Health and Social Services Committee **HSS-15-01(min)**

MINUTES

Date: Wednesday, 7 November 2001
Time: 2.00 to 5.40pm
Venue: Committee Room 3, National Assembly for Wales
Attendance: **Members of Health & Social Services Committee**

Ann Jones	Vale of Clwyd
(temporary Chair)	
Peter Black	South Wales West
Geraint Davies	Rhondda
Brian Gibbons	Aberavon
Jane Hutt (Minister)	Vale of Glamorgan
Dai Lloyd	South Wales West
David Melding	South Wales Central
Lynne Neagle	Torfaen
Rod Richards	North Wales
In Attendance	
Yvonne Apsitis	United Kingdom Home Care Association
Graham Benfield	National Steering Group on Structures *(Wales Council for Voluntary Action)*
Sandy Blair	Structures Task and Finish Group *(Welsh Local Government Association)*
Linda Bransbury	Welsh Local Government Association
Dr Tony Calland	Structures Task and Finish Group
Hugh Gardner	Association of Directors of Social Services
Jane Jeffs	Association of Community Health Councils
Mario Kreft	Care Forum Wales
Anthony Ramsey Williams	Registered Nursing Homes Association
Lynne Ryan	Bro Taf Health Authority
Jenny Theed	Cardiff and Vale NHS Trust
Hugh Thomas	Structures Task and Finish Group *(NHS Confederation in Wales)*
Officials	
Dr Ruth Hall	Chief Medical Officer
Carwen Wynne Howells	Chief Pharmaceutical Adviser
Joanest Jackson	Office of the Counsel General
Rosemary Kennedy	Chief Nursing Officer
Ann Lloyd	Director, NHS in Wales

Mike Ponton	Health & Well-being Strategy and Planning Team
Carolyn Poulter	Primary & Community Health Division
John Sweeney	Primary & Community Health Division
Helen Thomas	Director, Social Care Group
Bob Woodward	Social Services Inspectorate Wales
Secretariat:	
Jane Westlake	Committee Clerk
Claire Morris	Deputy Committee Clerk

Item 1: Apologies and Substitutions

1.1 An apology was received from Kirsty Williams. Peter Black substituted for her.

1.2 Members were reminded of the requirement, under Standing Order 4.5, to declare any interests before taking part in proceedings. The following declarations were made:

- Peter Black, member of the Council of the City and County of Swansea;
- Geraint Davies, pharmacist and member of Rhondda Cynon Taff County Borough Council;
- Brian Hancock, health, safety and environment consultant and registered safety practitioner
- Dai Lloyd, general practitioner, member of the Council of the City and County of Swansea and member of the Steering Group of the Welsh Medicines Resource Centre (WeMeRec).

Item 2: Prescribing Practices Task and Finish Group
Paper: HSS-15-01(p.1)

2.1 In response to the paper and the Minister's introduction, Members made the following points:

- There should be no overlap or conflict of interest between the All Wales Medicines Strategy Group (AWMSG) and the National Institute for Clinical Excellence (NICE).
- Reform of the Pharmaceutical Price Regulation Scheme could achieve massive savings on the drug bill.
- The pharmaceutical industry should be represented on the AWMSG.
- Meetings of the AWMSG should be held in public, except where restricted by issues of commercial confidentiality.

2.2 In response to Members' comments, the Minister made the following points:

- There should be no duplication between the AWMSG and NICE.
- The AWMSG would have a wider remit than NICE, looking at wider prescribing issues in Wales, advising the Assembly on resolution of problems and ensuring an interface between primary and secondary care.
- PPRS was not devolved under the agreement with the Department of Health, but the AWMSG

would have a role in identifying potential savings in the drugs bill in Wales.
- A Welsh approach to affordability was needed, which would recognise both cost savings and patterns of morbidity.

2.3 Carwen Wynne Howells said that she would expect the AWMSG to consider the option of developing an all Wales formulary but it was too early to say whether this would be a strategic objective of the Group.

2.4 The Committee agreed to the recommendations of the paper, subject to inclusion of the pharmaceutical industry in the membership of the AWMSG and meetings being held in public, wherever possible.

Item 3: Structural Change in the NHS in Wales
Paper: HSS-15-01(p.2)

3.1 The Minister made a statement on the emerging conclusions of the NHS Structures consultation. A copy is attached at Annex A.

3.2 In response to the Minister's statement, Members made the following points:

- There was no evidence that the proposed restructuring would achieve the objectives of improved patient care, or more democracy and accountability or less bureaucracy.
- Losing five health authorities and replacing them with 22 Local Health Boards (LHBs), 12 partnerships and three regional offices of the National Assembly would not make the NHS simpler for patients to understand.
- If the LHBs were fit for purpose partnerships and regional offices would not be necessary.
- Increasing the powers of Local Health Groups (LHGs) and making them Local Health Boards was welcomed but there was some surprise that Trusts were to remain unaffected.
- Concern was expressed at the capacity of LHGs to cope with what was being expected of them.
- There would be a conflict of interest in the same organisation commissioning and providing services.
- It was not believed that the creation of additional directorates within the Assembly would make access to services clearer or simpler for patients.
- It was suggested that an arms-length organisation be created, which would commission health services on an All Wales basis. LHGs could then be retained to deliver primary and possibly community care services.
- It must be ensured that reorganisation was long term.
- There should be an opportunity for a full plenary debate on the proposals.

3.3 In response to Members' comments, the Minister made the following points:

- Wales needed a primary care led service.

- Arrangements needed to be simplified between the national and local level.
- Many of the responses received during the consultation had been taken on board for example the proposal to establish three consortia had been abandoned.
- The creation of another publicly elected body to commission services was not supported.
- Public health professionals needed independence. It was not proposed that they all become civil servants.
- Clinical networks were already being established in Wales, which depended on collaboration and partnership.
- The Chair of the LHB would be the only public appointment. Other members would be nominated by their professional groups.
- The Primary Care Directorate in the National Assembly would work with reference and advisory groups drawn from practitioners across the whole of primary care.
- A number of trusts had come forward wanting to operate as pathfinders. Ann Lloyd confirmed that the process being discussed by the Structures Task and Finish Group for agreeing and developing pathfinders was extremely rigorous.
- It was vital to move forward with restructuring so that staff were clear about what the changes would mean for them.

3.4 Hugh Thomas, Structures Task and Finish Group, said that during his time with the NHS Confederation they had made strong representation to the Minister to look again at proposals for restructuring and the consultation paper had been the fruit of the task and finish group's report. He believed that the Minister had kept an open mind and what was being discussed were her emerging conclusions, not her final decisions. He had also contributed to a paper by Chairs of health authorities and trusts which offered two solutions, one of which would facilitate the principle of embracing a primary care led NHS.

He did not believe that effective interrelationships existed yet between primary and secondary care and therefore welcomed the Minister's emphasis on establishing the focus on primary care.

He also urged that the interface between the NHS and social services should not be forgotten. His own trust was affected by many delayed discharges which was why the partnership theme was so important and why the Chairs of health authorities and trusts had put forward an alternative model based on total integration.

3.5 Dr Tony Calland, Structures Task and Finish Group, said that the primary care workforce had been requesting the strengthening of LHGs for some time. He believed there was a danger in creating a strategic health authority of moving back to the days of the Welsh Hospital Board, when there was a lack of sensitivity to local issues. He expressed concern at the ability of LHBs to participate in pathfinders as they would initially have a very steep learning curve. There needed to be scope for commissioning services to be developed and shaped for local need. Dr Calland welcomed the establishment of a Primary Care Directorate, as a strengthened presence within the Assembly was needed. He was disappointed to see a reduction in the number of GPs in the proposed LHB membership and was not convinced that four members from local government were necessary.

3.6 Jane Jeffs, Association of Community Health Councils, said that she believed patients were now more involved in the NHS than ever before. It was important for patients to understand the management and structure, as, without this understanding they would not be able to participate fully. She emphasised the need for high calibre members of LHBs, who were able to visualise the bigger picture as well as their own locality.

3.7 Graham Benfield, National Steering Group, said that members of LHBs would need to receive the support and clarity of role necessary for them to operate effectively. He saw a lot of value in co-terminousity. He also believed that the public did not like to see artificial divisions between health and social services. He welcomed national standards but felt that the layers between national and local level were often difficult to understand.

3.8 Sandy Blair, Structures Task and Finish Group, favoured the bottom-up approach and thought the objectives would be best met through a significant shift to tackling the causes of ill health. Local focus and accountability on an inter-agency basis was needed and it was important to ensure there was no loss of capacity. He believed that strengthening LHBs, encouraging collaboration and investing in capacity was essential for the future. He was concerned that partnerships between local government and health were not restricted to social services, but embraced the wider issues such as housing.

3.9 Two Members proposed that the Committee should request that the Business Manager schedule time for the proposed structural changes in the NHS to be debated in full plenary session before the Christmas recess. Following discussion, consensus was reached without a vote and it was agreed that the Chair should write formally requesting time be scheduled.

Action

- Chair to write to the Assembly Business Manager requesting a full plenary session debate on the proposed structural changes in the NHS before the Christmas recess.

Item 4: Care Homes
Paper: HSS-15-01(p.3)

4.1 The Chair welcomed representatives of the care home sector and the statutory agencies.

4.2 Hugh Gardner, Association of Directors of Social Services, said that concern about service provision was widespread across the social care sector. The minimum wage and European working directives meant care homes were no longer a cheap care option. Local authorities could not afford to reflect higher costs in the fee rates offered to the independent sector, and this was a contributory factor in some complaints or home closures.

A realistic assessment was needed of the level of fees appropriate for the level of care provided. The

gradual decline in the number of homes and places was leading to the creation of a providers market. Further work was needed to develop an holistic approach to care through partnerships with the health and independent sector. In the long term, more realistic funding was also required.

4.3 Jenny Theed, Clinical Director of Community Nursing at Cardiff and Vale NHS Trust, said that the fragility in the care home sector was having an impact on NHS providers. There had been a significant increase in delayed discharges in the acute sector and deterioration in the number of beds available in Cardiff and the Vale of Glamorgan. She outlined many of the reasons for delayed discharge and other problems facing the sector. A copy of her presentation is attached at Annex B.

4.4 Mario Kreft, Care Forum Wales, said this was an important area not only for providers but also for the individual people living in independent sector care homes. The establishment of the Care Standards Inspectorate for Wales and Care Council were welcome and would drive up standards but would not be without cost. He believed the sector was facing a crisis of confidence as well as finance. He believed Wales should look to European examples where care homes were regarded as a partner in the range of service provision, and were generally viable: they offered a whole systems approach to care. The independent sector in the UK could provide excellent choice and value for money and there was now an opportunity to include them in strategic planning arrangements.

4.5 Anthony Ramsey Williams, Registered Nursing Homes Association, believed the sector was in despair and capacity was at significant risk as a consequence. The demands being placed on them required the sector to be robust in order to deliver and meet expectations. Quality provision would be lost, not just those homes and providers who operated on the margins of acceptable standards. He expressed concern that under the Care Standards Act homes would have to prove their continued viability before contracts would be renewed.

4.6 Yvonne Apsitis, UK Home Care Association, asked that home care be remembered when considering funding. Research showed that people would rather remain in their own homes. She said that commissioning and home care needed to develop close links. It was vital that all partners were engaged and home care had not previously had an opportunity to do this. Better investment and supported discharge was seen as the way forward. The workforce needed to be valued and have job satisfaction if their services were to be retained, and the Assembly was asked to take the lead in raising the profile of home care.

4.7 Linda Bransbury, Welsh Local Government Association, said that she did not think local government could resolve the problems facing the sector as they were underpinned by years of chronic under funding of community care. She welcomed the additional funding received since devolution but felt this would not yet redress the balance. A substantial injection of additional funding would be required to turn the problem around and a strategy was needed to ensure that problems were not just moved to another part of the sector.

The quality agenda was increasing the problems with the introduction of higher standards, and

incentives were needed to encourage staff to remain in the sector. The main problem facing the sector was how it would meet the Assembly's objective of enabling people to be cared for at home when the associated costs were so much higher.

4.8 In response to comments from Members, the presenters made the following additional points:

- It was acknowledged that people often progressed from residential to nursing care. It was felt that the private sector also had a role in the rehabilitative process but this was yet another demand it was unable to meet.
- It was difficult to improve the status of care workers. Rewards were minimal and the sector found it hard to compete with other industries, e.g. supermarkets.
- A career pathway strategy was needed to provide a greater degree of specialisation in an area of increasing need.
- The Care Standards Act would impinge greatly on homes that were of good quality but perhaps had some structural shortcomings that would require substantial capital investment.
- The minimum wage was not necessarily an issue: homes were competing with each other for staff, which was pushing up the wage rate.
- The capacity that already existed needed to be funded. There was a pool of people with substantial care needs that were not being addressed as a result.
- Social services departments were constrained in offering the most suitable care by the requirement to provide care in the most cost-effective way with the resources available.
- There had been very little commercial freedom since the early 1990's, with 80% of people being funded through the state.
- The Care Standards Act would inevitably result in the closure of certain homes. It was expected that the Act would result in an extra 12-15 hours of administrative work for the average sized home.
- The average hourly rate for a home carer was £5.40 but it was felt that £8.00 an hour would not be unreasonable given the level of responsibility involved.
- Management costs for delivering home care were significantly higher than the residential sector.
- A number of studies into fee structures recommended from £420 to £490 per week for nursing care. The majority of local authority fees fell between £336 and £342 per week.
- There was a role for the public sector in nursing homes. A whole systems approach was needed. There was significant evidence of patients staying in hospital because the appropriate level of nursing care was not available in a nursing home.
- Tens of millions of pounds would be needed to sustain the sector.

4.9 The Minister said that she had met recently with representatives of the sector, the NHS and LAs, to discuss the problems facing the sector. She believed that partnership was the only way forward and the presentations to the Committee would help inform how to develop this. Consultation on the regulations was taking place with the sector, particularly in terms of the financial implications. £8m additional funding for the sector in the current year had recently been announced, and it was anticipated that plans would be in place before Christmas as to how £5m of it would be spent. The Assembly was developing a strategy for older people, and other longer-term initiatives for supporting people at home and supporting

the home care sector but the independent sector should be assured that they had a key role in taking this agenda forward.

Item 5: Minutes
Papers: HSS-13-01(min) and HSS-14-01(min)

5.1 The minutes of the meeting held on 18 October were agreed, subject to the amendment of the second bullet point on page 3 to read "Whilst the NHS Reform and Decentralisation Bill would be prescriptive …".

5.2 The minutes of the meeting held on 24 October were agreed.

Annex A

STATEMENT FROM THE MINISTER FOR HEALTH AND SOCIAL CARE

TO

THE HEALTH AND SOCIAL SERVICES COMMITTEE

7 November 2001

NHS STRUCTURES CONSULTATION

Further to the paper circulated with the agenda for this meeting and to aid discussion I can now summarise the issues that are emerging from the consultation exercise.

The redesign of the NHS in Wales is rooted in the White Paper *Putting Patients First* published in 1998 by the then Secretary of State for Wales. This was designed to bring an end to the divisiveness of the internal market. Its key message was that all parts of the NHS must work together to provide good, effective services for patients; co-operation, not competition, was to be the watchword.

The existing framework of local government in Wales was seen to provide a suitable and stable basis for local action with Local Health Groups (LHGs) coterminous with unitary authority boundaries to facilitate joint working. On this basis 22 LHGs were set up in Wales.

In February 2001 *Improving Health in Wales - A plan for the NHS with its partners* was published. This signalled the proposed strengthening of the Local Health Groups to take on new responsibilities for commissioning, securing and delivering healthcare in their localities. At the same time the Assembly

would be strengthened to provide a new sense of leadership and direction at the national level. This removed the necessity for Health Authorities in Wales.

A clear message seems to be that we will emerge from consultation with renewed determination to:

- Strengthen the local and the strategic and
- Simplify the system

There is widespread support for both these principles but uncertainty existed as to whether the proposals outlined in the July Structures Report would simplify the system. The responses lead to the following emerging conclusions.

1. Firstly there is support for confirmation of powerful Local Health Groups to become Local Health Boards (LHBs), in each local authority area, as the building block of the new NHS in Wales. The principles of coterminosity with local authorities was also widely regarded as providing very important advantages.

2. Consultation has emphasised the importance of outlining the steps to be taken over the next 18 months to prepare LHBs for their new roles and functions in order to provide confidence that they will be fit for purpose. These purposes will include assessing the health needs of their area and the effectiveness of their local health systems; securing and providing primary health care; securing community and intermediate care and securing secondary care. They will also have responsibility for addressing health inequalities and inequality of access in their communities.

3. Many respondents have expressed the view that membership of LHBs would need to be widened to include local authority representation and to strengthen the place of voluntary and lay representation. This would result in a Board which would have a wider and more inclusive membership than at present.

4. Consultation confirms the original proposition that selection of individual members of the LHBs would need to be conducted in a way that secures the legitimacy of representation. It is clear that Boards would be required to conduct business in public and to strengthen ways in which engagement with the public can be ensured.

5. Many respondents provide a reaffirmation of the principle of *subsidiarity* in the new structure, in which no responsibilities would be located outside Local Health Groups which can be effectively carried out within their boundaries.

6. The weight of consultation responses raises concerns about the concept of LHB consortia, as outlined in the original document.

7. A range of consultees favour a model in which more local partnerships are brought together, between relevant LHBs, local authorities, trusts and the voluntary sector, to determine the commissioning of

acute and community services within local areas. My emerging conclusion is that these partnerships might be convened and serviced, in the first stages, from the local Assembly office. Partnerships would exist only as collaborations of their own members and for specific purposes. Their membership, however, should ensure that primary, preventative and public health interests are represented, as well as acute and community medicine. The Assembly would take powers to place an obligation upon each contributing organisation to work in partnership with all other members.

8. On the basis of such a model it has been envisaged that some 10-12 partnerships throughout Wales, most often made up of two LHBs, two local authorities and one trust.

9. My emerging conclusion, against such a background, would be that the originally proposed Strategic Partnership Boards would not, on this basis, be required in each LHB area. Instead, the Partnership Government would legislate to place a duty on each local council and each LHB to come together to agree joint investment priorities and joint planning of interface services, jointly formulating and implementing a strategy for the health and well-being of members of the public in the local authority's area.

10. Amongst those who addressed the issue, it was generally agreed that arrangements for Powys should differ from the rest of Wales, in that the Community Trust and the LHB would come together, to form a single Powys Health Board, as outlined in the Structures Report.

11. In relation to the responsibility for community services, the weight of consultation response favoured Option Three, as outlined in the Structures Report, in which a small number of pathfinder projects would be established, in which such responsibility would be assumed by LHBs, rather than by trusts as currently provided.

12. At the Assembly level, consultation confirms the view of the Structures Group, there would need to be strengthening of the NHS Directorate at two levels - in the area of strategic planning and in the operational arm of the organisation. In order to achieve this, my provisional proposal is to establish three Assembly Government Offices, in North, Mid and West and South Wales. This would allow for the removal of references to 'Health Economies', a term which did not receive general support in consultation, on the grounds that it provided a potentially misleading impression that such offices would represent a new tier of administration.

13. Strong representations have been received, within the consultation, in favour of a new national voice for primary care in Wales. My response, at this stage, would be to support the establishment of a Primary Care Directorate at the Assembly, supported by an advisory committee / reference group, representing professional interests.

14. Mental health policy and strategy also emerge in consultation as in need of strengthening. My proposal would be to have a lead director at Assembly level.

15. A number of consultees have supported the proposal that the medical advisory machinery as a whole should be renewed and refreshed. In my view, Medical Committees (based on the existing District Medical Committees) could provide an important means of engaging medical staff in planning and decision-making processes.

16. There is general support for the view that public health capacity should be strengthened in Wales. At Assembly level I consider that this could be achieved under the leadership of the CMO. Thereafter NHS Public Health services could be organised on an all Wales basis located within an NHS trust but with accountability to the CMO. Responsibility for the health of the population and meeting statutory and operational requirements could be located at LHB level where capacity will also be enhanced and supported by the national service. The Wales Centre for Health could provide an independent focus for the development and support of public health practice in all sectors and partner organisations.

A number of variations to the original structural model were put forward in the comments received. An immediate move to a model which would provide a reduced number of NHS Boards was also proposed but included an option for progressive integration based on LHB federations, coterminous with one or more unitary authorities and aligned with NHS Trusts. Clear elements of this latter model can be seen in the partnership approach described in point 7 above.

I am very grateful to all those who have given the time and commitment to contribute to this important debate and for the range and quality of responses that will play a vital part in the formulation of the decisions on the way forward.

Annex B