The Welsh Health Battleground

Policy Approaches for the Third Term

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Introduction

This volume comprises the edited contributions made to the inaugural conference of Academy Health Wales, organised by the Institute of Welsh Affairs and held at the University of Wales Institute, Cardiff (UWIC) in July 2007. The aim of the conference was to address on as wide a front as possible what would be in the Health Minister's in-tray at the beginning of the National Assembly's third term. The contents of this volume indicate how broad the issues are. The complex inter-relationship between health determinants, morbidity, lifestyle choices, and the delivery of primary and secondary healthcare are all illustrative of what a challenging policy area this is.

Health and social care comprise the largest segment of the Welsh public service, both in terms of expenditure and personnel. Yet there is a widely shared view that there is insufficient dialogue within the sector. Moreover, what dialogue there is tends to take place within the restricted comfort zone of a limited range of options. In short, we lack a plurality of viewpoints. The first objective of Academy Health Wales is to be a focus for improved communication between health and social care policy makers and practitioners. Secondly it aims to be a forum in which new thinking, however unconventional that may be, can be aired. A third objective is for it to facilitate an exchange of ideas between Welsh health and social care practitioners and those within the international arena.

Initially a partnership between the IWA, UWIC, and Pfizer Ltd., Academy Health Wales is now developing a wide membership, bringing together policy makers from the Assembly Government, Health Boards and Trusts, the political parties, academia, and the health care and pharmaceutical and other related health industries, as well as wider civic society. We hope to provide a regular forum for dialogue and discussion on health and social care policy.

In May 2007 Academy Health Wales convened a seminar to hear a presentation by David Helms, President and Chief Executive of Academy Health USA. Since 2000, Academy Health USA has been a forum for a number of health advocacy and representative organisations. It employs 60 people and has an annual turnover of $9 million. As the professional society for health service researchers and health policy analysts it has a three-fold mission, to:

- Strengthen the research infrastructure.
- Promote the use of best available research.
- Assist health policy and practice leaders in addressing major health care challenges.

As David Helms told us, "We work to both 'push' the production of research and promote the 'pull' by decision makers." This is a fair summary of the aspirations of Academy Health Wales.

John Osmond
Director, IWA

CHAPTER 1

The Health Battlefield

Cerilan Rogers

Before health can be considered, it needs to be measured. This is not as straightforward as it seems since the definition of 'health' is not always agreed. The World Health Organisation has an holistic definition of health as:

> *"… a state of complete physical, mental and social well being and not merely the absence of disease or infirmity."*

Although this makes it clear that health is more than the absence of illness, the measures used often relate more to illness and death than well-being. Various measures are used to describe the health of a population, which include:

- Mortality
- Life expectancy
- Morbidity
- Disability
- Quality of life
- Birth rates and birth weights

All have their advantages and disadvantages. Mortality is most often used and can be expressed in different ways:

- Age/gender specific rates
- Age/gender standardised rates
- Standardised mortality ratio (SMR)
- Condition specific mortality rates

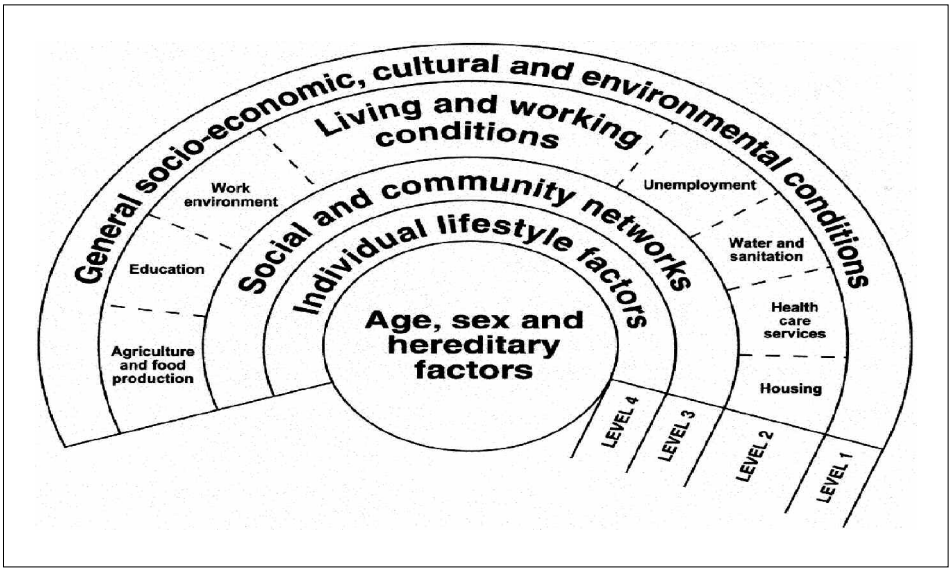
All allow comparison between populations and groups, as well as trends over time. The determinants of health include:

- Age, sex and hereditary factors (intrinsic factors)
- Individual lifestyle factors
- Social and community networks
- Living and working conditions
- Socio-economic, cultural and environmental conditions

Some of these are, like health itself, difficult to define and measure. Their role in influencing individuals' health is not always easy to understand and many interact with

each other. The main focus has often been on intrinsic and lifestyle factors, with some attention paid to living and working conditions, and there has been a huge increase in understanding how genetics influence the health of individuals. Issues, such as smoking and alcohol misuse, have also captured public interest.

However, there has been increasing attention on the 'wider' determinants, related to socio-economic, cultural and environmental circumstances, as well as the role played by social and community networks. This inclusive approach is captured by the 'social model of health' shown below:



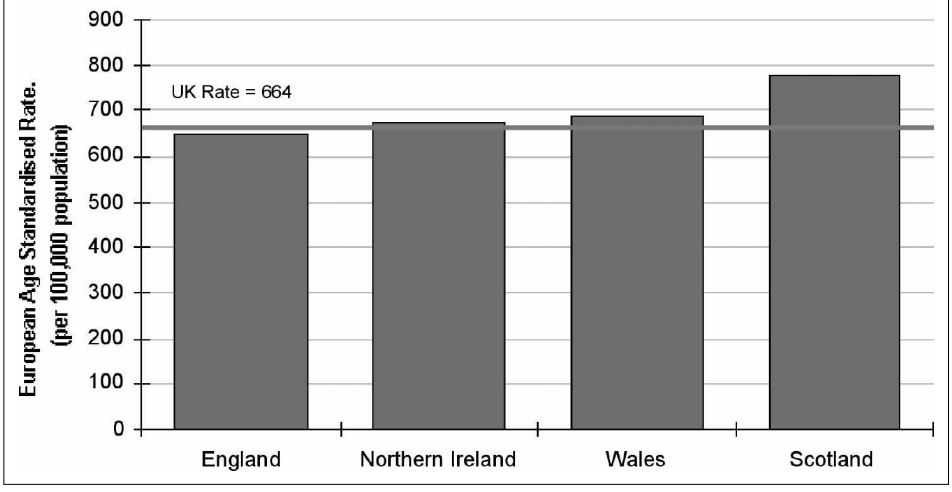
Source: Adapted from Dalgren and Whitehead, 1991

An example of the effects of health determinants is the 'epidemiological transition'. Over time, the causes of mortality in developed countries have moved from mainly infectious disease to cancer and degenerative disorders. This has been accompanied by an increase in life expectancy. Diseases that in previous times, and in developing countries, are usually seen in the most affluent, increasingly become the diseases of the poor.

Health care per se makes a relatively small contribution to the health of the population and it is only one of several sectors in the model above. Many people find this surprising. However, if you consider wider determinants as the 'battlefield' and medical care as the 'field hospital', then the greater impact of conditions on the battlefield on mortality can be appreciated, as can the importance of high quality health care for those who need it.

Various measures of health show the UK to be demonstrably poorer relative to many European nations. Health in Wales compares poorly to some other areas of the UK, most noticeably to England. The situation for deaths in the UK is illustrated in the table below.

Mortality: All Causes, All Persons, UK Nations 2002-04 (ICONS. All Causes)



Data Sources: ONS, GROS and NISRA

In addition, there are substantial inequalities of health within Wales. Many of these inequalities are associated with socio-economic differences. The map on the following page illustrates the geographical variation in all cause mortality in Wales. In particular, it shows a relatively poorer situation in the south Wales valleys and other known pockets of deprivation (source: NPHS).

The scale of these inequalities is also surprising, so for example:
- People in unskilled occupations and their children are twice as likely to die prematurely than professionals and their children.
- The unemployed are likely to display twice the level of common mental health problems as those in employment.

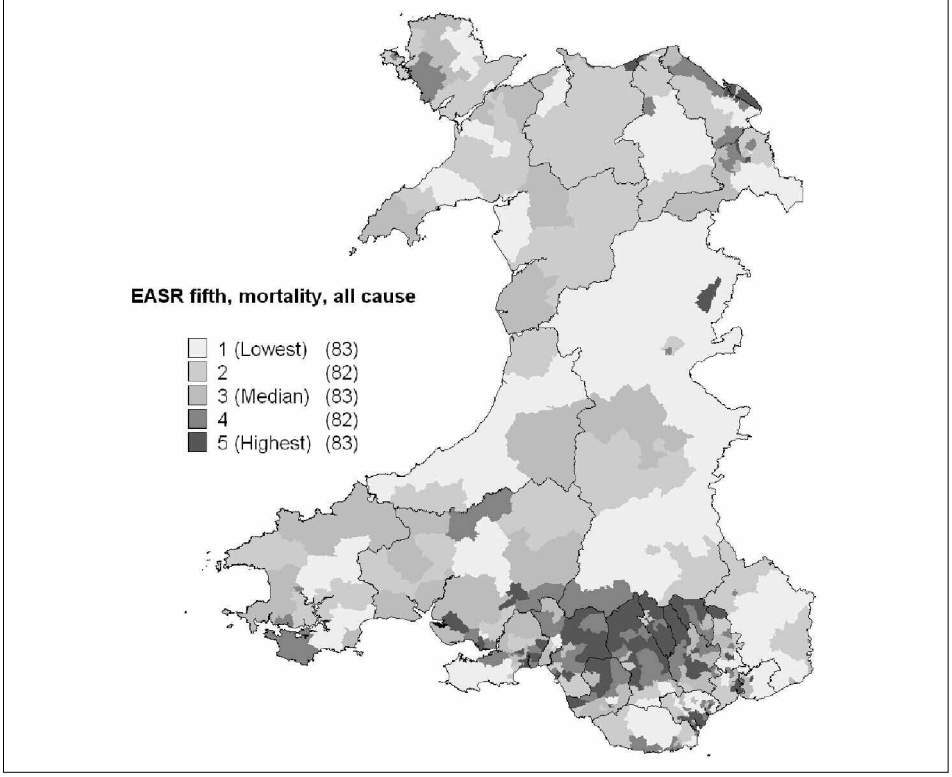
The risk of suffering from many conditions, when the most deprived are compared with most affluent, is increased (if the risk was equal, the value would be one):
- Lung cancer cases (1997-2001) 1.84
- Limiting long term illness (18+) 1.40
- Pedestrian injury (4-16) 2.52

- Pedestrian injury (65+) 2.66
- Diabetes (self reported) 1.78
- Obesity (BMI>30) 1.47
- Coronary heart disease 1.36

In summary, the poor have the poorest health, with a gradient apparent across socio-economic class, and the scale of these inequalities is increasing, despite increasing prosperity. Once the economic threshold for living has been reached, increased prosperity does not necessarily result in decreasing health inequality.

One proposed explanation for this has been the role of 'relative poverty', which relates to income distribution within a society, particularly those which have passed through the 'epidemiological transition'. The association between income distribution and health inequalities is stronger within developed countries than between them.

EASR Fifth, Mortality, All Causes (Data Sources: ONS 2000-04, MSOA)



The suggestion is that absolute income exerts its effects on health through the direct effect of material circumstances, while the effect of relative income is mediated through 'psychosocial' pathways, which themselves may include health related behaviours. Another way of expressing this is that the perception of inequality itself gives rise to inequalities in outcomes. Health is one of the most important of these outcomes, but other examples would be educational attainment and crime and disorder.

This is a complex area which is difficult to study. Most of the evidence comes from descriptive studies of populations, which makes it difficult to attribute cause and effect at an individual level. However, adverse socio-economic circumstances certainly increase the level of stress in which domestic life is lived and this, in itself, is known to be related to health and other outcomes. Those with close family, friends and/or community ties are less likely to die prematurely, compared with those who are socially more isolated. Social or economic disruption to childhood is an adverse factor in health outcomes and increases the likelihood of offending behaviour.

Many of the communities adversely affected by health inequalities are also those most affected by crime and disorder. The link between aspects of social exclusion, such as drug misuse, unemployment and truancy, and increased levels of antisocial and criminal behaviour, including domestic abuse, assault, fires and other crimes, is well recognised.

There is debate regarding the role of relative poverty and/or the perception of inequality in the genesis of health inequalities. However, although there is much we do not understand about the contribution made by these factors, or their precise role in any individual, socially just societies are amongst the healthiest. Moreover, the economy is a key element in producing socially just societies.

It is not enough to describe health inequalities and theorise about their genesis. The main issue is what we can do to reduce them. Let us start with what we know:

- Health is responsive to changes in income (however mediated).
- Health is a product of society, as well as of genetics.
- Focusing on just one type of determinant, for instance lifestyle, is not sufficient.

There is no doubt that improvement in health outcomes requires individuals to lead healthier lives, but to change behaviour it is necessary to change more than behaviour. Tackling health inequalities requires action designed to address:

- The social, environmental and economic circumstances in which people live.
- High risk groups and whole population change.
- Individuals and communities.

This is therefore a very complex agenda, which affects all sectors, public and private, and all levels of government, local and national. Above all, it requires supportive and consistent public policy, which is sustained over a long period. The public's health really is everybody's business. A strategic and 'joined up' approach is required for effective action. In turn, this needs to be informed by evidence and systematic in its application.

Public health has been defined as "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society" (Sir Donald Acheson). In Wales the specialist public health support for those efforts in Wales is provided by the National Public Health Service whose priorities for health improvement are:

- The economic and physical environment – housing, transport, waste, and economic development.
- Influencing behaviours – tobacco, alcohol, nutrition, physical activity, and substance misuse.
- Communities and families – child poverty, community development, and mental health promotion.

The policy context in Wales, in which the National Public Health Service and other public sector organisations operate, is supportive of a joined up approach. Indeed, there is a political commitment across the political parties to tackling inequalities. However, we are still some way from achieving and, as importantly, sustaining effective action on the ground. Wales has taken its first steps. It must now continue the journey.

CHAPTER 2

The Postcode Lottery

David Cohen

The term 'postcode lottery' describes the situation where two people with identical healthcare needs are treated by public services differently because of where they live. To many people, the existence of a postcode lottery is a violation of the basic principles on which the National Health Service was founded. It is therefore something which should not be tolerated. However, it can be argued that the decision on whether or not the postcode lottery should be tolerated can only be made by also taking into account the 'good things' which are brought about by those situations which allow it to occur.

The National Health Service was introduced in 1948 mainly because of a general consensus that healthcare was somehow different from other market goods. Access to healthcare was (and to most in the UK still is) regarded as a fundamental human right, like access to the ballot box or to the courts of justice, rather than as part of society's reward system. Such a view justified taking healthcare 'off the market' and allowing the State to provide it at zero price to users. People would now receive healthcare services according to their needs rather than their ability to pay.

Although 'equity' was not explicitly stated as an objective of the NHS, it was implicit from the start. If healthcare were to be distributed according to need, then it was evident that if the poor, the elderly or those in the North had greater needs, then they would receive more healthcare than the rich, the young or those in the South. Moreover, Aneurin Bevan's vision of a highly centralised service made it appear certain that the new NHS would be totally equitable.

At the same time, however, there was also an assumption – quite explicit in this case – that sufficient resources would be made available to ensure that all healthcare needs were met. With hindsight, it is easy to dismiss such a naïve assumption but at the time it was not at all unrealistic, given how the concept of 'need' was perceived at that time.

While it may be an exaggeration to say that people in the 1940s only sought medical help if they thought they were going to die, it is certainly true that expectations of what the NHS could and should provide have changed dramatically since then. It is this change in expectations that explains why all needs are still not being met despite huge growth in NHS expenditure since then. However, a more powerful explanation of why the NHS has not been able to meet all needs from its available resources relates to the changing definition of need.

What do we mean by 'need'?

From an economic perspective, need is normally perceived as the capacity to benefit from treatment, preferably on the basis of evidence as judged by a health professional. This view, therefore, does not equate 'need' with how unwell any individual may be or even how they feel about it, but by the extent to which there is an effective intervention which can alleviate the problem.

To this way of thinking, it is obvious that every new treatment which allows people to benefit who couldn't benefit before, or which allows people to benefit more than they could with the old treatment, has increased need. The exponential growth of new interventions in healthcare thus equates to an exponential growth in need. So although funding for the NHS has been continually increasing, it has not been increasing at the same rate as has need. The gap between total need (which would be met in an ideal world of infinite resources), and 'met need' (that can be met in the real world of finite resources) is thus growing all the time.

The conclusion from this is that NHS resources are scarce and always will be scarce so long as we continue to benefit from medical advances. This in turn means that it is not possible to do everything that we would like to do. Making difficult resource allocation choices will always be inescapable.

Such difficult choices can be understood as 'prioritisation'. This is because, if resources were infinite, the NHS could meet everyone's healthcare needs fully and immediately and then there would be no need to prioritise. While there can be many legitimate criteria on which prioritisation decisions should be based, it is easily argued that whichever ones are used should be stated openly and explicitly. For the moment, two alternative criteria are put forward:

- Prioritise in order to maximise health benefits to the population for whom you are responsible.
- Give priority to those who shout the loudest. These will be returned to shortly.

The Concept of Cost as 'Sacrifice'

Labelling any group as a 'priority group' has always carried positive connotations. These people will be given preferential treatment and more will be done for them than was done in the past. But doing more implies spending more and since overall resources are finite – each Local Health Board has a budget – spending more on one group must mean spending less on another.

If overall expenditure is growing fast enough then this need not necessarily mean a cut in anyone's actual expenditure. However, it still means that less will be spent on the non-priority group than would have been the case if the priority group had not been

identified as such. In any case people in the non-priority group will derive less health benefit than they would have done if the other group had not been made a priority.

To this way of thinking the 'cost' of doing more for one group is seen as being borne by those in another group who are now forgoing health benefits they would otherwise have had. Economists use the term 'opportunity cost' to emphasise this notion of an opportunity forgone. In this sense, 'cost' equates to sacrifice.

It is easy to understand why many people consider it unethical to take cost into account when making decisions about healthcare. The recent decision by the National Institute for Health and Clinical Excellence (NICE) to deny new drugs for Alzheimer's to those in the early stages of the disease was derided by many as unethical since it was based on cost-effectiveness rather than clinical effectiveness. How can you take cost into account when people's well-being is at stake?

Such a view clearly sees costs in money terms and to suggest that any individual's welfare is worth less than some sum of money is at best distasteful. An alternative (economic) argument would begin by pointing out that if NICE had approved the new drugs, no new money would be forthcoming to pay for them. The money would have to be taken from other services and the people who would otherwise have benefited from those services now won't. The idea that it is somehow unethical to take these sacrifices by other (non-Alzheimer) patients into account must be wrong. Indeed it would be unethical not to.

A Partly Fictitious Example of an Ethical Prioritisation Decision

The following example is loosely based on a true event but has been simplified in order to draw out its messages.

Haemophilia is a disease in which blood fails to clot and can lead to death from blood loss. Factor 8, which is derived from donor blood, allows a haemophiliac's blood to clot and thus saves lives. The problem is that if the blood donor was suffering from a viral infection (particularly HIV or hepatitis) then it is possible for the disease to be transmitted to the recipient through Factor 8. Fortunately, screening of donors and treatment of donated blood mean that the risk of viral transmission is very small.

Scientists have recently developed 'genetically engineered Factor 8' which is identical to donor Factor 8 in terms of its effectiveness in clotting, but carries zero risk of viral transmission. Unfortunately, genetically engineered Factor 8 is much more expensive than donor Factor 8.

The parents of a haemophilic child in England heard that genetically engineered Factor 8 was now available and quite understandably demanded that he be prescribed it. The

doctor explained that this was not possible as the local Health Authority (this was before the days of Primary Care Trusts in England) had recently taken a decision not to change its existing policy of paying only for donor Factor 8. This outraged the parents because the neighbouring Health Authority had in fact changed its policy and would pay for genetically engineered Factor 8 – a classic example of the postcode lottery. The parents then sued their Health Authority.

At court, the Health Authority began its defence by explaining that their budget did not allow them to commission all the healthcare services required to meet all the needs of all the people for whom they were responsible. That is to say, difficult prioritisation choices had to be made.

With that as background they explained the process they went through when considering whether or not to change their policy on Factor 8. First, they estimated what the benefit of changing the policy would be in terms of reduced risk of transmitted infection – cases avoided, costs avoided, illness and death avoided and so on. Second, they estimated what the money cost would be of paying for genetically engineered rather than donor Factor 8. They then went to various clinical directors and asked them to estimate what benefits would be forgone if their budgets were cut by the amount needed to pay for the policy change. Finally, they weighed the benefit of the change against the sacrifices others would have to bear and concluded that the value of the sacrifice would be greater than the value of the gain. Since they were responsible for all people in their area, changing the policy would represent less total health benefit to that population and therefore it couldn't be justified.

The judged ruled in favour of the Health Authority. He accepted that they could not escape making prioritisation decisions and that they had made this particular decision using a rational framework. Importantly, he accepted that they – and not a judge in a court of law – were the right people to make those difficult decisions.

It is also evident that the Health Authority's decision was based on the use of local information. While evidence of the risk of viral transmission from donor Factor 8 and its consequences was obtained from national sources, all the other required information was local: the number of haemophilic children in the area, the needs of other children in the area, local current service provision, what would be sacrificed (based on information from local service providers), local preferences, and so on.

But what about the neighbouring Health Authority? As angry as the parents were that their child was forced to accept an avoidable risk, what had made them pursue the case through the courts was the fact that the neighbouring Health Authority had changed its policy. Their son would therefore receive genetically engineered Factor 8 if they had lived just a few miles down the road.

But on what basis had the neighbouring Health Authority made its decision? In fact, what happened was that the parents there formed a local action group, went on marches, got the local press involved and enlisted the support of the local MP. The subsequent policy change was heralded in the press as a victory for common sense and a victory for patients against a bureaucracy controlled by faceless men in grey suits.

Two possible ways of making prioritisation resources were put forward earlier in this chapter. The Health Authority which was taken to court for not changing its policy had based its decision on an attempt to maximise the health benefits to the population for whom it is responsible (not to save money which is how it was portrayed in the local press). The Health Authority which changed its policy did so on the basis of giving priority to those who could shout the loudest. Which Health Authority behaved ethically?

Some patients in the Health Authority which changed its policy are bearing the cost of that change. If sacrificing the benefits they would otherwise have had is regarded as harm, then it is possible that from a societal perspective the change in policy did more harm than good – which would be a clear violation of the basic principle of medical ethics. By weighing the benefit to haemophiliacs against the harm to those bearing the cost, the Health Authority which stuck to its old policy – and got sued for its decision – appears to have been the one which behaved ethically.

Is the Postcode Lottery a 'Bad Thing'?

In 2001, the Assembly Government abolished the (then) five Health Authorities in Wales, and replaced them with 22 Local Health Boards. That change was consistent with a stream of initiatives in the preceding years in both Wales and other parts of the UK toward more devolution of decision making to local communities. The NHS Plan for Wales (2001) made constant references to the benefits of letting local people decide on what they wanted from their NHS. Plainly, there are many good things to be said about the benefits of local decision making.

At the same time, devolving prioritisation decision making must lead to different local priorities – otherwise what's the point? And different local priorities must mean people in different localities being treated differently. The postcode lottery (reduction in equity) is the cost of devolved priority setting.

There can be no 'right' answer on which way to move in the 'postcode lottery' debate. In the end it has to be a political decision. Any move either toward more centralised policy making or toward less centralised priority making will involve both good things and bad things which need to be carefully weighed against each other. However, the decision taken – including the decision to leave things as they are – should be defended through an honest explanation to the people of Wales of how and why it was taken.

CHAPTER 3

Improving Primary Care Integrating Health and Social care

Ceri J. Phillips

How health and social care services should be provided and the extent of resources required have been among the most contentious political issues in the relatively short history of the Welsh Assembly Government. Indeed, this is the case for most governments in the developed world.

At the inception of the NHS, there was a belief that the provision of health care services, free at the point of entry, would secure significant improvements in the health of the general population. It was also believed they would go a long way to reducing the inequalities in health which had existed prior to the establishment of a national health service. With the benefit of hindsight that view seems naïve. Instead, we have witnessed an exponential increase in demand for health care services, despite expenditure on health and social care consuming the largest proportion of Assembly Government spending. and on-going improvements in health and extensions in life expectancy, which at 80 years for women and 76 years for men is over seven years longer than in the early 1970s[1]. The factors contributing to these continuous increases in demand are many but significant among them are:

- Demographic changes The health system has been a victim of its own success and the fact that people are living longer puts additional pressure on healthcare services. The percentage of the population of retirement age in Wales is projected to increase to 22 per cent in 2021 from 17 per cent in 1999[2].
- Technological advancements Medical science and computer technology have advanced dramatically over recent decades, resulting in the development of new techniques and procedures, which have major implications for the delivery of patient care. For example, developments in surgical techniques have resulted in significant increases in the proportion of day-cases among hospital admissions.
- Increasing expectations Diseases which would have resulted in death or severe debilitation are now treatable and, in many cases, preventable owing to the advancements in knowledge and changing practices. Despite these developments utilisation rates for health services continue to increase, based on perceptions that healthcare services can meet a greater proportion of our needs. For example, even within the last five years the average number of prescription items per head of population has increased by 16 per cent to 18.2 items[3].

1) http://new.wales.gov.uk/topics/statistics/wales-figs/health/life-expect/?lang=en
2) http://new.wales.gov.uk/topics/statistics/wales-figs/population/2004pop-age/?lang=en
3) http://new.wales.gov.uk/topics/statistics/wales-figs/health/gp-prescribing/?lang=en

The organisational structure underpinning the provision of health and social care services is based around 22 local authorities which are responsible for the provision of social services, 14 NHS Trusts which provide secondary healthcare and community services, and 22 local health boards which act as commissioning agencies for the provision of health care services across Wales, and when necessary, from English providers.

In addition, the voluntary and independent sectors make significant contributions to service provision across Wales. The co-terminosity of local authorities and local health boards was engineered to facilitate a relatively seamless service between health and social care provision. In addition, a variety of innovative multi-agency projects have been developed in Wales during recent years involving collaboration between statutory, voluntary and independent providers.

However, there is limited awareness among providers about a number of these initiatives. If appropriate, patient-centred care is to be delivered barriers to partnership working between health and social care agencies need to be reduced, coupled with a wider dissemination of good practice. For too long patients have been regarded as bed-blockers, as referrals, as units of account and as pawns for scoring political points, rather than human beings who deserve high quality care at all stages of the health and social care process.

In recent years a stream of policy statements has emanated from the Assembly Government exhorting health and social services to work more closely together. Some are listed in the Appendix to this chapter. Yet, there is limited evidence that anything significant is being done to translate the aspirations contained in these documents into real action with meaningful outputs and deliverable outcomes. There are a number of factors preventing progress, including the following:

- **Target Overload** Health and social care agencies are confronted by an excessive number of targets, the pursuit of which often leads to conflicts both within organisations and also in terms of their relationship with other agencies.
- **Budgets** Closely aligned to the problem of achieving a multiplicity of targets, is the need to manage budgets effectively. The fragmentation of services and establishment of budget centres has resulted in priority being given to ensuring that objectives set out in budgets are kept. One result tends to be a lack of consideration to the impact on other budget centres, agencies and sectors.
- **Hospital Discharge** Hospital discharge planning, which has aroused much discussion and debate over many years, remains at the forefront of inter-sectoral conflict. Hospitals, desperately seeking to discharge patients 'deemed medically fit for discharge' to provide beds for those on waiting lists, are confronted by social services departments unable to offer appropriate care packages because of staff shortages and lack of appropriate community facilities and nursing home beds. In addition, emergency

admissions to hospital are often triggered by capacity constraints and deficiencies in primary care and social services systems, with the situation aggravated when discharge is delayed by the same problems. The result is that, far from being partners in a working relationship, health and social services are more akin to protagonists.

- **Continuing and Intermediate Care** These areas provide excellent opportunities to develop community-based services, which can provide rapid response, enablement, rehabilitation, admission avoidance and accelerated discharge services for all that need such provision. However, the reality is that budgetary and organisational obstacles preclude effective working. Initiatives that have been shown to be successful in other locations are unable to function as intended due to inter-agency conflicts, as opposed to the collaborations on which they were developed.
- **Independent and Voluntary Sectors** These often have to act as intermediaries and 'back stop' for services across the care spectrum, but especially end of life management. However, statutory agency reliance on these organisations is not matched by the resources or value given to them.

All these issues are basically manifestations of differences in the priorities and agendas of different organisations. Professionals' perspectives and structures can also be obstacles to creating a climate of co-operation and collaboration.

Despite these problems, collaboration and partnership working remain essential if we are to improve the quality of health and social care services. Moreover, there is a general willingness to promote more collaboration. Some potential remedies include:

- Developing common information systems and sources between health and social care.
- Establishing evidence for what works and what does not work in integrating health and social care.
- Greater communication in addressing deficiencies at the interface between health and social service organisations.
- More focus on the service user rather than the professional or the organisation.
- More effective performance measures.
- Reduce the number of targets while ensuring that meaningful accountability channels are in place.

Above all, we need to be clear what is meant by joined-up delivery in health and social care. Until the key obstacles to partnership working are removed, coupled with organisational and professional ownership and commitment, the aspirations and declarations in policy statements will remain merely words and not drivers towards a whole-system approach.

Appendix

Recent policy statements exhorting greater collaboration between health and social services provision include the following:

1) Designed for Life: creating world class health and social care for Wales in the 21st century (May 2005)

The specific policy aims of *Designed for Life* are to:
- Improve health and reduce, and where possible eliminate, inequalities in health.
- Support the role of citizens in promoting their health, individually and collectively.
- Develop the role of local communities in creating and sustaining health.
- Promote independence, service user involvement and clinical and professional leadership.
- Re-cast the role of all elements of health and social care so that the citizen will be seen and treated by high quality staff at home or locally or passed quickly to excellent specialist care, where this is needed.
- Provide quality assured clinical treatment and care appropriate to need, and based on evidence.
- Strengthen accountability, developing a more corporate approach in NHS Wales so that organisations work together rather than separately.
- Ensure full public health engagement at both local and national levels.

It is clear that the policy fully recognises the necessary organisational inter-relationships that need to be in place if Wales is to experience the vision – expressed in the title – of a world-class health and social care system.

2) Fulfilled Lives, Supported Communities: a strategy for social services in Wales over the next decade (February 2007)

This policy reflected the need for change to generate a "better Wales" and "to improve the lives of the people" by ensuring that services are:
- Strong, accessible and accountable;
- Focused on citizen, family and community needs;
- Focused on social inclusion and the rights of individuals;
- Concerned with good outcomes; and
- Delivered in a joined up, flexible and efficient way to consistently high standards and in partnership with service users.

The document provided further evidence of the policy drive towards collaboration and co-operation across the service sectors:

> *"This document primarily focuses on the vision for health services and health improvement. Local government has a crucial role to play in developing its own service contribution and in working with the NHS in bringing about the service changes and improvements needed. Throughout this strategy there is a clear commitment to working closely with the NHS and local government in Wales."*

To facilitate this the Assembly Government is committed, with the relevant agencies, to:
- Develop an enabling environment that maintains the independence of patients and service users.
- Provide an active approach to managing dependency and establishing a culture of re-ablement.
- Ensure access to services whenever they are required.
- Change the pattern of services to fulfill the wish of people to remain in or return to their own homes wherever possible .
- Provide support for carers in achieving these objectives.
- Safeguard and promote the rights and welfare of children and young people and frail and vulnerable adults.

3) Community Services Framework (March 2007)

This charged the Local Health Boards with strengthening community services by having:
- More effective services in the community.
- Better, more innovative use of the primary care contracts and the opportunities they give for development of local services.
- Better co-ordination and targeting of services across the community.
- A deliberate effort to anticipate and prevent problems, and tackle them early, reducing demands elsewhere in the system.
- Use of allocated resources effectively and as flexibly as possible to make the greatest health impact in meeting peoples needs.

Additionally it charged the Local Health Boards to take necessary action to manage the resource changes essential to make these outcomes happen. Services should be planned and managed to ensure that users receive fully integrated care.

4) Chronic Conditions Management Framework (March 2007)

This advocated the following objectives:
- Reduce the impact of chronic conditions on secondary care and care homes.
- Increase self management, independence, and the participation of people with chronic conditions and their carers.

- Improve the quality of patient care closer to home.

5) Beecham Report – Beyond Boundaries: Citizen-Centred Local Services for Wales (2006)

This proposed:
- More effective engagement with citizens;
- A stronger focus on delivery;
- A reinvigorated approach to partnerships; and
- More emphasis on constructive performance challenge

Primary Care Challenges

Helen Herbert

Good medical professionalism lies at the heart of being a good doctor. However, many of the Assembly Government's policies, such as encouraging large resource centres, centralisation of acute secondary care services and disease-focused models of care, have served to undermine these professional values by eroding clinical autonomy and distancing of services from the doctor. Taken together they are having a detrimental effect on the doctor-patient relationship. There is a danger that these policy changes will reduce the morale of the profession and lead to recruitment problems. Recruitment of GPs to some areas of Wales is already a problem and there is a need for innovative methods of attracting applicants.

The leadership role of the General Practitioner is important not only to the profession but to the future of Primary Care in Wales. Leadership is important at individual, practice, community, commissioning and national policy level. The GP acts as a patient advocate at many levels. It must be recognised that to fulfill this work, which is equal in importance to clinical care, resources, time and facilities must be provided within the working day of a GP.

General Practitioners wish to be involved and consulted on health policy in Wales and to engage with policy makers. There follows a discussion, from a GP's point of view, some of the key challenges for improving primary care in Wales.

Continuity of Care: the Doctor–Patient Relationship

In June 2007 the President of the Royal College of General practitioners, Dr David Haslam, presented a lecture in Cardiff in June 2007 entitled *You do not know what you have until you have lost it.* In it he discussed the importance of trust between the doctor and the patient which is built up over many years of contact and consultation.

On average, GP's see their patients 4.5 times as year for things that 'frequently do not matter'. However, it is important not to underestimate the 'credits of trust' build up over the years by having a GP who is sympathetic and who listens. Economists may state that a health service cannot afford such a luxury. However, it has been shown that continuity of care increases patient satisfaction, reduces hospital admissions, emergency department use, inappropriate prescribing, and inappropriate diagnostic testing.

It must be stated that continuity of care is more important for some groups, for instance those with those with chronic conditions, than others, for example young employed males. Different models of care need to be provided to accommodate the variance and ensure flexibility in access to services.[4]

Since the introduction of the GP contract in 2004, Local Health Boards have responsibility for Out of Hours care. It can be argued that the values of continuity of care and personal care have been sacrificed for the values of 24 hour walk-in facilities and a safer working practice for general practitioners by allowing them to sleep at night. Nonetheless, the benefits deriving from continuity should be able to be maintained by general practitioners being proactive in anticipating problems out of hours.

Combining Pastoral and Managed Care

The President of the Institute of Rural Health at Gregynog, John Wyn Jones, has argued that it is possible to combine the virtues of a disease, incentivised model of care (such as the GP Quality and Outcomes Framework) with those of a holistic, non-incentivised model in general practice.

The advantages in terms of disease outcomes following the Quality and Outcomes Framework are well documented. For example, the percentage of heart disease patients with controlled blood pressure rose from 47 to 72 per cent, and those with cholesterol within recommended limits from 18 to 61per cent.[5]

There is also evidence to show that implementation of financial incentives for quality of care did not damage the motivation of the general practitioner.[6] At the same time there is also much debate about the detrimental effect on holistic care. Critics of the Quality and Outcomes Framework have written:

4) Richard baker, Mary Boulton, Kate Windridge, Carolyn Tarrant, John Bankart, George K Freeman, *Interpersonal continuity of care: a cross sectional survey of primary care patients' preferences and their experiences*, BJGP Volume 57 Number 537, April 2007.

5) Steel Maisey, Clark, Fleetcroft, Howe. BJGP, *Quality of clinical primary care and targeted incentive payments: an observational study,* Page 449, June 2007.

6) Madonald, Harrison, Checkland, Campbell, Roland, *Impact of financial incentives on clinical autonomy and internal motivation in primary care: an ethnographic study.* BMJ, Volume 334 Page 1357, 30/6/2007.

> *"By following a medicine by numbers, pay performance path under QOF, the profession cannot lay claim to its own knowledge base and priorities. There is a real risk that general practice will lose its ability to deconstruct evidence and apply it critically in a bio-psychosocial model. The systematic mistrust of GP implied in paying for performance, and in care driven 'one size fits all' treatment guidelines, undermines the moral imperative of beneficence."*[7]

The Royal College of General Practitioners motto is *Cum Scientia Caritas.* The Quality and Outcomes Framework has made an important start in supporting the *Scientia;* the profession must maintain the *Caritas.*

Issues Relating to 24 Hour Care

Following the implementation of the GP Contact in 2004, the Local Health Boards took over responsibility for out of hours patient care. The contract was largely welcomed by the profession on the grounds of patient safety and the well being to the profession in terms of achieving work life balance.

It had to be recognised that a GP working all day, then all night (totally unsupported by other members of the team) and through the following day could not be considered safe practice. There are many examples of excellence in out of hours care[8] but there are problems in some areas with patients making inappropriate use of accident and emergency services and inappropriate hospital admissions.

It is vitally important that the out of hours service is appropriately resourced, that there are good communication systems between day and out of hours providers, that proactive care is instituted by practices and that the doctors who perform out of hours care are appropriately trained. The pattern of work of general practitioners has changed towards a model focusing on chronic disease management and many of the skills used in emergency care are no longer used on a regular basis. Only in retrospect, can it be appreciated the true financial cost of providing out of hours primary care – a burden that was previously shouldered solely by the general practitioner. Doctors of later generations recognised this burden leading to a dangerous situation of recruitment problems to General Practice in Wales.

Access to Primary Care is governed by the Local health Boards and in the majority of practices, there is no problem. However, there is anecdotal evidence of patients being unable to gain access to see the GP and this is unacceptable. There are many possible reasons for this and solutions need to found.

7) Mark Roland, *The QOF: too early for a final verdict,* BJGP July 2007.

8) Gold Standards Framework for End of Life Care. www.goldstandardsframework.nhs.uk

Increasing Problems of Multi-morbidity

Many patients suffer from multi-morbidity, that is to say from two or more coexisting chronic diseases. These may or may not have a common aetiology, but each requires differing management. For people over 65, this is a normal state of affairs. An average of 58 per cent per cent of people aged 65 years and over reported limiting long term illness.

However, chronic disease management is now based on protocols for a single disease across primary and secondary care – a model which can be detrimental to generalist clinical and holistic care. The Assembly Government recognises the need for a policy in Chronic Conditions management.[9] General practice plays a vital role in the proactive and planned management of chronic conditions and is best placed to manage complex cases.

There is a logical conclusion that the more highly trained clinical generalist within the multidisciplinary team will deal with the more complex problems. Yet the evidence shows that it is also the most experienced and highly trained clinicians who are also best at dealing with triage. General practice welcomes working with specialists and recognises the role of GPs with a special interest, but would encourage a policy to embed these professionals in primary care – working as members of the Primary Health Care Team. Specialists should be embedded in Primary care working as a multidisciplinary team.

Wider Challenges

There are wider challenges to improving primary care provision in Wales as a result of on-going societal, scientific, and cultural shifts. Societal changes include:

- An aging population.
- End of Life Care issues.
- Drug and alcohol abuse.
- Lifestyle diseases – diabetes, hypertension, obesity.
- Mental health problems.

Scientific and technological changes include:

- 'Predictive medicine'.
- The Internet and evidence based medicine.
- Influence of the pharmaceutical industries.
- Day case surgery.
- GP direct access for investigations.

Among cultural change are the following:

- Patients acting as consumers.

9) Assembly Government, Designed to *Improve Health and the management of Chronic Conditions in Wales: An integrated model and framework.*

- The requirements for transparency and accountability.
- The decline of "paternalism".
- Medicalisation of problems.

However, fundamental to improving the Primary Care service remains recognising the links between poverty and ill health. In a recent article Iona Heath states:

> *"Piggybacking on the distress of the poor becomes a substitute for difficult political effort – opium for the intellectual masses."* **10**

Health inequality is directly related to socio-economic inequality and cannot be separated from its underlying cause or solved independently. Iona Heath argues that doctors have a responsibility to pursue political answers alongside technical ones, drawing public attention to injustice as a cause of ill health. Doctors have a responsibility to speak to the powerful on behalf of the powerless. Only then will medicine contribute to the narrowing of health inequalities.

Our forefathers fought hard to achieve independent status for GPs and it has served patients and the profession well in terms of allowing professional autonomy and self regulation by the profession. General practitioners manage the administrative and financial affairs of running practices as well as the clinical aspects of care. With the changing health needs of the population, it is appropriate that different models may be necessary in certain areas and with an increasing proportion of GPs working as salaried doctors it is recognised that one model cannot address the needs of all.

There is a need for the Primary, Secondary, Social and the voluntary and private sectors to work together to promote good partnership to commission and deliver effective services across the boundaries of organisations. General Practitioners support this concept. A recent example would be of a practice nurse, working in general practice in Aberystwyth, who has a special interest in End of Life Care, being the first point of contact for the carers (employed by social services) of a terminally ill patient should they have a problem in care of the patient.

The changing needs of patient care and NHS reforms present great challenges and opportunities for general practice in Wales. We feel that we have an essential role in delivering patient care and welcome the opportunities of working with others to achieve success.

10) Iona Heath, *Let's get tough on the causes of inequality,* BMJ, Vol 334 Page 1301, 23/6/2007.

Care in the Community

Tina Donnelly

Every patient and, indeed, every health professional is a member of many communities, starting with our friends and family and extending to specialised professional networks. Social interaction makes us feel needed and valued as members of a community and promotes our well-being. Especially in Wales it is the first and most important way we define ourselves. I am reminded that one of the first questions you get asked at social functions in England is "What do you do?", whilst the question in Wales is, of course, "Where are you from?"

So it should come as no surprise that separating people from their community is not conducive to healing. There is a plethora of research demonstrating the benefit of recovering from illness in one's own home. Every patient should be cared for in their home if possible and, if not, as locally as possible to their families and social groups.

This concept is a particular challenge when a hospital admission has come to be seen, at least culturally, as the proof of an effective and caring universal healthcare system. Yet with increasing numbers of people suffering from chronic diseases, a new model of healthcare is needed, one that relocates the first locus of care as within the home and the community.

At the same time the advanced nature of medical and clinical specialisms means that there will be a need to centralise health facilities to ensure an acceptable cost effective and safe level of care. Needless to say, however, advances in science and technology should seek to serve the patient and not the other way around. The guiding principle should be to provide safe services as locally as possible rather than to provide local services as safely as possible.

There is also a need for the Government of Wales to ensure that the direction of travel is not always from west to east and north to south. Equally, in terms of innovation and policy development Wales must develop its own advanced specialisms and be at the forefront of innovative clinical research. This will drive up standards of care and importantly provide a stable basis to the recruitment and retention of all types and professional groups of specialists.

Wales has areas of sparse population and a geography that can prevent swift travel over long distances. To guarantee as best we can that Wales receives the world class health care it deserves, we must seek out alternative models of care and clinical practice that have been developed in countries with similar challenges to those we face today.

Social Care and the Voluntary Sector

When planning nursing care in the community we need to ensure effective co-ordination with the independent social care sector and statutory social services. There needs to be far greater use of pooled budgets between the NHS and local authorities over the long-term when commissioning services. This is well developed in England but has been far less successful in Wales.

Many of the pilot Local Service Boards are concerned with this issue and it remains to be seen how effective they will be. We know currently that social services in Wales are also suffering from their own pressures. The Report of the Chief Inspector on Social Services 2004-5 stated:

> *"A major area requiring continued effort and investment is that of achieving a workforce which is sufficient in numbers, skills and levels of qualification necessary to ensure that services of high quality are delivered to the people who need them."*[11]

The standard of performance continues to show significant variability. The Garthwaite Report identified clearly the recruitment and retention difficulties that need to be tackled to ensure a motivated and qualified social work profession in Wales.[12] The Royal College of Nursing endorses the recommendations of this report. The Assembly Government must have a long-term strategy in place to ensure a strong sustainable future for the social work profession in Wales if quality care in the community is to be realised.

There is also a lack of palliative and respite care in Wales for those that need it, particularly for the young disabled. These services are mostly provided by the independent sector and have developed in a haphazard fashion, often receiving funding on a short-term or case by case basis. This is simply not sustainable.

Carers (that is unpaid family or friends) constitute 16 per cent of the population in Wales compared to 12 per cent in England.[13] With health services being moved from the acute hospital setting to the community there is a real danger of the burden on carers being dramatically increased rather than reduced. It is time that the Assembly Government reviewed the provision of palliative and respite care across Wales and demonstrated commitment to a strategy that will deliver these services.

Care for the Older Person

Nursing care for the older person should be understood as distinct from the provision of residential care. By its very nature it is specialist care and where the fundamentals of nursing care are prescribed, these must be delivered under the supervision of a nurse.

11) Report of the Chief Inspector Social Services in Wales, 2004-5 p.3
12) Association of Directors of Social Services Cymru, *Social Work in Wales: a Profession to Value,* 2005.
13) Carers UK, *Facts About Carers,* April 2004

Currently nursing care for the older person is almost wholly provided by the independent sector in Wales. Funding is received from the National Health Service in an extremely complicated way and many people with serious health conditions may not realise they may be eligible for fully funded NHS care. The Grogan case highlighted how nurses are struggling to implement the two stage process for assessing continuing care health needs in a way that is clear and fair.[14] It is imperative that across Wales individuals are assessed for continuing NHS care in exactly the same way and that the unfair postcode lottery of assessments is ended.

The recommendations of the Sutherland Report on the provision of free personal and nursing care remain the fairest and most cost-effective way forward for the provision of care for the older person.[15] Although these recommendations were intended for implementation at a UK level, the Assembly Government should establish a Commission to examine the legal and financial detail of the various proposals for tackling the problem in Wales.

Nurses in the Community

If health services are to be developed effectively in the community then Wales will require an appropriate number of nurses trained to work in the community. A nurse cannot simply be moved from an acute hospital setting to the community without preparation. The levels and scope of practice are entirely different. There are currently over 43,000 nursing posts in the NHS in Wales – the largest professional group.

However, there are far fewer district nurses and specialist community public health nurses (formerly known as health visitors) operating in the community. The number of full-time equivalent district and specialist public health community nurses in Wales in 2006 was 1,479, compared with 1,652 in 1999. In fact, there has been a decline of full-time equivalent numbers by 10.5 per cent since 1999.

District and community nursing staff are under pressure across Wales and lacking in the infrastructure to support service delivery. Securing sufficient district and community nurse training places should be a priority as should occupational health training and learning disability nurses. Effort also needs to be made to encourage nurses in the community and primary care settings (such as practice nurses) to pursue specialist post-registration training in areas such as mental health.

Yet despite this need the second term Assembly Government cut the numbers of commissioned community nursing training places by 17 per cent in April 2007. This simply does not make sense.

14) Maureen Grogan from South East London successfully challenged a decision by Bexley NHS Trust that she was not entitled to full NHS funding. Mrs Grogan's £100,000 a year fees meant that she was forced to sell her house to pay for care in a nursing home . She won a High Court ruling in January this year, where the trust was found to have applied flawed criteria and was urged to reconsider its decision.

15) Sutherland Report, Royal Commission on Long-term Care, With Respect to Old Age: Long Term Care, Rights and Responsibilities.

We repeatedly asked the Assembly Government to provide the evidence base on which these figures were arrived at. Under a Freedom of Information Request the RCN received the notes of the official discussions which made depressing reading. It is not an overstatement to say that workforce planning in Wales is barely existent. While there must always be a balance between desired numbers and available finance. The notes reveal that the numbers of training places commissioned in 2006-07 were based simply on the available finance. The little discussion of need that did take place recommended that community nursing numbers should be increased. But this did not happen.

There is no effective method in place for estimating the staffing numbers required based on the health need of the population. The NHS Partnership Forum and the new Health Minister should review this process, while the Assembly's Health Committee should focus its scrutiny effort on the problem.

Walk-in Centres

A 'walk-in centre is a nurse-led, no appointment, health centre designed to meet the needs of the local community in which it is based. Many groups, including the RCN, are calling for walk-in centres to be introduced in Wales. In England media attention has been given to walk-in centres based in supermarkets or train stations, aimed at the busy professional who cannot take time off work to attend their local GP.

However, this is just one model. In Bristol, for example, one such centre is based in a large council estate. The service can be combined with a GP service or therapy services such as podiatry. Other services such as help with claiming benefits or parenting skills could be provided or specific health clinics on topics such as smoking cessation, travel advice or managing diabetes. The evidence demonstrates that the majority of all 'walk-in centre' attendees are dealt with at the centre with no need for further referral and at half the cost of an A & E visit.[16]

One great advantage of the 'walk-in centre' model is that it can be designed to meet the needs of unscheduled or out-of hours care. 'Unscheduled care' is a health problem that requires immediate unplanned care and/or advice; 'out-of-hours' care is often a predictable health problem such as the need for a repeat prescription that occurs outside the 9-5 weekday.

Yet the concept of 'out-of-hours' is out of date. The traditional appointment-based system is struggling to meet these needs and some areas in Wales are having serious problems trying to cope with 'out-of-hours' need. This can result in extra pressure on emergency care services as 'inappropriate attendees' increase. At the same time, it is important to note that 'walk-in centres' are not a magical way of making A & E patients disappear. They are just one way of meeting patients' needs.

16) NHS England walk-in centres website: figures from South Bristol 2007 and Peterborough 2007.

Nurses in Primary Care

We need to increase the number of nurse practitioners and practice nurses in primary care. Evidence shows that nurse practitioners spend more time with their patients and that patient satisfaction is higher than with a GP consultation.[17] Primary care nurses in advanced roles can be the key to implementing the principles of the Wanless Report and pushing forward the public health agenda. They can engage in illness prevention activities by supervising clinics, educating communities and running chronic disease management programmes. Primary care nurses are a trusted source of advice to the public and their role should be expanded.

Nurse-led Community Hospitals

Community or Cottage Hospitals could provide a range of services including overnight stays. These services could be maternity, diagnostic, rehabilitation or short-term nursing care. There is no doubt that rehabilitation services are in great demand in Wales, particularly for stroke patients.

Lack of intermediate care beds is an issue in palliative care as not all patients require specialist beds, nor do they need acute beds. In geographical areas of sparse population or in specialist fields where there is great pressure on bed capacity such as in orthopaedics, these small, locally-based hospitals would prove an invaluable and integral part of the health service provision, rather than be a drain on resources. A network of such hospitals across each health region of Wales should be planned.

It is clear that many of the beloved older buildings currently in such use are unsuitable and must be closed. However, it is unacceptable that decisions to close community facilities are clearly being made in response to short-term financial pressures and that no plans are being put in place to develop services to meet the future needs of the people.

The services provided in many of these community hospitals would be nurse-led with nurses making decisions on discharge and referral, nurse consultants deployed if appropriate and independent nurse prescribers in place.

Nurse and Non-medical Prescribing

Nurse and other non-medical prescribing fall into two main categories: independent and supplementary prescribing. Supplementary prescribing, established in Wales since 2002, is based on a partnership between a medical prescriber, a supplementary prescriber and the patient to manage a condition or conditions. Independent prescribing takes place independently of any original medical prescription, and can be

17) British Journal of General Practice, 2006 Feb 1, 56(223): 137-138; and 2005 Dec 1, 55(521): 938-943.

autonomously implemented by the independent prescribing nurse or pharmacist. There are approximately 9,000 independent nurse prescribers in England where the practice was established in 2000.

The five higher education providers for nurse training in Wales and the Welsh School of Pharmacy have worked together to produce an 'All Wales' curriculum. Each centre has been accredited by both Health Professions Wales (on behalf of the Nursing and Midwifery Council) and the Royal Pharmaceutical Society of Great Britain. The All Wales curriculum is highly regarded across the UK because of its emphasis on calculation, and has since been implemented as a UK standard, and is included in the NMC guidelines and standards. However, there is difficulty for many practice nurses in accessing this training. England and Scotland have both facilitated distance learning for these courses.

Legislation allowing independent nurse prescribing was introduced in Wales in January 2007. We now need investment to roll out these skills to the workforce. The most important impact is the improved service offered to patients and clients. The patient has improved access to and advice about their medicines, while the skills of pharmacists and nurses are more effectively deployed. It will also enable the more effective development of nurse-run clinics.

CHAPTER 4

The Reconfiguration Debate Challenging 'Group Think'

Siobhan McClelland

All health systems are politicised – health is an emotive and therefore political issue ultimately representing life and death and something which touches all of us during our lives. The fact that the NHS was founded in 1948 on the basis of funding through general taxation ensures that it is inevitably political given that public money is being used. It is the democratic responsibility of politicians to ensure not only that that money is spent effectively, but that the way in which resources are allocated reflects society's priorities. It would be both unrealistic and undemocratic to remove politicians from the decision making process, as some have suggested. Politicians are ultimately responsible for the NHS and are therefore beholden to behave responsibly.

Since the advent of the National Assembly in 1999 Welsh health policy can be divided into two distinct phases – the Jane Hutt and the post Jane Hutt eras. In this I make no apology for emphasising the personal. The Minister for Health and Social Services is a key figure in shaping health policy and this cannot be underestimated. Jane Hutt's 2001 document *Improving Health in Wales: A Plan for the NHS and its Partners* was highly influential. It not only created the current organisational structure, but also inaugurated a policy context which was dominated by the agendas of collaboration, partnership and localism with an emphasis on public health and reducing health inequalities. What was perhaps sacrificed during this period was a much needed focus on improving service delivery. Rising waiting lists were seen by some commentators as the consequence.

The appointment of Brian Gibbons as Minister in 2005 demonstrated the complexity of the politicisation of the health service in Wales. In the run-up to the 2005 general election Welsh Labour MPs voiced strong concern with the growing waiting lists. These were in stark contrast with England where there had been a sustained political and managerial focus on reduction. In Wales the NHS is doubly politicised since many voters do not differentiate between devolved and non devolved areas. As a result the health service tends to be a dominating issue in both Assembly and Westminster elections. Although it was denied that Jane Hutt had been sacked and claims were made that there would be continuity in policy, Dr Gibbons came to his new role with a clear agenda of reducing waiting times with the concurrent emphasis on improving service delivery. 'Modernisation', the once forbidden word so beloved of English politicians and NHS managers, became acceptable parlance in the Welsh health service.

Even so, the 2003 Wanless report united both the Jane Hutt and post Jane Hutt eras. This emphasised the importance of reducing the demand for health services through public health, health promotion and early detection and also stated that the configuration of health services in Wales was not "sustainable". This is a view which most would still sign up to. Of course, what has particularly challenged our politicians is how to change the configuration. It was an attempt to do so through the now infamous 2005 *Designed for Life* strategy which ultimately resulted in electoral disaster for more than one Welsh Labour AM.

Most politicians are engaged with the overarching vision of the *Designed for Life* document that services should be provided as close to the patient as possible and more often in primary and community settings. However, when this also means the centralisation of more specialised services into fewer hospital settings it is a brave, or foolhardy, politician who will risk his or her seat in the face of the almost inevitable 'save our hospital' campaign that will spring up in response.

Persuading the public of the need for change and a move away from services provided in hospital requires a major shift of hearts and minds. Hospitals are the symbolic representation of the NHS. Moving our allegiance from them is a difficult task that requires a high level of maturity from politicians combined with strong and determined leadership at a political, managerial and clinical level. This was something which *Designed for Life* and in particular the documents that were produced to detail the changes for North and Mid and West Wales singularly failed to do.

The lack of any real articulation of how patients would benefit from more services provided more locally and the clinical, quality and patient safety drivers for reconfiguration of specialised services made it very difficult to sell the changes to what was always going to be an antagonistic public. Attempting to do this in the run up to Assembly elections was particularly problematic. Some Labour AMs were left in the unenviable position of protesting against their own government's proposals while their opposition counterparts inevitably jumped fully onto the 'save our hospital' bandwagon.

The neurosciences debate was a clear case study of how local politics can even overcome party political loyalties. When you look at the photographs of the protests in Swansea you see a true rainbow coalition of all the parties with ultimately votes in the Assembly split across east/west rather than party political boundaries. The neurosciences debate also demonstrated how politicians can set up supposedly rational although not perfect mechanisms for decision making and reject these when they do not fit the realpolitik of the time.

So the NHS was clearly a battleground for the Assembly elections and one which no doubt contributed to the Red-Green coalition and the development of the *One Wales* document which offers a basis for commenting on the future of the Welsh NHS.

Starting with that most contentious issue – reconfiguration – the document states that there will be a moratorium on changes to community hospitals in particular and that District General Hospital services will not be changed until community and primary care services are in place. This has been coupled with the charge that health service managers and professionals are responsible for the failures of *Designed for Life.* However, this is unacceptable given that the timescales and frameworks for change were shaped and determined by the Welsh Assembly Government and responsibility for this must ultimately lie there. This raises major concerns regarding how the necessary changes to health services in Wales will now happen.

Will it be possible to double fund the development of community and primary care services whilst the same services are provided in secondary care settings, particularly in what is likely to be a more stringent financial climate? Can we afford to pump prime change and how much will this cost? Moreover, there are some services that will need to be changed in their delivery and that do not have community and primary care alternatives. At the end of the day there will still be very difficult decisions to be made about where to locate these services. There are some factors such as Royal College approval, the European Working Times Directive and financial pressures which will force us to make difficult decisions. The status quo is not an option. The health service is constantly changing in both positive and negative ways. Equally, it is important to ensure that services do not deteriorate and that patients receive the highest quality and most effective services possible.

Making NHS services more democratic also emerges within the *One Wales* document. Whilst this is something that most of us would support, again there must be a debate about what this actually means. For example, are those involved in 'save our hospitals' campaigns truly representative of the public any more than those engaged in the 'decibel planning' which has too often dominated decision making? The NHS has many vested interests. The challenge is to truly engage members of the public in the debate on the delivery of services at both national and local levels in ways that allows them to engage with complex arguments and trade offs and moves away from parochialism.

The *One Wales* document also mentions abolishing the internal market by 2011. I am unclear as to what this means, but concerned if we are to embark on another structural reorganisation. Politicians and managers too often use organisational restructuring as a proxy for service change. There is no real evidence to demonstrate that changing structure has any impact on service delivery and indeed there is a dearth of evaluation on optimal organisational forms. I have been a critic of the current complicated organisation of the NHS in Wales. Yet, we have little evidence on whether Local Health Boards or even the large integrated NHS Trusts we have in Wales are effective. However, I am clear that a major reorganisation along the lines of the one we had in 2001 will be nothing more than a 'smoke and mirrors' exercise.

The *One Wales* document emphasises the importance of an evidence-based approach to reconfiguration but what does this mean? There are various definitions of evidence and people may only define something as evidence if they agree with it. This is a concern in the somewhat complex and time consuming process of consultation suggested within the document. I do wonder if in discussing evidence-based policy we may well be searching for a fruitless grail of rationality in what is intrinsically a political process. However much we might want it to be, health policy is not a rational process of assessing needs and seeking cost effective options to meet that need. Fundamentally it is a representation of society's values at any one time. This is why high profile campaigns can be effective in impacting on resource allocation. The challenge is to capture, combine and inspire this with evidence.

The *One Wales* document has been described as part of a 'progressive left consensus' and as such reinforces the orthodoxies of Welsh health policy. These include the mantras of partnership working, collaboration, primary care led services, seamless services and reducing health inequalities. All have dominated the thinking of many of those within the tightly formed Welsh health policy community and find their voice once again within the *One Wales* document. These are orthodoxies that require challenge yet this has become increasingly difficult.

The 'group think' that has dominated the shaping of health policy in Wales has made it difficult to even raise issues like PFI Tariffs, Foundation Hospitals and personal responsibility. Yet there should be no shibboleths in our thinking if we want a dynamic and modern health service in Wales. We need radical thinking and should encourage debate. Consensus does not have to mean decision making of the lowest common denominator. It should mean challenging each other with different ideas. Ultimately it must mean gaining consensus to take the hardest and most challenging decisions.

A Time For Brave Decisions

Tony Beddow

The reorganisation proposals in the Assembly Government's 2005 *Designed for Life* policy provides the latest in a long line of analyses of the need for change if NHS Wales and its social care partners are to cope with the challenges of the 21st Century.

It proposes a concentration of some clinical expertise at fewer hospital sites across Wales, and a shift away from hospital-based care towards care at home or in community settings.

Designed for Life had a distinguished pedigree: *A Question of Balance*[18], *Access and Excellence*[19] and the *Stocktake Report*[20]. All outlined the need for service reform in

18) Williams P. *A Question of Balance- a Review of capacity in the Health Service in Wales,* NHS Wales 2002
19) NHS Wales Corporate Strategy Unit, *Access and Excellence- A Review of Acute Services in Wales* 2000
20) The Audit Commission in Wales, *Public Services in Wales; A Stocktake of the Performance of Public Services in Wales;* Audit Commission 2002

NHS Wales and came to broadly the same diagnosis. However, to date, attempts at change have foundered on the difficulty of overcoming a distrustful and parochial opposition, in particular to altering the scale and nature of the clinical services provided by district general hospitals. Where local populations see hospital changes as the loss of vital services, intense pressure is put upon policy makers and politicians.

Attempts at making changes in parts of Wales, all demonstrate a number of common features of the reform process, which include:

- An inability of political, managerial and professional interests to coalesce around a saleable analysis of the issues facing service provision in the future, and thereby present a united front.
- Failure on the part of the NHS to engage local government, politicians and professionals as informed and skilful advocates for the changes being proposed.

Invariably these characteristics have prompted opposition to reforms, and the reasons for these difficulties are not hard to discern.

First, government seeks to convince the public that the NHS in Wales is currently well funded with waiting times and services improving as a result. But, it is then difficult at the same time to argue that the present range of services is somehow failing the Welsh public and is not capable of being sustained. Politically, it is difficult to sell taking action now to avoid a future failure.

Second, the components of the health care system most under attack are totemic buildings, often with a long and proud history of serving their local communities who rightly feel great ownership of all they represent. Moreover, the 'bird in the hand' is a powerful force in resistance to healthcare reform.

Third, the required shift away from the forms of care that hospitals represent towards more diffuse and less visible community and preventive care services is difficult to sell. This requires not only a shift in perspective but also the funding of local government services that have to underpin any increase in community care implied by *Design for Life*. These include social services, occupational therapy and housing adaptation.

Fourth, it is not clear whether proposed changes are intended to address present or future problems, and whether the problems are financial or clinical in nature. Vague worries about 'safety' are difficult for members of the public to assess. Increased travel times and costs to access services are more easily computed.

Last, the main thrust for change does not reside in deeply held political or ideological views about the way the NHS should develop. Rather, it comes from pressure exerted by

parts of the medical profession, particularly some Royal Colleges. The political process is, then, given the task of managing changes that rest upon the evidence offered by eminent, but inevitably partial, professional interests and which cannot necessarily command unqualified support from all parts of the profession.

Any approach to service redesign cannot ignore the new politics of a devolved Wales. It is inevitable given the electoral arithmetic – with a broadly bi-annual cycle of elections for the Welsh Assembly and the UK Parliament – that no great window of political calm will present itself within which difficult political decisions can be both made and actioned. And it is clear that major service changes of the sort indicated cannot proceed without overt political agreement and support.

Nonetheless, there are some basic requirements. The first is the forging of a long-term political agreement among two or more of the four main parties around a set of NHS reform principles – hopefully evidence based – that will endure across electoral timescales for at least two Assembly terms. The new coalition between Labour and Plaid Cymru seems to offer this.

Agreement would need to be embraced through both Westminster and Assembly elections at least, and probably needs to extend to local elections too. It will need to cope with localised challenges to particular proposals – either 'rogue' ones from within the consenting political parties, or from political parties opposed to the changes, and from single issue candidates. Far from seeking to "take the NHS out of politics", this would be an attempt to "put politics (at its best) into the NHS". This is essential if the secondary care strand of the redesign approach is to have any chance of success.

The second requirement is derived from a conclusion, reached by some, that the scale of change required of hospital services is such that even if the support of a sufficient number of local interests is obtained it will never be sufficiently enthusiastic. It is the Health Service equivalent of seeking to convince the Welsh through calm, evidenced argument that the ending of their mining industry was necessary and right, and awaiting consent before a single pit is closed.

Once Government has determined, rightly or wrongly upon a controversial course of action, the political process has to lead the charge arguing for it and defending as best it can. But, in the end, it must implement change and, perhaps, be damned. Delay, until the public has been completely convinced and pledge their support, is a strategy for inertia. Politicians will need to find ways of making changes in hospital provision that sit within wider trade-offs of other investments so that few communities feel stripped of hospitals, jobs and schools.

If the Assembly has the best long-term interests of Wales at heart, it will have to sanction unpopular, but necessary, decisions, despite having to pay a short or even medium-term

political price. The re-design of hospital services, whether attempted by one party alone or through some form of coalition, requires bravery.

Secondary care changes are, of course, only part of the overall re-design picture. An equally important component is a re-balancing of hospital and primary, community, health and social care within each locality. Here, it is essential the NHS learns lessons from the difficult consultation exercises recently undertaken in parts of Wales, where the genuine concerns of local government about the impact and cost of proposed changes were not fully addressed prior to changes being proposed and public consultation undertaken. Far from having local politicians committed to the changes and arguing for them, the NHS saw them leading opposition to the plans.

When a relocation of hospital services is being proposed, there are both financial and political reasons to proceed at a steady pace. Financially, there will be capital investment needed – some of it significant – and this will need to be found and spent wisely. The requirements should be spread over a number of years if they are to be manageable. Previous experience of significant all-Wales capital programmes suggests that an in-house design and project management capability should be re-created if, as seems certain, PFI is to be avoided.

The changes required in south west Wales, Swansea, Gwent and north Wales, in particular, would probably require a lengthy period of time – perhaps three or four Assembly terms – to plan, design, implement and consolidate.

'Consolidation' in itself is important. The re-distribution of acute services across Wales is bound to cause significant turbulence to revenue spending as costs in the 'receiving' locality will vary from those in the 'losing' locality. If past experience of service change is any guide, the whole cost base of NHS Wales, at least in the short term, will rise. The scale of change in hospital services envisaged by *Designed for Life* is such that it could threaten the financial stability of NHS Wales unless carefully planned, implemented and monitored.

Politically, any government is likely to pay a price for such turbulence. It seems sensible therefore that the number of disgruntled and aroused electorates should be kept manageable so that losses in any one election (local authority, Wales or UK) are minimised. This, too, argues for a staged approach.

Where, by contrast, the redesign of services requires a shift from secondary care to primary and community care services, it might best be allowed to proceed as follows.

Investment plans should be drawn up to allow for the necessary improvements in alternative forms of care to be put in place first, so that they become visible and able to reduce the requirements for hospital care, and thus minimise the impact of changes. This

requires a very tight control to be kept on the re-use/mis-use of freed hospital capacity so that, in due course, it should be possible for the redundant hospital services to naturally close and the 'locked-up' resources redistributed across the care system.

Such a process of redesign by atrophy will require considerable short term investment to allow the dual running of facilities. For this reason it will almost certainly need to be undertaken in a sequential way across Wales.

It is important that, very soon, a strategic timetable is drawn up which identifies the sequence in which any north, south and east Wales service reconfigurations will occur so that the necessary funding can be put in place and, crucially, the necessary plans for well managed dis-investments overseen.

Given the financial constraints that apply, it is probably necessary to have a phased programme of service changes – completing them in one part of Wales before moving to another. In this way dual running can be sustained for a time and the necessary unlocking of secondary care costs achieved in that locality before moving to the next.

Lastly, there should be some attempt to reach agreement across political, professional and managerial groups about two matters. First, what is the diagnosis of the problems we are setting out to address. Is it a fear that our future care system will just be unaffordable, or sub optimal, or downright dangerous? If any of these, what measures of risk or cost can be offered?

Second, assuring some agreement on the diagnosis of the problem, can we also build consensus on the best all Wales solutions that address such problems.

NHS Wales has witnessed a number of false dawns and unfulfilled grand plans as far as hospital service changes are concerned. These were difficult to progress under the old Welsh Office and they are likely to be even more problematic now that they are overseen by the Assembly.

If the logic behind *Designed For Life* holds, then active planning is necessary if it is to be implemented. Clinicians and managers have their part to play, but change on the scale suggested can only, in the end, come about through dogged, brave political leadership.

Perhaps the NHS in Wales and the Assembly might now strive to complete the debate about what service changes should be made in west Wales, as the locality chosen for the commencement of the first major service re-design. Politics and planning must penetrate each other to create a new and positive synergy. Once that is achieved, the rest of Wales can begin to travel with greater confidence down a road which will inevitably involve major upheaval.

Priorities for the Incoming Government

Mike Ponton

In 2003 Derek Wanless declared the health and social care landscape unsustainable.[21] While much progress has been made in improving services – waiting times being a good example – the threats and pressures on services are still relentless. For example, to bury our heads in the sand and do nothing about hospital reconfiguration will condemn the people of Wales to a future of worsening health and social services. There is no doubt that the Assembly Government, politicians, citizens, health and social care professionals all want to avoid such a future. The question is: how?

Over the last eight years, the Assembly Government has produced a plethora of strategic policies, strategies, and service frameworks. At the same time it has been unable to resist the temptation to drill down into operational issues. The performance management process, for example, is a tapestry of too many mixed-up strategic and operational objectives. It lacks the focus, clarity and application the 'balanced approach' is intended to adopt. The Centre itself is still not truly joined up and this has been further confused by the uncertainty on the role, responsibilities and relationships of the Regional Offices. Above all we need focus, joined-up thinking and a shared sense of direction at the all-Wales level.

From a local perspective we know that there is continuing concern about the complexity of structures, service safety and sustainability, matching resources and expectations, partnership working, and the need to improve commissioning.

In any structural reform in Wales, the concept of localism is important. This must be based on the fundamental strategic principles of the delivery of safe and effective care as locally as possible, built on a thorough knowledge and understanding of the distinctive communities and neighbourhoods.

Localism is about local people being more actively engaged, through improved information and communications, enabling them to help shape their collective future, giving them influence over local services and action, and helping them to develop the capacity to tackle local issues for themselves. There are three key dimensions to localism: community leadership, governance, and action.

Community leadership involves influence, power, and input into public decision-making. It is about securing the consent and active engagement of the wider community and depends on:

21) Welsh Assembly Government, *Review of Health and Social Care,* 2003.

- Effective political leadership.
- Professional leadership from public service organizations.
- Leadership from the third sector and from citizens themselves.

John Kotter of Harvard University says that a key function of leadership is communicating vision and strategy by words and deeds to those whose co-operation is needed.[22] The result should be a creation of coalitions that understand and accept the validity of the vision and are committed to its achievement. This seems to me to be a very important perspective to public service leadership.

Community Governance is about having the structures, processes, legitimacy and institutional capacity in place in order to exercise jurisdiction by way of sound decision-making and accountability. It is essentially concerned with creating the conditions for ordered rule and collective action.

Community action makes things happen, turning the rhetoric, strategies and plans into action and achievement.
- Finding innovative solutions to problems.
- Bringing to life a strong sense of community.
- Identifying under-used or inappropriately used resources – people, buildings, equipment – and using them better.
- Creating and investing in social capital.
- Helping people take charge of their lives.
- Spotting gaps in provision.

Addressing these issues of community governance, democracy and engagement is key to the development of public services in Wales. Our Local Service Boards and Local Service Agreements will need to major on these issues.

I have six main priorities for the incoming administration:
- We urgently need a strategy and a plan of action to face up to the unsustainability of existing services. We need: (i) provision of more diagnosis, treatment and care by primary and community healthcare services, closer to people's homes; and (ii) refocusing of the role of hospitals and the way they work together.
- We must find better and more effective ways of informing, engaging and involving politicians, professional leaders and citizens in the process of change and modernisation and to gain their support and commitment to our decisions. This also moves us into the area of citizens and public service governance.
- Health and local government must develop effective partnerships. They must work closer in health improvement and the delivery of services and look for innovative solutions to generic issues such as mental health, delayed transfers of care, and continuing care.

22) John P Kotter, A Force for Change – How leadership differs from management, Free Press, 1990.

- We must review our organisational structures and functions (central and local) to make them less complex and fit for purpose. Organic change is already under way but major structural upheaval would be unwise and a distraction from the real job of improving services. Better to wait for service reconfiguration to assess future organisational form based on the maxim – form follows function
- We have to improve and streamline our key processes and functions such as commissioning, performance management, inspection and regulation.
- We have to look at the way we manage money both within and between the NHS and its partners, particularly in terms of flexibilities and in budget versus cash management and the fiscal year.

Of course, there is nothing new in these priorities. However, we should heed Henry Ford's words: "You can't build a reputation on what you are going to do."

CHAPTER 5

Improving Performance of NHS Trusts in Wales

Malcolm J. Prowle

The Audit Commission has identified robust performance management as one of six levers for change if the Welsh NHS is to achieve its strategic vision.[23] A performance management framework for the NHS in Wales has been developed based upon the 'Balanced Scorecard' model[24] with four main aspects:

- Resource utilisation (Financial)
- Stakeholders (Customers)
- Business processes (Management processes)
- Learning and innovation (Learning and growth)

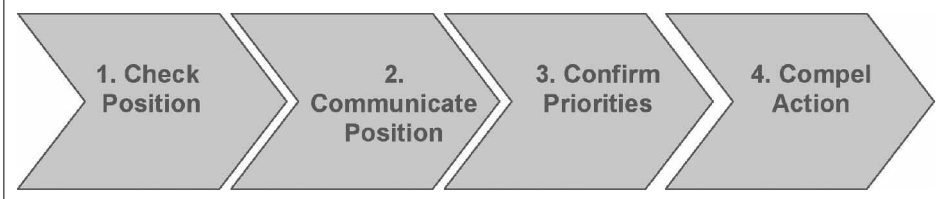
The NHS can be divided into commissioners, the Local Health Boards, and the providers, the Trusts. Although it is possible to think of performance frameworks and performance measures for the commissioner arm of the NHS, this paper only addresses the provider arm. It discusses the following issues:

- Performance management frameworks
- Performance measures
- Benchmarking performance
- Improving performance
- Barriers to improving performance
- Overcoming the barriers

Performance Management Frameworks

A comprehensive performance management framework has four main elements as illustrated below:

Performance Management Frameworks



23) Audit Commission Wales, *Transforming health and social care in Wales: Identifying and overcoming barriers to change,* April 2004.

24) Kaplan R., and Norton D., *The Balanced Scorecard: Translating Strategy into Action, Harvard Business Press,* 1996.

- **Check Position** Knowing where you are as an organisation is absolutely critical. Without this information it is difficult to identify which areas of performance improvement effort need to be addressed.
- **Communicate Position** Communication of performance may be done formally or informally, internally or externally, and may be compulsory or voluntary.
- **Confirm Priorities** It is not possible, in practice, to deal with all gaps in performance. Hence, this third aspect of performance management is concerned with prioritising objectives.
- **Compel Action Mechanisms** for compelling progress in dealing with gaps in performance, perhaps the weakest aspect of performance management systems.

For a performance management system to be effective, all of these aspects need to be in place. Checking an organisation's position without subsequently communicating it and taking remedial action is a sterile exercise. In practice, however, it is not uncommon for some elements of this performance framework to be absent or under-developed thus inducing a weakness into the overall approach.

Performance Measures

There is always an interplay between a message and its recipients. Many different groups of people may be interested in the various types of performance data and performance measures emanating from an organisation. Thus, for example, in relation to NHS Trusts the following groupings are possible:

- Patients and the general public
- Health professionals and professional bodies
- Health regulators
- Government and government agencies
- Others (for example, MPs, Councils)

To understand the audience-message interface should involve some form of stakeholder analysis. Users of performance information can be classified according to their interest in the organisation and their power or influence over it, shown in the following graph:

Audience Message Interface Between Stakeholders

	Low level of interest	High level of interest
High level of influence or power	Keep them happy and they will stay out of your way	Key stakeholders: Consult, involve, communicate, safety
Low level of influence or power	Ignore these wherever possible	Keep these people in touch with what and how you are doing

Determinants of Quality Outcomes

Dimensions of quality	Determinants of quality	Description of determinants
Tangibles	Tangibles	The physical aspects of the service such as equipment, facilities, staff appearance.
Reliability	Reliability	Providing consistent, accurate and dependable service, delivering what was promised.
Responsiveness	Responsiveness	Being willing and ready to provide services when needed.
Assurance	• Competence	• Having the skills and knowledge to provide the service.
	• Courtesy	• Politeness, respect, consideration friendliness of staff at all levels.
	• Security	• Physical safety; financial security; confidentiality.
	• Credibility	• Trustworthiness, reputation and image.
Empathy	• Access	• The ease and convenience of accessing services.
	• Communication	• Keeping customers informed in a language they understand.
	• Understanding the customer	• Knowing individual customer needs; tailoring services where practical to meet individual needs.

In the NHS this type of analysis is not always easy to undertake since there tends to be a preponderance of stakeholders in the top right hand segment representing both interest and power and influence.

Performance data and measures can be derived from a number of sources, including the following within NHS Trusts:
- Professional judgements (HIW inspection reports)
- Individual perceptions (patient surveys)
- Organisational data (LOS, unit costs)

Dimensions of performance

A key question concerns the dimensions of performance of NHS Trusts in which stakeholders might have an interest. In the case of NHS Trusts service quality and use of resources are likely to be paramount. One approach to the measurement of service quality measurement is known as Servqual. This is based on ten determinants of quality,

grouped into five dimensions as shown in the graph on the previous page. A more conventional approach to defining service quality measures in the NHS might be as follows:

- Service access (in terms of waiting times)
- Clinical outcomes
- Patient experiences
- Composite measures (Healthcare Commission star ratings for NHS bodies in England)

Benchmarking Performance

This can involve the benchmarking of performance measures or the operational practices which underlie those measures. With the benchmarking of performance measures, it is not usually the case that a performance measure can be used in isolation in an absolute manner. For example just stating that in an NHS Trust patient satisfaction is 89 per cent or the cost of an MRI scan is £300 tells very little about performance in itself. To be meaningful it is more likely that the information will need to be presented in comparative terms:

- **Target comparisons** How good is our performance in comparison to a pre-determined target (for example, waiting lists)?
- **Temporal Comparisons** How good is our performance compared to previous time periods?
- **Inter-organisational Comparisons** How good is our performance compared to other organisations?

Benchmarking of sector-specific activities could be undertaken against organisations working in the same or a variety of different sectors. Alternatively, it can be undertaken in relation to generic activities such as finance, personnel, and IT. There are three main sources of benchmarking information:

- **Publicly available** This includes Government statistics, annual reports and accounts, audit and inspection reports. However, it is often the case that such information is of limited use for any serious benchmarking because of its high level of aggregation.
- **Restricted availability** Related organisations may form a consortium arrangement, often known as benchmarking clubs, whereby they agree to share information between themselves for benchmarking purposes. Usually the range of information shared is much greater than is found in publicly available information.
- **Special exercises** An organisation may undertake a one-off exercise to obtain benchmark information. This might involve identifying a cohort of comparable organisations and requesting them to share information with the quid pro quo that they too would have access to a range of comparator information on a non-attributable basis. The type of information to be shared can be quite detailed and comprehensive but there may be difficulties in getting organisations to agree to share such information.

Welsh NHS Trusts should make comparisons with similar NHS Trusts in other parts of the UK and not just restrict comparisons within the NHS in Wales. Recent work undertaken at Cardiff Business School does not portray the NHS in Wales in a very good light compared with comparable areas in England.[25] According to this study, on virtually every measure used in primary and secondary care, the performance of the NHS in Wales is inferior to that of comparable areas in England. This argues for more comparison with England not less.

Improving performance in NHS Trusts in Wales

Performance improvement in NHS Trusts in Wales can be achieved either strategically or operationally. Strategic approaches would involve major changes to the way in which services are provided, including:

- Change in the balance of service provision between primary and secondary care, between the NHS and social services, and between different types of hospital.
- Investment in buildings and equipment.
- Substitution of one skill or profession, for example nurses and physiotherapists, for an another skill or profession, for example doctors.

Operational approaches to improvement include:

- Reviews of existing operational systems and procedures for delivering health services. In the NHS, these days, this could involve the application of lean production systems akin to those developed in the Toyota Motor Company and other automotive manufacturers.
- Improvements in staff productivity could be brought about by a variety of means such as training or by the development of improved remuneration mechanisms which promote improved productivity.
- Provision of services in a more economic manner through the use of outsourcing of shared service arrangements with other NHS Trusts

Barriers to Improving NHS Trust Performance

There are both internal and external of barriers to improving performance in NHS Trusts. Internal barriers include:

- An incomplete performance management framework. It may be the case that performance information is not communicated properly or action is not taken to deal with performance gaps.
- Improving performance can often involve significant change in working practices. Such changes often generate resistance which needs to be effectively managed and countered.
- Data problems often bedevil the search for performance improvement in the NHS. Data sets may often be inconsistent with one another or may be incomplete. Absence of robust data often makes it difficult to convince staff of the merits of a particular change needed to improve performance and thus fuels organisational resistance.

25) Andrews R., and Martin S., *Has devolution improved public services?*, Public Money and Management, April 2007.

- Organisations sometimes lack the management capacity to identify performance improvement opportunities and to drive their implementation. Performance improvement is a complex task which requires a range of skills, including data analysis, modelling, finance, change management. Even if sufficient managerial time is available the skills required may not be present.
- Improvements may be inhibited by lack of the capital funds required to implement improvement projects.

Some examples of barriers external to Trusts themselves include:

- Plans may have to be watered down or even curtailed because of public opposition
- Changes to services which involve changes in the interface between health professions may generate strong opposition from professional groups.

Overcoming the Barriers

A key to improving the performance of the NHS in Wales lies in finding mechanisms to reduce the impact of such barriers. They can be addressed by four main approaches.

The first is to find ways of countering public opposition to change. This is clearly a hard nut to crack but must be attempted if performance of the NHS in Wales is to be substantially improved. The objectives should be as follows:

- **Achieving political consensus** There seems a trend for political parties to be in favour of service reconfiguration when in power, but hostile to it when in opposition. This partisan attitude fuels public opposition and inhibits performance improvement in the NHS for short term political party gain. Achievement of a political consensus on the need for health service reconfiguration in Wales would be a major achievement.
- **Promoting more constructive media reporting** The media in Wales has a reputation for shallowness and triviality when addressing health service issues. Instead of attempting to explain the complexities of delivering health services in the 21st century issues are often trivialised for headline purposes. This trend is probably fuelled by the absence of a political consensus which again encourages public opposition.
- **Improving communication** There needs to be more effective communication between the NHS in Wales and the general public regarding the aims and desirability of service reconfiguration. This must be based on a longer term process of education as opposed a short term public relations approach which will probably fail. Such an education process would be assisted by a political consensus and more effective media reporting as referred to above.
- **Building Confidence** To reduce public opposition to service reconfiguration it is important that the public have confidence that the plans are realistic. One particular problem concerns convincing the general public that the future of health service delivery should be based on enhanced primary care. This may be difficult for them to follow given that their recent experiences might have involved loss of Saturday morning surgeries and poorer 'out of hours' services.

A second approach is to secure improved access to capital funds. Much of NHS capital expenditure in England is now financed through some form of public-private partnership. The coolness of the Assembly Government towards the PFI has been articulated in the *One Wales* coalition government agreement. However, analysis of HM Treasury data shows that the proportion of PFI investment in Wales (in all sectors and in health) is significantly lower than what might be expected from the size of the Welsh population. A recent IWA report concluded that

> *"Capital investment in our health and education infrastructure is lagging behind the rest of the UK partly because of an aversion to the use of private capital. On a wider front Wales cannot afford to ignore this source of finance, and could tap its potential without compromising public service objectives."*[26]

The NHS in Wales should give further and more detailed consideration to the potential role of the PFI as a means of financing capital expenditure. This should be done on the merits of the case rather than on ideological standpoints.

A third approach is to improve information systems. Data inconsistency and incompleteness are major barriers to the implementation of performance improvements in the NHS in Wales. This points to a need for a wider range of information and greater reliability of that information. NHS Trusts in Wales need better information systems that will probably require a greater level of investment. Again, PFI holds out a potential source of funding.

Finally, the management capacity of NHS Trusts needs to be addressed. Partly this is an issue about the numbers of managers but it is also a skill issue. Performance improvement requires a multiplicity of skills which undoubtedly need further development, including data analysis, modelling, and change management.

26) Institute of Welsh Affairs, *Time to Deliver: The third term and beyond: Policy Options for Wales,* page 10, 2006.

CHAPTER 6

Medicines Usage

Richard Greville

The expenditure on medicines in Wales is significant, although relatively small, in comparison to the total cost of the NHS. Especially when you consider that the use and role of medicines has been described by National Clinical Director and Runcorn GP Dr David Colin-Thome as "arguably the most effective therapeutic activity we doctors undertake".

The £574 million spent on primary care prescriptions in Wales during 2005 amounted to just over 10 per cent of total NHS expenditure. In fact, over recent years, the percentage of the NHS Wales budget spent on primary care prescribing has been falling steadily, from just under 12 per cent in 2002.

The cost of medicines and, in particular, new medicines is very much under scrutiny at present. To develop a medicine, so that it is available for patients, the regulatory bodies need to be satisfied in terms of quality, efficacy and safety. The cost of producing this evidence has increased to about £550 million for each new medicine – 60 per cent of which is spent on clinical trials. Adding to the financial investment risks involved is the fact that only about a third of medicines actually make a profit against investment in their research and development. In recent years, additional evidence for clinical and cost effectiveness is demanded by Health Technology Appraisal bodies such as NICE and the All Wales Medicines Strategy Group.

The time scales needed for clinical studies are variable. For example, if a new compound is an antibiotic for treating urinary tract infections, a positive result will be apparent in each patient within a few days as the infection is eradicated. However, in chronic diseases, such as multiple sclerosis, AIDS, Alzheimer's, arthritis, cardiovascular disease or some forms of cancer, a trial may last a year or more in each patient and involve long-term follow up to verify that clinical benefits persist over time.

Despite these complexities, the number of entirely new medicines reaching the public has remained fairly steady for the last 10 years at around 25 a year, with the time from discovery to launch averaging 10-12 years over this period. The UK has been particularly effective in contributing to this research and has attracted a near 10 per cent share of global pharmaceutical research and development, despite only contributing 3.5 per cent of world medicines sales. In 2004-05, for the UK, this investment amounted to about £3.25 billion.

A recent ABPI survey of members found that some 950 compounds are currently in clinical development. The largest number of potential new medicines are being developed for cancer (170), diseases of the cardiovascular system (109), mental disorders (62), diabetes (59) and respiratory disease (53). All these are priority areas for Wales.

The large number of compounds mentioned above illustrates the unpredictability and therefore financial risk associated with the development of medicines. Although attempts to minimise these risks are ongoing there have been many recent examples where compounds have 'fallen through' at a very late stage. For example, one company has recently announced that in its 'war on Alzheimer's' it has 11 products in clinical development. None of these is guaranteed to provide the disease modifying results aimed for, despite enormous intellectual and financial investment. Certainly there is no way at this stage to identify which compound, if any, is going to have the greatest value to Alzheimer's patients and carers. What is certain however, is that without this or similar commercial investment, a cure for Alzheimer's will remain a pipe-dream.

It has been suggested that 'medicines inflation' in Wales is running at record levels. However, this is not an entirely fair view of the situation. True medicines inflation is running at an annual rate of 0.5 per cent, as the cost of a medicine is very rarely increased after it is launched. According to the joint Department of Health/ABPI report by the Ministerial Industry Strategy Group, medicines today are 21 per cent cheaper in real terms than ten years ago. However, what is inflating or growing is the volume of medicines usage, based on clinical need and perhaps increasing patient expectation.

Chronic conditions such as asthma, diabetes and cardiovascular disease have been called "the 21st century healthcare challenge" by the World Health Organisation. The challenge faced by Wales is particularly critical as we have one of the highest levels of chronic conditions in the UK, with around a third of adults reporting at least one condition:

- Over 28 per cent of visits to the GP are due to respiratory illness.
- Chronic conditions as a whole account for 80 per cent of all GP consultations and 60 per cent of hospital days.

The challenge of chronic disease management is recognised by the re-modelled approach to the NHS identified in *Designed for Life* and the newer *Designed to Improve,* the integrated chronic conditions model and framework. The key role to be played by medicines in these ambitious plans is clear: identification of at-risk groups/patients; early and accurate diagnosis; optimal use of medicines; alongside increased patient responsibility and remodelled services.

However, the management of medicines in Wales is dominated by a budget-led approach, which has led to a high volume, low cost model for their use. GPs are

incentivised to underspend their medicines budget. They are encouraged to switch patients to cheaper medications. 'Quality' is often associated with lower medicines expenditure, ignoring the all important measurement of patient health outcomes. It is uncertain and debateable as to whether this approach leads to the optimal use of medicines. Moreover, it appears to be divergent from the policy adopted in other parts of the UK.

It is essential that all parts of the NHS budget are being spent wisely and effectively using a rational and valid evidence base. This is particularly true in Wales where, despite the obvious health needs of the population, we have historically spent less per head on health than other parts of the UK with similar health issues. The evidence base should be improvements in holistic health outcomes and not just simply aiming to cut costs. For example, it has been estimated that over five years, the current use of statins in Wales will save £54.1million in hospitalisation costs and a massive £3.5 billion in wider economic benefits. The question remains as to whether Wales could achieve even greater benefits?

A progressive and holistic approach to medicines management would set clinically relevant standards, with the management challenge being to identify and move resources to achieve that outcome. Of course, such an approach would require a flexibility in resource allocation and involve changes in areas such as staffing, systems and skills. For example, it has been estimated that in Wales the tighter management of type 2 diabetes to recognised clinical standards, would annually save over 30,000 hospital bed days and £48 million in wider economic costs through reductions in employee sickness absence.

At present the 'silo budget' approach to medicines does not allow a holistic approach to health and is compounded by the fact that the Local Health Board budget allocation is based on historical data as opposed to identified population characteristics. Additionally, the responsibility for the local prescribing budget is disassociated from the commissioning of services to improve health outcomes. This means that the medicines management effort is being led by what is easiest to manage, costs, not what should be managed, improved health outcomes. Indeed, there is recent evidence which suggests that in Wales clinical judgement and optimal clinical targets are being compromised due to concerns for the prescribing budget as opposed to the overall health gain.

NICE itself appreciates that the success of it's guidance should not be measured in medicines costs alone. All of NICE's positive guidance is judged to be clinically and cost effective for the NHS. Yet, they may be cost negative, that is, savings greater than the cost of medicines; cost neutral, where increased medicines usage is offset by other NHS savings; or cost positive where increased use of medicines is justified by improved health outcomes. It is well to note at this time however that NICE limits itself to considering NHS costs and does not attempt to consider the wider socio-economic benefits of improved health outcomes – or life itself.

It is also important to clarify the original and intended role of health technology appraisals and for the guidance issued by such processes not to be hijacked. Indeed, it has been suggested in Wales that one of the roles of the National Institute for Health and Clinical Excellence (NICE) and the All Wales Medicines Strategy Group (AWMSG) appraisal is to "provide a check on the inflationary pressures of new products". It is well to remember that NICE was created and devised to ensure that good, reliable and consistent prescribing guidance was available, at a time when modern clinical and cost effective prescribing was inconsistent.

A 'YES' from NICE was meant as an encouragement to clinicians to prescribe. However, we are all now very aware that a 'NO' from NICE has far greater patient significance. Further, Health Commission Wales, which is responsible for providing funding for certain services and medicines, has a policy which denies funding in advance of final NICE guidance. Such an approach could deny individual patient access to the medicine for anything between six months and a couple of years despite clinical evidence and patient need.

A routine 'not approved for use in Wales', if applied and implemented across the country, would of course end the so called 'post-code lottery', but may not provide the best answer for our citizens. In fact, there would be considerable doubts as to any cost savings achieved from such an approach and it would challenge the universally accepted need for service modernisation and re-configuration.

The challenge for all health technology appraisals remains the full implementation of its guidance. Currently, the financial advantage of implementing a negative guidance does not appear to be balanced by the clinical advantage of fully implementing positive guidance.

An insight to the importance of utilising clinically effective medicine was provided recently and published in the *Annals of Oncology*. The UK as a whole has a well recognised conservatism towards the use of modern medicines, some of which may be explained by clinician concerns about medicines costs and the 'silo-budget' approach to medicines. According to the Karolinska Institute Study, in comparison to several developed and Western European countries, the uptake of new oncology treatments is 'low and slow' in the UK.

This 'low and slow' use appears to be correlated with the lowest five year survival in most cancer conditions. For example, France has the highest five year survival rate for all cancers apart from non-melanoma skin cancers – 71 per cent for women and 53 per cent for men. The UK has the lowest at 53 per cent and 43 per cent respectively. Over 50 per cent of patients in France receive cancer treatments that were launched after 1985, whilst in the UK only 40 per cent of patients have access to such medicines.

Cancer survival is of course a complex issue and medicines should not be considered a panacea. Early detection and high quality specialist services contribute greatly. However, it is well to remember that according to another study looking at cancer survival, recent one year survival rates in Wales are similar to the five year survival rates in the European countries with the best outcomes.

The affordability of medicines remains a political hot potato. It seems rather ironic that in 2006, when there was intensive lobbying for the availability of a certain oncology treatment in Wales, over £35million was transferred from the prescribing budget due to savings achieved from patent expiry (medicines available generically) and the imposition of a seven per cent cut by the pharmaceutical industry in the cost of branded medicines. The uptake of new medicines in the UK remains low in comparison with other Western European countries.

Looking ahead, through advances in technology such as genomics, proteomics and synthetic chemistry a greater specificity in the development of medicines will be possible. The advent of 'personalised medicine' has obvious advantages for the individual. However, as the potential population pool is much smaller than that for a typical 'blockbuster' medicine, the cost per treatment per patient is likely to be larger as the development costs are recouped. Alongside the political challenge of affordability and funding, this may also require the re-assessment of the appropriateness of current Health Technology Assessment (HTA) decision making, thresholds and processes.

It is well recognised by some, but forgotten by others, that as new medicines become available, more widely prescribed medicines fall off patent and become available to prescribe generically at, an almost over-night, significant cost saving. If these cost savings were considered alongside other NHS and wider socio-economic benefits enabled by medicines, this would provide an excellent financial headroom to fund clinically effective modern medicines.

In the case of medicines it is essential not to view the expenditure on medicines in isolation. We should consider the overall impact of the technology on the healthcare system, taking into account factors such as improvements in patient outcomes or saving from the NHS and wider budgets. In short, when it comes to assessing the pros and cons of medicines we need to look at the whole picture not just at the bill. The aim for the NHS in Wales should be to establish a cutting edge, world class health and social care service and not be fixated by short term cost cutting of an isolated aspect of the NHS budget.

CHAPTER 7

Legislating for the Health of the People

John Wyn Owen

In the Summer 2007 edition of the IWA's journal *Agenda* John Davies made the case for Wales to build on the ancient foundations provided by Hywel Dda:

> *"For the first time since the establishment of localised Norman rule in the latter decade of the 11th century we have freedom to create and manage our own legal system and develop a unified body of Welsh law. Among the oldest enlightened bodies of legislation the laws of Hywel Dda not only informed the laws of Sweden but the basis for modern European Equality legislation."*[27]

According to David Moore, Welsh Law fell into the juristic category of 'volksrecht', that is to say 'people's law' which did not lay great stress on royal power. This was in contrast with 'konigsrecht' that applied in England and Scotland where it was emphasised that both civil and common law were imposed by the state.[28]

The Government of Wales Act 2006 has enabled Wales to renew its historic legislative contribution. Now both the time, and the need, is right for the National Assembly to use its powers to develop a distinctive public health bill, a Health of the People of Wales Bill. This should be informed by Sweden's public health law which is based on the determinants of health. So we have the potential influence of the laws of Hywel Dda reaching to Sweden and thence back home to inform health legislation in our own time.

The IWA's volume *Time to Deliver* identified challenges that required a pursuit of healthy public policy across the areas for which the Assembly has responsibility.[29] This means fully integrated health and social care services and a shift to primary care as well as hospital specialisation. However, the reforms face almost insurmountable resistance from the public. Proposals for hospital reorganisation featured prominently in the May 2007 election to the National Assembly. Further, the Beecham Report was clear that though the citizen-centred model was wholly defensible intellectually and socially, it was also "an extremely challenging model and requires transformation in culture, capacity and processes".[30]

27) John H. Davies, *Llyfrau Da,* IWA Agenda, Summer 2007.
28) David Moore, *The Welsh Wars of Independence,* Tempus, 2005.
29) *Time to Deliver: The Third Term and Beyond: Policy Options for Wales,* IWA, 2006.
30) Beecham Review, *Beyond Boundaries: Citizen-Centred Local Services for Wales,* Welsh Assembly Government, 2006.

The last 25 years have seen a substantial change in the manner in which our health is determined. Changes in behaviour, advances in technology, and the impacts of global markets have all had advantageous as well as detrimental impacts on population health. If challenges such as the persistent increase in obesity remain unchecked then they will have dire economic consequences for Wales as an economy. This relationship between a nation's economic well-being and its public health are being increasingly recognised. It is why, for example, the National Heart Forum and the Royal College of Physicians are jointly involved in the *Health Creating Economy* programme. After all, 'good health is good economics'. There are four challenges for the health community in Wales:

- To achieve responsible engagement for the pursuit of healthy public policy right across the areas for which the Assembly Government has responsibility.
- To involve citizens in policy choices that balance encouragement of personal responsibility for life style, informed and knowledgeable self treatment when applicable. Alongside this government has the responsibility to create life chances through good housing, safe play areas, accessible and reasonably priced food, education, the provision of health and social care and employment opportunities.
- To acknowledge importance of 'Futures' and 'Systems Thinking'.
- To understand the need for modern public health legislation. This would entail a Health of the People of Wales Bill founded on the determinants of health compatible with UK, European and International Laws and Regulations, coupled with strong leadership and effective management as all levels.

The Assembly Government's Health Stewardship

Securing the health of the people of Wales is as vital a part of the Welsh Assembly Government's stewardship as promoting their economy. In short, good health for Wales is the new wealth and vulnerability the new poverty. The World Health Organisation programme of work to 2015 looks at how health should be seen as a dynamic instrument for achieving social and economic development, justice and security.

It is essential that Welsh health policy should be developed in terms of 'Health Gain', 'Systems for Health and for Health care', and 'Futures'. In turn, this should involve appreciating trends that can be made with certainty, threats and opportunities, and the key drivers of change and ways of influencing them. The longer view – 'Futures' – is necessary because good health for the people of Wales cannot exist outside the UK's economic, foreign and security policy. Systems for health include effective regulation of the health market place and promoting and protecting health through effective public health laws and regulations.

Globalisation and Health

Legislation for sustainable public health policy should be undertaken within a global context. Recent reports by Lord Crisp and Sir Liam Donaldson, the UK's Chief Medical Adviser, provide significant acknowledgement of this.[31] And as Ilona Kickbusch has put it:

> *"… globalization is qualitatively a new phenomenon and more than an increase in interconnectedness of nations, people, capital and information. It is creating new spheres of action through transformation in space, time and knowledge with networks not territories as organization spheres. Further, as governments fight to preserve their sovereignty of health care policy, they have lost the sovereignty over the determinants of health to multi national enterprises, and the finance and marketing of consumer goods – food tobacco, media, information technology – which have greater impact than healthcare on health outcomes."*[32]

It is in response to these drivers that the Assembly Government should recognise public health as a priority across all government policy. Indeed, the routine use of health impact assessment should be a statutory routine underpinning all policy development.

Assembly Measures as Health Laws Fit for Purpose

In his Second Report to the Treasury, Derek Wanless stated that:

> *"Public health is the science and the art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals."*[33]

Public health law is critical to underpinning the role of the Welsh Assembly Government and sustainable public health. Gostin defines public health law as the:

> *"… legal powers and duties of the state to assure the conditions for the people to be healthy- to identify, prevent and ameliorate risks to health in the population – and the limitation on the power of the state to constrain the autonomy, privacy, liberty, property or other legally protected interests of individuals for the protection or promotion of community health."*[34]

31) Nigel Crisp, *Global Health Partnership: the UK contribution to global health in developing countries,* COI, 2007, and Sir Liam Donaldson, *Health is Global: Proposal for a UK government-wide strategy,* Department of Health, 2007.

32) Ilona Kickbusch, *The Future of Health: Health of the Future,* World Health Organisation and Nuffield Trust, London, 2002.

33) Derek Wanless, *Securing Out Future Health: Taking a Long-Term View,* Final Report, April 2002.

34) Gostin L., *Health of the People the Highest Law,* Conference Proceedings, Nuffield Trust. London, 2004.

Current legislation is not fit for purpose to deal with communicable, non communicable and chronic diseases. This has been comprehensively documented in the Nuffield Trust's Health of the People project.[35] This studied the legislative position at the three levels of the devolved nations, the UK, and the European Union. It found that the legislative framework is relatively incoherent even for trained lawyers:

- It fails to demonstrate a cross-cutting approach to population health protection and improvement.
- There is a dangerous lack of clarity about (legal) public health accountability.
- Communicable disease powers are grossly outdated and have little relation to contemporary scientific knowledge concerning effective control methods.

The project recommendation was that a comprehensive legal rationalization is required to set out coherent public health structures, and effective powers, duties and accountabilities – including those relating to communicable disease. Much of the existing public health laws were originally drafted in the 19th century as a result of crisis measures taken to a particular event rather than as a comprehensive body of legislation to protect people from chronic and communicable disease, and to promote and improve the health of the people. Some progress is being made:

- The International Treaty on Tobacco Control.
- The ban on smoking in public places in the UK.
- New International Health Regulations.
- The Health Protection Agency has been established.
- The Scottish Government is consulting on a new public health bill.
- The Department of Health and the Welsh Assembly Government are consulting on control orders for communicable disease.

Overall, however, public health legislation in the UK is still not fit for purpose. The time is right for an Assembly Measure for the Health of the People of Wales as an exemplar modern public health bill founded on the determinants of health compatible with UK, European and International Laws and Regulations.

Public Health Law and the Determinants of Health

Another of the IWA Health and Social Care Group's recommendations was the political courage to look beyond England, for example to Scandinavia, for models of good practice in health policy development. Given that the laws of Hywel Dda influenced the laws of Sweden, does Sweden offer a comprehensive legislative model worthy of further consideration in Wales? The answer is a very definite yes. It is a model to inform Futures thinking and sustainable public health around

- Strengthening social capital.
- Growing up in a satisfactory environment.

35) Stephen Monaghan, Dyfed Hughes and Marie Navarro, *The case for a new UK Health of the People Act,* Nuffield Trust, London, 2003.

- Improving conditions at work.
- Creating a satisfactory physical environment stimulating health promoting life habits.
- Developing a satisfactory infrastructure for health.

The 2003 Swedish Government Public Health Bill paid particular regard to health determinants. The legislation recognised the importance of the power and the possibility of people to influence the world around them and that this was crucial for health. The recent incoming reforming Swedish Government, more disposed to the market place, has re-affirmed its commitment to the legislation. By adopting passing its Public Health Act, the Swedish Government signalled that it intended to improve public health in general and to reduce differences in health between various population groups. The Bill has 11 target areas:

- Involvement and influence on society.
- Economic and social security.
- Secure and healthy conditions for growing up.
- Better health in working lives.
- Healthy, safe environments and products.
- Health and medical care that actively promotes good health.
- Effective prevention of the spread of infections.
- Secure and safe sexuality and good reproductive health.
- Increased physical activity.
- Good eating habits and safe food stuffs.
- Reduced uses of tobacco and alcohol, a drug free society, and a reduction in the harmful effects of excessive gambling.

The Government of Wales Act 2006 enables the Assembly Government to instigate Measures to pioneer a Modern Public Health Bill which would serve as an exemplar for the devolved administrations throughout the UK. It would consolidate through legislation a distinctive Welsh approach to sustainable health of the people based on 'Futures Thinking', 'Systems for Health', and 'Systems for Health and Social Care', founded on the determinants of health and compatible with UK, European and International Laws and Regulations.

There is however a post script. This was a reminder from Lord Wilson, former Head of the Civil Service that the health of the people is the highest law.[36] Law matters but it can not be a substitute for management. Moreover, bad legislation can have the wrong effects. If there is to be legislation not only should it be wisely drafted but it should be accompanied by strong leadership and effective management at all levels. Above all, political will is required, not least around the cabinet table, to bring about change. You cannot legislate for these things. Without them legislation will fall short of achieving a sustainable future for the public health.

36) Richard Wilson, *Health of the People the Highest Law,* Conference proceedings, Nuffield Trust, London, 2004.

Notes on the Contributors

Tony Beddow joined the NHS in 1969 and has held substantive NHS posts including Deputy Hospital Secretary, Queen Elizabeth Hospital Birmingham, Sector Administrator, Kidderminster Acute Unit, Assistant District Administrator, North Devon District, Planning Officer and then Chief Executive, West Glamorgan Health Authority and Chief Executive, Morriston NHS Trust. In 1997 he joined the Welsh Institute for Health and Social Care at the University of Glamorgan where he is currently a Senior Fellow with interests in devolution and policy and performance analysis. A regular broadcaster, he is a company director of two charities and companies operating in the health field.

David Cohen is a Professor of Health Economics and Director of the Health Economics and Policy Research Unit at the University of Glamorgan. He has been a member of the Royal College of Physicians Working Party on Preventive Medicine and the Department of Health Advisory Group on Genetics Research. He has acted as specialist adviser to the World Health Organisation and to the House of Commons Select Committee on Welsh Affairs. David has been a member of several research commissioning panels including the MRC Health Service and Public Health Research Board, the NHS Health Technology Assessment R&D Programme, the Wales Office for R&D in Health and Social Care and the National Prevention Research Initiative. In 2002/3 he acted as Deputy Director of the NHS Service Delivery and Organisation R&D Programme and is currently Co-Vice Chair of its Programme Board.

Tina Donnelly completed her registered nurse training in Belfast and midwifery training in London. She has a BSc (Hons) in nursing from Leeds, a PGCE and MSc(Econ) from the University of Wales Cardiff. She has held management posts in the NHS and also senior academic posts in higher education. Mrs Donnelly also worked in the Welsh Assembly Government as a Nursing Officer and advised on health and nursing policy. She took up her current post as Director, Royal College of Nursing Wales in August 2004 and is a member of the RCN UK Executive Team. Mrs Donnelly maintains clinical practice in intensive care nursing and has worked internationally in areas of conflict and humanitarian aid.

Rick Greville started as Director ABPI Cymru Wales in May 2003 after serving an apprenticeship of 15 years within the pharmaceutical industry. Since then he has enjoyed the challenges of raising the understanding and profile of the pharmaceutical industry with a variety of stakeholders, including professional bodies, Welsh Assembly Members and the NHS in Wales. Richard has recently been re-elected as Vice Chair of the NHS-Industry Forum, working alongside colleagues from industry and the NHS in Wales. He is also a member of the Advisory Board of the Wales Office for Research and Development in Health and Social Care (WORD) and the Commercial Committee of the Clinical Research Collaborative (CRC) Cymru.

Helen Herbert has worked as a full time general practitioner in Aberaeron since 1984. She appreciates that Primary Care must change to accommodate the demands and expectations of our patients – but that the changes should also be underpinned by the traditional values of our profession. As Chairman of the Royal College of General Practitioners in Wales, one of her key roles has been to facilitate discussion amongst her general practitioner colleagues in Wales to state their future vision.

Siobhan McClelland After graduating from Oxford University with a vocational history degree Siobhan joined the NHS graduate management training scheme. She worked in the NHS in a variety of management positions before moving to academia. Siobhan has taught and researched within a number of universities in Wales including Swansea University and UWCM. She is currently Professor in Health Policy and Economics in the Health Economics and Policy Research Unit in the University of Glamorgan and also works as a consultant with the public affairs company Positif Politics. Siobhan has led a number of research projects exploring the application of Welsh health policy and has published in a wide range of journals on this subject. She appears regularly on television and radio. She most recently wrote and presented the BBC Radio Wales series *"How to Survive the NHS"*.

Ceri Phillips is Professor of Health Economics at Swansea University and is a member of the Centre for Evidence Based Medicine at Oxford. He has undertaken commissioned work for the World Health Organisation, Department of Health, Department of Work and Pensions, Welsh Assembly Government and a range of health authorities and pharmaceutical companies. He has published extensively in the field of health economics, evaluation and health policy and is a member of the Welsh Health Economists Support Service, which has led the work on the health policy chapter in the IWA publication *Time to Deliver.* He is the Health Economist member on the All Wales Medicines Strategy Group which advises the Minister on issues relating to prescribing and medicines management. He is also a leading member of the Well Being in Work Initiative, set up by the Welsh Assembly Government and funded by the Wales Centre for Health to explore strategies and interventions in the context of the work/health interface.

Mike Ponton joined the NHS in 1962 and his early career also included time in Cardiff Royal Infirmary, St Mary's Hospital Paddington and Leicester General Hospital. In 1974 Mike returned to Wales to become Sector Administrator at Swansea's Morriston Hospital. He worked for West Glamorgan Health Authority in a series of senior management posts culminating in 1985 as Unit General Manager back at Morriston. Between 1990 and 1996 Mike was Chief Executive of the Pembrokeshire and East Dyfed Health Authorities following which he became Chief Executive of Health Promotion Wales. In 1999 he moved to the Welsh Assembly Government, initially working on health promotion and public health strategy and then becoming Head of Health Policy and Development. He has been Director of the Welsh NHS Confederation since 2004. Mike is a Fellow of the Institute of Health Management and an Executive Education Alumnus of Harvard Business School.

Malcolm Prowle has over 30 years experience of the health sector. Currently he is a management consultant with HLSP and a visiting professor at two universities. He has been an adviser to the House of Commons Health Select Committee and the World Health Organisation. He has published many books, research reports and papers on various aspects of health services and has spoken at numerous events organised by the Prime Minister's Policy Unit, the Kings Fund, WHO etc. He has particular interests in relation to achieving sustainable performance improvement in the NHS.

Cerilan Rogers is National Director of the National Public Health Service for Wales. The NPHS provides a wide range of public health services, including health protection, health improvement, health and social care quality and health intelligence. As Director, she plays a lead role in the strategic development of public health across Wales. She has a key role in forging partnerships with, and influencing, all agencies to ensure the widest participation in protecting and improving health in Wales. Until 2003, Dr Rogers was Director of Screening Services, with responsibility for the all Wales breast, cervical and newborn hearing screening programmes and for the antenatal screening project. Dr Rogers started her career in public health in North Wales in 1991 and before that had been a principal in general practice, both in north and south Wales.

John Wyn Owen is currently Chairman of University of Wales Institute Cardiff. Until his retirement he was Secretary of the Nuffield Trust from March 1997 to June 2005 having previously been Director-General of New South Wales Health in Australia and Chairman of the Australian Health Ministers Advisory Council and, until 1994, Director of NHS Wales. He is an Honorary Doctor of the University of Glamorgan and Honorary Doctor of Science of City University London.