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Health and Social Care Committee

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
25 January 2012

Meeting time:
09:30

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda

1. Introductions, apologies and substitutions

2. Scrutiny of the Minister for Health and Social Services (09.30 - 10.30) (Pages 1 - 14)

HSC(4)-03-12 paper 1

Lesley Griffiths AM, Minister for Health and Social Services
Dr Chris Jones, Medical Director NHS Wales
David Sissling, Director General for Health and Social Services, Welsh Government

Break 10.30 - 10.40

3. Committee forward work programme - EU matters (10.40 - 11.10) (Pages 15 - 40)

HSC(4)-03-12 paper 2 - Update on EU policy issues relevant to the Health & Social Care Committee *(This paper was originally considered by the Committee on 8 December 2011)*

HSC(4)-03-12 paper 3 - EU legislation relating to health inequalities
HSC(4)-03-12 paper 4 - EU drugs approval process
HSC(4)-03-12 paper 5 - Models of ownership for residential care for the elderly in EU member states

4. Papers to note (11.10) (Pages 41 - 42)

Minutes of meeting held on 11 January

Health and Social Care Committee

HSC(4)-03-12 paper 1

Scrutiny of the Minister for Health and Social Services

Purpose

1. This paper provides background information to inform the Health and Social Care Committee's discussion with the Minister for Health and Social Services at its meeting on 25 January 2012.

2. This evidence paper covers the following areas at the Committee's request:
   - Recent progress and achievements, and portfolio priorities
   - Health Board Service Reconfiguration Plans
   - Capital Projects
   - Finance Position of Health Boards
   - GP opening hours
   - Recruitment for doctors
   - IT in the NHS
   - Over 50 health checks
   - Adult Mental Health

Recent progress and achievements, and portfolio priorities

3. The **Programme for Government**, launched by the First Minister in September, is the Welsh Government's plan of action for Wales. It represents a real commitment to delivery, measured by the impact Government is actually having on people's lives. For my portfolio, it sets out the actions we will take to ensure better health for all, with reduced inequalities in health.

4. Two of the priorities set out in the Programme for Government, form part of our 'Five for a Fairer Future' – extending access to GPs and extending the Flying Start Programme. I have provided an update on extending access to GPs at paragraphs 24 – 28 below. Our commitment on the **Flying Start Programme** is to double the number of children and families who benefit from it. We have made available a total of £55 million of revenue funding over the next three years to support the expansion of the programme and £6 million of capital funding for the delivery of additional multi-agency childcare settings.

5. We are also continuing to develop plans and strategies for specific service areas. Our Strategic Vision for Maternity Services in Wales, published in September 2011, sets out our expectations of NHS Wales in delivering safe, sustainable and high quality maternity services. In December 2011, we launched a consultation on

'Together Against Cancer' our National Delivery Plan for the NHS up to 2016. Delivery plans for cardiac care and stroke care will follow later this year.

6. We are also continuing to work on an ambitious **programme of legislation**. Our Organ Donation consultation ends on 31 January 2012 and we remain on track for publication of a draft Bill this summer, with introduction of the Bill following by the end of 2012. Our consultation on cosmetic piercing also concludes at the end of this month. On 14 December 2011 I published a draft Food Hygiene Rating (Wales) Bill, which will make the display of the food hygiene ratings mandatory in food businesses and I intend to introduce the Bill later this year. We also remain committed to introducing a Social Services Bill in October 2012, to provide the legislative basis to take forward the commitments contained in "Sustainable Social Services for Wales: A Framework for Action". We have already begun engaging with key stakeholders on our proposals and we will launch a full public consultation on the proposed content of the Bill in March. We will also be consulting this year on the need for a Public Health Bill to place statutory duties on bodies to consider public health issues.

7. In November 2011, I launched **Together for Health** – a Five Year Vision for the NHS in Wales. It outlines the challenges facing the health service and the actions necessary to ensure it is capable of world-class performance. It sets out the case for reform – a rising ageing population, inequalities in health, increasing numbers of patients with chronic conditions, medical staffing pressures and some specialist services being spread too thinly. The responsibility for planning, funding and delivering healthcare services at a local level rests with Health Boards, and I expect them to provide healthcare to their local population which is safe, effective, accessible and affordable and to keep services under constant review. Service change is covered at paragraphs 8-13 below, and I will be providing six-monthly updates on progress against Together for Health, starting in May 2012.

Local Health Board Service Re-Configuration Plans – current position

8. As described above, Together for Health sets out the case for reform of the NHS. I am clear as are the Health Boards that change is essential if we are to meet the challenges facing the NHS in Wales. To address these challenges, all Health Boards are currently working on their proposals for reform. Each Health Board will have it's individual service plans but the 4 South Wales Boards are working collaboratively to ensure planning recognises the common challenges they face.

9. The regions are at different stages of plan development, with Hywel Dda leading the way, closely followed by Betsi Cadwaladr. As such, the precise extent of stakeholder and community engagement to date varies between Boards. However the overall process that has been agreed with the Boards are as follows:
   - Pre – Consultation engagement between now and April 2012
   - Presentation of Consultation Proposals: May to June 2012
   - Formal Consultation Period: June, July, August, September 2012
   - Proposals Review: August/ September 2012
   - Final Plans Agreed and Implementation: August 2012 onwards

10. We anticipate options for service change will begin to develop during the engagement phase from December 2011 until April 2012. During the engagement period, Health Boards will have full, frank and open discussions with stakeholders and the local communities on the issues faced, and how they might be tackled. In line with the National Guidance on Engagement and Formal Public Consultation in the NHS, Health Boards may reach agreement with local communities and CHCs that some service changes can be progressed and implemented without the need for formal public consultation. However, this will depend on how the engagement process pans out and the scale of the changes that emerge.

11. The purpose of the next four to five months, is to ensure a robust engagement period is undertaken, in which as many people and stakeholders are involved as is possible. It is anticipated a full set of proposals will be available late in May although these may contain a number of different options which will then require formal public consultation.

Local Health Board Service Re-Configuration Plans – role of the NCF

12. The National Clinical Forum (NCF) is a multidisciplinary group of clinicians who hold senior advisory roles in their fields. Each member has been asked to develop a set of high level criteria for their area, against which service plans will be formally assessed during the planning and consultation process. Where required, the NCF will also invite external clinical experts to provide advice and guidance on areas it feels it requires external input.

13. The criteria each member develops for their area, will take into account National Clinical Guidelines/standards, Royal College Guidelines, and any other evidence of best practice that informs as to appropriate service configuration which is both safe and sustainable.

Capital Projects

14. The vast majority of the HSSC capital allocation for 2011/12, £310 million, is being spent on schemes that are contractually committed and on site. Since May 2011, several additional schemes have started on site including the Childrens Hospital for Wales, the Redevelopment of Cardiff Royal Infirmary and the Redevelopment of Operating Theatres at Ysbyty Glan Clwyd. The total value of these schemes is £137 million.

15. A large number of other schemes are being developed by LHBs / Trusts but the proposals are not advanced and business cases are not expected within the next 6 months. Little or no capital expenditure is being incurred on these schemes in 2011/12.

16. Priorities for capital investment are decided by the strategic section/case within the business case developed for each capital scheme. Those schemes with approved business cases are meeting previously identified priorities and so are unaffected by the service plans. Schemes being actively progressed by LHB/Trusts are reviewing their business cases to ensure synergy with the service plans is evidenced.

17. Each business case is developed with consultation of the major stakeholders including clinical, financial and estates professionals. Usually this is evidenced in the option appraisal section of the business case, to determine which of the available options is the preferred one to deliver the investment objectives.

Financial Position of Local Health Boards at the end quarter of this financial year

18. Each year the NHS faces unavoidable and predictable cost increases. These flow from a number of factors including cost inflation, increased demand for services as a consequence of demographic change, new technologies and new drugs.

19. As a result of these cost pressures, at the beginning of the 2011-12 financial year the LHBs reported savings of approximately £456m were required to achieve financial balance. To address this significant gap, each LHB prepared detailed savings plans to mitigate against the identified cost pressures. In all cases, each detailed plan provides key management actions by savings category and has been subject to intense management scrutiny.

20. At the time of the draft budget announcement the LHB plans had forecast a savings achievement by the year end of £295m. These savings plans, together with additional funding provided to the LHBs of £145m (from a combination of additional funding from central Welsh Government reserves and further allocations from the Health Departments own reserves), is expected to ensure the LHBs

meet their financial targets for the current year. Although further savings of approximately £16m are still to be achieved, the levels of risk identified by the Health Boards have been significantly reduced by the additional funding provided and are now considered to be at a level which can be successfully mitigated by the year end.

21. I hold regular meetings with Chairs of LHBs, where delivery is discussed and where I make clear my expectations for the service. In addition, the Director General meets with Chief Executives on a monthly basis and delivery against all key priority areas are reviewed. The Director General reiterates to Chief Executives my expectations on delivering targets by year end.

22. The Director of Operations holds regular monthly Quality and Delivery meetings with Senior Operational Executives from LHBs, where specific performance areas can be focussed on.

23. It is the responsibility of LHBs to provide services to meet the needs of the population they serve, whether that be locally within their own LHB area, or for more specialised services, at tertiary centres either in Wales or, in some cases, in England.

GP opening hours

24. We are committed to improving access to GP services for working people by ensuring appointments are available at times which are convenient to them. The current proposals include improving access to appointments in the evenings and also on Saturday mornings.

25. We have considered a range of options on improving access to appointments in the evening, including flexible opening times and extending opening hours. Our favoured approach will initially focus on redistributing appointments during contracted core hours towards the latter part of the day - from 5.00pm to 6.30pm. This will be explored fully before seeking to extend opening hours beyond 6.30pm. There are no additional cost implications of redistributing appointments within contracted core hours.

26. In relation to access to GP services on a Saturday morning, we have commissioned a review to explore the potential for this to be delivered through the Out of Hours Service. This review is expected to be completed by the end of March 2012. For some working people, particularly those in rural areas or who work a fair distance away from their home, morning appointments may be more convenient for them.

27. We are in discussions with the BMA, GPC Wales and Local Health Boards in respect of this commitment. It is for local GP practices, in conjunction with Health Boards, to ensure services are available

to meet the reasonable needs of patients within their local area. They are committed to ensuring the delivery of high quality services and are currently reviewing plans to ensure access to GP services continues to meet the needs of local people within their respective area.

28. Our intention is to deliver this commitment within existing budgets, over the period 2012/13 to 2015/16. We will develop a detailed delivery plan for May 2012, to take account of the outcome of the Out of Hours Review and also the local delivery plans for each Health Board and we will establish mechanisms to ensure progress against this commitment is monitored.

Over 50 health checks

29. Our Programme for Government makes it clear activity for 2011-13 is focused on preparatory work to determine what the approach for health checks should be. I am keen to ensure we make full use of the preparatory period to ensure we develop a fit for purpose health checks programme. When I have decided what the approach should be, it will be implemented from 2013-16.

30. My officials are currently reviewing the evidence base and the health checks models which are in place elsewhere, such as the health checks programmes currently in operation in England and Scotland.

31. As part of the developmental phase, we will work to ensure the programme complements and builds upon other relevant work. For example, consideration will be given to Public Health Wales' work around the identification and management of cardiovascular disease risk. Other guiding principles include the need to target investment proportionately to risk and the need to ensure any programme complements our drive to close the gap on health inequalities. We will also explore the role technology can play, as an online approach has potential to raise awareness of key public health messages and provide signposting to appropriate advice and support, particularly for people who are potentially in a 'low risk' category.

32. The development of a health checks programme will be of interest to a number of organisations and stakeholders. I have asked my officials to establish an external reference group, to comprise a range of key stakeholders. This group will assist us to capture a broad range of views, which we will consider during the preparatory phase.

Recruitment plans for doctors

33. It is important to note Wales does not have medical staffing issues across the board. Rather, there are acute recruitment difficulties in particular specialties/grades/geographical areas:

- a UK-wide shortage of doctors in certain specialities, such as Accident & Emergency, Anaesthetics, Obstetrics & Gynaecology and Paediatrics;
- Reduction in doctors from outside Europe to fill posts due to new immigration rules has exacerbated recruitment difficulties.
- Wales has not historically been a particularly popular place to train owing to its rurality and less accessible areas.

34. Nonetheless, we have taken a number of steps to improve matters; for example:

- Our Junior Doctor Review Group is working with the BMA to improve Wales' attractiveness to junior doctors (Wales providing free accommodation for Foundation Year 1 doctors, promoting the attractiveness of a medical career in Wales - producing DVDs and improved Deanery website, increased presence at UK events, working with Health Boards on co-ordinated recruitment drives abroad)
- I have announced plans to launch a marketing campaign at the end of this month which will be run in the context of the wider comms strategy for Together for Health.
- The Deanery is reconfiguring a number of training programmes to improve training quality and thereby should improve their attractiveness.

35. While these measures aim to fill current vacancies, effective workforce planning is vital to ensure vacancies do not persist into the future:

- The integrated workforce planning process for NHS Wales requires each Board/Trust sets out in detail their anticipated requirement for junior doctors in each specialty (as well as other staff) for six years into the future, giving the Deanery an overview of the number of new junior doctors who need to be trained in the future. .
- NLIAH have developed a software model to compare anticipated future supply versus demand for newly-trained consultants. It can, therefore, identify broadly how many Specialist Registrar (SpR) posts are required in each specialty across Wales allowing the Deanery/Health Boards to determine what would be a reasonable number of junior doctor posts to have.
- NLIAH are also developing a software model that forecasts how many Medical Graduates and Foundation Doctors Wales is likely to produce in future, allowing us to provide forecasts of whether there are likely to be sufficient numbers of new junior doctors to meet Health Boards' future requirements

36. Where our forecasts identify a future shortage of junior doctors is likely across Wales, we can then consider mitigating action.

IT in the NHS

37. At a plenary debate in March 2011, the National Assembly recognised the good progress made by Wales' NHS ICT Programme, Informing Healthcare[1], which has established Wales as a leader in the use of digital technology for better patient care.

38. NHS Wales has a long tradition of using computers to support care. However, most have been stand alone systems with their valuable information locked away in silos. To deliver best value for money, the Informing Healthcare Programme aimed to combine existing systems with new digital technologies. Connecting them together would deliver the shared information that is essential for a truly integrated healthcare service.

39. This approach has delivered significant success and has seen integrated electronic health records introduced across primary and secondary care, contributing to better services for patients.

40. GPs are successfully sharing patients' records with the out of hours doctor services through the **Individual Health Record**, providing vital and often life-saving information for the emergency care delivered out of hours to around 2,000[2] patients every day. By the end of December 2011, the IHR was available for all GP practices using Egton Medical Information Systems (EMIS) and In-Practice computer systems, providing access to the IHR for over 60% of practices and around 2 million patients. GP Practices using the iSoft GP Computer System will have access to the IHR during 2012.

41. Referrals by GPs for hospital outpatient appointments have been streamlined with the introduction of an **electronic referral service**, using the Welsh Clinical Communications Gateway (WCCG). This replaces the paper referral letter with an e-form, reducing the referral process from around a week to under 24 hours. It also avoids referral letters being 'lost in the post'. By the end of December 2011, this service was available for over 50% of practices and had managed over 130,000 referrals. All GP practices will be able to use e-referrals by Spring 2012, to help manage the 700,000 referrals sent annually. We are also trialling electronic discharges from the hospital directly to the GP, using the WCCG.

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[1] The Informing Healthcare Programme closed in March 2010 and its portfolio was transferred to the NHS Wales Informatics Service.

[2] All statistics and figures derived from the NHS Wales Informatics Service Achievements Report 2010/2011.

42. We are also making good progress with **My Health OnLine**, which allows patients to use the internet to book GP appointments and order repeat prescriptions. Eventually it will allow them to access their own electronic records.

43. There has been a quiet revolution in the way **prescription information** is shared between GPs and high street and community pharmacies. High-tech barcodes are printed onto all prescriptions issued by every one of Wales' family doctors. The barcodes hold all the prescription information, including the unique drug codes for the medications or preparations prescribed. Each barcode can hold information for up to four prescription items and the patient's name and address details. Bar codes are now used to scan in prescriptions at all 707 local pharmacies, making it easier and safer to dispense medicines.

44. As our hospitals use many different computer systems, information has been held in silos. To address this, we have developed the **Welsh Clinical Portal**, an advanced web service that integrates the information about a patient and makes it available in one place, making it easy for staff in hospitals to do their job. No more chasing up paper records.

45. The Portal gives fast access to information about medication, referrals and discharges, allows health professionals to request tests and results from various sources and ultimately improves patient safety and a reliance on paper records. It also gives doctors and nurses a personalised workspace with access to their own relevant patient lists.

46. The Portal is currently in use at hospitals in Hywel Dda Health Board area, and will go live across North Wales (Betsi Cadwaladr Health Board) from February 2012. All other Health Boards will begin implementation by the end of March 2012, with full implementation of version one by Christmas 2012.

47. The Portal is underpinned by a Master Patient Index, which ensures each patient is identified correctly and reduces the number of duplicate records held across the many systems used by our hospitals.

48. We are also making good progress with the introduction of a new **Laboratory Information Management System** (LIMS). This will replace the current 13 different systems used across 18 pathology laboratories with one national integrated system. In Wales over 69 million pathology tests are ordered each year. The new LIMS will reduce the number of tests that are duplicated and will mean that no matter where a patient receives care, the results of tests will be readily available.

49. Hywel Dda Health Board and Betsi Cadwaldr will implement in February and March 2012. Planning is underway with the other Health Boards and the system is due to be fully implemented by early 2013.

50. **Radiology information** has been integrated through one upgraded system, known as RADIS2 and has been introduced at 11 of 13 sites, including Velindre Hospital Trust.

51. We are also upgrading and integrating the system we used to manage the 10,000 **digital x-rays and scans** captured every day by NHS Wales. A few years ago we achieved a major step forward when we introduced electronic Picture Archiving and Communications Systems (PACS). However, contracts with suppliers were all locally let, so we ended up with many systems from a range of different commercial companies, which were unable to share X-ray images. As those contracts are expiring, we are now streamlining and moving to an all-Wales approach, based on a new procurement framework, currently in progress.

52. Use of **video conferencing** has trebled in recent months particularly for Multi Disciplinary team (MDT) meetings in cancer and cardiac networks. Now available in high definition, video conferencing allows doctors to share and discuss results and see tests in greater detail. There are currently over 400 video conferencing units throughout Wales within GP practices, hospitals and specialist facilities.

53. Great progress has been made in moving to a national **Patient Administration System (PAS).**The Myrddin PAS was developed by NHS staff in Hywel Dda Health Board and became so successful it was adopted as an integral part of the NHS Wales' ICT strategy. The system has been externally accredited and in making full use of it we have reduced implementation costs. Myrddin is currently in use at six out of seven health boards and over 15,000 members of NHS Wales use the system daily.

54. All GP practices, pharmacies, Health Boards and hospitals are now connected to the Public Service Broadband Aggregation (PSBA) network. This is a high-bandwidth **secure network** for the public sector that provides the infrastructure to support joined up care with social care and across all public services.

55. NHS Wales now has a **secure national email service** that gives staff an email address for the entire length of their career in NHS Wales. There are now over 60,000 email addresses for staff working in NHS Wales with 5 million email messages sent every month.

56. NHS staff also have a single user ID and a single password to remember- making it easier to 'log on' to national NHS systems, wherever they are working in Wales.

8. Adult Mental Health

New Mental Health Strategy for Wales

57. On 30 October 2011, I wrote to the Chair of the Health & Social Care Committee to outline a timetable for the development of a new Mental Health Strategy for Wales. That correspondence confirmed the new Strategy will take a unified approach to mental health, address the holistic needs of children and adults of all ages, complement and embed the Mental Health (Wales) Measure 2010, and consolidate existing policy. It will specifically address the need for integrated working and joint strategic planning in line with the requirements of *'Together for Health'* and *'Sustainable Social Services'.*

58. Presently being developed by a cross-departmental steering group, and informed by engagement of key stakeholders, a draft Strategy will be made available for a formal 12-week consultation in late spring 2012. A National Partnership Board – to be established later this year following the final meeting of the Mental Health Programme Board on 25 November – will play a key role in overseeing and scrutinising implementation of the new Strategy.

'Adult Mental Health Services: A Follow-up Report' **(Wales Audit Office)**

59. The recommendations outlined by the Wales Audit Office (WAO) in *'Adult Mental Health Services: A Follow-up Report'* (July 2011) will directly inform the new Mental Health Strategy.

60. Since the WAO undertook fieldwork preparatory to the publication of the report, a number of improvements have been made, including the establishment of crisis resolution and home treatment services, and outreach services in virtually all parts of Wales. Where such services do not exist, developmental plans are in place. Our commitment to improving access to psychological therapies was set out in our manifesto, and a review of service availability is underway. We have also invested in new children and adult mental health facilities and introduced new teams to care for people with eating disorders and those with post-traumatic stress.

61. In response to Recommendation 1, it is our intention the new Strategy addresses inequalities in service provision and expedites improved operational working between the health, social care and third sectors. In line with Recommendation 2, the Strategy will

actively promote an outcome-focused recovery approach, one that builds upon our existing approach to care planning and the forthcoming requirements of Part 2 of the Mental Health (Wales) Measure 2010. For Recommendation 3, I have confirmed our commitment to the continuation of ring-fenced in 2012-13, but we will continue to monitor the efficacy of this approach and seek to identify material variations in the sums allocated to LHBs and actual expenditure. Recommendation 4 focuses on key posts, guidance and performance management and with this in mind we will review the priority accorded to mental health by LHBs. and continue to advocate the importance of multi-agency strategic planning.

62. The new Strategy will also reflect the findings and recommendations made by the Auditor General in *'Housing Services for Adults with Mental Health Needs'* (November 2010). In response to that report:

- The statutory Code of Guidance on Allocation of Accommodation and Homelessness has been redrafted to strengthen the references to the Adult Mental Health NSF and its housing objectives
- The Auditor General's report has been circulated to local authorities and Supporting People providers
- A survey has been undertaken of action at local authority level to address mental health needs

A series of events in November and December 2011 (organised in conjunction with Cymorth and Public Health Wales) brought together health and housing services to discuss the report and other aspects of joint-working

Mental Health (Wales) Measure 2010

63. My letter of 30 October 2011, to the Chair outlined the timetable for implementation of the Mental Health (Wales) Measure 2010 by October 2012 - affording LHBs and local authorities sufficient time to effectively plan and prepare to meet their new duties - and implementation is proceeding in accordance with that timetable.

64. My recent announcement confirmed that allocated funding is in line with the Explanatory Memorandum and Regulatory Impact Assessment. From 2012-13 this amounts to £5.5m per annum - £3.5m to support implementation and running costs for local primary Mental Health support services under Part 1, and £2m p.a. to support the expanded Independent Mental Health Advocacy (IMHA) Service under Part 4.

65. Part 1 of the Measure places duties on LHBs and local authorities to establish prescribed local primary mental health support

services, delivered within and alongside GP settings. Part 2 places duties on LHBs and local authorities to ensure all users of secondary mental health services have a care and treatment plan, and that care is managed by a care co-ordinator. Part 3 will introduce an entitlement for former users of secondary mental services to request assessment should they believe their mental health to be deteriorating. Finally, Part 4 expands the Independent Mental Health Advocacy (IMHA) scheme established under the Mental Health Act 1983 to include both certain persons on short-term (emergency) sections and informal (non-detained) in-patients.

Dementia Services

National Dementia Vision for Wales

66. The Vision – launched in February 2011 – outlines the importance this Government places on improving and expanding existing services and information, heightening awareness, improving training and learning resources, and recognising the importance of, and supporting research.

67. In recent months we have supported and funded certain key developments to assist with implementation of the Vision:

- £1.5 million p.a. has been used to augment Older People Community Mental Health Teams and develop a Young Onset Dementia Service for Wales
- Capital investment of £25m and £56m respectively has been made available is to establish new units at Wrexham Maelor and Llandough (Cardiff) hospitals, and the newly opened Angleton Clinic, Bridgend (Glanrhyd hospital) provides 42 beds for older people
- The Dementia Services Development Centre (DSDC) Wales has been provided with approximately £250,000 by the Welsh Government to deliver training designed to improve the attitudes, skills and knowledge of those providing support and care (provided to staff in care homes, general, mental health hospital and primary care settings, those working in the community – including Telecare staff – and family care-givers)
- The bilingual Wales Dementia Helpline and website provides emotional support and advice 24 hours a day, 365 days a year
- The Book Prescription Wales Scheme has been expanded to include four books on dementia
- Over £80,000 has been allocated to the Alzheimer's Society to design information packs, and operate two Dementia Information Liaison Officers in north and south Wales – to both co-ordinate training and to raise awareness of dementia-related illness.

68. An improved understanding of the causes and treatment of dementia is critically important, and we have provided support and funding to establish the MRC Centre for Neuropsychiatric Genetics and Genomics at Cardiff University, and the Wales Neurodegenerative Disease and Dementia Research Network.

69. Four dementia-focused *Intelligent Targets* have been produced to monitor outcomes, providing a good indicator of where improvements are required and how best they might be implemented. One of these focuses on the general care setting, and related work will ensure that LHB progress is monitored through the use of established *Dignity in Care* monitoring mechanisms (following the production by LHBs of action plans in response to a Royal College of Psychiatrists England and Wales audit of dementia care). Regarding *Dignity in Care,* my statement of 10 January outlined the action being taken by all NHS organisations in response to the 2011 review of the Older People's Commissioner for Wales.

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Research Service
Y Gwasanaeth Ymchwil

Health and Social Care Committee

HSC(4)-03-12 paper 2

EU policy issues relevant to Health and Social Care Committee

Committee briefing

Date of session:	25 January 2012

This briefing has been produced by the Research Service for members of the Health and Social Care Committee.

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Research Service

Enquiry no: 11/1185/Gregg Jones

29 November 2011

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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1. Introduction

Under the new Committee structures for the fourth Assembly agreed by Business Committee in June 2011, Europe and EU related matters are to be mainstreamed across all relevant Committees rather than having a dedicated European and External Affairs Committee.

This means that the Health and Social Care Committee has responsibility for dealing with those European issues that fall within its portfolio.

There are two main ways in which this is likely to occur:

- dedicated sessions focused on priorities/issues on the EU policy agenda in Brussels;
- scope to look towards Europe (and the international dimension) in terms of comparing practices in Wales, identifying witnesses and experts to bring an external dimension to the other areas of work undertaken by the Committee.

This paper provides the Committee (in section 3) with information on relevant policy developments that are ongoing or planned for 2012 at EU level.

Before going into the detail on these actions, some background information is provided in section 2 on the EU policy-making process, to explain:

- the competences at EU level in the area of health and social care and types of actions coming out of the EU as a result of exercising these competences;
- the relevant organisations and structures operating in Brussels (including the formal EU Institutions and some EU networks) with responsibilities for issues affecting health and social care.

Actions for the Committee:

Section 4 sets out a number of potential areas of action for the Committee to consider and agree in terms of follow up work on EU-related matters.

2. EU policy-making process

2.1. Health and Social Care

Health and social care are areas of **exclusive national competence**, which means that the powers for the EU to act in these areas is limited, and is restricted primarily to undertaking actions that support, co-ordinate or supplement the work of Member States (i.e. national and as appropriate sub-state/regional Governments) in this area.

Consequently the power of the EU to influence and shape health policy within Wales is very limited. It also means that Wales potentially has an interest in being involved directly in policy debates and discussion at EU level where these could be useful in terms of helping support or add value to the work undertaken in Wales.

The EUs role in health policy is focused in particular on the following three areas:

- protecting people from health threats and disease
- promoting healthy lifestyles
- helping national authorities in the EU cooperate on health issues.

To give a strategic focus to this the Commission adopted a five-year **EU Health Strategy** in 2008, which is due to come up for review during 2012 (although the European Commission's 2012 Work Programme makes no reference to this review, so there is no indication yet of the timing of the review).

The European Commission also provides financial support to the implementation of the EU Health strategy, to which organisations in Wales (including the National Health Service) are eligible to participate. This includes support from a dedicated EU Health funding programme, the current one running from 2008-2013, which will be succeeded by a new programme *Health for Growth Programme 2014-2020* – for which proposals were published in November. More details on this are included in section 3.3 below.

Health also features as a theme in other EU funding programmes: for example, there is some scope to support health-related initiatives within the EU Structural Funds programmes, mobility actions under the EU education and youth programmes; and health-related research within the EU Framework Research Programme (in particular funding support for clinical trials). In each of these areas the European Commission has published new proposals for the period 2014-2020, which will go through a negotiation process in Brussels before finally being agreed (probably sometime in 2013). The Enterprise and Business Committee is undertaking an inquiry into EU Structural Funds and will also look at the future EU Research Programme (Horizon 2020), whilst the EU education and youth mobility proposals (Erasmus for All) would most naturally fall within the remit of the Children and Young People Committee (and they considered this as part of an EU update at their meeting on 1 December).

Finally, there are a number of other areas where the EU has competence to make legislation, and these could potentially impact on provision of health and social care services in Wales. This includes, in particular:

- **Employment and social protection legislation:** this covers a range of areas including workers' rights, health and safety, working conditions, equalities and equal opportunities. Such legislation is developed in the context of ensuring a smooth functioning of the EU single market, to enable free movement of workers across national boundaries.
- **Public procurement legislation:** provision of goods, works and services exceeding minimum thresholds set by the EU legislation must go through an open tendering process. The directives set out requirements on the rules to be followed to ensure an open fair process, where entities from across the EU can potentially participate.

2.2. Food Safety

With regard to food safety, the EU has a stronger remit to take action.

This includes scope to develop EU legislation and undertake other types of actions that are focused on assuring effective control systems and evaluating compliance with EU standards in the areas of: food safety and quality, animal health, animal welfare, animal nutrition and plant health sectors within the EU and in third countries in relation to their exports to the EU.

Some of these areas fall outside the remit of the Health and Social Care Committee and would fall within the remit of the Environment and Sustainability Committee (e.g. animal welfare, animal nutrition and plant health sectors).

To support the preparation and implementation of EU legislation in this area there are a number of EU level committees and agencies in place. These merit mention as important decisions affecting the shape of future policy as well as the implementation of existing EU legislation can be made by these bodies.

Those of most relevance to the work of the Health and Social Care Committee are:

- **Scientific Committee on Food**: its mandate is to answer scientific and technical questions concerning consumer health and food safety associated with the consumption of food products. In particular questions relating to toxicology and hygiene in the entire food production chain, nutrition, and applications of agrifood technologies, as well as those relating to materials coming into contact with foodstuffs, such as packaging. As with all the Scientific Committees its work is managed by the European Commission but its membership is comprised of independent experts.
- **European Food Safety Authority (EFSA)**: set up in 2002, EFSA provides independent scientific advice and communication on existing and emerging risks associated with the food chain, which is aimed at ensuring the protection of the health of European consumers and the safety of the food and feed chain. EFSA's work covers all matters with a direct or indirect impact on food and feed safety, including animal health and welfare, plant protection and plant health and nutrition (including genetically modified crops).
- **European Centre for Disease Prevention and Control**: established in 2005 and based in Stockholm, its mission is to identify, assess and communicate current and emerging threats to human health posed by infectious diseases.
- **Standing Committee on the food chain and animal health (SCFCAH)**: Standing Committees are regulatory committees that are set up to ensure practicable and effective implementation of EU legislation. They are 'technical' committees, comprised of the European Commission plus experts from the Member States, in the case of the SCFCAH this will be DEFRA officials plus relevant officials from the UK Permanent Representation in Brussels.

2.3. EU policy-making and legislative process

For those areas referred to in sections 2.1 and 2.2 where the EU is able to make legislation, there is a formal negotiating process through which such laws are adopted. The National Assembly for Wales can play a role in influencing this process, both during the pre-

legislative phase (i.e. policy formulation – which is led primarily by the European Commission) and during the legislative process itself.

Where the EU has powers to develop legislative proposals (including areas covered in section 2.1 and 2.2 – such as food safety, employment law, patients' rights, and EU funding programmes), such proposals will be prepared through the ordinary legislative procedure, which requires the European Parliament and the Council of Ministers (i.e. Member State Governments) to agree on the final text of the proposed law (on the basis of a legislative proposal from the European Commission) before it can be formally adopted. This process can take anything from around one year to several years, and in some cases agreement may not be possible (e.g. recent attempts to revise the Working Time Directive failed in 2009).

Once legislation has been adopted there is a requirement on all Member States to **implement EU legislation on the ground**, and the legislation will include provisions on deadlines by which transposition (i.e. creation of new domestic legislation as relevant) must take place at national/regional level. In Wales, the Welsh Government will have responsibility to ensure implementation and transposition of relevant EU legislation falling within devolved competences. Where it fails to do this it will bear the brunt of any fines imposed by the European Commission.

For those areas where the EU does not have legislative competence, policy formulation takes place in a number of ways. This includes communications from the European Commission aimed at encouraging common approaches by national governments in particular areas, e.g. promoting use of e-health, and other follow up action involving stakeholders such as the newly established *European Innovation Partnership on Healthy and Active Ageing* (see section 3.5). It also includes inter-government co-operation through the *Open Method of Co-ordination* (see section 2.5). Within all of these areas there is no binding requirement on Member States to take actions, and the only power at EU level is peer pressure through naming and shaming of Member States that do not deliver on commonly agreed actions.

2.4. European Commission

The European Commission has the main role in taking forward initiatives, both policy and legislative proposals, on health, social care, and food-safety issues.

The European Commissioner responsible for Health and Consumer Affairs is John Dalli.

The lead directorate-general (DG) within the European Commission for health-related matters, including food safety is DG Health and Consumer Affairs (often shortened to DG SANCO, from the French version).

For issues falling into the broader policy areas (such as research, employment) then these would be covered by the relevant thematic department, e.g. DG Employment and Social Affairs.

2.5. *Council of Ministers*

Membership of the European Union (EU) is structured around national Governments or Member States, which means that Wales is represented in the EUs formal Government structures (Council of Ministers and the European Council) through the UK Government.

Health and food safety issues fall across two Council formations within the Council of Ministers:

- Employment, Social Policy, Health and Consumer Affairs Council
- Agriculture and Fisheries Council

These two Councils will be involved in the negotiations on any relevant legislative proposals falling within their remit. They will also engage in policy formulation, adopt *Council Conclusions*, including adoption of *Recommendations* (i.e. soft EU law – non-binding) on particular issues or subjects. For health care related issues this is largely structured in terms of the *Open Method of Co-ordination* (an inter-governmental approach), where Member States (with supporting role from the European Commission) share best practice and benchmarking, which is focused on improving the access, quality and sustainability of national healthcare services.

Wales is represented in the Council of Ministers by the UK Government, however, an arrangement has been agreed with the devolved administrations that devolved ministers can attend meetings of Council (acting as representative of the UK) on issues where they are of particular interest to the devolved administration (e.g. Education and Culture Council meetings have been attended by Welsh Ministers).

The UK Government has also agreed a **Memorandum of Understanding** with the devolved administrations – the latest version was signed in June 2011 – which includes within its scope the approach to European affairs. In terms of policy content/issues the UK Government and Ministers from the devolved administrations meet through the format of the Joint Ministerial Committee (Europe). The devolved administrations are also consulted in the preparation of explanatory memoranda by the UK Government on EU proposals and policy documents, in all areas of devolved competence and where there is a devolved interest in the respective dossiers.

2.6. *European Parliament*

Wales is represented in the European Parliament by its four Welsh MEPs: John Bufton (UK Independence Party); Jill Evans (Plaid Cymru); Dr Kay Swinburne (Conservatives); and Derek Vaughan (Labour).

The lead Committee for health policy and for food safety issues is:

- **Environment, Public Health and Food Safety Committee**, which is chaired by German MEP Jo Leinen (Socialists and Democrats Group – same political group as Welsh MEP Derek Vaughan). Welsh MEP Jill Evans is a member of this Committee.

Other relevant committees would be:

- **Employment and Social Affairs Committee:** Chaired by French MEP Pervenche Beres (there are no Welsh MEPs on this Committee), has responsibility for all employment policy and all aspects of social policy such as working conditions, social security and social protection. It would be the lead Committee on revisions to the Working Time Directive (covered below)
- **Internal Market and Consumers Protection Committee:** Chaired by UK Conservative MEP Malcolm Harbour (there are no Welsh MEPs on this Committee), will be the lead Committee for the revision of the Public Procurement Directives (covered below) and is also the lead committee on state aid issues.

2.7. Committee of the Regions

Wales also has representatives on the two consultative bodies (that are located in Brussels), the *Committee of the Regions* (including Christine Chapman AM and Rhodri Glyn Thomas AM) and the *Economic and Social Affairs Committee*. These two bodies are consulted on all EU policy developments, although they do not have power to force changes in draft EU legislation.

2.8. EU networks

Within these policy areas there are a number of EU networks actively engaged on health and social care related issues.

Some examples would include (this list is for illustrative purposes only):

- **National Health Service European Office**: the Brussels office of the NHS Confederation.
- **British Medical Association Brussels Office**
- **European Public Health Alliance**: a not for profit network of voluntary organisations working in the area of public health.
- **EuroHealthNet**: a not for profit network of 35 organisations, agencies and statutory bodies (including Public Health Wales) from 27 European countries, that are all working to promote health and equity by addressing the factors that determine health directly or indirectly. Its current President is David Pattison, Head of International Development with NHS Health Scotland.
- **AGE Platform Europe**: a European network of around 165 organisations of and for people aged 50+ representing directly over 30 million older people in Europe. The Older People's Commission Wales is a member of the network.

3. Potential priority areas of interest to Wales

3.1. Europe 2020 Strategy

Europe 2020, the EUs job and growth strategy which is focused on delivering 'smart, sustainable and inclusive growth' and which was adopted in 2010, provides the overarching framework through which all other EU policy developments (as relevant) are being aligned.

The *Europe 2020* strategy sets out five headline targets for the EU to be delivered over the coming decade (covering employment, climate change, research and development, poverty and education). Health is not one of these, however, it is viewed by the European Commission as one of the themes that can contribute to delivery of the overarching targets (e.g. through active ageing, supporting innovation in the economy, healthy workforce etc.) as is clearly evident in the title of the proposed new health funding programme *Health for Growth Programme 2014-2020*.

Europe 2020 is implemented through a combination of EU level action and actions undertaken at Member State level (national, regional and local).

EU level action, as well as including financial support through the various EU funding programmes, also includes a series of themed flagship initiatives to provide a coherent framework for actions by Member States on the ground. Those most relevant to health related issues are:

- Digital Agenda (including actions on eHealth – see section 3.4).
- Innovation Union (including actions focused around active ageing – see section 3.5).
- European Platform Against Poverty and Social Exclusion (including actions aimed at addressing health inequalities and poverty/social exclusion).
- An Agenda for New Skills for Jobs (which identifies a shortage of 15 per cent of the healthcare workforce needed in the EU by 2020, i.e. a shortfall of around two million jobs, of which half would be healthcare professionals).

At the national level (UK level) there is a requirement on Member States to prepare each year a National Reform Programmes (NRPs) setting out the actions planned and underway to deliver the *Europe 2020* targets. The **UK's NRP** this is prepared by the UK Government in consultation with the devolved administrations (including the Welsh Government). Health is mentioned in one context in the Welsh sections of the NRP, in terms of child poverty and addressing health inequalities. In the English context it is mentioned in reference to research and addressing healthcare challenges through stimulating business activity and innovation in the health sector.

3.2. EU Health Strategy 2008-2013

As noted in section 2.1 the EU has a mandate to complement national action on health and this is undertaken through the EU Health Strategy. This is due to be reviewed before the end of 2013, however, there are no details yet available of the anticipated timing of this review.

3.3. EU Health for Growth Programme 2014-2020

On 9 November 2011 the Commission published proposals for a new ***EU Health for Growth Programme 2014-2020***, with a budget of €446 million. This would replace the current Programme of Community Action in the Field of Health, which runs from 2008-2013.

These proposals will be adopted through the ordinary legislative procedure, which (as described in section 2.1 above) means Council and European Parliament must agree on the final text in order for the programme to be adopted.

The European Commission has proposed that the new *Health for Growth Programme 2014-2020* will support and complement the work of Member States to achieve four objectives:

- **Developing innovative and sustainable health systems:** action to facilitate uptake of innovation in healthcare through eHealth, expertise on healthcare reforms and support to the European Innovation Partnership on Active and Healthy Ageing. Action under the programme will also contribute to forecasting demand for health professionals and help Member States secure a solid health workforce.
- **Increasing access to better and safer healthcare for citizens:** action will aim at increasing access to medical expertise and information for specific conditions; developing solutions and guidelines to improve the quality of healthcare and patient safety through actions supporting patients' rights in cross-border healthcare, rare diseases, prudent use of antibiotics and high standards of quality and safety for organs and substances of human origin used in medicine.
- **Promoting health and preventing disease:** to promote good health and prevent diseases by addressing the key risk factors of most diseases, namely smoking, alcohol abuse and obesity. This will involve fostering the identification and dissemination of best practices for cost-effective prevention measures; as well as specific action aimed at preventing chronic diseases including cancer.
- **Protecting citizens from cross-border health threats:** action will contribute towards developing common approaches for better preparedness coordination in health emergencies, e.g. improving risk assessment capacity and joint procurement of medical countermeasures.

Three types of actions would be funded through the programme to deliver these objectives:

- **Joint actions:** grants for action co-financed by the competent authorities responsible for public health in the Member States and with international health organisations.
- **Grants to support NGOs working in the area of public health** who play an effective role in civil dialogue processes at EU level and contribute to at least one of the specific objectives of the programme.
- **Procurement contracts**

In most cases, the EU grants would contribute up to **60 per cent** of the costs of the action or project. NHS Wales and other bodies involved in healthcare in Wales could participate in this programme.

3.4. eHealth Action Plan

The European Commission is expected to publish the *eHealth Action Plan 2012 – 2020* in early 2012.

This is a follow-up to the *2004 eHealth Action Plan*, which was the first initiative at EU level aimed at encouraging the widespread adoption of eHealth technologies across the EU.

One project that has been highlighted by the European Commission is **RENEWING HEALTH, REgioNs of Europe WorkINg toGether for HEALTH**, which is an eHealth project supported under the EU's *ICT Policy Support Programme*. It brings together health care providers from nine European countries that are described as the 'most advanced European regions in the implementation of health-related ICT services'. These are regions where services are being provided at local level for the tele-monitoring and the treatment of chronic patients suffering from diabetes, chronic obstructive pulmonary or cardiovascular diseases. The services are designed to give patients a central role in the management of their own diseases, fine-tuning the choice and dosage of medications, promoting compliance to treatment, and helping healthcare professionals to detect early signs of worsening in the monitored pathologies.

3.5. Active and Healthy Ageing

The European Commission has identified active and healthy ageing as a major societal challenge common to all European countries, and views it as an area with potential for Europe to lead the world in developing innovative responses.

To support achieving this goal it has launched, as one of the actions identified in the Innovation Union flagship initiative (Europe 2020 Strategy), a pilot ***European Innovation Partnership on Active and Healthy Ageing***. EU Member States gave their backing to the initiative in February 2011, and in November 2011 the High Level Steering Group (set up to develop the pilot) published a ***Strategic Implementation Plan***, which sets out a common vision and a set of operational priority actions to address the challenge of ageing through innovation. It is described as a stakeholder-driven plan and the European Commission invites national Governments and other stakeholders to become involved in delivering a range of actions that will be launched in 2012, which include:

- Innovative ways to ensure patients follow their prescriptions – a concerted action in at least 30 European regions.
- Innovative solutions to prevent falls and support early diagnosis for older people.
- Co-operation to help prevent functional decline and frailty, with a particular focus on malnutrition.
- Spread and promote successful innovative integrated care models for chronic diseases amongst older patients, such as through remote monitoring. Action should be taken in a number of the EU's regions.
- Improve the uptake of interoperable ICT independent living solutions through global standards to help older people stay independent, mobile and active for longer.

Linked to this, the theme of the 2012 European Year will be ***Active Ageing and Solidarity between Generations***, which will include a number of awareness raising activities across the EU. The *European Year 2012* web-site includes details of planned initiatives, and at the moment none are listed for Wales.

3.6. Modernising the Professional Qualifications

The European Commission is undertaking a review of the *EU Directive on the Recognition of Professional Qualifications*. This Directive aims to facilitate the free movement of EU citizens by making it easier for professionals qualified in one Member State to practise their profession in another, as part of the efforts to strengthen the single market within the EU. The Directive covers all professions, including healthcare professionals.

In January 2011 the European Commission launched a public consultation and in June 2011 it published a Green Paper, which was also the subject of a stakeholder consultation. The main proposals outlined in the Green Paper included a professional card, partial access, reviewing the scope of regulated professions and making information and applications procedures available online.

Concerns have been expressed about the existing Directive, in particular in terms of the competence of some European health professionals - both their clinical competence and their communication (English language) skills, which were highlighted by the House of Commons Select Committee in April 2010.

The revision of this Directive is high on the priority list of the **NHS' EU Office in Brussels**, which submitted responses to the consultation and Green Paper on behalf of the NHS. This highlighted the need for the minimum qualification standards required for professionals to practice across Europe to be updated, for regulatory bodies across Europe to have access to a shared electronic system to exchange information about professionals and their qualifications. It called for the introduction of a more rigorous warning system that requires regulatory bodies across Europe to alert their counterparts if they take action against fraudulent or incompetent doctors or healthcare professionals; called for all EU countries to ensure they require health professionals to keep their skills up to date, rather than being admitted to a professional register for life; and called for the avoidance of any relaxation on checks for migrating professionals, for example by allowing those who are qualified in one specialised area to practice in general areas of medicine.

3.7. Revision of the Working Time Directive

The 2003 *Working Time Directive* provides the framework for EU law on the maximum number of hours that employees can be expected to work during a week (48 hours). It includes definitions of working time and also provides the possibility for employees to agree to 'opt out' of the 48-hour limit.

The European Commission sought to revise the Directive in light of European case law, but these efforts failed in 2009 when the European Parliament and Council could not reach a compromise agreement on the proposed revisions. The UK Government was one of the blocking minority of Member States within the Council that prevented an agreement being reached.

The ***NHS Employers*** expressed its concerns about the potential impact of any changes to the application of the *Working Time Directive* to health workers, in particular in terms of the potential costs of including non-worked on call time as part of the working week.

The Commission was originally expected to bring forward proposals during 2011 having already carried out during 2010 two consultations to prepare the revision. However, these have been delayed and it is as yet unclear as to when they will be published, and the 2012 European Commission Work Programme did not mention an anticipated timeline.

3.8. Implementation of the Directive on Patients Rights' to Cross-border Healthcare

In March 2011 a new EU Directive on patients' rights in cross-border healthcare was adopted, following almost three years of negotiations in Brussels. The draft Directive was the subject of a short inquiry by the **European and External Affairs Committee** during the third Assembly. The deadline for transposition of the Directive into national law in the UK (and across the EU as a whole) is 25 October 2013.

This Directive was adopted on 31 March 2011 after almost three years of negotiations in Brussels. The Directive:

> …provides rules for facilitating the access to safe and high-quality cross-border healthcare and promotes cooperation on healthcare between Member States, in full respect of national competencies in organising and delivering healthcare… (Article 1.1)

It sets out:

- the responsibilities of Member States in provisions of cross-border health care (from the perspective of the Member State where treatment is given and the Member State of origin of the patient treated);
- the principles on which costs of cross-border treatment will be reimbursed;
- addresses a number of issues around the practicalities of authorising and administering cross-border healthcare services;
- looks more broadly at ways of facilitating mutual co-operation in healthcare such as e-health, setting up European reference networks (e.g. in area of rare diseases), and co-operation in technology assessments.

The Directive includes a transposition date of 25 October 2013 for the Member States (including the UK) to

> … bring into force the laws, regulations and administrative provisions necessary to comply with this Directive… (Article 21.1)

The European Commission will prepare a first report on compliance with the Directive by the same date (25 October 2013) and every three years after that date.

The European and External Affairs Committee undertook an inquiry during the third Assembly, to assess the potential impacts of the (then draft) Directive in Wales.

3.9. Health inequalities

The European Commission published a communication in 2009, *Solidarity in Health: Reducing Health Inequalities* in the EU setting out actions it proposes to take to help address health inequalities. This is based on collaboration with national and regional

authorities, production at EU level of regular reports and statistics, assessing impact of EU policies on health inequalities and so forth.

3.10. Children and health

On 2 December the EU Health Ministers adopted *Council Conclusions* on two health problems affecting children:

- **Chronic respiratory diseases in children:** calling for continued and strengthened action for the prevention, early diagnosis and treatment of these diseases, in particular through promotion of best practices, support for research, smoking prevention, improvement of air quality and stronger cooperation.
- **Communication disorders (hearing, vision and speech impairments) in children:** stressing the need for early detection and treatment of these disorders and pointing to the importance of raising public awareness, exchanging information, knowledge and experiences, and using e-Health tools and innovative technologies in order to improve healthcare in this field.

3.11. Public Procurement directives

Proposals to ***modernise the EUs Public Procurement Directives*** are due to be published on 13 December 2011, following a review of the operation of the existing rules including a public consultation earlier this year. This will be of direct relevance to all public authorities in Wales tendering contracts above the EU thresholds, and consequently any changes in the rules will also be of interest to businesses looking to bid for such tenders.

The Enterprise and Business Committee (as noted above) will undertake an inquiry into this issue during the first quarter of 2012.

3.12. Information to patients

The European Commission published on 10 October 2011 revised proposals for a new ***Directive on information on medicinal products*** to be provided to patients on prescription-only medicines.

The European Commission originally brought forward proposals in 2008, aimed at addressing an identified gap in terms of information to patients on prescription-only medicines (based on research in 2007 and a subsequent public consultation). However, these original 2008 proposals met with objections within the European Parliament in terms of the types of information and the way it should be presented to patients. The European Commission has sought to address these concerns in the revised proposals, saying these strengthen consumer rights, and provide clearer obligations and requirements in terms of the way information is to be presented.

The draft proposals will go through the ordinary legislative procedure requiring European Parliament and Council to agree on the final text in order for the proposals to become EU law.

3.13. Package on innovation in health (medical devices)

The *2012 European Commission Work Programme* includes a number of proposals anticipated in the area of medical devices, as well as a communication on innovation policy in medical devices.

3.14. Communication on long-term care (to come out in 2013)

The European Commission is planning to publish a communication on long-term care in the EU in 2013.

4. Potential follow up actions for Committee to consider

Potential Action 1:

Committee to consider holding a dedicated EU update session with some of the organisations active in this area, focusing on a broad range of issues highlighted in this paper. The focus of this session would be to consider how these developments potentially impact in Wales and where priority emphasis could be given in terms of engaging with them.

Potential Action 2:

Committee to hold a session with relevant Welsh Ministers looking at how they participate in the EU policy-making process on health related matters, in particular in terms of making use of the opportunities for benchmarking, sharing information on best practice with other Member State and sub-states/regions within the EU. To clarify how devolved interests are reflected in discussions within the Council of Ministers on health related matters.

Potential Action 3:

Committee to consider holding an inquiry looking at the opportunities under the *Health for Growth Programme 2014-2020* for organisations within Wales working in this area to participate in. [Narrower focused EU funding inquiry]

OR

Committee to consider holding an inquiry looking at how organisations in Wales engage more broadly with EU funding opportunities in the area of health, including some of the other programmes mentioned in the briefing. Particularly in terms of opportunities to secure research funding, to try out new and innovative ways of providing healthcare, and to learn from best practice in other parts of Europe. [Broader EU funding inquiry]

Potential Action 4:

Committee to review *eHealth Action Plan 2012-2020* following publication, and explore potential relevance to developments in Wales, including possibility to look at best practice initiatives in other parts of Europe.

Potential Action 5:

Committee to consider holding sessions on: (i) *Modernisation of Professional Qualifications Directive* (ii) *Working Time Directive* – once the revised proposals for both directives are published.

Potential Action 6:

Committee to consider holding a specific session focused on active ageing in context of the *European Year for 2012* and exploring the potential benefits to Wales of actively engaging in the new *European Innovation Partnership on Active and Healthy Ageing*.

Potential Action 7:

Committee to look at issue of health inequalities in terms of the Communication published by the European Commission in 2009 and looking at comparative practices in addressing health inequalities in other parts of Europe.

Health and Social Care Committee

HSC(4)-03-12 paper 3

Follow up action: EU legislation in preparation relevant to health inequalities

At the Committee's meeting on 8 December Lindsay Whittle AM asked for information on any EU legislation in preparation that is of relevance to the issue of health inequalities.

Health inequalities policy and actions

As noted at the meeting the background briefing provided information on the most recent policy action addressing health inequalities as a whole, namely the **Communication on Health Inequalities** published by the European Commission in 2009.

During the meeting I also referred to a **Joint Action Plan: Equity Action**, launched in 2010 as one of the actions to come out of the 2009 action plan.

I have obtained further information on this, which shows that the Welsh Government is one of the core partners of this initiative. The information I used at the meeting was taken from the EuroHealthNet web-site. This did not show Wales as one of the listed partners. However, in follow up research I have found dedicated Equity Action web-pages on the following web-site http://www.health-inequalities.eu/, which shows that Wales is listed as a partner in the project. This clarifies the point raised by Elin Jones AM at the meeting.

Other related areas

I also noted at the meeting that health inequalities is a broad issue cutting across a number of areas of policy work and action.

The DG Health and Consumers web-site of the European Commission lists the range of different areas affecting health inequalities, as does the EU-Health portal web-pages.

These are broad in scope and focus on the social environment within which people live. The briefing for the Committee's meeting on 8 December covered a number of issues relevant to this, such as the Europe 2020 Strategy (and a number of the flagship initiatives relevant to health issues), and the EU Health for Growth programme proposals.

One additional development that merits mention are the **EU Structural Funds programmes**, and in particular the draft legislative proposals for the 2014-2020 period published in October 2011. These proposals are the subject of an inquiry by the Enterprise and Business Committee. There is scope within the draft regulations to support actions within the area of health, whilst the European Commission has proposed that a minimum of 20 per cent of European Social Fund support actions should be ring-fenced to combatting poverty and social exclusion.

Health and Social Care Committee

HSC(4)-03-12 paper 4

Follow up action: EU drugs approval process.

At the Committee's meeting on 8 December Mick Antoniw AM asked for information on the process by which drugs are approved within the EU.

There are two processes through which drugs can be authorised within the EU is explained on the European Medicines Agency web-site and this is reproduced below for ease of reference.

To note that the European Medicines Agency is a decentralised agency of the European Union, located in London. The Agency is responsible for the scientific evaluation of medicines developed by pharmaceutical companies for use in the European Union, which fall within the scope of the centralised authorisation procedure (described below).

Extract from European Medicines Agency web-site:

…In the European Union (EU), medicines can be authorised by the centralised authorisation procedure or national authorisation procedures.

Centralised authorisation procedure

The **European Medicines Agency** is responsible for the centralised procedure for human and veterinary medicines.

This procedure results in a **single marketing authorisation** that is valid in all European Union countries, as well as in Iceland, Liechtenstein and Norway.

The centralised procedure is **compulsory** for:

- human medicines for the treatment of HIV/AIDS, cancer, diabetes, neurodegenerative diseases, auto-immune and other immune dysfunctions, and viral diseases;
- veterinary medicines for use as growth or yield enhancers;
- medicines derived from biotechnology processes, such as genetic engineering;
- advanced-therapy medicines, such as gene-therapy, somatic cell-therapy or tissue-engineered medicines;
- officially designated 'orphan medicines' (medicines used for rare human diseases).

For medicines that do not fall within these categories, companies have the option of submitting an application for a centralised marketing authorisation to the Agency, as long as the medicine concerned is a **significant therapeutic, scientific or technical innovation**, or if its authorisation would be in the **interest of public or animal health**.

Applications through the centralised procedure are submitted directly to the Agency. Evaluation by the Agency's scientific committees takes up to 210 days, at the end of which the committee adopts an **opinion** on whether the medicine should be marketed or not.

This opinion is then transmitted to the **European Commission**, which has the ultimate authority for granting marketing authorisations in the EU.

Once a marketing authorisation has been granted, the marketing-authorisation holder can begin to make the medicine available to patients and healthcare professionals in all EU countries.

- More information is available on the regulation of medicines.

National authorisation procedures

Each EU Member State has its own procedures for the authorisation, within their own territory, of medicines that fall outside the scope of the centralised procedure. Information about these national procedures can normally be found on the website of the national medicine authority in the country concerned.

- National competent authorities for human medicines[1]
- National competent authorities for veterinary medicines[2]

There are also two possible routes available to companies for the authorisation of these medicines in several countries simultaneously:

- **Decentralised procedure**: companies can apply for the simultaneous authorisation in more than one EU country of a medicine that has not yet been authorised in any EU country and that do not fall within the mandatory scope of the centralised procedure;
- **Mutual-recognition procedure:** companies that have a medicine authorised in one EU Member State can apply for this authorisation to be recognised in other EU countries. More information is available via the Co-ordination Group for Mutual Recognition and Decentralised Procedures – Human and the Co-ordination Group for Mutual Recognition and Decentralised Procedures – Veterinary.

In some cases, disputes arising in these procedures can be referred to the Agency for arbitration as part of a referral procedure.

[1] The competent authority in the UK for human medicines is the **Medicines and Healthcare products Regulatory Agency**, an executive agency of the Department of Health, based in London.
[2] The competent authority in the UK for veterinary medicines is the **Veterinary Medicines Directorate**, an executive agency of the Department of Health, based in Surrey.

Health and Social Care Committee

HSC(4)-03-12 paper 5

Models of ownership for residential care for the elderly in EU member states

Follow-up action from Health and Social Care Committee meeting on 8 December 2011

At the Committee's meeting on 8 December 2011 Mick Antoniw AM asked for information on the different systems of ownership of care provision that exist throughout the EU.

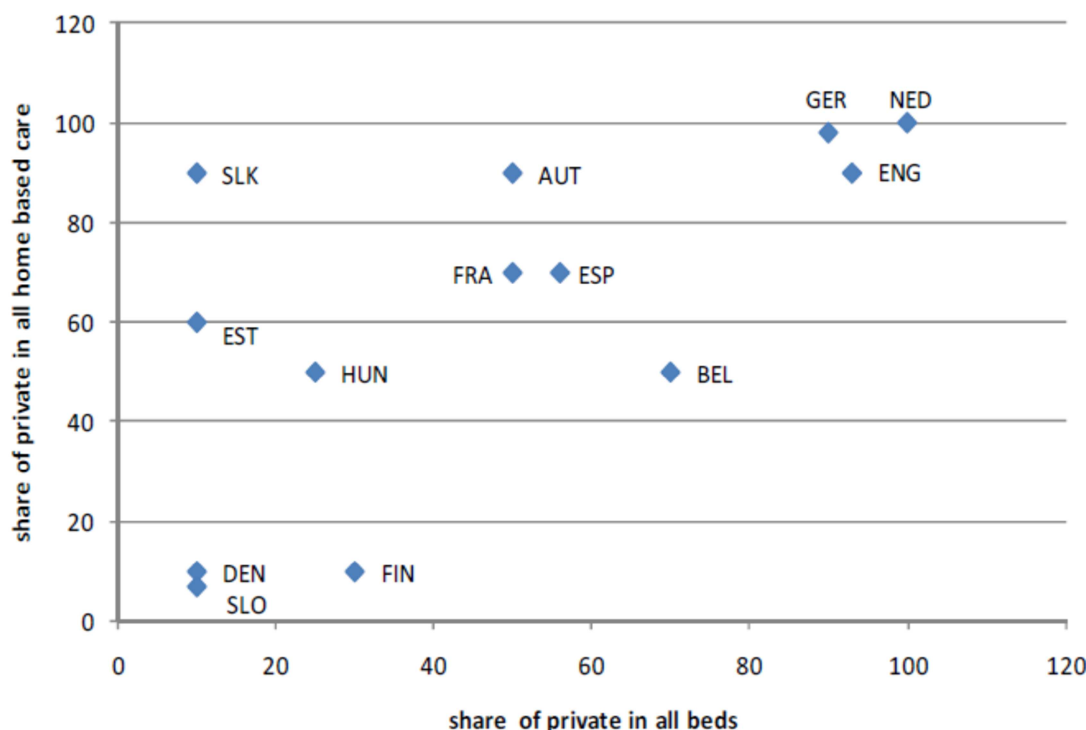
Provision of long-term care services for the elderly by sectors in EU member states

From January 2009, partners from 20 EU member states have developed the *Assessing Needs of Care in European Nations*[1] (ANCIEN) research project, which has looked at different long-term care systems for the elderly in 21 EU member states. One of the areas looked at in the research project is whether long-term care systems in EU member states are predominantly provided and financed by the public or private sectors. **Reports providing further detail on long-term care systems within individual member states are available on the ANCIEN website.**[2]

A study by two researchers involved in the ANCIEN project provides an estimate of public and private (including non-profit) provision of long-term care services across 13 EU member states. Figure 1 below shows the level of private sector provision in home-based care and institutional care in these member states.

[1] Assessing Needs of Care in European Nations, Home [accessed 10 January 2012]
[2] Assessing Needs of Care in European Nations, Most recent reports [accessed 10 January 2012]

Figure 1: Estimated share of public/private provision of formal long term care services for institutional care and home-based care, 2010



Source: Riedel, M. and Kraus, M, The Organisation of Formal Long-Term Care for the Elderly: Results from the 21 European Country Studies in the ANCIEN Project, page 16, November 2011 [accessed 10 January 2012]

Key: AUT=Austria, BEL=Belgium, DEN=Denmark, ENG=England, ESP=Spain, EST=Estonia, FIN=Finland, FRA=France, GER=Germany, HUN=Hungary, NED=The Netherlands, SLO=Slovenia, SLK=Slovakia

It can be seen from Figure 1 that there are differences in the proportion of long-term care provided by the public and private sector across EU member states. In the Netherlands virtually all long-term care is provided by the private sector, and the majority of institutional care is provided by the not-for-profit private sector.[3] In Germany the not-for-profit private sector provides the majority of institutional and home-based long-term care services, although Riedel and Kraus note that increasingly long-term care is being provided by profit-making private sector firms in Germany.[4]

Denmark, Finland and Sweden are cited as examples of the Scandinavian welfare system, which typically has high levels of public provision of services. Of the other countries covered in the ANCIEN study, the only one with a comparable level of public ownership in providing long-term care is Slovenia. In these countries there appears to be less provider choice than in other EU member states.[5]

[3] Riedel, M. and Kraus, M, The Organisation of Formal Long-Term Care for the Elderly: Results from the 21 European Country Studies in the ANCIEN Project, page 16, November 2011 [accessed 10 January 2012]

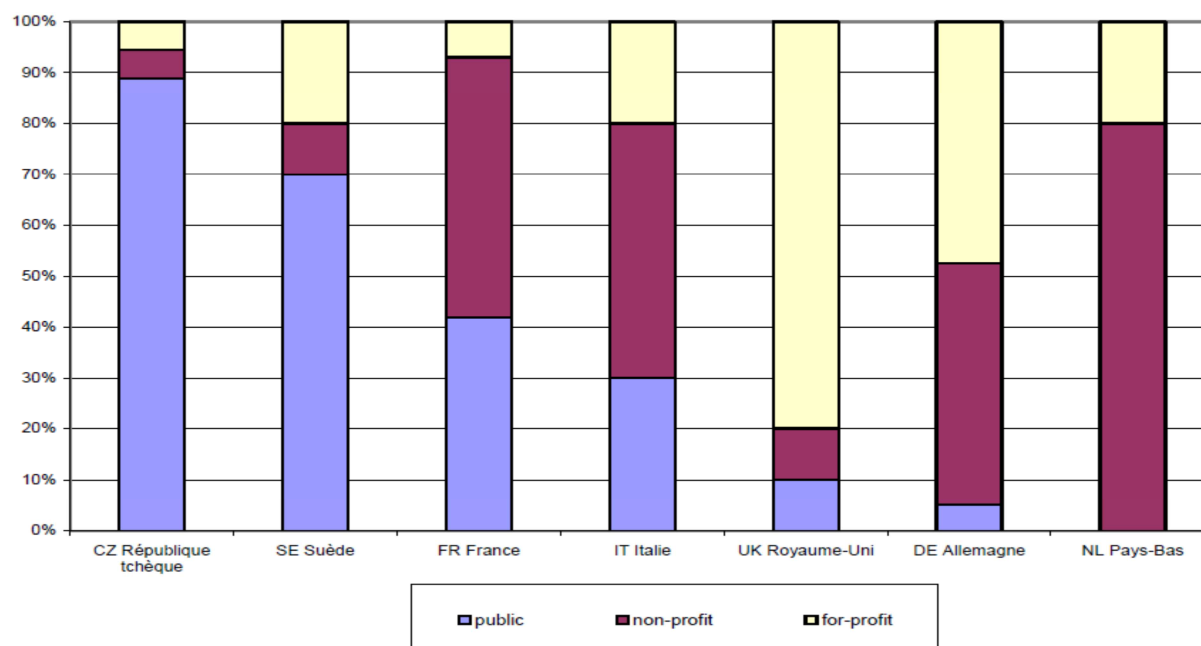
[4] Ibid. page 16

[5] Ibid. page 23

Private provision typically plays less of a role in institutional care than home-based care across EU member states, and Riedel and Kraus state that this is particularly the case in the newer EU member states, citing Slovakia as an example.

A study by Reimat (2009) provides greater detail on the weight of public, non-profit and for-profit services for 7 EU member states (Czech Republic, France, Germany, Italy, the Netherlands, Sweden and the United Kingdom), and this is provided below in Figure 2. It can be seen that of these 7 member states, the UK has the highest proportion of for-profit services in the private sector providing long-term care.

Figure 2: Weight of public, non-profit and for-profit services in long-term care provision, 2006



Source: Reimat, A., Welfare regimes and long-term care for elderly people in Europe, March 2009 [accessed 10 January 2012]

Types of long-term care models in EU member states

Kraus et al looked at two different ways of categorising the different approaches towards long-term care for the elderly in EU member states in a recent study.[6]

The first way they identified of categorising member states was according to how care is organised and financed across 21 different nations for which qualitative data was available. The variables included when assessing organisation of care included information on entitlements to services, availability of cash benefits, provider choice, quality assurance and integration of care. The measures used to assess financing of long-term care systems for the elderly included public expenditure for long-term care as a proportion of GDP and cost-sharing. The four clusters of countries identified by Kraus et al using this approach are set out in Table 1.

[6] Kraus, M. et al, How European nations care for their elderly: A new typology of long-term care systems, July 2011 [accessed 10 January 2012]

Table 1: Types of long-term care systems for the elderly in EU member states based on organisation and financing of long-term care

Countries in cluster	Characteristics of long-term care system
Belgium, Denmark, France, Germany, the Netherlands, Sweden	Highly developed organisational system with relatively high levels of public financing.
Austria, England, Finland, Italy, Latvia, Spain, Slovenia	Moderately developed organisational system with moderate levels of public financing.
Bulgaria, Czech Republic, Estonia, Slovakia	Highly developed organisational system with relatively low levels of public financing.
Hungary, Lithuania, Poland, Romania	Less developed organisational system with relatively low levels of public financing.

Source: Kraus, M. et al, How European nations care for their elderly: A new typology of long-term care systems, July 2011 [accessed 10 January 2012]

The second approach used by Kraus et al considered public expenditure on long-term care as a share of GDP, private expenditure as a share of long-term care spending, informal care recipients aged 65 and over as a percentage of the population aged 65 and over and informal care support. Results were obtained for 14 countries for which quantitative data was available. The clusters identified by Kraus et al using this method are set out below in Table 2.

Table 2: Types of long-term care systems for the elderly in EU member states based on care use and financing of long-term care

Countries in cluster	Nature of long-term care system	Characteristics of long-term care system
Belgium, Czech Republic, Germany, Slovakia	Oriented towards informal care. Low levels of private financing.	Low public spending, low private spending, high levels of informal care use and support, cash benefits modest.
Denmark, the Netherlands, Sweden	Generous, accessible and formalised.	High public spending, low private spending, low informal care use, high informal care support, cash benefits modest.
Austria, England, Finland, France, Spain	Oriented towards informal care, high levels of private financing.	Medium public spending, high levels of private spending, high levels of informal care use and support, cash benefits high.
Hungary and Italy	High private financing, informal care seems a necessity.	Low public spending, high private funding, high informal care use, low informal care support, cash benefits medium.

Source: Kraus, M. et al, How European nations care for their elderly: A new typology of long-term care systems, July 2011 [accessed 10 January 2012]

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 – Senedd**
Meeting date:	**Wednesday, 11 January 2012**
Meeting time:	**09:45 – 11:30**

Cynulliad Cenedlaethol Cymru

National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_200000_11_01_2012&t=0&l=en

Concise Minutes:

Assembly Members:	**Mark Drakeford (Chair)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Witnesses:	**Lesley Griffiths, Minister for Health and Social Services** **Dr Gwyn Thomas, Chief Information Officer, Welsh Government** **Prof Roger Walker, Chief Pharmaceutical Officer, Welsh Government** **Andrew Evans, Welsh Government**
Committee Staff:	**Llinos Dafydd (Clerk)** **Catherine Hunt (Deputy Clerk)** **Joanest Jackson (Legal Advisor)** **Stephen Boyce (Researcher)**

1. Introductions, apologies and substitutions

1.1 There were no apologies or substitutions.

2. Inquiry into Residential Care for Older People – Discussion on the inquiry timetable and appointment of expert adviser

2.1 The Committee discussed the timetable for its inquiry into residential care for older people and the appointment of an expert adviser.

2.2 The Committee agreed the outline timetable and the allocation of key themes to individual Members. The Committee did not agree the proposed role specification for an expert adviser and, as such, was unable to nominate a preferred candidate. Members agreed to delegate further work on the role specification and possible candidates to the Chair.

3. Draft Food Hygiene Rating (Wales) Bill - Discussion on approach to consideration of Draft Bill

3.1 The Committee noted the publication of the Draft Food Hygiene Rating (Wales) Bill.

3.2 The Committee discussed the approach it should take in considering the draft bill and agreed that it should seek a briefing from Welsh Government officials. The Committee agreed that the purpose of this briefing would be to keep abreast of developments with the draft bill as opposed to expressing a view on its content.

4. Inquiry into the contribution of community pharmacy to health services in Wales - Evidence from the Minister for Health and Social Services

4.1 The Minister for Health and Social Services and officials responded to questions on the contribution of community pharmacy to health services in Wales.

4.2 The Minister agreed to provide the Committee with a copy of a paper published in the Journal of Public Health on the evaluation of a community pharmacy minor ailment scheme held in North East England.

5. Papers to note

5.1 The Committee noted the minutes of the last meeting, letters from the Deputy Minister for Children and Social Services, and the additional written evidence on the contribution of community pharmacy to health services in Wales.

TRANSCRIPT
View the meeting transcript.