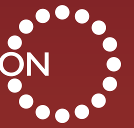
THE **WELSH NHS** CONFEDERATION
CONFFEDERASIWN **GIG CYMRU**



A summary of comments on the proposed structural changes to NHS Wales

1) The overall criterion for any new structure for NHS Wales is that it must better serve citizens, patients, families and carers than the existing arrangements.

2) We agree with the desirability of the six benefits sought from restructuring as discussed in the paper and seen as important and attainable through abolishing the internal market:

a) Strengthening partnership working.
b) Providing a balanced attention to different parts of the health system.
c) Bringing together service planners and the caring professionals.
d) Reducing public confusion over roles.
e) Changing the language to emphasise clinical quality and outcomes.
f) Better overall cost control.

Any proposals put forward for changing the structure of NHS Wales must demonstrate real and lasting improvements in these areas and must be resilient enough to withstand the test of time. There is much evidence that organisational change distracts and detracts from the essential business of service development and improvement. We have much to do to transform the NHS in Wales and to make it sustainable for future generations, the sooner we can settle down to deal with this the better.

Success will depend on signup and strong leadership at all levels to a sustained and determined shift toward health improvement, out of hospital care and a refocusing of hospital services. This will require strong leadership, solidarity of purpose, and a shared commitment to change the system.

3) We support the proposal that health policy and service delivery should be separated as part of the new structure. WAG has an important role in shaping vision, building strategic direction, preparing health and social policy and setting strategic health and well being outcomes as objectives for the NHS and its partners. The structure of the NHS needs to be strengthened to enable it to better plan and deliver services with clearer roles, accountabilities and more focussed performance management.

4) The concept of a National Board in the form of a Special Health Authority is supported. It should take responsibility for leading and overseeing the NHS in Wales and in allocating resources to enable the implementation of WAG's vision and policies, and the achievement of the required strategic health outcomes. However, should single integrated health bodies be introduced, then the role, constitution and relationship of a National Board vis a vis the Welsh Assembly Government and the NHS would need careful consideration.

5) We acknowledge the need to reduce the number of organisations involved in the planning and delivery of health and social care in Wales. The issues of capacity, skills and experience in the existing structures are recognised and need to be addressed in a sustainable way. The ultimate aim should be to bring health and social care together in one organisation, but the first step must be to put in place a more effective structure for the NHS. Early pilot/pathfinder projects to bring health and social services together might be a way forward.

6) Community services and their relationship with primary, secondary and social care are crucial to the future success of the NHS and the quality and timeliness of the care it provides. Strong and

appropriate out of hospital services are key to the improvement and modernisation of health care in Wales. A funded strategy will be essential to provide focus and priority to the development of these services to enable more appropriate use of acute hospital services and a more flexible use of resources.

7) A better balance must be struck in the prioritisation and allocation of resources between hospital and out of hospital services. The iconic nature and high profile of hospital services has traditionally attracted more attention in our society. But we know that if an effective platform for out of hospital care is not developed, the existing workload and function of hospitals will increasingly become unsustainable. We also know that if organisational boundaries could be pushed aside, care pathways and networks would be better placed to meet the needs of patients and their families and to provide seamless care.

8) The discussion on structures has revealed the absence of an agreed definition of community services, this is a handicap when discussing the role and future fit of these services. The information we collect/use about them is often light and limits our knowledge (as opposed to that of acute hospital services), on outcomes and their value for money. Progressively the differentiation between some aspects of hospital and community is difficult, particularly where services follow patients and support them through the care pathway. Services once provided in hospitals are increasingly being provided in the community. The management and funding streams in integrated trusts are interweaved and, if hospital and community services are separated, would need to be disentangled. On this basis an effective and well thought through transitional plan will be essential.

9) Unsurprisingly there are differing views on the optimal organisational model for community services. By and large LHBs believe that these services should be vested with them in order to build a strong and increasingly integrated care between primary, community and social care, while Trusts believe that the concept of integration which shaped their organisations is still sound, is inextricably weaved into their organisations and is effective in delivering a seamless care pathway between home and hospital.

10) The merit for introducing dual organisations as discussed in the consultative document would be the focus they could give to health improvement and the integration of primary care and community services. They could also create a platform on which integration with social care could be built in the future. The potential disbenefit would be the disjunction created between hospital and community services and the challenge this would place on achieving seamlessness in the delivery of care plans.

11) A growing view is emerging that a single organisation integrating LHB and NHS Trust roles might be the best way forward. Intuitively it seems hard not to argue that to improve the continuity of care, and to achieve the benefits sought by the abolition of the internal market, a single organisation at health community level could better serve the needs of patients, citizens and staff. The reforms in Scotland and Northern Ireland appear to be showing the benefit of bringing provider services. together. The scenario of a single integrated provider with an incentive to move patients more effectively through the system is indeed attractive and has the potential for better services, reduction of unnecessary admissions, and more effective discharge management. Additionally, joining the

strategic planning, funding and service delivery functions has the potential of bringing balance and whole system thinking to the decision making process.

12) If a single organisation could better fulfil the required benefits from abolishing the internal market, then it would ultimately be the most effective restructuring solution for patients, citizens and staff. On this basis, such a model would be a likely scenario for the future, and it would be better to introduce this now rather than to face a further organisational change a few years on. Most believe that a possible prolonged two-stage NHS reorganisation would be bad for staff morale, patient care and service development.

13) However, with the single integrated organistion model we must be clear that this Is not a reincarnation of the '80's style health authorities in which decision-making tended to be concentrated at the centre rather than operational issues being dealt with locally and with a number of "layers" needing to be navigated before a decision was made. Clinical staff, stakeholders and external partner organisations were not particularly enamored with this system, which was eventually discarded. In a single body arrangement we would need to address how the system could remain sharp and responsive, and clear why the benefits of single organisations proved so illusory for many Health Authorities at that time.

14) Thus we must be entirely satisfied that, if the single organisation option is chosen it must be fit for purpose and is:

a) Structured, operates and is seen to be a completely new and integrated organisation.
b) Set up with a clear mission and a determination to bring whole system balance and service integration.
c) Run with governance and management arrangements that are clearly built on whole system balance and accountability, with localism and stakeholder representation at the heart of its structure and processes.
d) Focused on breaking down barriers to enable the development and delivery of out of hospital care and better, more appropriate use of hospitals.

15) Essential to the success of this would be a sensible and sustainable implementation programme that could meet WAG's imperative to get things moving, but fashioned in such a way as to provide a smooth transition. Change on the scale contemplated will take time, not just in structural terms, but also in developing staff and evolving a new culture. In Scotland, their change is part of a 10 Year Plan. This cannot be a quick fix, but a journey that will take time and tenacity to see it through. In previous restructuring, shadow boards and chief executives elect were put in place to manage the transition. In our case with either a dual or single organisation model will take at least a year. Something similar has happened in Northern Ireland where they have made CE appointments and considered the merging bodies as legacy organisations, each working toward and responsible for forming one new body.

16) The governance of the new health organisations in Wales will need balance to ensure effective corporate management, while engaging citizens and other stakeholders in the decision making process. Boards of the future will need not only to oversee the performance of their own

organisation, but also the effectiveness of the partnerships involved in delivering integrated care. There will need to be an internal focus on how the organisation is performing and an external focus on the perceptions of how the organisation is delivering for others ie the community, individual patients and the local partners with whom they work closely.

The make-up of boards as is now being developed with the new merged trusts provides a strong model of local knowledge and specific experience in core issues such as finance, law, planning and IT. The links between the governance arrangements and the communities they serve will be paramount. This, complemented by staff representation, provides an holistic approach to governance with one exception, that of local government, which is of course present in the existing LHB model and needs to be considered in a new model of governance. The professional advisory function needs to be strengthened and aligned to the governance structure and will be particularly important in the integration of GPs and theirprimary care teams. The public health function should also be an integrated part of these new organisations. Either the single or dual organisational model would need a range of executive directors representative of the key management divisions.

17) The proposed continuation of the statutory duty on the NHS to produce local strategies with local authorities, and for local authorities to produce integrated community plans, provides a platform for local partnership and engagement that in which a Welsh version of Community Health Partnerships with networks of stakeholder groups could play a major part. The retention of the statutory duty of partnership between local authorities and the NHS should be retained. Community Health Councils, while needing to be reshaped and their role realigned better with health and social care, should continue to play an important part in public engagement.

18) A National Board could be seen by WAG as the best place for some if not all support functions. However, it is widely felt in the NHS that those services which are patient services or directly related to operational management would be better left to the same or similar arrangements as at present. A centralisation of these functions would cause real concerns (as existed with WHCSA) on issues of governance, accountabilities, working relationships and customer centeredness.

19) The National Public Health Service should be seen in the context of the new structures both in terms of providing central sub specialist expertise and support, and directly accountable public health services at health community and locality levels.

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About the Welsh NHS Confederation

The Welsh NHS Confederation represents the organisations making up the NHS in Wales: trusts and local health boards. We act as an independent voice in the drive for better health and better healthcare through our policy and influencing work, and by supporting members with events, information and training. To find out more about us go to -

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