiveness; and new approaches, including those outlined later in this White Paper, to give professionals greater control over financial as well as clinical decisions, can reap rewards in more cost-effective services. Equally, it is clear that tough choices have to be made. Performance has to improve if patients are to receive the quality of services they need.

The Health Deficit

1.4 Health in Wales is poorer than in the UK as a whole and than in many other Western European countries. Life expectancy is about one year less than in England; the death rate from heart disease in Wales is about 18% higher, and rates of cancer are about 10% higher.

1.5 There is increasing evidence of substantial variations in health between people living in different parts of Wales. Death rates from heart disease, lung cancer and breast cancer can be twice as high in some parts of Wales than in others and communities in the South Wales valleys tend to have poorer health on a wide range of indices than communities in many other parts of Wales.

1.6 In 1997 there were also very high numbers of people registered as economically inactive; people with long-term illness make a disproportionate contribution to this number. This is particularly so in the South Wales valleys. NHS Wales has, therefore, to address a considerable extra burden of illness.

1.7 Improving health generally, and where the inequalities are worst, is a challenge for all agencies, private as well as public. They need to engage with the NHS at all levels to tackle the underlying causes of ill health, to support doctors and other health professionals in caring for the patients involved, and to co-operate with other agencies to provide the collaborative programmes which are necessary to enable individuals to undertake a wider range of appropriate employment. It is also a long-term challenge and one with which the organisations, resources and principles of the new NHS must be aligned. This White Paper, and a companion paper on a national strategy for improving health to be published early this year, seeks to establish this collaborative approach with organisations whose decisions on community services, housing, employment and the environment considerably affect the health of the people.

The NHS Internal Market

1.8 The NHS needs to be well organised to respond to the health needs of Wales. The internal market was introduced in 1990, ostensibly to improve the management of the NHS. It has had some limited success, but it has failed to address the most fundamental issues facing the NHS in Wales and, most damagingly, was divisive in a service where co-operation between staff and between organisations is the key to good care. The Government intends to remove those aspects of the internal market which have stood in the way of improving health and good patient care, while retaining what has worked.

1.9 The Government will:
retain the separation of the commissioning process, by which health care needs are assessed and health services are designed to meet them, from the provision of those services. This allows commissioners, particularly health authorities, to step back from the demands of day-to-day operational management and ensure that services better meet the needs of local people;

promote further the involvement of GPs and other primary care professionals in commissioning services for their patients. This has moved on from the narrow confines of GP fundholding to a variety of models in which groups of primary care professionals can work together in the wider interests of their patients;

improve still further data about activity and cost, which have given a clearer picture of what is happening to patients and to the NHS, and other information which has progressively helped health care practitioners and patients make informed choices about treatments;

continue to develop better communication between the primary and secondary care sectors, which has encouraged closer working between the two;

retain the devolved operational management of NHS trusts.

1.10 However, the internal market created new and avoidable problems:

inequalities in health and access to health services have been made worse by the creation of new divisions between the patients of fundholder and non-fundholder GPs. The services patients receive are too often determined more by where they live and who their doctor is than by their clinical needs;

In 1996-97:
Population coverage by GP fundholders ranged from 42% in Bro Taf to 73% in Dyfed Powys;
GP fundholder allocations per head of population in Wales ranged from £116-£289.

while health authorities, local government and the primary and secondary care sectors are all agreed that the long-term planning of health services and the wide range of associated decisions on education, training, research, evaluation and resource effectiveness should be a major responsibility for the new NHS, there has been no recent effort to provide a planning framework within which the NHS can function coherently. Getting the best care and the best value out of an organisation as complex and large as NHS Wales calls for longer-term planning, something which has been particularly difficult within the fragmented structure of the internal market

In the Southern part of Wales only one hospital has an exclusive catchment population for accident and emergency services. Some communities in south Wales have access to four A&E departments within a 30-minute travelling distance. In north and west Wales such overlap is rare.

competition among providers and annual contracts for health services have focused management attention on what can be costed and counted rather than what should be. Resources have been diverted from patient care into a bureaucratic process that has had little to do with the quality of care provided for
patients. That process has been inefficient.
By September 1997:
no health authority has agreed all its contracts for 1997-98 with health service providers;
no NHS trust could be confident about what its income would be for the current year;
less than half of fundholding practices had agreed their funding allocation with their health authority.

A New Beginning

1.11 The Government recognises that it is the system which has failed, not the staff working in it. Clinicians and managers have worked harder than ever before to make sure that services are delivered and that patients have not been disadvantaged. Building on this spirit, the Government’s aim is to put teamwork and collaboration back at the heart of the NHS in a programme of co-operative activity which extends over a number of years but has clear milestones.

1.12 The key objectives of the new NHS will be to:

. remove obstacles to integrated care;

. develop local responsiveness to take advantage of the greatly enhanced prospects for providing care in, and close to, patients' homes;

. reduce health variations across Wales and tackle inequalities in health and in access to health care;

. better align responsibilities for clinical and financial decisions within local settings which are best able to deliver integrated programmes of care;

. exploit modern technology to the full to provide better information to people and their local GPs so that both may make better informed choices about care;

. improve efficiency at all levels within and between organisations and their individual members of staff;

. enhance the quality of care, starting with good quality research and development, which embraces clinical effectiveness and includes organisational performance measured, in part, by programmes of continuous benchmarking;

. make the continuous training and development of staff at all levels and in all sectors a priority.
Working in Collaboration

1.13 This vision reinforces the strategic themes set for NHS Wales ten years ago, but which have been hampered by the internal market and the lack of political conviction. They are that:

. the NHS should be health gain focused, seeking to reduce both the number of premature deaths in Wales and to improve the quality of life;

. it should be people centred, managing its services for the benefit of patients and informed by patients' views;

. the service should be resource effective.

1.14 The Secretary of State accepts that these objectives remain relevant today, but they need to be interpreted and pursued within the context of society's wider efforts to improve health and the need for NHS Wales to work in collaboration with other organisations. The NHS should be a service which embodies fairness, efficiency, effectiveness, responsiveness, accountability, integration and flexibility. Patients should receive the same level of service and quality of care for the same level of need. As health needs vary across Wales, so services need to be tailored to local circumstances to deliver equity of access and treatment. Responsibility for decision-taking should be devolved as close to patients as possible to encourage responsiveness and innovation in service. Devolution of responsibility must be matched by mechanisms for accountability and control.

1.15 Competition, fragmentation, avoidable bureaucracy and insularity will be brought to an end. The new NHS will be a unified national service in which staff and users share a common understanding of what patients can expect from the NHS; and how patients, families, local communities and related organisations can contribute. This will require a new commitment to partnership at every level:

. nationally, between the Government and the people to give improved health and appropriate health services priority in its decisions and to honour its pledge to continue with real terms increases in funding year on year;

. between patients and the professionals who serve them to ensure that personal responsibility for health matches professional duties of care and that both groups share a common commitment to developments in the NHS;

. between the NHS and its partner organisations, whether in the public and voluntary agencies or in the private sector, to ensure maximum benefit from available resources and maximum co-ordination of related activities;

. between NHS organisations themselves to promote maximum integration of services and foster co-operation.
The Patient Focus

1.16 The new NHS will start from the patient in his or her home and community, providing:

. information to help the individual lead a healthier life and respond appropriately to minor ailments;

. access to a network of primary and community care services for most needs. For those specialist services which cannot be provided locally, primary and community health care professionals will act as a conduit to refer patients to the appropriate services;

. integrated and flexible programmes of care which span organisations and encourage doctors, nurses, pharmacists, midwives, dentists, opticians, therapists, social services departments and others to work together;

. general hospital services, covering emergency and non-urgent care and diagnostic services;

. specialist services, where quality of care can best be provided from a small number of expert centres.

1.17 This concentration on the patient and integrated, individual and population-based programmes of care must shape the NHS of the future and inform the ways in which the service is managed.

Care through Performance

1.18 Establishing the new NHS will demand the highest level of performance. The Government will be clear about what the NHS must deliver. It will establish new systems and structures to support and motivate all in the NHS and give them the flexibility to find local ways forward; and it will hold participants to account for how well they perform. The Government is committed to raise spending on the NHS in real terms every year and to invest the money in patient care. In return, it will expect utmost effort at all levels to use resources to address the new agenda. Good performance will be recognised and rewarded; deficiencies will be acknowledged and tackled.

1.19 To ensure that standards of performance are comparable with the best, the Secretary of State will:

. measure progress against the values set out in paragraph 2.3;

. set clear objectives for NHS Wales, including National Service Frameworks for major diseases and programmes of care (for example, cervical cytology);

. promote best practice through the development of performance measures and a benchmarking culture;

. ensure that the work programmes of the new Commission for Health Improvement and the National Institute for Clinical Excellence address the needs of NHS Wales;

. develop new performance indicators to measure progress against key objectives;
Health authorities will monitor the performance of NHS trusts to ensure that objectives are achieved. The Welsh Office, and subsequently the Assembly, will monitor the performance of health authorities.

1.20 The NHS alone cannot deliver real improvements in health. It must work in partnership with the public and the individual - doctors can offer advice on healthier lifestyles, but they cannot force their patients to give up smoking, take more exercise or drink more sensibly. The pressures on the NHS are increased by the many people who do not take personal responsibility for their own health or for dealing with minor ailments, and who continue to make unnecessary demands upon the service. It is for every individual to ensure that when they call out their doctor or turn up at the local casualty unit they do so only in circumstances of real need. When they are called for treatment, patients have a responsibility to turn up or to advise the hospital in good time that they cannot attend.

Roles and Responsibilities

1.21 The Secretary of State has canvassed the views of NHS Wales on weaknesses in the existing arrangements, on strengths to be retained and enhanced, and on new measures which are necessary to deliver its more inclusive and forward-looking agenda. There is agreement on the need to limit turbulence from organisational upheaval, to reinforce the strategic commissioning role within a broader framework of health and to facilitate stronger links between clinical and community services at all levels. The model proposed in this White Paper acknowledges and responds to these concerns. It offers a framework which builds on the distinctive strengths of each participant, provides clarity about their respective roles, encourages flexible and co-operative working across boundaries and focuses on the needs of patients.

1.22 The new NHS Wales will be composed of:

- **Health Authorities**, who will have new duties of partnership and to improve the health of their residents, while retaining existing responsibilities for public health protection, health needs assessment, strategic planning and performance management, and relationships with newly-created Local Health Groups;

- **NHS Trusts**, who will be charged with new responsibilities for co-operative action with health authorities, Local Health Groups, local authorities and others, and for improvements in service quality and relationships with patients and the public;

- **Local Health Groups**, which will be based largely on local authority areas to enable more effective commissioning of local services, encourage inter-agency co-operation, provide real leverage on services and resources for primary care practitioners, and facilitate the progressive provision of a wider range of local services. They will decide what services are needed locally and reflect the priorities of the people they serve in the services that are commissioned for them.
1.23 These new arrangements will need to be resourced in a manner which is both equitable and provides proper accountability for public money. The Secretary of State will continue to make discretionary allocations to health authorities based upon a weighted capitation formula. Health authorities will be able to retain funds, in addition to whatever sums they need to commission services at the health authority level for purposes set out later in this White Paper.

1.24 The vast bulk of the allocation, however, will be delegated to Local Health Groups. The Government expects that this will normally be done on the same formula basis, although the health authority will need to have the discretion to adjust allocations to improve equity of service and of access to service where it felt that was appropriate. At first, this will be on an indicative basis, to provide Local Health Groups with a budget and a cash ceiling to work within.

1.25 Over time, as Local Health Groups gain experience, the range of their decision-making powers will be increased and their budgets will move from being indicative to being actual - in other words, the money itself will be delegated and Local Health Groups will become directly responsible for administering their budgets.

1.26 The Local Health Groups will, in due course, extend indicative budgets to individual practices for the full range of services. Within these budgets, practices will have discretion and flexibility to make appropriate clinical decisions. Local Health Groups will be expected to develop practice level incentive arrangements approved by health authorities where this promotes best use of resources.

Evidence of good and bad practice from the locality commissioning pilots currently being set up in both England and Wales will be used to refine these arrangements over time.

A National Assembly for Wales

1.27 The environment within which the changes proposed in this White Paper will be implemented has been transformed by the decision of the people of Wales to establish a National Assembly for Wales. From 1999, the Assembly will assume responsibility for health functions currently exercised by the Secretary of State. It will remove the democratic deficit which has damaged the conduct of public policy in Wales for so long and it will supervise the development and delivery of policies which will make a real difference to the quality of life in Wales and the welfare and care of its people. The Assembly will have freedoms to:

. draw up strategic policies for health and health services and allocate resources accordingly;

. configure NHS Wales in ways which are consistent with its wider agenda for health and facilitate a collaborative and performance-driven approach to the provision of health care;

. hold NHS organisations to account for their performance;

. promote the provision of particular services or take direct action in support of particular priorities at an all-Wales level.

1.28 Devolution provides an opportunity to build on the strengths and distinctiveness of NHS Wales and
its work with others. The proposals in this White Paper will redress the inequities of the past decade, take advantage of professional and technological developments, provide better value to the taxpayer and return NHS Wales to its roots as an outward looking but distinctively Welsh service responsive to its peoples' needs and views. Most of all, it will put patients first.

**SUMMARY**

*The NHS will be required to:*

- reduce health variations across Wales and tackle health inequalities;
- build services around integrated, flexible programmes of care for patients;
- develop new ways of working collaboratively;
- improve efficiency;
- make maximum use of the opportunities created by modern technology; and
- give priority to the training and development of staff at all levels.

The creation of the National Assembly for Wales will provide a democratic means to supervise NHS Wales. It will inherit the three strategic themes which have underpinned the development of NHS Wales over the past decade - to be health gain focused, people centred and resource effective. These themes will be reinforced by the drive to engage society as a whole in efforts to improve health and they will be pursued through programmes of activity at every level which measure progress against key criteria - fairness, effectiveness, efficiency, responsiveness, integration, accountability and flexibility.

*New NHS Wales will be comprised of Health Authorities, NHS trusts and Local Health Groups. Each will be given new responsibilities and powers to improve services for their patients.*
The National Assembly for Wales will give Wales its own, distinctive democratic voice. The Assembly will oversee NHS Wales, ensuring that it works in partnership with others to deliver real improvements in health and high-quality care for the people of Wales. Through the Assembly, NHS Wales will be made more accountable and responsive than ever before to the people it serves.

The National Assembly: Shaping and Leading

2.1 The Government of Wales Bill is currently before Parliament. Subject to Parliamentary approval, the establishment of the National Assembly for Wales in 1999 will transform public life in Wales and introduce for the first time democratic control of the management and performance of the NHS and its partner bodies. The White Paper, "A Voice for Wales", outlined the Assembly's intended health functions:

. to monitor the health of the Welsh population and respond with policies to promote health and tackle ill-health;

. to decide the scale of financial resources for health from within its overall budget;

. to identify and promote good practice in health services and hold NHS bodies in Wales to account for their performance;

. to canvass and act upon the views of patients, staff and carers on the quality of NHS services;

. to ensure that NHS Wales has a workforce of well-trained staff.

2.2 The Assembly will be able to set goals for NHS Wales which reflect a commitment to improve the
health of the population and provide care as locally as possible. These goals are set within the three strategic themes - health gain focused, people centred, resource effective - which have underpinned the development and management of NHS Wales and continue to provide a valuable framework for planning and action.

2.3 In turn, these themes will be pursued through programmes of activity which reflect the values set out below. Within Government policy, the Assembly will be able to ensure that all parts of the NHS are targeted on, and contribute appropriately to, these values:

. fairness - all patients should have access to treatment and services according to their clinical needs;

. effectiveness - patients should be treated on the basis of the most up-to-date scientific evidence and clinical practice;

. efficiency - the NHS should use all its resources, including capital assets and staff, to achieve best value for money;

. responsiveness - services should be designed around the patient so that, consistent with the other values, the NHS delivers the quality of treatment and care that patients and carers need, in the way they want it;

. integration - organisations both inside and outside the NHS work together to deliver integrated care packages, tailored to the individual patient's needs;

. accountability - the NHS must be made accountable to the people it serves;

. flexibility - management systems must be flexible enough to respond to local circumstances and needs while also enabling the NHS to deliver health improvements for the wider population.

The National Assembly: Promoting Co-operation

2.4 An overriding objective for the Assembly will be to rekindle the principles of co-operation and partnership throughout the new NHS:

. nationally, through agreements between the professions, the public and NHS bodies on new approaches and standards;

. locally, through new duties of partnership between NHS organisations, the public, local government and voluntary agencies and via new programmes of co-operative action;

. within communities, with the joint commitments of patients, primary care professions, community and social services and voluntary bodies;

. via mechanisms, including the Welsh Health and National User Surveys and a revised NHS Charter, which identify need and priority and balance the legitimate expectations of patients with the
2.5 Over the next eighteen months preparations will be made to ensure that the Assembly can take on its responsibilities for health and health services. This will require information, organisation and policy developments. However, renewal and reform in NHS Wales cannot wait until the Assembly is fully operational. Once it has taken up the reins, the Assembly will be able to review the preparations made and progress in reshaping NHS Wales and confirm or further adapt them. This section describes the work needed to prepare the ground for the Assembly.

Organisations and Relationships

2.6 There are well-established relationships between the Welsh Office and the other UK health departments and between Welsh professional bodies and their counterparts in the other countries. The Government intends that these should continue within the new settings that will follow devolution and that the policy making and performance management roles of the Assembly should be strengthened. This will be assisted by the absorption into the Assembly of the Health Promotion Authority for Wales and some aspects of the Welsh Health Common Services Authority.

2.7 To prepare for that, the Welsh Office will be examining how its current Health Department, Health Professionals Group and Nursing Division, with HPAW and parts of WHCSA, should be organised in future and how their working practices could be better integrated. The new agenda and its implications for organisational responsiveness will also require closer working between Assembly and NHS staff and new training and development programmes to improve collaboration and understanding between the organisations. The Welsh Office will work with NHS Wales to ensure that these programmes are developed.

2.8 The Assembly will set clear objectives and standards for NHS Wales including, as necessary, National Service Frameworks covering major diseases and linked to the Government’s priorities for improved health. These will be developed in collaboration with other UK health departments. In particular, the Assembly will lead the development of comparative information on performance and benchmarking in the NHS, which will, in time, include a national schedule of costs to support the drive for enhanced efficiency and effectiveness.

Performance Management

2.9 At the heart of the new arrangements will be the efficiency with which services are provided and run. The efficiency theme applies equally to clinical practice as to management performance. Significant progress has already been made:

- efficiency savings: in the last five years, the NHS in Wales has delivered efficiency savings in excess of £350 million;

- a comprehensive clinical effectiveness strategy and programme has been in place in Wales for the past
two years;

following consultation, a decision on the configuration of NHS trusts across Wales will be announced in October 1998, with a new pattern for the management of hospital and community health services established from April 1999;

comparative trust costs have been published for the past two years.

2.10 But more is needed if the philosophy is to root itself equally in the management culture of all NHS organisations. Performance measures and benchmarking have an important role to play in exposing poor performers and charting progress, improving public accountability, providing a basis for setting targets and promoting best practice. With this in mind, the Welsh Office will work with the Department of Health in establishing a new National Institute for Clinical Excellence and a Commission for Health Improvement. These are explained in greater detail in Chapter 3. The structure and operation of these bodies will be expected to reflect the needs and circumstances of Wales and to relate to its existing NHS bodies. The Department will also lead an information-led programme of benchmarking for improvement. The existing Benchmark Reference Centre - currently a performance measuring unit within the Welsh Health Common Services Authority - will be substantially reformed within the Health Department to support this process.

Information for Performance

2.11 To discharge its responsibilities the Assembly will need ready access to good quality, timely information. Principally, this information will need to cover the health status of the Welsh population and the performance, including the comparative performance, and expenditure of NHS bodies.

2.12 Information systems will need overhauling and bringing together as a "Health of Wales" information system to meet these requirements. A review is already in hand; further changes will be needed as the Assembly’s role develops. Immediately, action is needed on several fronts:

- the Department will consult NHS Wales on the development of new performance indicators designed to measure progress against the targets and objectives set in this White Paper;

- the Department will take the opportunity to streamline and refocus the collection of information from NHS Wales bodies for central purposes;

- to make full use of new technology to automate central returns, reducing the costs of administration and making important information available more quickly;

- data quality still leaves much to be desired and, as part of the review of information systems, the Department will be introducing a programme of work to improve data quality for all NHS bodies, from which central returns are largely a by-product.
Services at the All-Wales Level

2.13 Existing arrangements for the planning of specialist and key new services have not always worked well. As a consequence, opportunities have not always been taken up and some services have encountered avoidable turbulence or delay. Similar concerns have arisen where services are being rationalised. Work will be put in hand to devise improved arrangements, under the Assembly, for the planning and management of these services across health authority boundaries and between NHS trusts.

2.14 Similar considerations apply to the oversight of research and development in Wales. High-quality research and development is fundamental to the NHS, both at a national and UK level. Health services face unprecedented levels of demand; at the same time the evidence base to support the existing patterns of provision is limited and there is a constant need to review and re-evaluate the approaches used in health. The factors which create the demand on health services need to be understood and effective and efficient interventions used to address the needs of those requiring services.

2.15 The Wales Office of Research and Development was established in 1995 as part of the University of Wales College of Medicine to take forward the R&D strategy for Wales and to represent Welsh R&D interests in UK settings. Its primary role is to support the development of an evidence-based culture by encouraging high-quality research in health and social care.

2.16 Since its creation, the Office of R&D has established the existing baseline of health and social care research within Wales, set in place arrangements for the evaluation of bids for new research and begun the process of distributing new grants. In parallel, the Welsh Office, in co-operation with the Office of R&D, has initiated a review of the management arrangements, particularly the role and status of the Research and Development Forum which was established to provide a wider forum for the R&D community within Wales. The outcome of this review will need to inform decisions about its future management and status, taking account of any new structures that may be established within the Assembly or NHS Wales. Whatever its future management and status, it will be important that its programmes reflect the Government's new objectives and priorities for the health, welfare and care of the population. With this in mind, the Secretary of State has invited the Office of R&D to produce a new strategic framework for research and development in Wales for consultation during 1998.

2.17 The encouragement of healthy lifestyles and the promotion of healthier environments is an important aspect of the Government's approach. Some of this will be pursued through policies which encourage health as well as addressing sickness, which operate across agencies in a longer timeframe and which make progress by co-operative action at the local level. It will be equally important to have organisational structures in place in Wales which are best able to respond to this agenda and make a value-adding contribution without duplication. The Secretary of State has, therefore, invited the Health Promotion Authority for Wales, in advance of its absorption into the Assembly, to review existing arrangements for health promotion in Wales within the intended structures outlined in this White Paper and make recommendations for their improvement. This report will also be subject to discussion with NHS bodies and local government in 1998.
Planning for the Future

2.18 In readiness for the changes set out in this White Paper, the Department has reviewed the existing framework of strategic guidance - including Strategic Intent and Direction, Caring for the Future and the New Strategic Plans - and its relationship with the setting of planning and priorities guidance and the annual review of performance. It has concluded that change is needed to establish a much clearer focus for authorities' strategic planning and to put the review process on a firmer footing centred around the performance framework outlined in this White Paper. Eventually, both the guidance and performance review will relate directly to a new NHS Corporate Plan. In the meantime, the Department will reconsider the planning and priorities guidance and refocus the performance review process on the priorities set out in paragraph 2.3. This is likely to require some mechanisms to be abandoned, including Health Authority Plans, which are already on course for completion in June 1998, while others, including the contributions of the New Strategic Plans, will be absorbed into the new mechanisms for planning and performance monitoring.

A New Corporate Plan for NHS Wales

2.19 NHS Wales cannot operate effectively without a firm, fair and forward looking strategic framework. The Assembly will provide this following its creation. In the meantime the importance of clear corporate and strategic planning arrangements for the NHS has been recognised in the All Wales Service Review, jointly commissioned by the Health Authorities with the support of the Welsh Office, which concludes that there is a:

"need for a clear and rational planning process that facilitates the development of a strategic framework for NHS Wales, which provides health and related targets, linked to practical guidance on what and how strategic change might be delivered, and engages key stakeholders in an on-going dialogue about how best to achieve desired change".

2.20 The Secretary of State has accepted this conclusion, and a number of the related recommendations, and has invited the NHS to work under the leadership of the Welsh Office to produce a Corporate Plan for NHS Wales which will provide the basis for national activity as well as a focus for the performance of health authorities and their providers, and address manifest deficiencies in existing information systems.

2.21 The All Wales Service Review also identified a number of strategic issues requiring further examination, in part to inform the content of the proposed Corporate Plan. This work, too, will be led by the Welsh Office working in co-operation with the NHS. In addition to further work on the provision, utilisation and cost of specialist services, the Review proposes an examination of the provision and performance of General Medical Services across Wales, the performance of community services, including the contribution of community hospitals, and the role and configuration of acute services. These are important strategic issues which have the potential for significant impact on the future provision and rationalisation of services across Wales and for the mechanisms which will be needed to implement proposals. The work will be expected to consider implementation and transitional issues, alongside the service and performance factors which will be expected to drive the review.
Making it Happen

2.22 The NHS will achieve its aims and deliver what patients expect of it only if it makes the best possible use of all its resources. It is not enough to distribute funding to the NHS fairly; if some parts of the NHS use their resources less efficiently than others, the result will be a poorer level of service to their local populations. Everyone in the NHS must take responsibility for the effective stewardship of the resources they use. The Assembly will be able to promote this by:

. devolving responsibility to - and within - NHS trusts and Local Health Groups, so that those delivering services have effective control over performance and the power to redeploy resources where they will be most effectively used; health authority performance in setting budgets for Local Health Groups will be monitored by the Assembly as part of the performance review process;

. merging budgets for hospital and community health services, GP prescribing and GP staff, premises and computers, creating new opportunities to improve cost-effectiveness within an overall cash limit;

. developing and publishing comparative data, promoting a benchmarking culture that challenges inefficiency and promotes best practice;

. publishing a Welsh schedule of service costs to inform local service agreements;

. cutting avoidable bureaucracy - the abolition of the internal market will create savings of up to £10 million per annum which can be redeployed to patient care; at the same time allowing management effort to be refocused on the true purpose of the NHS.

SUMMARY

The National Assembly for Wales will take responsibility for the configuration and performance of NHS Wales and lead particular programmes of action.

The Assembly will foster co-operation and partnership between the NHS and its partner organisations.

The Assembly's policy-making and performance management roles and structures will be strengthened and new performance-related monitoring mechanisms centred on the values in paragraph 2.3 will be developed.

Reviews of the functions and organisation of health promotion and research and development in Wales will be undertaken by the respective national bodies for consultation in 1998, and a Health of Wales information system will be developed.

A new Corporate Plan for NHS Wales will be developed.
3. IMPROVING SERVICES FOR PATIENTS

Higher quality services for patients featured as a priority for the NHS in the manifesto on which the Government was elected. A quality strategy should respond to patients' needs and expectations, and inform and influence working practice of all NHS staff. New and systematic action is needed to raise standards and ensure consistency. This White Paper seeks to promote continuous improvement of the quality of care by proposing a strategic framework which addresses:

. High Quality Standards;

. Quality of Delivery;

. Monitoring and Evaluation of Standards and Delivery.

Defining Quality

3.1 The pursuit of improving quality underpins the Government's commitment to better services for patients and must be a shared responsibility of everyone in the NHS. It must extend to all aspects of the work of the NHS, including the effectiveness of clinical practice, the achievement of ever higher standards, the creation of conducive physical and organisational environments and responsiveness to the needs of users. While quality of health care has been defined as a level of performance or accomplishment that characterises the health care provided, increasingly more user-orientated definitions have been applied which also recognise the importance of peoples' needs and expectations. Patients often experience services differently from the NHS staff who provide them. Patients want to be seen quickly in conditions which respect their privacy and dignity and to be cared for by staff who understand their needs and concerns as individuals.

3.2 Concern with quality of care is not new. In common with other public sector services, the NHS has a long history of protecting patients' interests. There are a wide range of mechanisms in existence, including educational accreditation by professional bodies for training purposes; the series of formal
Confidential Inquiries into critical events, such as Maternal Deaths, Perioperative Deaths, Stillbirths and Deaths in Infancy; clinical audit; Audit Commission studies; Chartermarks; organisational accreditation systems and the contributions of Community Health Councils and the Health Advisory Service.

However, in spite of some outstanding examples, activities remain fragmented, coverage is incomplete or arbitrary and there have been serious lapses which have harmed individuals and dented public confidence.

3.3 The NHS Wales Clinical Effectiveness Initiative, which is unique in the UK, was launched in May 1995. It aims to build on the personal commitment and enthusiasm of all who provide health care and help them to review and adapt their practice wherever appropriate to achieve better results for patients. There has been much activity in the past two years - at both local and national levels. Today, all NHS trusts in Wales have clinical effectiveness teams and the national demonstration projects for pressure damage, emergency admissions for chest pain, schizophrenia, stroke and diabetes are reporting practical difficulties associated with implementing changes in clinical practice. This feedback will be used to target shortfalls through the future work programme for clinical effectiveness. Notwithstanding the progress made, it is becoming increasingly evident that a successful quality strategy can be implemented effectively only by adopting and managing a comprehensive and coherent approach which is owned by everyone working in the NHS and is responsive to the needs and expectations of patients.

A Strategic Framework for Quality in NHS Wales

3.4 In his speech to the Institute of Health Service Management Conference in June, the Secretary of State for Wales gave a commitment to continuous improvement in the quality of care. From the outset, service planning and delivery should be designed through the eyes of the patient. To meet that requirement the Welsh Office proposes that a strategy to improve services should:

. enshrine high quality standards which link directly to effectiveness and the ability to achieve improvements in outcomes for patients;

. ensure a quality of delivery which is sensitive to patients' needs, provided in a conducive environment, by a workforce which is trained and educated to the highest professional standards;

. monitor and evaluate standards and delivery, by measurement of the outcomes of care against agreed standards for continuous improvement to take place.

3.5 Quality should be a unifying theme for all health care sectors and high-quality management should ensure that these components are considered at appropriate points in the planning and delivery of health services, from the overarching Health Improvement Programmes to treatment programmes drawn up for individual patients.

High Quality Standards
Clinical Effectiveness

3.6 Patients and the public need to be confident that the care provided by the NHS is of the highest standard. Decisions about the provision and delivery of clinical services must be driven increasingly by evidence of effectiveness and evaluated by outcome measurement supported by appropriate measurements of structure and process.

3.7 The Department will continue to support research which generates new evidence where none exists and to develop mechanisms which ensure that available evidence is used to good effect. Central funding has supported the NICE Project (New Information for Clinical Effectiveness) which uses the NHS Wales Intranet as a vehicle for improving access to sources of research information. This will be rolled out in 1998 to 200 health care teams across Wales.

3.8 The Welsh Office will build on the work of its clinical effectiveness initiative which has a stated objective that all who provide health care will work together and in partnership with patients to increase the proportion of clinical care which has been shown by evidence to be effective. The Government wishes to ensure that ineffective practices are discontinued and that inappropriate variations are targeted. In order to demonstrate use of evidence, health authorities will be required to monitor and explain statistical trends for ten surgical interventions which fall into either a high cost or high volume category and for which evidence exists to support changes in practice.

3.9 Improving clinical effectiveness is at the core of the quality agenda and will remain one of the key priorities for NHS Wales. In future, health authorities will be required to work with trusts and Local Health Groups and publish a strategy and action plan for clinical effectiveness to deliver a rolling programme of work which will form part of the local strategy for improving health and be monitored for progress.

3.10 Much work has been done on the production of guidelines at national and local levels and the development, publication and maintenance of guidelines will remain the responsibility of the appropriate professional body. But the production of guidelines and evidence-based material needs better planning and targeting if the full potential is to be achieved. To streamline and strengthen these activities the Welsh Office proposes to work with the professions by being party to arrangements for a new National Institute for Clinical Excellence. This professionally-led body will work to a programme agreed by the health departments and will produce and disseminate:

. clinical guidelines which draw on relevant evidence of clinical and cost effectiveness;

. associated clinical audit methodologies and information on good practice in clinical audit.

National Service Frameworks

3.11 The Welsh Office will collaborate with other UK Health Departments to develop National Service Frameworks which combine best available evidence of effectiveness with the user perspective. Its approach to the development of cancer services in the Calman/Hine and Cameron Reports signals the way forward for other service priorities. The next framework will relate to the cervical screening programme in Wales. It is vitally important that all women invited to take part in any screening service
have confidence in its high quality which is rigorously monitored. To ensure that the cervical screening
service in Wales is both consistent and of the highest standard, a new National Service Framework will
be produced during 1998.

3.12 The guidelines issued by the new National Institute for Clinical Excellence together with National
Service Frameworks will help ensure greater local consistency between health authorities and Local
Health Groups in the planning and provision of top-quality services for major diseases and conditions.

**Patient's Charter**

3.13 The Patient's Charter has been a mixed success. It has gone some way to improving the
responsiveness of key NHS services and has helped the NHS demonstrate that it is an organisation which
puts the patient first. However, the Charter and the NHS performance tables, which are published each
year, focus too much on service delivery and too little on the issues which concern patients most, such as
the quality and success of treatment and on what they can do for themselves. While the Patient's Charter
has placed a new emphasis on the availability of information about health issues, a gap exists between
public expectation and what happens in practice. This was confirmed by the Welsh Health Survey, which
found that four out of ten people wanted better information about their treatment. If patients are going to
be equal partners in their health care they should be given clear, comprehensive and personalised
information about the risks, benefits and treatment options for their conditions. They and their families
should have an opportunity to make up their own minds within a supportive doctor-patient relationship.
We must also ensure, where appropriate, that the opportunities offered by new technology - especially
the Internet - are fully exploited in improving access to information. A new NHS Charter for Wales will
be developed by July 1998 and views are being sought from NHS Wales and the public about what
should be included.

**Waiting Times**

3.14 In addition, the Government is committed to a fresh approach to waiting times. Public concern has
increasingly focused on the time that patients have to wait for treatment. The current Patient's Charter
focuses on guaranteeing a maximum waiting time for all patients. This reflects the process by which the
NHS delivers health care, rather than the outcomes of health care. A more discriminating approach to
waiting times is now needed - one which reconciles rising demand with available resources and which
includes a greater emphasis on clinical prioritisation. This will provide quicker access to treatment for
those who need it most. Consultation on a new approach is already under way in Wales, alongside two
pilot projects which are testing a waiting list priority scoring system and are expected to produce results
in 1998.

3.15 This need not delay progress. We will improve access to specialist services so that everyone with
suspected breast cancer will be seen by the hospital's breast team within five working days of receipt of
their GP’s request that they should be seen urgently. We will also guarantee that from 1998 all
diagnostic tests that are needed will be carried out in one visit and that patients will receive their results
within five working days.

3.16 Patients need to be sure that different concerns are dealt with by specialist teams working to agreed
standards. During 1998 we will establish multi-professional groups for breast, colorectal, lung, urological and haematological cancers. By 1999 all cancers will be covered by similar arrangements.

Better Information for Improved Care

3.17 Good quality information is essential to the pursuit of the Government's key objectives for the NHS. Staff must be able to record, retrieve and share information about patients and services to enable them to care for their patients and to plan and manage services effectively and efficiently. The Information Management and Technology (IM&T) Support Programme for Wales will ensure that the NHS has an adequate infrastructure to enable health care information to be shared promptly, economically and securely in fulfilling its objectives, through delivering the key components of the programme:

- a secure telecommunications network;
- a common language to enable consistent meanings to be attributed to words, terms and data;
- corporate standards for data quality (accurate, timely and complete);
- corporate information services, including the development of a "Health of Wales" information system;
- training and development in better use and management of information; and
- a corporate strategy for IM&T.

These issues will be included in the next phase of work on the NHS Service Review.

Quality of Delivery

Patient Responsiveness

3.18 The NHS must provide health services which are of a consistently high quality and available to all. Patients should be treated in an environment which is conducive to improving health and provided by a workforce trained and educated to the highest standards. Underpinning this White Paper is the need for the planning and delivery of NHS services to be viewed from the perspective of patients. This means finding out what patients want, shaping services which are sensitive to patients' needs and meeting their preferences wherever this is practicable. The NHS should give the highest priority to looking at services from the patient's perspective and to making changes designed to improve their experience. Changes which have already been made include the setting up of waiting times information services and telephone helplines, and steps to provide more privacy and dignity for hospital patients - including more single sex accommodation. But increasing attention must be paid to involving patients more in decisions about their care and to providing adequate information on which to base those decisions. The Audit Commission report, What seems to be the matter?, which examined communication with patients in hospitals, identified three areas where changes can lead to improvements in the quality of communication:

- structuring multidisciplinary and team working;

- developing an awareness of the patient's point of view;
3.19 The Government will continue to drive to ensure that patients are better informed and will expect health authorities and NHS trusts to work in partnership with education and regulatory bodies, assess the continuing education and training needs of staff and, in meeting them, promote multi-professional team working, evidence-based practice and lifelong learning.

3.20 To inform this process a new national survey of patient and user experience will be introduced at the health authority level from 1998. Further consultation on the conduct, content and use of the survey in Wales will be undertaken, but its fundamental purpose is to provide systematic evidence of NHS performance against the relevant criteria in paragraph 2.3, and to provide an authoritative basis for comparing performance across the nation and further afield.

Complaints

3.21 There needs to be an efficient and effective complaints system. When things go wrong it is important that people are able to complain and that their concerns are handled quickly and fairly. New complaints procedures came into effect in April 1996. They will be evaluated in 1998 and the results used to decide whether changes are desirable in association with the results of consultation on new ways of involving the public.

Clinical Governance

3.22 The assurance and promotion of appropriate professional standards will continue to be provided by the responsible professional bodies with a continued emphasis on professional self regulation. The Government will work with professional and statutory bodies to promote and enforce the highest standards, but there is a requirement for practitioners to accept responsibility for developing and maintaining standards within their local NHS organisations. Every NHS trust and Local Health Group must take forward the concept of clinical governance by adhering to the requirements laid down in Chapters 4 and 6.

Accreditation

3.23 The Department will investigate the extended use of accreditation systems. In some ways the structural aspects of care, eg availability of suitable buildings, equipment, numbers of trained staff, are the easiest to measure and have been used as proxy measures for quality assessment purposes. In recent years the NHS has invested in a range of accreditation systems which include:

- Kings Fund Organisational Audit;
- Health Services Accreditation;
- ISO 9000;
In 1998, the Value For Money Unit will complete an evaluation of the current accreditation systems and, in consultation with the NHS, make proposals for the way forward for NHS Wales and share best practice in the achievement of a successful and coherent accreditation strategy.

Organisational Development

3.24 There is increasing awareness of the need for whole-systems approaches to improving clinical and service quality, which is reflected in part by the development of systems accreditation. Such systems are limited to single organisations. With the greater emphasis on continuity of care for patients, working across professional, departmental and organisational boundaries and the development of care partnerships are coming to the fore. Increasing attention is being paid to care programmes, care pathways and service frameworks which focus on the patient and his/her journey through the health care process. Such mechanisms are being supported by the development of explicit standards of care and service delivery protocols, for example the Calman/Hine Report on Cancer Services. In Wales, this is being implemented by adopting the recommendations described in the Cameron Report.

3.25 The Government wishes to encourage such developments but recognises that successful change of such magnitude will require a new culture within the NHS in Wales, its organisations and care partners in other public and private sector organisations. To effect such change, so that consistency and continuity of care for all patients is the norm, will require the commitment of whole organisations at all levels to develop partnerships. It will also require collaborative development of information systems which enable the secure, effective and timely sharing of patient care information across professional and organisational boundaries. A key component of this is the reliable identification of individual patients as they move across these boundaries. The new NHS Number was introduced last year as an important aid to patient identification, and it is essential that all NHS organisations ensure its universal use as soon as possible in all communications about patients, and in all patient records.

3.26 Sharing patient information is about more than technical issues; it is also about better services. Patients and their GPs benefit from leaving hospital with accurate information about their continuing care. We will improve existing levels of information; by March 2001 60% of hospital and community health services will be able to provide electronic discharge information at the time of the patient's discharge. By early 2003 this service will be available across the country.

3.27 Changing practice in one small part of an organisation has knock-on effects on other organisational systems. Fundamental change to the delivery of services requires time for organisations to build new relationships, new information flows, a common understanding and new skills. Organisational development is seen as crucial to bringing fresh approaches to care and firmly embedding them within developing systems. NHS organisations are required to examine new approaches to care which:

- focus on the patient's journey through the process;
- are capable of creating alternatives to existing functional and organisational arrangements;
are open to testing and validation;

.. are capable of developing process-based performance measures.

**Monitoring and Evaluation of Standards and Delivery**

3.28 Monitoring of quality standards and delivery is a weakness in the NHS as it currently operates and will need to be strengthened for the sake of public and patients' confidence. In the past, quality assessment has been performed by a variety of methods, some professionally and others managerially led.

**Clinical Audit**

3.29 Clinical audit is a professionally-led exercise which seeks to improve the quality and outcome of patient care through clinicians examining their practices and results against agreed standards and modifying practice when appropriate. At present, clinical audit requires the painstaking and laborious review of (mainly paper) clinical records. The replacement of paper with electronic records as part of clinical information systems will enable the convenient and efficient collection, retrieval and analysis of patient care data. Professional bodies and the NHS should collaborate to maximise the potential of audit by:

.. recognising the importance of patients' views/experiences;

.. recognising the role of managers, who have a responsibility for quality assurance within their organisations. Whilst it is the task of clinical staff to identify clinical standards against which to audit their practice, managers have a role in the endorsement of those standards to ensure that they are recognised as organisationally appropriate and can form the basis of discussions with bodies which have responsibility for accessing health care;

.. linking with education programmes; and

.. conducting intersectoral audits.

3.30 In order to achieve this in the new settings, health authorities, trusts and Local Health Groups will be required to agree a rolling programme of work for clinical audit activities and monitor results, and a rolling programme of investment in clinical information systems to support clinical audit and clinical care.
Local Responsiveness

3.31 NHS services and organisations need to be responsive. Steps must be taken to find out what patients and communities want and to consult them over proposed changes in the pattern of service delivery. As statutory bodies, Community Health Councils (CHCs) have a role to play in pulling together local views. However, there may be other ways by which the NHS can tap the views of the communities it serves; user surveys, focus groups and citizen’s juries may be useful mechanisms amongst others for gauging reaction to particular proposals and engaging local opinions.

3.32 This White Paper provides an opportunity to relook at arrangements for public involvement and the roles and responsibilities of CHCs. The simple status quo would be inconsistent with the changes being introduced elsewhere and would be a lost opportunity to develop relevant leverage for patients and communities in the new settings.

3.33 Ministers see some advantage in providing the public with mechanisms that relate directly to the particular responsibilities of the different organisations. This White Paper requires all trusts to put in place new arrangements for patient representation and all Local Health Groups, where decisions will increasingly be taken on the services which are needed, to develop new ways of including the public.

3.34 The Secretary of State is also considering fresh ways of facilitating service development and changes where these are responding to local needs. These may be by giving health authorities delegated powers to approve minor local changes following consultation, with local voices having earlier opportunities to influence proposals as they are being developed, and by looking afresh at the implementation of the existing regulations (the Community Health Council Regulations 1996). In addition, the Welsh Office will publish a consultation paper in 1998 seeking views on other options available to engage the public in the planning and oversight of services provided by the NHS.

Performance Monitoring

3.35 All parts of the health service will need to emulate the best. In the exercise of strategic leadership, health authorities should ensure that resources are deployed to best effect. Variations in performance have been too wide in the internal market because incentives and levers have not adequately reflected responsibilities and objectives.

In 1996-97 in NHS trusts in Wales:

. the cost of an inpatient hernia operation varied from £700 to £1,500 between trusts;

. the percentage of varicose vein procedures undertaken on a day-case basis ranged from 10% to 70% between trusts; and

. the average length of stay for joint replacement varied from less than ten days to more than eighteen days.

3.36 To emulate best performance, we need to be able to identify it. This calls for relevant information, openly shared. It is important that we continue working towards establishing a common language and
systems so that meaningful comparisons can be made. Early in 1998 the Department will begin a pilot study of a range of clinical indicators and subsequently evaluate their use.

3.37 The use of benchmarking in the field of service quality is limited. In addition to benchmarking the wider performance measures, health authorities, Local Health Groups and trusts will be required to explore ways of comparing the quality of the services they provide with those of the best elsewhere. This need not be restricted to other bodies within the NHS; much can often be learned from organisations in very different fields.

The New Commission for Health Improvement

3.38 The importance of monitoring and evaluation of health care is that benefits, or otherwise, for patients can be assessed and appropriate steps taken. Current mechanisms lack clarity about responsibility and accountability for tackling shortfalls and for ensuring remedial action when problems are detected. The Department will be party to the setting up and work of a new Commission for Health Improvement. This will be a statutory body, which will operate at arm's length from Government. It will offer an independent guarantee that local systems are in place to monitor, assure and improve clinical quality and it will support local development of quality. It will 'spot check’ the new arrangements and will also have the capacity to offer targeted support on request to local organisations facing specific clinical problems.

3.39 Where local action is not able to resolve serious or persistent problems, the Commission will be able to intervene, by invitation from NHS bodies or on the direction of the Assembly. In these instances, the Commission would both investigate and identify the source of the problem, and work with the organisation on lasting remedies. It will also be able to recommend to the Assembly other immediate action. The Assembly will have powers (like the Secretary of State now) to remove NHS trust chairs, boards and non-executive directors where there is evidence of systematic failure. The Commission may also undertake an agreed programme of systematic service review, following through implementation of the national service frameworks and the guidelines developed by the National Institute for Clinical Excellence. The Commission will have a membership drawn from the professions, NHS, academic and patient representatives. It will be funded from existing resources.

Openness in the NHS

3.40 There should be less secrecy in the NHS. The Code of Practice on Openness set out the basic principles underlying public access to information about the NHS in Wales. Health authorities and NHS trusts are now required to hold their board meetings in public. The NHS must adopt the spirit as well as the letter of the Code, not only by responding positively to requests for information but looking for opportunities to reduce secrecy and share information with patients and the public. As a first step we will require NHS bodies to establish a web page on the Internet and NHS Cymruweb which gives information about service availability and performance standards.

3.41 Procedures for filling non-executive vacancies on health boards will create a more representative and local membership and provide another vehicle for local people to influence health services. The process will be open and transparent and in conformity with the Nolan Principles and the guidance
published by the Committee for Public Appointments. In addition, the Welsh Office will explore further options for adding to the local competence and representativeness of health authority and trust boards, in particular to enhance their abilities to work across organisational boundaries.

**SUMMARY**

The new focus on quality requires:

. trusts and Local Health Groups to adopt the concept of clinical governance and make arrangements to ensure that responsibilities for quality are met;

. health authorities to work with trusts and Local Health Groups and publish a strategy and action plan for clinical effectiveness and clinical audit activities to deliver a rolling programme of work as part of the local strategy for improving health.

In support of this work:

. nationally, the Welsh Office will be party to the establishment and management arrangements of a new National Institute for Clinical Excellence and Commission for Health Improvement;

. a new NHS Charter will be produced by June 1998 and a waiting list priority scoring system tested;

. the new complaints procedures and accreditation system will be evaluated and proposals made in 1998 on the way forward;

. a National Service Framework for the cervical screening programme will be produced in 1998.

Valuable progress can be made immediately in the following areas:

. all urgent referrals for breast cancer to be seen within five working days;

. monitoring and analysis of statistical trends for ten surgical interventions for which evidence exists to support changing practice;

. hospital and community health service organisations making arrangements to provide patient discharge information electronically and transfer GP test results electronically.
The Government intends that the NHS should plan to protect, promote and improve health as well as treat illness. To achieve this, all parts of the service will need to be clear about their roles and responsibilities which should be devolved to the lowest effective level. With additional statutory responsibilities, health authorities will develop strategic alliances with those statutory and voluntary bodies which can make a contribution, and they will harness the efforts of all members of the local NHS family to achieve strategic health objectives on behalf of the population they serve. They will establish Local Health Groups, usually coterminous with unitary authorities, to include primary care professionals and representatives of the local community in delivering the wider health agenda and in promoting the development of primary and local care.

Health authorities will play their part in rebuilding public confidence by securing public participation in the development of Health Improvement Programmes; ensuring that Local Health Groups have effective public involvement; publication of their performance agreement with the Assembly and including a requirement in their agreements with local trusts that improved arrangements are established to represent the views of service users.

An enhanced role for health authorities

4.1 With the abolition of the internal market and the introduction of new responsibilities and new structures, the functions of health authorities need to change. They continue to be needed to protect and improve the health of their populations and to promote equity for their residents; but these must be addressed within the operational principles set out below.

4.2 The present commissioning arrangements, based on five health authorities, have been established as the result of careful consideration by the Welsh Office and NHS Wales. After less than two years, the disruption associated with merging and reducing the number of district health and family health service authorities is only now settling down. The Secretary of State wishes to avoid fresh turbulence; the proposals in this White Paper, therefore, consolidate existing gains. The Assembly will have powers to review the number and functions of authorities, but retaining the existing bodies will allow them to respond to the new world and deliver the Government's objectives.
Roles and Responsibilities

4.3 The new priorities for health authorities will require them to become more strategic and more focused on improving health. They will retain many of their existing responsibilities which were not associated with the internal market. Unless otherwise revised, these include agreeing what needs to be done to improve the health and health care of local people and to extend choice, supporting the work of GPs and other contractor professions, the measurement and public reporting of health status and epidemiology, the provision of independent medical, dental, pharmaceutical and nursing advice and a range of functions to protect public health and to respond to outbreaks of communicable diseases.

4.4 Local sensitivity and flexibility are key to the Government's health agenda; Local Health Groups will deliver this. Health authorities will be called on to establish and support them, ensure they have access to appropriate information, skills and management support and to provide them with a clear and fair share of available resources. Proposals concerning Local Health Groups are set out in paragraphs 4.15 to 4.33. The Government recognises the value of primary care and is committed to enhancing its role in the NHS. Health authorities will support and develop the practice of primary care both directly and via the Local Health Groups which they establish. Local Health Groups will produce frameworks for the development of primary care which health authorities will draw together and support financially from an earmarked development fund.

Working Across Boundaries

4.5 A new statutory duty will be placed on NHS bodies to work together in the pursuit of common goals. The Government intends that this should also extend to local authorities, with whom health authorities will be required to develop shared goals, aligning efforts and information systems to facilitate the development of a common approach to improving health. Health authorities will have the overarching role to ensure that the NHS locally works together for the benefit of the populations they serve and to secure co-operation more widely where health matters are concerned. In particular, they will co-ordinate inputs into local Health Improvement Programmes which will identify the health needs of local people and how it is intended to meet those needs.

4.6 Health authorities will work with others to develop strategies and commission services to improve the health of local people. Some essential tasks such as protecting and promoting public health and shaping health care systems are best undertaken at higher population levels. Some tasks could be undertaken more locally, but the extra costs and bureaucracy would outweigh the benefits.

4.7 Other functions, which could be carried out more locally, need to be co-ordinated at higher population levels; among these are health needs assessment; balancing competing priorities and determining the need for major service development. The Secretary of State will consider whether there is scope to streamline some tasks to focus the management resource on the key strategic functions. He will also review with health authorities the executive structure needed to address the new agenda.

4.8 Health authorities should provide strategic leadership at this population level and co-ordinate the efforts of the NHS family in their areas to improve the health of the population they serve. They will also need to form stable alliances with other organisations which can play a part in improving population health. Health authorities, Local Health Groups, trusts, local government and others will plan appropriate
services together. For patients with continuing health care needs or where organisational and professional co-operation is of the essence (for example, services for children), health authorities and unitary authorities will produce joint investment plans. In Wales, Joint Consultative Committees will be expected to co-operate in a comprehensive plan at the higher population level of health authorities. The Government will also explore the scope for even closer working between health and social services. This more integrated approach will be of particular benefit to patients such as those with disability or mental health problems, who need the support of both health and social care systems. Specific proposals for inter-sectoral working in the interests of public health will be set out in a consultative paper early in 1998, but it is clear that health authorities will play a pivotal role in delivering the NHS part of that agenda. In this way they will form the bridge between the Assembly's national strategic role and the activities of the Local Health Groups at the community level.

**Strategic Leadership**

4.9 Health authorities will draw together Health Improvement Programmes. These programmes will set out in a single document a clear agenda for the first three years and indicate broad intentions for years four and five. They will include a number of strands:

- a framework for primary care;
- a pattern of local service configuration which takes account of clinical, accessibility and affordability considerations, and the views of local people; and most importantly
- comprehensive and integrated action plans to improve the health of local people across a range of health gain areas.

They will be drawn up in close consultation, and jointly agreed with Local Health Groups and trusts, working with local government to express a common purpose and put an end to fragmentation.

4.10 Health authorities will also be required to work together to agree strategic principles and cross boundary flows and to contribute to the planning, development and oversight of new and supra-district services commissioned by the Assembly.

4.11 This White Paper emphasises the need for organisations and individuals to work together. This ideal may not always be achievable. Health authorities will monitor implementation of Health Improvement Programmes by NHS trusts, Local Health Groups and others. To ensure that objectives are being realised health authorities will be empowered to intervene where the actions of either Local Health Groups or NHS trusts go against the grain of health improvement strategies or are otherwise failing. Specifically, they will be able to:

- require their agreement to new developments, including key permanent new posts in NHS trusts;
- direct local service configuration in line with Health Improvement Programmes, indicating where necessary which facilities will become surplus to requirements;
The bureaucracy associated with annual contracts will be eliminated in the new system. Instead, acting to fulfil the agreed requirements of Local Health Groups, health authorities should establish longer-term agreements with NHS trusts which:

- deliver the service aspects of Health Improvement Programmes;
- are driven by proposals from Local Health Groups;
- incorporate, as a minimum, national quality and outcome standards;
- promote efficiency;
- indicate trust funding levels; and
- set the strategic direction of trusts.

These agreements will typically cover periods of three years, though longer-term agreements may be appropriate in some circumstances. Local Health Groups and trusts may agree to vary activity and funding more frequently. Local Health Groups will also be able to inform health authorities that they wish to work with an alternative trust in the event that agreed standards or costs have not been achieved within the timeframe of the agreements. Mechanisms will be introduced to underpin new service configurations agreed by health authorities and to enable Local Health Groups to transfer work to new providers, retaining any savings for reinvestment in patient care. On the basis of the agreements, trusts will develop operational plans setting out details of activity and costs which, in their turn, will be signed off by the health authority.

Extra Contractual Referrals (ECRs)

In the ECR system, the care of patients with special clinical needs was often the subject of heated debate between GPs, health authorities and trusts about the coverage of contracts and whether the patients’ care would be paid for. Under the new arrangements, ECRs will be abolished, but the Government recognises that there will always be occasions when patients’ special needs or circumstances will require flexible arrangements. From April 1999, new arrangements will be established based on adjustments to Local Health Group and health authority allocations, rather than invoicing. Further guidance will be issued during 1998.
Local Health Groups

The Government intends to build the NHS around the needs and wishes of the people who use it. It is the GP, supported by community health staff, who is the most familiar point of contact for most patients, who knows the patient best and who opens the gate to other services. The GP has the central role in ensuring that patients have access to the best the NHS has to offer. GPs, along with others in the NHS in recent years, have taken on extended duties and responsibilities in influencing the services their patients need. The Government intends to develop this so that local communities can benefit from the enthusiasm, skill and experience of GPs, nurses, dentists, community pharmacists and their colleagues in primary care. GPs and other primary care professionals will be given the opportunity to take their place at the heart of an inclusive network of local interests with a remit to shape and deliver local health care tailored to the needs of the patients they serve. Local Health Groups will be established to give GPs and other local stakeholders the opportunity to take increasing responsibility for shaping health services to meet local need and by taking responsibility for commissioning local health care.

NHS Wales and its communities already enjoy significant levels of national cohesiveness and consistency. It would be wrong to replace the divisiveness of the internal market with new and different divisions. Accordingly, the proposals for Local Health Groups have been developed to maximise continuity and consistency across NHS Wales while providing comparable opportunities for the Local Health Groups to improve local services within their control.

Present Position

4.15 The present commissioning arrangements based on five health authorities were established in April 1996. Welsh local government was reorganised at the same time and the 22 unitary authorities now provide a valuable and stable basis on which to build the spirit of co-operation which is at the heart of this White Paper. All five health authorities have boundaries based upon those of their constituent local authorities.

4.16 All health authorities have established arrangements to work with and support local communities, forge links with local authorities and develop partnerships with primary care teams. In four of the five authorities, these arrangements are already based on local authority areas. Primary care staff already play a key role in making these arrangements work.

4.17 Three Locality Commissioning Pilots will be going forward from April 1998. These will identify the opportunities for developing the role of GPs, working together with other professions and their local communities to shape health services and improve the health of the people who live there. They will provide valuable lessons for the future.

4.18 A reconfiguration of trusts has already been set in hand and consultation on a fresh framework of trusts will begin in the summer of 1998, with a view to the new arrangements being put in place from April 1999. The Secretary of State intends that the development of Local Health Groups and the reconfiguration of trusts should be mutually reinforcing in addressing common approaches to managing services across organisational boundaries.
The Way Forward

4.19 We wish to see local arrangements in place to:

. ensure that primary care is empowered and supported to improve the health of its population and the health services provided to them and to take greatest advantage of the experience and enthusiasm of practitioners;

. ensure that quality standards and service protocols are determined by direct discussion between primary and secondary clinicians;

. identify health and service needs that reflect the priorities of the local people and their representatives;

. ensure that the resources available are distributed fairly both to and within localities;

. build effective links between providers of primary, community, secondary, and social care so that local people benefit from comprehensive, integrated services closely attuned to their needs.

New Responsibilities and Fresh Opportunities

4.20 At the heart of the Government's reform of the NHS is its vision of local decision taking in collaboration with others. We will, therefore, create Local Health Groups across Wales. Local Health Groups will bring together GP practices, other health care professionals, representatives of social services departments and voluntary organisations to work with local NHS trusts on behalf of local populations. All Local Health Groups will have two objectives - to provide the building blocks of the Health Improvement Programmes, which the health authorities will draw together to ensure that they reflect the needs and perspectives of local people, and to provide improved services for their patients in primary, community and secondary health care settings.

4.21 At the outset, Local Health Groups will be established as sub-committees of health authorities, but they will be responsible for commissioning local services and will be able to take decisions about resource use so that they can provide the best fit between need and resources. Under this relationship, accountability will be expressed through a publicly-available performance agreement which will be monitored by the health authority and contribute to the health authorities' performance monitoring programme with the Assembly.

4.22 The existing framework of local government in Wales already provides a suitable and stable basis for local action in most areas. Unless there are firm local agreements to alternative configurations, therefore, each Local Health Group is likely to be coterminous with unitary authority boundaries to facilitate joint working. Within that wider framework, opportunities will exist for smaller groups of practices to establish closer links to test out innovative approaches to meeting their patients' health needs.
Roles and Responsibilities

Each Local Health Group will:

. have a governing body which reflects the range of health professional interests within the locality, including GP practices, the social services department and other community interests. The chairman will be appointed from within the governing group and will often be a general practitioner;

. play a full part both in establishing and implementing the Health Improvement Programme of their district to reflect local need;

. develop primary care locally;

. make clear arrangements to involve, consult and respond to the local community and to better integrate the delivery of primary and community health services in local settings;

. working with the health authority, commission services to meet identified need;

. have a clear management structure agreed with the health authority;

. account to the health authority for progress and, if necessary, correct off-track performance.

4.24 Local Health Groups will be expected to help primary professionals to enhance the quality of care. Good progress has been made in Wales with the work of primary care effectiveness groups. In future Local Health Groups will be required to agree action plans for clinical effectiveness and clinical audit.

In addition, as part of the development of clinical governance in NHS Wales, each Local Health Group will nominate a senior professional to take the lead on standards generally, on professional development within the Group and to encourage action within GP practices.

Delivering Local Care

4.25 The Secretary of State intends that Local Health Groups should become more than advisory bodies to health authorities as quickly as practicable in differing local settings. They will, therefore, have available to them budgets reflecting their population's share of available resources for hospital and community health services, prescribing and GP staff, premises and computers. Groups will commission services and prescribe within this budget and have freedoms to redeploy resources to address local health needs as identified by individual practices. The new arrangements will give flexibility within the total sum to fund services that clinicians decide best meet patients' needs, while removing artificial boundaries on drug treatments in the current funding arrangements. These freedoms will reflect the full range of flexibilities valued by fundholders and others.

4.26 In addition, in support of the development of locally configured and managed services, the Welsh Office will explore and encourage innovative ways of building on existing models for the provision of health care in new settings managed by Local Health Groups. Along with local trusts, local authorities
and voluntary bodies, they will make a reality of delivering comprehensive services which reflect patients' interests, including the planning and provision of services which cross boundaries, which might include continuing care, substance misuse, child protection services, community services, some aspects of mental health and health promotion services, and services for people with learning difficulties.

4.27 The Groups will work with individual GP practices and others to ensure best use of resources to promote good practice and address weaknesses. They will also be able to play an important role in developing primary care through joint working across practices, by providing a forum for professional development, audit and peer review and through using resources in new ways.

### Funding

4.28 Budgets will remain within the ultimate financial control of the health authority and its accountability frameworks. Local Health Groups will be expected to work within those budgets, which may be net of reasonable and transparent strategic reserves which the health authority considers it necessary to retain, for example for centrally commissioned services, service reconfiguration, and risk management. Each Local Health Group will have available their population's share of the available resources for hospital and community health services, prescribing and general practice infrastructure. These resources will allow the Group and its members to commission and provide services. Within this single cash limited envelope, the Group will have the opportunity to deploy resources and savings to strengthen local services and ensure that patterns of care best reflect their patients' needs.

4.29 Everyone with public resources at their disposal - whether financial or otherwise - will be expected to add value by responding positively to the needs and concerns of local communities and by changing existing methods of working and programmes for the better. The Local Health Groups will fail in this objective if they settle for the status quo, give priority to organisational ambition over patient interest or fail to grasp the opportunities available to them. The new arrangements will give Local Health Groups the tools as well as the incentives with which to develop prompt, accessible and responsive services for local people and to play a part in improving health in its widest sense.

4.30 Local Health Groups will have access to the information, support and skills they need to carry out their role. The decision about how to make best use of relatively scarce skills such as information analysis, management and epidemiology, will be for local decision. By co-ordinating tasks at the locality level and avoiding the bureaucracy associated with GP fundholding, economies of scale will be realised when viewed across the health authority as a whole; these can be used for better patient care.

4.31 Local Health Groups will build on the experience and best practice of developments under the fundholding scheme in the particular settings of Wales and its institutions. They will be the model within which the advantages of GP fundholding have their new expression. In parallel, the Welsh Office will look to learn lessons from the locality commissioning pilots as they develop, explore with interested bodies, particularly professional bodies, good practice from existing models, and look to health authorities to encourage rapid progress in areas where circumstances are encouraging. Health authorities will be required to give help and support to Local Health Groups wishing to expand and develop their role.
The Future

4.32 The development of Local Health Groups will be evolutionary. From a position where Local Health Groups act simply in support of health authorities in commissioning care for their populations, they will be able progressively to take devolved responsibility for managing budgets as part of the health authority; become free-standing bodies accountable to health authorities for their commissioning functions and, as appropriate, managing a range of community services.

4.33 Legislation will be brought forward which will provide for the creation of Primary Care Trusts. Decisions in this area will be for the Assembly in the light of experience, local circumstances, demonstrable evidence of managerial, financial and risk management competence across the participating players, and the patient benefits which are intended.

SUMMARY

Existing health authorities will be retained with reinforced responsibilities for improving the health of the local population. New statutory responsibilities will be introduced to require health authorities to work in partnership with local government. They will be expected to become more strategic organisations working through Health Improvement Programmes.

The executive structure of health authorities will be reviewed to align it with the new agenda.

Each health authority will establish Local Health Groups to involve primary care practitioners and representatives of local government and community groups to work together to determine local services within the boundaries of a fair proportion of resources. As they grow and develop, Local Health Groups will have progressively more influence in determining the shape of health care services for local people.

Annual contracts will be replaced by longer-term agreements as the key mechanism for driving up performance.

Health authorities will have reserve powers to:

. direct the configuration of local services, where necessary, indicating which facilities will become surplus to requirements;

. veto new developments, including important new posts, which are not in line with strategic objectives.
5. PRIMARY CARE: A SOUND FOUNDATION

This chapter recognises and builds upon the traditional strengths of primary and community health care. It looks forward to a new and invigorated primary service, playing a major role in the delivery of health care within the wider relationships and responsibilities of a modern National Health Service.

It encourages patients to take on more responsibility for their own health, places a firm emphasis on their needs and on those needs being met by increasingly close co-operation between health professionals and other agencies.

Wasteful and bureaucratic market structures do not fit well with this emphasis on co-operation and equality of treatment. GP fundholding is to be abolished and replaced by Local Health Groups which will give flexibility and responsibility to those nearest the patients they serve.

There is a continued emphasis on delivering care and meeting need. The Government is committed to comprehensive local health services for all the people of Wales.

5.1 Primary health care is the foundation of the NHS. It is usually the patient's first point of contact with the health service; it is readily accessible to all. In recent years primary care has been under strain. Demands have increased and there have been further pressures as advancing technology and new patterns of care enable more and more work to be done nearer to people's homes. The future must bring a better balance between legitimate need, individual responsibility for healthier lifestyles and a responsible use of services.

Promoting Healthier Lifestyles

5.2 The Government will encourage a greater emphasis on personal responsibility by effective health promotion measures which will include a limitation on the advertising of tobacco products. There will be other innovative approaches such as a network of Healthy Living Centres which we will fund from the proceeds of the National Lottery. Policies will be developed and tailored to ensure that they are equally available to all the people of Wales, not just the articulate and the well off, and initiatives will be brought forward to encourage the provision of services by pharmacists and others which will compliment the
more traditional services provided by the NHS. In everything, the needs of the patient will be paramount.

**Developing Present Practice**

5.3 Primary health care lives by co-operation. It is a responsive service provided by self-employed practitioners whose terms and conditions of service are common throughout the United Kingdom. To a large degree they decide what services to provide and their degree of commitment to the NHS. Whether doctors, dentists, pharmacists or opticians, they, their teams, and the community nursing and other services provided by NHS trusts, provide for Wales a comprehensive range of flexible and efficient services.

5.4 The Government does not propose to change these arrangements. It is determined to preserve them and their contribution to the life of a caring society; but they can be improved and the Government is equally determined to ensure that whenever and wherever possible inequalities are eliminated and deficiencies replaced by strengths. To carry this agenda forward the Government is determined to:

. reduce deficiencies and inequalities in the provision of services;

. encourage co-operation with secondary health care, social services and the voluntary sector;

. foster forward looking primary and community health services prepared to push out the boundaries of care, while preserving those standards which have served the nation well;

. facilitate progress on all of these by instituting a sustained programme of development and investment in clinical information systems and related technology.

5.5 The Government recognises that if these aims are to be achieved it is important that it retains the confidence and co-operation of professions in the field, that proper recognition be given to their skills and that that recognition should be backed by positive encouragement to use those skills in co-operation with others to the best benefit of patients.

**Developing Roles**

5.6 This was one of the main objectives of a package of measures announced in Wales shortly after the Government took office. Without being prescriptive, it aims to encourage many more professionals to work at the top end of their range of skills, thereby creating greater job satisfaction and offering a better service for patients. Experience has shown that there are occasions when a problem can be addressed by the substitution of one profession for another: for example, expert nurses are developing new roles and improving the quality of patient care. They work across organisational and professional boundaries, ensuring continuity in the diagnosis, treatment and after-care of patients and their families. Similarly, therapists are providing some treatment which a dentist would normally have provided. The Government is ready to encourage such developments where it is safe and appropriate and in the best interests of patients. We will also encourage better and more appropriate training fully to equip professionals to fill their expanding roles and to meet the changing needs of their patients.
Meeting Need

5.7 A more flexible approach to the delivery of health care can help the service to accommodate increasing demands and go some way to meeting present deficiencies. The Secretary of State will be watching closely the trials in England of a new 24-hour telephone helpline for patients and will consider its rollout in Wales in the light of experience of cost effectiveness and benefit to patients.

5.8 The Government accepts that greater flexibility will not provide a complete answer to existing and emerging problems in respect of primary care manpower. For many years the Principality has had insufficient dentists to meet its needs. Accordingly, increased amounts of money have been made available to attract new dentists to Wales and such support will continue to be offered. The Government has also recognised that there are emerging problems in the provision of medical and some other services and has already announced a programme of support which will help health authorities and practitioners to address those problems as or before they arise.

5.9 New technology offers important opportunities, too. Wales has been at the forefront of developing telemedicine. An experimental project in North Powys showed the potential for extending the roles and knowledge of local practitioners by having electronic access to distant specialists, as well as reducing patient and health professional travelling. To take this work further, the Ceredigion and Mid Wales NHS Trust is conducting a project to review the full range of trust services to find ways of using telemedicine technology to benefit much larger numbers of patients. The results will be published in the spring of 1998 and the Government expects health authorities and trusts to learn from such work and to exploit opportunities in their own areas.

Local Health Groups

5.10 The pressing need for a closer involvement with secondary health care, social services and the voluntary sector will be met only through action by all the parties involved. Primary health care has more flexibility than ever before to meet that challenge. Local Health Groups will involve all GPs and other professionals in decisions about local services, which will enable those services to be more responsive to local conditions than ever before. There will be new opportunities to work alongside other agencies to provide the seamless care which has been lacking in the past when the emphasis was on competition rather than collaboration. Within primary care the pilot schemes available for medicine, nursing and dentistry under the Primary Care Act will enable members of the NHS family to test new ways of doing things and to free themselves from the restrictions of complex central regulation. Taken together, they have the capacity to provide a comprehensive service, carefully attuned to local need and flexible enough to meet emerging health care needs in the new millennium.

5.11 This Government’s vision is of an NHS with a common purpose, at ease with itself and with its partners. There is no place in that vision for wasteful competition or avoidable bureaucracy. Fundholding will be brought to an end in Wales. This will be approached in an orderly way, taking into account the views and aspirations of those who have committed themselves to the scheme. So far as it is practicable, there will be measures to minimise the impact upon those who will be adversely affected and to allow accumulated savings to be used for genuine patient care.

5.12 Active participation as influential members of Local Health Groups is the future for GP
fundholders. All GPs will be offered a new role in the Local Health Groups which will enable them to continue to provide care and influence the quality of community and secondary health care services so that they best meet the needs of their patients. The Government aims to preserve those flexibilities which have allowed some practices to improve the range of services available to patients and also sees value in removing the burden of routine administration from GPs so that they can concentrate on the planning and delivery of care. These opportunities must be available to all and the Government expects the professions to respond positively.

5.13 The Government will discuss with those affected by this change:

- future arrangements for services currently purchased by fundholders;
- arrangements for GP fundholding staff;
- arrangements for winding up practice funds, including the handling of GP fundholder savings.

5.14 The Government will bring forward legislation to provide for the move from GP fundholding to Local Health Groups and to redistribute the fundholder management allowance to Local Health Groups on an equitable basis which will give support to all GPs. Subject to the availability of Parliamentary time for the necessary legislation, Local Health Groups will formally succeed fundholding from April 1999. In the meantime, there will be no further admissions to the fundholding scheme.

5.15 In the intervening period, the Welsh Office will explore with all interested bodies the lessons to be learned from existing models and will look to health authorities to work with local health care practitioners and other providers of primary care services to promote the formation of Local Health Groups.

Primary Care Development

5.16 Health authorities will be expected to earmark a primary care development fund within the resources delegated to Local Health Groups to support the development of services outside hospitals and to allow practices to maintain or develop services which fall outside the scope of the old GMS arrangements. Such developments are a direct response to local needs and for that reason the Government believes that it is appropriate that from the outset that the use of these new development funds should be in the hands of the Local Health Groups though health authorities will remain formally accountable. Where necessary arbitration will be available.

5.17 Together with the other flexibilities available to primary care, the Government believes that this arrangement will retain the better features of the GP fundholder scheme while avoiding its inequities and wasteful bureaucracy. In particular, GPs will retain their ability to influence local services, push out the boundaries of primary care and develop the contribution of their practice teams without a time consuming involvement in administration. Both they and their patients will benefit as a result.

5.18 The benefits of GP fundholding will now be available to all practices and will allow for innovation and flexibility to deal with continuing pressures on community health services. The NHS and social service departments will be encouraged to work more closely together and bring to an end the divisive
situation where the availability of services varies from place to place. All of this will require much fuller sharing of patient care information, and the organisational, professional and technical barriers to information sharing must be addressed urgently. Within health, it will require Local Health Groups, health authorities and others to encourage the development of those specialist services, such as speech therapy, where there can be a long wait for treatment. We want them to ensure that the needs of those disadvantaged in our society, or not well placed to make their voices heard, are articulated and acted upon.

A Service Attuned to the Individual

5.19 Among such groups are those people who suffer from mental illness or have learning difficulties. For many years policies in Wales have sought to provide the opportunity for these people to lead as full and complete lives in the community as they can. The Government remains committed to that ideal. The further development of the multi-disciplinary community mental health teams will be encouraged, while accepting that there will remain a place for in-patient care for some patients. Above all, we expect all agencies, whether GPs, trusts or social services departments, to work together to provide a full range of care, carefully attuned to individual need. Additionally, school health services are designed to meet part of the primary care needs of the population of children aged 5-19 in full-time education. Local Health Groups will work with education services to develop health profiles for this age group, including children with disabilities and special educational needs.

5.20 Many people prefer to be treated in or near their homes. Health authorities and Local Health Groups will be expected to maintain a good level of community nursing services complementary to, but not duplicating, those services provided by local authorities. The Government is mindful of the needs of carers; their task is a hard one and the Government will encourage the development of respite care to complement the day care already generally available.

Matching Resources to Need

5.21 The Government's goal is to achieve the best that can be done, within resources that are inevitably limited. If that is to be achieved, it can only be with the co-operation of health authorities and NHS trusts. Health authorities will have a specific duty to promote, improve and preserve primary health care, using to the full the flexibilities and initiatives which are now available. Both health authorities and trusts will need to acknowledge that; as new techniques enable more work to be done outside hospitals there must be a transfer of resources to enable that work to take place. We are past the point where savings can simply be reinvested only in hospitals without regard to the consequences elsewhere.

5.22 The resources available to address these problems will not be inexhaustible, nor entirely within the Government's control. The Government will play its part by reducing bureaucracy and encouraging others to do so, by combating fraud and promoting best practice. That is only a partial solution; patients should not abuse the system and practitioners should accept that they have a duty to handle public money well, particularly by prescribing in a cost effective manner. The Government remains committed to the principle that those who need drugs should get them but there must also be regard to the relative effectiveness of treatments and to their cost in those cases where there are other, cheaper, drugs which adequately meet the same need. To do otherwise means that money will continue to be spent
inappropriately and that other health services will suffer as a result. The Government is determined to address the issues. We will invest in new and better information systems and encourage a new approach by increasing the amount of pharmaceutical advice available to practitioners. By 2001 the Department plans to have in place new information systems which will provide better prescribing and dispensing information to improve medicines management, facilitate a collaborative approach to drug therapy within the health care team and reduce the risk of fraud.

5.23 Local Health Groups, rather than individual practices, will decide what services should be provided by trusts for their patients. Local Health Groups will also need to work with practices to ensure best use of resources for their patients. Over time, Local Health Groups are expected to extend indicative budgets to individual practices to develop practice-level incentive arrangements.

5.24 Finally, and perhaps most important of all, this Government values those who work in primary or community health care. Whether they be a receptionist, a health visitor or a therapist we recognise the care they bring to the service and the contribution they make to society. We know, too, that the whole is greater than the sum of the parts and that the greatest benefit is when they are all able to bring to bear the full range of their skills and experience. We welcome the enthusiasm and eagerness to work together which is so much in evidence in today's NHS. Primary care remains a sound foundation and we will build upon it.

SUMMARY

In pursuit of its policies of bringing care closer to patients and their communities, the Government will encourage a greater emphasis on personal responsibility by effective health promotion and facilitate a network of Healthy Living Centres.

It will also support and encourage a forward-looking primary and community health service, wherever possible reducing inequalities and replacing deficiencies by strengths.

To support local responsiveness it will promote co-operation between professionals and agencies, particularly social services departments, and underpin these arrangements with new statutory powers in key areas and a fair distribution of resources.

It will abolish the divisive GP fundholding scheme and replace it with Local Health Groups which retain local flexibility and decision making.

The Government will insist on the effective use of public resources and bear down on needless bureaucracy and fraud.
6. NHS TRUSTS - PROVIDING QUALITY SERVICES

This Chapter outlines how NHS trusts will operate in the new NHS. It demonstrates where roles will be built upon and changed to meet the Government's new agenda. Responsibilities for ensuring efficient working and best practice as well as performance monitoring are also detailed and explained.

In future, NHS trusts will participate in strategy and planning by helping to shape the local Health Improvement Programme. Doctors and nurses will be more closely involved in designing services for their patients; new standards of quality and efficiency will be introduced and trusts will be made more open and accountable to help restore public confidence in the NHS.

A New Direction

6.1 All hospital, community health, mental health and ambulance services in Wales are provided by NHS trusts. Trusts are visible and familiar parts of the NHS, accounting for an annual expenditure of £1.5 billion and employing 54,000 staff. They also have important programmes of research and education. Trusts are responsible for a complex network of services and the Government intends that they should retain managerial autonomy for their own operations. They will also continue to play a significant role in delivering the key objectives of NHS Wales. However, the Government believes that the emphasis on competition between trusts has been damaging to their ability to recruit and retain staff, wasteful of scarce resources and a significant blow to the NHS's reputation of providing equity of service for all when and where it is needed. In future, trusts will be required to operate in ways which foster co-operation and collaboration, as well as concentrating on delivering high quality services to patients rather than focusing on the bureaucratic aspects of contracting. The Government will introduce a new statutory duty on NHS trusts to work in partnership with other NHS organisations. This will extend to Local Health Groups and others in planning the local health and health care strategy under the overarching leadership of health authorities.

6.2 Trusts will remain public corporations, responsible for their own operational management. They will continue to be able to take their own decisions affecting the staff they employ and the income they spend, though with much clearer linkages to health authority plans and priorities. Their statutory duties will be
amended to give them responsibility, with health authorities and Local Health Groups, for the delivery of national and local health and health care objectives and quality standards. The Assembly will have powers to intervene if there is a serious failure in service quality.

6.3 Trusts need to be able to work with each other, Local Health Groups, health authorities, the Assembly and others, including local authorities and voluntary bodies, to ensure that patients receive high-quality services regardless of where they live or which GP they see.

Shaping Responsive Services

6.4 Trusts will be responsible for producing annual plans in response to the requirements of Local Health Groups and health authorities which demonstrate how they intend to respond to the objectives set. Trusts will be accountable for the delivery of the volumes and clinical quality of activity required by Local Health Groups and health authorities. Principally, however, they will be responding to the commissioning decisions of Local Health Groups with whom they will be developing long-term relationships.

6.5 Trusts will to be able to engage with health authorities in the pursuit of better health for the local population and the implementation of Health Improvement Programmes. They will be empowered to work across boundaries to deliver integrated programmes of care. As Local Health Groups increasingly express their abilities to provide services locally, as has been the case with the more progressive GP fundholders, trusts will need to work closely with health authorities and Local Health Groups to facilitate the changes. This calls for close collaboration from the outset and a willingness to operate flexibly in the best interests of patients. These responsibilities will be backed by a new statutory duty.

6.6 Key investment decisions in capital, senior medical appointments and service developments may be taken only in line with long-term strategies and local health and health care plans. Health authorities will, therefore, have a key role in this area and they will be given the power to intervene in selected areas where necessary to ensure that trusts' decisions reflect health authorities' plans. In addition, because of the greater strategic role given to health authorities, trusts will need to work with them closely on any proposals for significant capital developments, including public and private partnerships; and decisions on declaring assets surplus to requirements will pass to health authorities.

Providing Quality Services

6.7 All NHS trusts will be required to adopt the concept of clinical governance to ensure that quality is integral to the organisation and working practices of staff.

6.8 A high-quality organisation will ensure:

. that a rolling programme of clinical audit activities and strategy for delivering clinical effectiveness is agreed with the health authority and Local Health Groups;

. availability and access to evidence-based information;
. enhancement of skills and knowledge through education, training and experience with particular attention paid to development of improved communications with patients;

. clinical risk reduction programmes are in place and that where adverse events are detected lessons are learned and promptly applied.

6.9 This overdue attention to quality will be reflected in the responsibilities and management of NHS trusts. Legislation will be brought forward to introduce a new duty for the quality of care. Under these arrangements, chief executives will carry ultimate responsibility for quality in their trusts, just as they are now accountable for the proper use of resources.

6.10 It is expected that chief executives will set up appropriate local arrangements which will give them and the trust board firm assurances that their responsibilities for quality are being met. The local arrangements might be in the form of a sub-committee of the board and led by a senior clinician who holds the confidence of the clinical body in the trust. Regular reports to the trust board and an annual published report will provide assurance that quality is a priority for board members.

**Promoting Efficiency: Improving Performance**

6.11 In the reformed NHS Wales, trusts will be assessed by the contribution that they make to the wider goals of better health and health care outcomes, enhanced quality and effectiveness of service and improved access. They will be measured against the criteria set out in paragraph 2.3. Boards and clinical staff will be held to account on this basis through their agreements with Local Health Groups and health authorities. This accountability will be enhanced by the greater confidence possible from the longer-term service agreements, but will be no less rigorous.

6.12 In future, improved performance will be rewarded by allowing the retention of a share of any savings within the clinical teams who have made them in ways which are consistent with the Health Improvement Programme and the wishes of Local Health Groups. As a consequence, all trusts should be working to devolve responsibility to clinical teams and to involve clinicians in the planning agreements struck with Local Health Groups and health authorities.

6.13 The downward pressure on costs will continue to ensure that resources can be targeted where they are needed most. This drive for efficiency will take several forms:

. trust reconfiguration - the Government believes that the current configuration of NHS trusts in Wales is haphazard and not well placed to deliver effective health care in the most efficient manner in the new, non-market NHS.

A major exercise is already under way to review the number and shape of NHS trusts in Wales. Its overall objective is to improve the quality of health care in Wales through the establishment of a more effective and efficient structure for the management of hospital and community health services. It is expected that formal public consultation on proposals will take place over the summer of 1998. The current timetable envisages the announcement of a decision in October 1998 which will lead to the establishment of a new pattern of trusts across Wales on 1 April 1999.

No target has been set for the number of trusts at the end of the exercise. Ministers have made it clear
that the reconfiguration process is being driven principally by the need for better clinical and managerial effectiveness. However, it is also an objective of the exercise that resources should be diverted away from wasteful and avoidable bureaucracy. Reconfiguration will release between £5 million and £10 million per annum for reinvestment in improved patient care.

Benchmarking - many trusts are already comparing their own performance with that of the best and taking action where necessary to make improvements. This will continue and expand to enable trusts to aim for the best value in all they do. Within the Assembly's national benchmarking programme, trusts will be required to benchmark major efficiency drivers in their organisation to strive for improvements in cost, quality and throughput. This programme will be one in which data will be shared openly with all interested parties in the NHS. It will lead to a clear exposition of poor performance, be a significant contribution to the drawing up of long-term agreements and provide information to enable measures to be put in place which will ensure improved performance to the level of the best elsewhere.

Management costs - trusts will be expected to minimise costs associated with management and administration. Benchmarking will prove a useful tool to test trusts' performance in this area. Again, this will be a factor which health authorities will take into account when making decisions on long-term agreements with trusts. Following the reconfiguration exercise, each new trust will be required, as a minimum, to benchmark its management costs.

The Financial Framework

6.14 Trusts in Wales will receive their funding via long-term agreements (LTAs) from health authorities, which will aggregate the proposals of Local Health Groups and take account of health authorities' own decisions, for example on centrally commissioned services. The level of funding will be based on agreed costs which trusts have to incur and long term agreements on cost structures and service developments.

6.15 In future, some tertiary, supra-district and specialist services will be overseen by the Assembly, perhaps with funding allocated to health authorities on a ring-fenced basis. It is expected that health authorities will be given the task of ensuring (via collaborative arrangements) that trusts are providing good quality services, though the Assembly will wish to develop arrangements which will enable it to monitor progress carefully and intervene if things go wrong.

6.16 Health authorities and Local Health Groups will be expected to develop their own arrangements for monitoring trust performance in respect of financial management, volumes of activity, clinical quality and adherence to local priorities. The key mechanism for this process will be the LTAs between Local Health Groups, health authorities and trusts. There may be occasions when these agreements reveal the need for intervention and short term cash help from the Assembly. In these circumstances, it is expected that subsequent monitoring of the trust's return to an acceptable cost base will be undertaken jointly by the Assembly and the health authority concerned. Trusts will be major partners in the preparation of Health Improvement Programmes, with responsibility for contributing to the authorities' targets for improving health. They may, therefore, be required to join formally with health authorities in performance review arrangements including, as necessary, through chairs and chief executives joining authorities in review meetings with the Welsh Office. Ultimately, trusts' performance will be monitored by the Assembly. As now, key financial targets will be stringently monitored on a monthly or quarterly
basis. Performance against key elements of the annual plan, national and local priorities and long term agreements with health authorities will be reviewed on a regular (usually quarterly but exceptionally monthly) basis to ensure that trusts are delivering high-quality services to patients in their area.

6.17 Where a Trust's costs are shown to be too high, a programme of reduction will be agreed between the health authority, the Local Health Group and the trust which will enable the latter to continue to deliver high-quality services while aiming for an acceptable cost base within a reasonable time period. This arrangement will effectively replace the existing contract arrangements. Where trusts fail to achieve financial balance they will still be expected to agree recovery plans with commissioners and the Assembly.

Public Accountability

6.18 Trusts will continue to publish an annual report but this will be expanded to demonstrate performance against the core values of fairness, efficiency, effectiveness, responsiveness to the public, accountability, integration and flexibility. They will also be expected to publish a summary of their operational plan. Operational plans will articulate and express the features of the trust's Long-Term Agreement with the health authority and will be signed off by the authority. Local people will also have an opportunity to be informed about the trust via open meetings of the board, which members of the public should be encouraged to attend. In support of the Government's intention of making the NHS more open and responsive, each trust will be required to establish new arrangements for patient representation to provide a focus for public and patient views, oversee a programme of public liaison, co-ordinate the dissemination of information and respond to complaints and suggestions.

6.19 Chairs and non-executive directors will be appointed by the Assembly. All non-executive members of boards will be selected and appointed within the guidelines set out by the Office of the Parliamentary Commissioner for Public Appointments (the Nolan principles). Chairs and non-executive directors will be selected purely on merit with due regard to their ability to contribute to the running of complex organisations, their knowledge of local circumstances and needs and in the light of the results of the further considerations outlined in paragraph 3.41. Terms of appointment will normally be for four years.

6.20 Executive board members will continue to be appointed under current arrangements, but augmented by Welsh Office officials participating as assessors. Below that, most trusts have developed robust clinical directorate arrangements to ensure that those best placed to take decisions about patient care are given the necessary delegated responsibility. The reconfiguration exercise will result in fewer and bigger trusts in Wales and it will be important for sound management arrangements to be put in place to run those large organisations. Trusts will be required to ensure that clinicians are at the forefront of these arrangements.

6.21 These changes go with the grain of what has been shown to work or to be needed. They will give trusts a challenging new agenda with partnership, performance and quality at the heart. They will also give trusts the incentive to find best solutions to local needs, working with local people.
Trusts will remain as autonomous, corporate bodies in their own right but will increasingly work collaboratively with partner organisations, particularly Local Health Groups, to deliver integrated programmes of care.

They will continue to produce annual plans in response to health authority Health Improvement Programmes and will be required to work with health authorities on any significant developments or investment decisions. They will be accountable to health authorities and Local Health Groups for the volumes and quality of activity required.

Improved efficiency will continue to be important; benchmarking will be used as a tool to expose poor performance and demonstrate where improvements are necessary. This will be a significant factor in the development of Long-Term Agreements which will replace annual contracts.

Trusts will have a new statutory duty to contribute to improvements in health and the quality of health services.

Appointment procedures will be fair and objective and based on merit. Trusts will be required to put in place new arrangements to engage local opinion, become more transparent and respond to user interests.
7. PEOPLE - OUR GREATEST ASSET

This chapter sets out the features of the human resource strategy which will build on the strengths and commitment of all staff, to bring about the changes in organisation and culture which the new NHS will demand.

7.1 The new NHS set out in this White Paper will be successful only if the people working in it make it so. As workloads have increased clinicians and managers have increased their efficiency, come to terms with new ways of working and have faced extensive organisational change. Throughout, they have responded professionally and effectively, maintaining, and in many respects improving, on standards of patient care. Nurses, midwives and health visitors and the professions supplementary to medicine (PAMs) have responded magnificently to this process by developing the scope of their practice to meet the needs of a changing service. This development has been underpinned by advances in education and is a valuable contribution to health care.

7.2 This White Paper will require further changes. They will be neither abrupt nor turbulent but the cumulative effect of the proposals set out in the earlier chapters of this White Paper is intended to add up to a radical agenda for organisational change, but more fundamentally for changes in attitudes and relationships. The Government will provide appropriate support to implement this agenda and to assist managers to ensure that staff are equipped to contribute as effectively as in the past within the new organisational arrangements proposed.

The Workforce

7.3 The capacity of the NHS to treat patients depends on the number and quality of available staff. Recruitment difficulties are already evident in medical specialties, nursing and other health professional groups. The Welsh Office will therefore continue to focus on this issue and work with the School of Post Graduate Medical and Dental Education of the University of Wales College of Medicine, Higher Education Institutes and the Education and Training Group to ensure that central resources are targeted to best meet demand. It will continue to develop initiatives that are tailored to tackle specific problems; for example, this year additional resources have been made available to trusts to encourage nurses to return to practice through the provision of "Back to Nursing Courses". The Welsh Office will continue to review national intake to medical schools and also support the progress made in increasing the numbers...
of nurses and PAMs in training.

7.4 The Government understands the importance of making recruitment and retention a priority in the new NHS Wales. A review of some of the issues underlying PAMs' career development has already been conducted. Among the many issues identified for action are those concerned with work pressures, lack of recognition of status, relatively poor pay and loss of career structure. The report will be published this month. The Welsh Office intends to use the outcomes of this to review those values which are important to staff and to work with relevant groups to implement the recommendations and share the lessons more widely within NHS Wales.

7.5 To address the difficulties faced by NHS Wales, the Welsh Office will focus on two key areas - the management of human resources and the Government's commitment to education and training.

Human Resource Strategy

7.6 In November 1991 the Welsh Office published PEOPLE: Personnel Principles for NHS Wales. Its purpose was to identify the key principles underpinning effective human resource policies and to require managers to prepare their own local strategies in both the primary and secondary sectors. These key themes:

. Performance Management
. Equality of Opportunity
. Open Communication
. Planning Ahead
. Local Emphasis
. Efficiency and Effectiveness

remain applicable to the human resource needs of today. However, the service will need to review them in order to reflect the changes that have taken place and to help underpin the agenda set out in this White Paper. With other Health Departments, the Welsh Office is consulting on human resources management across NHS Wales, specifically to address the need for a clear strategic direction at a national level.

7.7 Key issues currently being addressed are:

. NHS trusts will retain their role as local employers within the NHS. In a national health service, the current mix of national and local contracts is divisive and costly. The Government's objective for the longer term is therefore to see staff receive national pay, if this can be matched by meaningful local flexibility, since current national terms of service for a multitude of staff groups are regarded as inequitable and inflexible. Exploratory discussions on these issues are already under way with staff organisations and NHS employers;
. putting good industrial relations at the heart of the new NHS. Continuous development in NHS Wales is important because of the known benefits it can reap in terms of its ability to compete in the labour market;

. the make up of the NHS workforce of the future. Increased flexibility in working patterns and practices is important if NHS Wales is to be able to respond to patient need and meet the challenges described in this White Paper. There are changes for professional staff, including an increasing emphasis on clinical effectiveness and the delivery of multi-professional education; the new specialist registrar training for doctors; and mandatory continuing professional development for nurses linked to continuing registration and right to practice. Statutory frameworks regulate the health care professionals. However, our emphasis must be on greater flexibility within those structures that are already in place and on building on developments that have already started. One important example is the work of the Chief Nursing Officer's Task Force for Continuing Education and Practice which is currently undertaking work that will ensure an appropriately qualified and flexible Nursing, Midwifery and Health Visiting workforce in Wales to meet the changing agenda. As a result of this work a strategic framework will be agreed with key interests by December 1998;

. promoting equality within NHS Wales to ensure the development of a workforce that is competent to meet the diverse needs of the population it serves. The Equality Unit will continue to work with NHS Wales to develop this further to provide fair and equitable opportunities for all. The focus will be in two major areas: to recognise opportunities to release potential abilities among the existing workforce, and to support staff through more creative and flexible employment practice. Since 80% of the NHS workforce are women, family-friendly policies will continue to be an important ingredient in retaining staff and will be beneficial to management and staff alike.

Education and Training

7.8 Education and training of staff will continue to be a key component in delivering the changes. Currently, over £73 million is being spent from centrally-administered funds on providing education and training in NHS Wales for medical and non-medical health care professionals. The "Towards 2000" strategy introduced in 1993 centralised funding to safeguard pre-registration non-medical education and improve the potential for meeting needs identified through work-force plans. The arrangements have bedded down well but there is still work to be undertaken; by July 1998, therefore, we will review the needs of primary care practice staff to better reflect the changing needs of the NHS. This will be reinforced by Practice Development Plans.

7.9 This will build on an initiative currently taking place through the use of the new Primary Care Development Fund. In recognition of the difficulties experienced by practices with small workforce numbers in releasing staff for education and training purposes, we have committed £500,000 to set up a programme to enhance practice development. We are currently liaising with the School of Post Graduate Medical Education and others with an interest in primary care on the most effective use of this funding.

7.10 The Welsh Office recognises also that the "Towards 2000" arrangements are distinct from those for medical education; there is a need for greater integration. In 1998 we will seek to identify those areas where greater collaboration can take place; post registration continuing professional development could
be a key focus in this. The Welsh Office will also continue to work with the University of Wales College of Medicine on the contribution of education to inter-professional working.

7.11 The need for education and training is not limited to clinical staff. Management development is another area of significance. It was agreed in 1995 that responsibility for management training should lie with NHS Wales, and the health authorities now fund the running of these schemes through the NHS Staff College. In addition, the Welsh Office is seeking other opportunities, on an England and Wales basis, with the NHS Executive Development Unit. Most recently, this has meant opportunities for senior managers to apply for career registration, again facilitated with the Staff College in Wales.

7.12 A commitment to National Occupational Standards and National Vocational Qualifications has reaped benefits in recognising the competence of staff.

Further development will come from the establishment of the emerging National Training Organisations (NTOs). This Department for Education and Employment initiative is intended to help employers and employees to meet their sector training and education needs. The health care NTO will more closely align opportunities with developments in service priorities and the skills needed to respond to change. We and the other Health Departments are currently working with the NHS Confederation and other health care associates from the private, voluntary and independent sectors to establish the NTO in April 1998.

7.13 These changes, and the others which this White Paper will introduce, will offer new opportunities for staff to locate in areas where the service is under strain, to extend professional boundaries and to provide better services to patients. All of these will require a team effort and will lead to an emphasis on the need to review the full range of services available in order to use the skills of the staff in NHS Wales to their best effect. If we do not recognise and encourage the development of the wide range of skills and services employed in today’s NHS we will miss a chance to provide better, more integrated care and risk leaving needs unmet. We, in partnership with NHS Wales, will assist staff to take this agenda forward.

Summary

The Welsh Office will continue to review the numbers of health care professionals in training to best meet work force plans.

We will work with NHS Wales during 1998 to improve career structure and development for PAMs.

We will review the current Human Resource strategy for NHS Wales to align it with the current agenda.

The Welsh Office will review the "Towards 2000" arrangements to better reflect primary care and practice development needs.

Together with other Departments, we will work towards establishing a National Training Organisation for Health Care.

The Welsh Office will continue to support the development of managerial skills to implement the organisational and culture changes arising out of this White Paper.
8. How the money will flow

NHS Wales is a major consumer of resources. Existing resource mechanisms have been designed to take account of the outmoded market structure. The Government believes that the measures proposed in this chapter will permit the best use of resources within the reformed NHS; will ensure that the NHS remains properly accountable for its actions; and that the value of every pound spent in the NHS will be maximised to ensure the best return for patients.

8.1 The NHS is the second biggest spender of public sector resources in Wales, accounting for almost £2.4 billion of public expenditure in the current financial year. This represents 34% of all Welsh Office expenditure. The Government is committed to increasing total expenditure on the NHS in real terms in each year of the present Parliament. It has already taken action to give substance to this pledge:

. an additional £9.5 million has been made available in the current financial year to help the NHS deal with the surge in emergency medical admissions which is expected during the winter months;

. in his budget statement in July, the Chancellor announced an additional £60.2 million for NHS Wales for 1998-99. This is on top of planned increases in spending and means that real terms growth in the next financial year will be in excess of 2%.

8.2 But it is not enough for the Government to provide more money. It is important that this money is spent well and used effectively so as to maximise patient care; secure value for money for every pound that is spent; and minimise the amount that is spent on unnecessary bureaucracy and ineffective clinical procedures. The NHS can make better use of the resources it already has available. The changes outlined in this White Paper will reduce costs by up to £10 million per annum. These savings will be reinvested in patient care. The rest of this chapter describes how money will be allocated to the NHS under the new arrangements proposed elsewhere in the White Paper; how the NHS will be held accountable for spending this money; and how we will secure value for money.
8.3 The vast bulk of NHS resources are directly allocated to health authorities so that they can determine their priorities for spending locally. The remainder is held in a number of centrally managed budgets within the Welsh Office Health Department to be spent on agreed national priorities: for example, on professional education and training for new doctors and nurses. The Government proposes to maintain this system but will continuously review the division of responsibility between the Health Department and health authorities with a view to ensuring that money is spent as effectively as possible. In particular, the Assembly will directly oversee the provision of particular specialist or national services.

8.4 The Welsh Office has already established a Resource Allocation Working Group to review the existing allocation formula which determines the shares received in each health authority area with a view to determining a fairer distribution of resources that more nearly meets the specific needs of different areas within Wales. In particular, the Working Group has been charged with the task of achieving a better recognition of the impact of rural sparsity and urban deprivation on health needs and the resulting allocation of resources. The Welsh Office will consult on the recommendations of the Working Group soon and will implement the agreed recommendations in time for the financial year 1999-2000. It may be necessary to implement any changes on a phased basis over a number of years so as to avoid any unnecessary disruption to services.

8.5 Health authorities will need to make delegated allocations to Local Health Groups. The allocation formula must be robust enough to allow allocations to be made at this lower level on the basis of smaller population sizes. The Government will provide health authorities with the data necessary to make such subsidiary allocations. It will be up to health authorities to determine how much of their total discretionary budget is delegated to Local Health Groups. They may wish to retain some resources centrally where services can be purchased on a more effective basis across a bigger population; and they may also wish to consider "top-slicing" some element of resources for investment in specific areas where services are currently provided at a lower standard than elsewhere or where strategic change is required. Such "top-sliced" monies would be returned to the formula-based allocation to Local Health Groups in future years.

8.6 Budgets will be delegated to Local Health Groups and operated within that cash ceiling. Local Health Groups will be able to take decisions on which services they wish to commission from which providers, but initially operational accountability will remain in the hands of the health authority. This will have the effect of minimising the bureaucratic overhead which Local Health Groups will need, while ensuring that health authorities retain the critical mass of technical expertise necessary to deliver an efficient service. As Local Health Groups demonstrate financial and managerial maturity, so they will be given greater financial freedom in line with provisions set out in paragraph 4.32.

8.7 Only one part of the Local Health Group's budget will be ring-fenced, to provide resources for a new Primary Care Development Fund. The purpose of this will be to support the development of services outside hospitals and to allow practices to maintain or develop services which fall outside the scope of the old GMS arrangements. Previously these opportunities have only been available to fundholders but now all practices will be able to take advantage of them. The health authority will have discretion over the sum to be ring-fenced subject to a minimum amount to be determined by the Assembly.

8.8 In order to facilitate the best use of resources, the Government will undertake to provide health
authorities with the earliest possible indication of their allocation for future years. The Government will also seek to provide health authorities with the most robust possible planning assumptions for a period of up to three years ahead of the current financial cycle. This, in turn, should permit health authorities to provide their Local Health Groups with timely notification of their budgets; enabling them to enter into meaningful discussions with providers in both primary and secondary care sectors at the earliest possible point.

8.9 The Government believes that these arrangements will ensure that services are commissioned at an appropriate level, combining responsiveness to local needs with efficiency and due regard for national priorities.

Capital

8.10 As with other parts of the public sector, the NHS is expected to test capital projects with the private sector as part of the Private Finance Initiative. In the recent past this policy has been allowed to dictate the pattern of capital developments, with those developments which were attractive to the private sector more likely to proceed than those which were not. This was in disregard of the legitimate demands of strategic planning. The Government will shortly issue guidance to the NHS on the reinstitution of a managed capital programme - covering both public sector capital and the PFI approach. Central to this approach is the need for health authorities to develop strategic plans that will provide a context against which individual capital schemes can be judged. The Government does not propose that Local Health Groups should be responsible for the capital process. But they will be partners in the health authorities' strategic planning, and they will be consulted on individual capital projects.

Providing Flexibility and Control

8.11 Resources voted by Parliament for the NHS in Wales are either cash limited or non-cash limited. Broadly speaking, cash limited resources are spent on hospital and community health services and the vast bulk of them form the discretionary allocation for health authorities. Non-cash limited resources are "demand led" and are spent on the provision of family health services by doctors, dentists, opticians and pharmacists.

8.12 It is important that arrangements for funding streams enable clinicians to take decisions about cost effective treatment options and offer scope to redeploy funds to support their decisions. The reality is that prescribing drugs is only one of a range of treatment options available to GPs. There are clear advantages in enabling local flexibility across the drugs budget, hospital and community health services funds, both for more cost effective care and achieving better overall value within the total resources available for health care. The Government has decided it is right to create a single stream of funds covering both hospital and community health services, GP prescribing and GP staff, premises and computers. The effect of this will be to give Local Health Group clinicians greater flexibility within overall budgets to determine which is the right treatment and to access resources for the patient. At the same time it provides greater control over the drugs budget, which typically grows in cost year-on-year at a rate far exceeding headline inflation.
Value for Money

8.13 The Government believes that it is important that the NHS should provide value for money and operate at maximum efficiency. To this end, the Government will continue to demand that health authorities and trusts deliver efficiency savings year-on-year. In a £2.4 billion organisation it cannot be argued that there is no scope for further efficiency. Nevertheless, the Government believes that the policy of imposing a blanket efficiency requirement on all NHS bodies at the same level has been taken to extremes and can no longer deliver real improvements. Accordingly, the Government proposes that 1998-99 will be the last year in which such a requirement is imposed on the NHS. Instead of this blunderbuss, the Government proposes to develop a more sophisticated approach to efficiency, with a view to establishing differential efficiency targets for individual trusts and to securing greater efficiency through a more holistic approach, similar to that being developed within local government.

8.14 Traditionally, management costs have had to deliver their share in delivering greater efficiency. Obviously, this must continue. The Government believes that valuable resources currently locked up in managing an artificial internal market should be released to pay for improved patient care. In particular, GP fundholder management allowances will be recycled to support the operation of Local Health Groups. But this should not be allowed to become a crusade against management in the NHS. While wasteful bureaucracy needs to be cut out of the system, the Government recognises that the highly complex organisation which is the modern NHS needs to be well managed and that managers in the NHS do a valuable job. Welsh health authorities and trusts are already operating on lower management overheads than their English counterparts. Accordingly, the Government does not propose to establish further arbitrary targets or cuts in management costs, but will look to management to deliver its share of improved efficiency in the modern NHS.

8.15 The Government is concerned that NHS bodies do not pay sufficient regard to the findings of "Value for Money" studies undertaken by the National Audit Office and the Audit Commission. These studies, together with similar work conducted by the NHS Wales VFM Unit, often identify significant savings which could be realised if health authorities and trusts worked in accordance with established good practice. The Government proposes to establish mechanisms to ensure that health bodies respond appropriately to the findings of such studies and that savings are delivered in reality.

8.16 In addition, the Welsh Office will establish a Health Policy Evaluation Group. This Group will ensure that all new health policies and major service changes contain at the outset fully developed proposals for evaluation; and that, subsequently, the evaluation takes place and its findings are acted upon. Proper evaluation is a significant tool for ensuring that policy developments deliver what is expected of them and for securing the best return from public expenditure.

Accountabilities

8.17 The NHS is a public institution, serving the public and spending public money. It is important that it should be properly and publicly accountable for its actions and, in particular, for the way in which it spends taxpayers’ money.

8.18 At the level of total NHS spending in Wales, the Director of the Welsh Office Health Department is the Accounting Officer. As well as being responsible to Ministers (in future, the Assembly) the
Accounting Officer is directly accountable to Parliament and to the Public Accounts Committee of the House of Commons for the conduct of National Health Service business in Wales and for the way in which health resources are used in Wales.

8.19 To assist him in these responsibilities, the Accounting Officer is supported by a structure of accountable officers. The chief executives of health authorities, special health authorities and NHS trusts are appointed by the Accounting Officer as accountable officers. In effect, he delegates part of his responsibilities to an accountable officer in each NHS body who is then responsible for ensuring that that body conducts its business in accordance with the highest standards of probity, propriety and regularity and who is charged with ensuring that there is no misuse of public funds.

8.20 The Government proposes that this arrangement should continue to operate. While it is important that all key NHS bodies should have their own accountable officer it is equally important that there should not be an unnecessary proliferation of accountabilities. Accordingly, each Local Health Group will appoint an officer with closely defined responsibilities for financial management and control, who will be personally accountable to the accountable officer of the health authority. Local Health Groups will report to their parent health authority and will be accountable for their use of public money and for the propriety of their decision making through the health authority accountable officer.

Summary

The Government is committed to increasing total expenditure on the NHS in real terms in each year of the present Parliament; new resources have already been announced.

The Government will introduce a fairer system for allocating resources to health authorities.

Local Health Groups will have the opportunity to take progressively more responsibility for local budgets as they develop financial and managerial maturity.

Local Health Groups will have officers with defined responsibility for financial control.

The Government will shortly take action to reinstitute a managed capital programme based on health authority Health Improvement Programmes, and informed by the views of Local Health Groups.

Artificial boundaries between funding streams will be abolished to give clinicians more flexibility to determine appropriate treatments for their patients.

New, more sophisticated, and fairer arrangements for improving efficiency will be introduced.

The Government proposes to establish mechanisms to ensure that health bodies respond appropriately to the findings of Value for Money studies.
9. MAKING IT HAPPEN

9.1 This White Paper sets out a radical but essential new agenda for NHS Wales and its partners. It is an agenda for evolutionary progress. The NHS does not need further costly structural upheaval but it does need, and seeks, change where patients can benefit. The Government shares this view and brings to the programme of change a commitment to improving the NHS year by year. In implementing the proposals, all organisations need to balance the benefits of change against the costs of turbulence and uncertainty, while maintaining services to patients. In particular, patients must be able to rely upon:

- prompt access to integrated primary/community care services;
- prompt access to emergency care;
- constant downward pressure on waiting times;
- a responsive service of quality by clinicians and others with whom they come into contact.

9.2 For these reasons, as well as the measures needed to integrate action with the creation of the Assembly, the Welsh Office will co-operate with NHS organisations, professional bodies and others to introduce progressively the intended changes. However, the firm intent of the reforms is both radical and far reaching; the new NHS must:

- reflect the full range of its objectives, including improving health as well as providing high-quality care;
- tackle unacceptable variations in quality provision and performance so that the service, once again, can become genuinely national;
- address systematically and include the views and experience of users.

9.3 The Welsh Office will initiate action on each front and work with other organisations on programmes of action which fall to them. The Department will co-operate with other health departments on the measures set out in the White Paper which require national action. These include proposals which require
primary legislation or inter-departmental co-operation, for example to establish the National Institute for Clinical Excellence and the Commission for Health Improvement.

**9.4** Within Wales, the Department will give priority to:

- completing the reconfiguration of NHS trusts;
- issuing guidance on the implementation of Local Health Groups;
- co-operating in the establishment of the National Institute for Clinical Excellence and the Commission for Health Improvement;
- issuing guidance on the preparation of Health Improvement Programmes;
- overseeing the development of the first National Service Framework for cervical screening;
- putting in hand arrangements for the preparation of the Corporate Plan and tackling the subsidiary strands of work identified in the All Wales Service Review;
- ensuring the completion of the review of health promotion activities in Wales and the preparation of a new framework for research and development in Wales;
- provide information to support the provision of budgets to Local Health Groups;
- consulting on alternative and additional means of involving the public and patients in decisions affecting their experience of the NHS;
- aligning performance review and planning mechanisms and information to the new priorities to ensure that they address the new objectives set by the Government;
- overseeing delivery of the service guarantees.

**9.5** In parallel, the Secretary of State expects NHS Wales and its partner organisations to respond to the challenges set out in the White Paper. Each organisation has a role to play, each is given flexibility to make a contribution, and each will be expected to co-operate in a rolling programme of implementation. In particular:

- health authorities should develop new mechanisms to work co-operatively with local government in key areas, establish sub-committees and mechanisms to inaugurate and support Local Health Groups, and to address inequalities in health within the context of Health Improvement Programmes;
- trusts should establish mechanisms to monitor and report on quality measures, consider new means of securing patient representation and also open dialogues with Local Health Groups as they are set up and work with health authorities on the new agenda.
9.6 This is a demanding agenda but there is no alternative to dynamic change if the Government's ambitions for the NHS and its users are to be realised. Many of the improvements signalled in the White Paper can be realised only with time. The Government recognises that some of its objectives for improved health for all through a collaborative programme of action will take time to develop and deliver; but others are capable of early action and speedy results. The measures in this paper reflect both streams of activity and both are necessary if the nation is once again to have a service which is true to its founding principles, faithful to its ambitions, responsive to its users and confident in its future.
Glossary

Accreditation

The professional and national recognition of a health care facility which has voluntarily sought to be measured against high professional standards and is found to be in substantial compliance with those standards.

Acute Services

Medical and surgical treatment and care mainly provided in hospitals.

Benchmarking

A process whereby organisations identify best performers in particular areas and examine how the good results are achieved with a view to bringing their own performance into line with the best.

Cash Limit

The amount of money the Government proposes to spend or authorise on certain services or blocks of services during one financial year. Cash limits will apply to the total budget at each level: Assembly, health authority and Local Health Group.

Clinical Audit

The systematic analysis of the quality of care, involving the procedures and processes used for diagnosis, intervention and treatment, the use of resources and the resulting outcome and quality of life as assessed by both professionals and patients.

Clinical Effectiveness Initiative

Initiative launched in May 1995 to ensure that all who provide health care, work together and in partnership with patients to increase the proportion of clinical care which has been shown by evidence to be effective.

Clinical Governance

A new initiative in this White Paper to assure and improve clinical standards at local level throughout the NHS. This includes action to ensure that risks are avoided, adverse events are rapidly detected, openly investigated and lessons learned, good practice is rapidly disseminated and systems are in place to ensure continuous improvements in clinical care.

Clinical Indicators

Statistics used to assess aspects of clinical care that may raise issues, for example of quality, for further investigation but which do not, of themselves, measure quality or outcome attributable to care in individual hospitals.
Commissioning
The process of identifying local health needs, drawing up plans with strategic partners to meet those needs, identifying appropriate health services and making agreements with health service providers to ensure that services are delivered.

Community Health Services
Services such as home nursing and child health surveillance provided outside the hospital setting by health care professionals employed by NHS trusts.

Community Nurses
Includes practice nurses, district nurses, health visitors, school nurses.

Extra Contractual Referrals (ECRs)
An arrangement under the NHS internal market to cover a referral to an NHS Trust for which there was no existing contract with the patient's Health Authority of residence or

General Medical Services
General medical services are services provided by family doctors (GPs) and their staff, as provided for in Section 29 of the 1997 Act, and framed in the General Medical Services Regulations 1992.

GP Fundholding
A GP whose practice manages a budget for its practice staff, certain hospital referrals, drug costs, community nursing services and management costs.

Health Authority
Bodies which are accountable to the Secretary of State for assessing the health needs of their local populations and ensuring that, working with other members of the NHS family and partner organisations, appropriate plans are drawn up and implemented to improve the health and commission appropriate services. Their roles and responsibilities are set out more fully in Chapter 4.

Health Improvement Programme
An overarching strategic plan, drawn together by the health authority, reflecting the views of all members of the NHS family and other strategic allies. It will incorporate service configuration proposals and associated changes in the estate; primary care development plans; and most importantly, integrated programmes for improving health across the health gain areas. It will set a clear agenda for action in the first three years and indicate broad direction of travel in years 4 and 5.

Hospital and Community Health Services (HCHS)
The main elements of these are the provision of hospital services, and certain community health services, such as district nursing. These services are provided in the main by NHS trusts.

Local Health Groups
Groups established and supported by health authorities to bring together GPs, nurses, and other primary
care professionals with local government and other representatives of local communities. They will identify local need and determine local priorities. Within the parameters of the Strategic Health Plan, they will decide what services should be provided for the population they serve. Chapter 4 sets out proposals in more detail.

**Locality Commissioning Pilots**

A small number of projects which will go forward from April 1998 to explore the opportunities for GPs, working with others from within the NHS, local government and local communities, to address the health agenda and commission health services for local people. The projects will be evaluated during 1999 and the lessons learned will be disseminated to promote the effective development of local arrangements for organising health care.

**Longer Term Agreements**

Agreements established between health authorities, Local Health Groups and NHS trusts on the services to be provided for a local population. These replace the annual contracts of the internal market and cover a minimum of three years to offer greater stability. Explained in more detail in Chapter 4.

**National Schedule of Reference Costs**

NHS Trusts will be required to publish their costs on a consistent basis, and the data will be published in a national schedule of reference costs so that performance on efficiency can be benchmarked. This will build on developments in recent years to introduce a standard way of identifying the cost of different kinds of treatment based on diagnosis related groups (DRGs).

**National Service Frameworks**

National Service Frameworks which bring together the best evidence of clinical and cost-effectiveness with the views of service users to determine the best ways of providing particular services. See Chapter 3.

**NHS Trusts**

NHS trusts are public bodies providing NHS hospital and community health care. They will have new duties to work in partnership with other NHS organisations and to contribute to improving the health of local people.

**Nolan Principles**

Principles governing propriety in public life.

**Primary Care**

Family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners.

**Primary Care Act Pilots**

The NHS (Primary Care) Act 1997 allows members of the NHS family, ie an NHS trust, an NHS employee, a qualifying body and suitably experienced general medical practitioners, to submit proposals to provide services under a pilot scheme and contract with the health authority to do so.
Primary Care Trusts

Subject to the enactment of legislation, a new form of freestanding NHS trust accountable to health authorities for commissioning care, and with added responsibility for the provision of community services for their population. The ultimate potential expression under the legislation of Local Health Groups.

Social Services

Personal care services provided by local authorities for vulnerable people, including those with special needs because of old age or physical or mental disability, and children in need of care and protection.

Specialist Services

Services which are best organised for large populations because demand for them is relatively small, cost of provision is high, and they call for high levels of expertise, often from centres of excellence.