Date: **Wednesday 26 November 2003**

Venue: **Committee Room 1, National Assembly for Wales**

Title: **Ministerial Report**

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1. The Review of Health and Social Care in Wales (Wanless)

The broad Implementation Plan presented to the Committee on 5 November 2003, set out the high level outcomes and actions in response to the Review's recommendations. Currently Sub Groups reflecting the four themes of the Review are working through the Implementation Plan setting out the detailed outcomes required against specific target dates. In parallel with this work, the Programme Board will pull together the Sub Groups' work in a Programme Initiation Document which will be the vehicle to monitor progress on actions and to report regularly through the Ministerial Report to the Committee.

The Review's recommendations present significant challenges for NHS Wales and Social Care and drew attention to a number of areas where immediate action is required consistent with the medium to long term radical remodelling of services.

At the Assembly Government's Plenary debate on 18 November 2003, further details in respect of the Implementation Plan were set out concentrating on three priority areas:

- providing services that meet demand more effectively
- strong financial management with robust and measured performance and delivery
- much more involvement from people and communities in decisions about services and about their own health and treatment.

Regional Directors of the NHS in Wales will facilitate 'local Wanless Action Plans' led by Local Health Boards working with their NHS Trust partners, local government and others, to assess local services and prepare by Spring 2004 outline Action Plans for their areas.

The £25m recently announced will provide incentive funding and act as a catalyst to stimulate changes which the local Plans will have to bring about. This will include actions which help to promote independence through providing more choice and care at home, intermediate services and preventing unnecessary hospital admission through earlier and better assessment and more timely intervention.

The Plans should focus heavily on remodelling services along the lines of managed clinical networks. Building the involvement of local communities, patients and staff into all change processes from the outset is an absolute necessity.

Regional Directors will facilitate these reviews with a whole system perspective, through the Commissioning Partnership arrangements. The importance of engaging local government, partners and stakeholders as an integral part of the process is self-evident. Similarly, effective public involvement at all stages in the review is paramount, and evidence of the effective involvement of local people and their communities must be demonstrated.

There is now an integrated national framework with policy guidance and service standards to underpin the plans for change. National service reviews are being undertaken into maternity services, accident and emergency, neurosciences services and diagnostic services.

The above work will underpin the local Wanless Action Plans.

2. Implementation of the Pharmacy Strategy

‘Remedies for Success - A Strategy for Pharmacy in Wales’, set out my plan to ensure Wales offers an attractive and challenging environment, to enable the profession to fulfil its potential and deliver high quality pharmaceutical services to the population of Wales over the next ten years.

The strategy made 50 wide-ranging recommendations affecting all areas of pharmacy practice and was published as a consultation document in autumn 2002. It generated over 100 responses from pharmacists throughout Wales.

The responses have been collated and analysed and an action plan produced. This prioritises the 50 recommendations under specialised sub-headings, for example Education, Information Technology, Research and Development and Workforce**.**

I have invited my statutory committee, the Welsh Pharmaceutical Committee, to advise me on the delivery of work in these areas. Where appropriate, the work will be aligned with the ongoing development of the new contractual framework for community pharmacists.

Considerable development has already been made in progressing some of the strategy’s recommendations. For example, we are taking forward supplementary prescribing; we have begun the implementation of automation in secondary care; we have taken the first steps towards a comprehensive review of community pharmacy services and have established two working groups to look at means of providing repeat dispensing services and the "Direct Supply of Medicines" at pharmacies.

I look forward to reporting on further progress on implementation of the pharmacy strategy under the guidance of the Welsh Pharmaceutical Committee.

3. National Patient Safety Agency

The National Patient Safety Agency, created in July 2001, has had an agreement with the National Assembly for Wales since May 2002, with the objective of improving the safety of NHS patients. The NPSA will achieve this by promoting a culture of learning and reporting from patient safety incidents - and through this - develop practical solutions. It has began a major patient safety campaign to help local NHS organisations in England and Wales focus on delivering safer care.

NPSA in Wales

The Agency has recently appointed an Assistant Director of Patient Safety for Wales, Dr Mike Rejman. Dr Rejman will oversee a new network of three patient safety managers, one for every NHS region in Wales, who began work in late October to support local NHS organisations in improving patient safety.

Seven Steps to Patient Safety

Detailed guidance on best practice in patient safety is being published online this month. The guide contains tangible steps to build a culture of learning from patient safety incidents.

National Reporting and Learning System

Ten early adopter sites across England and Wales will soon begin participating in the national reporting of patient safety incidents, marking the start of the roll out of the NPSA's National Reporting and Learning System (NRLS). This will include sites in Wales with all NHS organisations joining by the end of 2004. NHS organisations that have joined become entitled to receive free Root Cause Analysis training, which will empower them to investigate, identify and correct error.

Safety Solutions

The NPSA is already conducting a wide range of safety solutions work including:

- hand hygiene;
- analysis of data from Health Safety Executive (HSE) on burns/scalds in hospitals;
- reducing the risk of Methotrexate dosage error;
- root cause analysis of infusion device incidents (work undertaken on this by staff at Cardiff and Vale NHS Trust);
- standardising crash call numbers;
- use of non-latex products in the care of latex sensitive patients;
- bowel care management for spinal cord injured patients in acute hospitals.

New NPSA Chair

Professor Rory Shaw’s first term as Chair of the National Patient Safety Agency (NPSA) ended on 1 July 2003 and he decided not to seek a second term. Professor Shaw agreed to remain in post until his successor was appointed. The NHS Appointments Commission has undertaken a recruitment process and agreed to the appointment of Lord Philip Hunt, to commence on 1 January 2004.

4. Healthcare Associated Infections

Wales has one of the most robust systems of disease surveillance in the UK. The Assembly distributed funds last year to each Trust, specifically for IT equipment for Infection Control Teams to enable them to develop their surveillance systems. The Datastore project looking at the whole range of antibiotic resistance not just Methicillin Resistant Staphylococcus Aureus (MRSA) allows straight froward comparisons between the results obtained from different laboratories. What this does is to identify the high and low levels, so that we can go on to obtain more detail of what is going on in that particular hospital. This gives an indication of why the rates are different, that information is then used to examine and where necessary alter practice to reduce infection.

Control of infection is a mutli-disciplinary issue and has been fully recognised as an integral part of Cleaning in NHS Hospitals. Earlier this year the National Audit Office (NAO) report 'The Management and Delivery of Hospital Cleaning Service in Wales' was presented to the Welsh Assembly Government Audit Committee (17 July 2003) and at the end of July the 'National Standards of Cleanliness for NHS Trusts in Wales' were published. The inclusion of control of infection staff in the development, implementation and monitoring of these standards is an essential component together with the requirement for all staff to be fully and regularly trained.

In April of this year, the Assembly issued a Welsh Health Circular to inform health professionals of recent developments relating to the prevention and control of healthcare-associated infections, and to notify all hospital of expectations for the control and reduction of Health Care Associated Infections (HAI). This new guidance connects clinical practice with managerial responsibility and allows each trust to set performance indicators that can be evaluated within a Wales wide structure.

The Welsh Health Circular (WHC) introduced an extension of HAI surveillance with the introduction of mandatory surgical site infection surveillance in orthopaedics (similar systems will be developed for other surgical specialities in the near future), hospital outbreak reporting and infection reduction activities. We now have a system of mandatory surveillance that can give an accurate picture of infection rates and how best they can be tackled.

The Wales Committee for the Control of Communicable Disease has identified healthcare associated infections as a priority and therefore created a Welsh Healthcare Associated Infections Sub Group (WHAISG), which provides advice about the best way to address the issue of such infections. This is a multi-disciplinary group that evaluates the systems in place to monitor, prevent and control all healthcare associated infections in Wales.

The sub-group is finalising its strategy to support the achievement of a reduction in healthcare associated infections. The major focus of the recommendations is the development of an infection control infrastructure that places strong emphasis on the need for all healthcare workers to understand and discharge their roles and responsibilities in relation to infection control within a clinical governance and risk management approach.

The strategy includes an action plan for the management of HAI, which outlines four principle areas:

- the organisation and infrastructure of infection control -including managerial responsibilities
- training requirements and their delivery - a standards based approach
- the adoption and implementation of surveillance systems - gathering evidence to inform practice
- interventions that demonstrably reduce infection - performance indicators

This will be published at the end of the year, when work on a strategy for community healthcare associated infections will be started.

5. Update on the Carlile Report

The Carlile report was published in March 2002. A report was made to Health and Social Services Committee in March 2003 outlining the progress that health authorities and NHS trusts had made in implementing the recommendations contained in the report.

In January, the shocking report of the Victoria Climbié Inquiry was published. The report related to events that occurred in England, and the bulk of the recommendations relates to policy and practice there. However where safeguards for children are concerned it is not possible to be complacent. The Welsh Assembly Government aims to ensure that all children should enjoy the best possible physical, mental, social and emotional health free from abuse, victimisation and exploitation. Consideration has therefore been given to Lord Laming’s recommendations for health and social services.

In March I wrote to health authorities, local authorities, NHS trusts and local health boards across Wales drawing their attention to a checklist of recommendations that related to basic good practice. As a result of the Carlile recommendations a year earlier it was reassuring to learn that very largely the NHS had adopted working practices that were in line with the recommendations contained in the Laming report.

In July, the Welsh Assembly Government asked the Commission for Health Improvement (CHI) to undertake a comprehensive audit of the child protection arrangements in the NHS in Wales based on the recommendations contained in the Carlile and Laming reports. The audit was launched on 17 November and every NHS organisation in Wales must take part. The child protection audit tool, which was developed with the help of child protection experts across Wales, will be considered at board and senior team level. It examines board awareness of child protection responsibilities, and whether systems and processes are in place to properly safeguard children. CHI will report its findings early in 2004.

On 18 November the Welsh Assembly Government commissioned CHI to undertake the second stage of this project – to develop child protection self-assessment tools for clinicians. The tool will help managers and front line staff to systematically assess standards of practice against national guidance. The tool is presently in the development phase. It is anticipated that the tool will be published in the early Spring 2004.

Work to strengthen safeguards for children has been progressing in the in the following areas:

- Officials are working with representatives of General Practitioners to produce "A Guide for Child Protection Arrangements in General Practice". This is currently at third draft stage and it is hoped to finalise it over the coming months. A meeting has been arranged with representatives of dentists with a view to extending this guidance to dentists.

- The number of registered children's nurses has increased from 1080 in 2000 to 1136 in 2002. The number of commissioned student training places has increased from 119 in 2002 to 131 in 2003. Further the 18 month accelerated programmes for children's nursing has been reinstated and will provide an additional 30 training places for nurses wishing to gain children's nursing qualifications.

- The number of consultant paediatricians has been increased from 92 in 2001 to 123 in 2002.

6. Diabetes Services in Wales

The Diabetes National Service Framework (NSF) roadshows have now been completed across Wales. Over 700 people attended and the feedback has been excellent. The Roadshows have enhanced people's knowledge and understanding of the requirements required by each sector involved with the delivery of diabetes care, including a patient perspective, to achieve the Standards.

The Baseline Service Review of Diabetes Services across Wales was commissioned from the Audit Commission and is due to be published on 27 November, together with the 22 individual locality reports. These will assist with the Delivery Strategy and the implementation plans being compiled by the Local Health Boards (LHB) in partnership with the Local Diabetes Service Advisory Groups and Patient Reference Groups. Implementation plans and workforce issues are to be received at the Assembly by 14 January 2004. In support of this partnership £3,000, non-recurrent funding, has been allocated to each LHB from the Diabetes NSF final year £250,000.

Further All Wales projects being funded from this £250,000 in the current year. These are projects that have been identified from the Action Plans of the Delivery Strategy where there are known to be gaps in the service, as follows:

- All Wales Foundation Course in Diabetes for General Practitioners
- Diabetes Education Resource Pack for Practice and Community Nurses across Wales

- All Wales Diabetes Specialist Nurse, Dietician, Consultant Course – insulin dose adjustment for normal eating. This course will enable people with Type 1 diabetes who are on multiple dose injection regimes to adjust their insulin dosages according to their dietary intake/exercise. The aims are to empower people to live normal active lives.
- Additional training to support Expert Patient Pilot Project

And in respect of vulnerable groups, as follows:

- One person from each of the prisons to attend the University of Wales College of Medicine Diabetes Course
- The Royal College of Nursing to co-ordinate a training programme for people working in residential and nursing homes
- Diabetes Health Promotion in Minority Ethnic Communities, Diabetes UK Cymru Database officer

The Diabetes NSF Project Board is to have its final meeting on Monday 1 December 2003 where decisions will be made on how to take forward the future monitoring of implementation of the Delivery Strategy and associated issues.

7. Race Equality Scheme

At a recent consultation event on the Welsh Assembly Government Race Equality Scheme, minority ethnic community members had the opportunity to discuss health issues in relation to their perspectives with the Chief Medical Officer and a senior colleague in the NHS department.

There was a useful and constructive discussion from which the following key issues (*in italics*) were identified for health:

- *New ways of communicating with the minority ethnic communities should be explored, for example using the 'faith' communities.*
- *Consideration should be given to setting up an ethnic health forum*
- *Impact assessment of health policy development should specifically address minority ethnic community issues, and ethnicity health issues should be reflected in the SaFF and balanced scorecard*

The department has already established a working group with community representatives and will progress these issues in partnership with colleagues and the group.

- *Data on service delivery for minority ethnic people should be collected*
- *Ethnicity monitoring of NHS Staff by Trusts should be improved*

The NHS Wales Equality Unit is already working with Health Solutions Wales to progress the

introduction of the electronic staff record and the single patient record to bring these up to the appropriate standard for ethnicity monitoring.

- *Consideration of establishing a 'development' seat on their board specifically for minority ethnic people who are interested in seeking public appointment in health*

A capacity building scheme for Public Appointments in Wales is currently under development. This will provide opportunities such as this for members of under represented groups to develop their experience and skills in this role. Under pilot arrangements, there are 2 NHS Trusts that already have a minority ethnic person on their board in this role.

There were also some issues raised in relation to NHS Trusts and Local Health Boards.

- *Those Chairs and Chief Executives who visibly demonstrate their commitment to Equality and Diversity are highly valued and participants wished to encourage others to adopt a similarly high profile.*
- *Participants wished Trusts to ensure that local arrangements for handling issues and incidents that arise for minority ethnic staff members on a day to day basis are in place.*

All Trusts have Race Equality Schemes in place, and policies for handling bullying and harassment. The department will ensure that Trusts and Local Health Boards are made fully aware of the issues raised during the consultation.

Monitoring of the progress of health bodies in Wales with regard to all matters of equality and human rights is undertaken by the NHS Equality Unit on behalf of the department, Currently, an audit of progress in the secondary care sector is underway. A new audit tool is being developed for Local Health Boards.

8. Joint Reviews of Social Services

The joint review of Monmouthshire was published on 6 November. It judges the authority to be serving some people well with promising prospects for improvement. This is one of the most positive reports so far in Wales, though still does not reach the right-hand half of the judgement grid. I have written to the Leader of the Council as usual to acknowledge what has been achieved so far and to encourage further improvement.

The joint review of Flintshire was published on 18 November. It too judges the authority to be serving some people well with promising prospects for improvement. It reports that substantial progress has been made from a low base and praises in particular an excellent range of family support services. I have written similarly to the Leader of the Council.

Inspection of children's services in Cardiff

The report of this inspection, which I requested following the joint review, was published on 12 November. It showed that, despite the efforts made by the Council to improve, services to support and protect vulnerable children were still not good enough. In accordance with the protocol agreed between the Welsh Assembly Government and the Welsh Local Government Association, the Chief Social Services Inspector is writing to the Council to set out specific improvements needed and how these will be monitored.

We have already discussed my response to this report in a plenary session of the Assembly. My response is proportionate and consistent with my response to other authorities, such as the Vale of Glamorgan. I remain determined that the quality of children's services in Cardiff shall improve and confident that the course of action I have outlined is most likely to bring about the necessary improvements.

Future arrangements for joint reviews

SSIW and the Audit Commission in Wales are continuing work to develop the next round of joint reviews. They are preparing an analysis of the consultation responses (26 written responses) and are establishing the reference group – along the lines suggested by Committee members – to advise on the development of the methodology. A fuller report will be available in the near future.

9. General Medical Services (GMS)

9.1 Out of Hours Services

We have carried out a great deal of work to ensure that across Wales we have effective, efficient out of hours services in place by December 2004 when GPs lose the legal responsibility for providing these services. It is a complicated task but we must not cut corners. It is clear that we should not simply replace existing systems with similar services. I am determined to use this opportunity to re-organise services to ensure a close fit between out of hours providers, NHS Direct, accident and emergency units and the ambulance service. This is something that needed doing regardless of the GMS contract. We can make services more efficient and prevent duplication if we plan properly now. Understandably, LHBs, out of hours co-operatives and other key organisations are very anxious to see practical guidance issued as soon as possible. I share that impatience but I would rather we took the time to get this right now than rush it out and suffer the consequences.

All LHBs have already submitted plans to the Welsh Assembly Government that include indicative costs of future out of hours services. The purpose of the plans was to obtain a clear view on how the LHB would be taking forward Out of Hours services for their respective area and obtain first estimates of the costs of the service. The plans contained some indicative costs, but naturally required refining. Based on the information within the plans all LHBs received responses advising them of points that required further clarification.

Guidance is being developed for LHBs which will be available in December. That will cover the detail required for the final Out of Hours plans due in Jan 2004. LHBs will receive their financial allocations in December and will be able present a fully costed model after that. Information to support LHBs is being provided through our GMS Implementation project via regular updates and responses to questions. A seminar is planned for December to discuss problems and share best practice.

9.2 Implementation of the New General Medical Services Contract Legislation

I advised you at Committee on 5 November that I would provide you with further details in relation to the secondary legislation necessary to implement the contract. Annex 1 sets out the clauses contained within the Health and Social Care Bill which outlines the main features of the Assembly's new regulation making powers.

The clauses required to implement the changes require significant amendment to the legislative basis under which general medical services is presently provided and the repeal of a significant amount of primary and secondary legislation. The proposed amendments provide for the replacement of a number of delegated powers and a small number of new powers. The approach has been to leave the detail to secondary legislation and to use the primary powers to signal the areas in which we will legislate. This approach has been discussed at length with the British Medical Association who continue to be involved in discussions.

The measures are aimed at simplifying the legislative base. Despite the new delegated powers it is intended that the volume of delegated legislation post implementation will be smaller and more coherent than that currently in existence. For example the regulation making powers in relation to Primary Care Performers List, which are extended to include doctors, will replace two similar powers relating to medical lists each of which is exercised in a separate set of regulations.

The clauses provide for the existing provisions in Part 2 of the National Health Service Act 1977 to be repealed and replaced with a set of new provisions that, for example:-

i. place a new duty on LHBs to provide, or secure the provision, of primary medical services;
ii. sets out in some detail the structure and nature of the new GMS contract; including the provision of a legal definition of a GMS provider;
iii. allows LHBs to directly provide primary medical services or to commission care from alternative providers;
iv. allows the LHB to offer financial and other assistance to GMS providers;
v. Rationalise the professional list arrangements.

All this accords with the agreement concluded by the GPC and the NHSC and is reflected in paragraph 7.59 of their agreement.

Whilst we cannot be certain at this stage exactly what the secondary legislation will be, the information

contained within the paper indicates that there may be regulations in the following areas:-

- LHB Information Regulations (see sections contained within clause 170)
- GMS Contract Regulations (see sections contained within clause 171 except section 28T)
- Statement of Financial Entitlement Directions (see section 28T contained within clause 171)
- Transitional Regulations (see clause 172)
- Performer List Regulations (see section 28X within clause 175)
- Consequential Regulations (see clause 180)

Directions may also be required in certain areas to support the implementation of the contract.

All clauses are currently subject to amendment until the Bill is enacted. The Bill went through the report stage in the House of Lords in early November and the 3rd reading was held on 18 November 2003. The earliest we can expect the Bill to receive Royal Assent is late November.

I am unable to provide you with a timetable of the proposed regulations at this time but legislation will be implemented on a phased basis and priority will be given to instruments required before 1 April to set up the contract. However, even though the Bill has not yet been enacted work has begun on the Regulations. Instructions for the GMS Contract Regulations, which will contain the key principles of the contract and will probably be the first of the regulations to be implemented, have been given to lawyers who have commenced the drafting process. My officials and lawyers are working closely with their opposite numbers in the other 3 health departments and they will continue to provide me with regular updates on developments.

I trust that these steps will help ensure that you have all the information you require for the time being. As soon as I know the full details and timetable for the programme of legislation I will share this with colleagues at the earliest opportunity.

I hope I can continue to rely on your support to steer the necessary legislation through by 1 April 2004.

10. Gwent Value for Money Evaluation

Evidence confirms South East Wales has the longest waiting times for elective orthopaedic services (inpatients, daycases and outpatient appointments) in Wales.

Professor Edwards' review earlier this year of orthopaedic services in Gwent found not only a lack of capacity but also a need for tighter management and innovation. Early scrutiny of the Gwent business case also suggested that there still remained a number of inefficiencies. As a result an external expert review, from the University of Birmingham, was sought to provide further information.

Scrutiny in Gwent has highlighted that there some anomalies in regard of activity levels and benchmarking of costs; performance issues are already being addressed as part of the Edwards' Action

Plan and improvements will be delivered on a phased basis. The health community shall therefore be required to address the efficiency shortfalls identified as an integral condition of the investment.

Value for Money Evaluation:

Indicator	**Gwent**	**England**	**Wales**
Total admissions / 1,000 catchment population	17.71	16.84	17.47
Emergency admissions / 1,000 population	8.63	6.89	9.15
Non emergency admissions / 1,000 catchment population	9.08	9.95	8.32
Average length of stay	5.61 days	7.2 days	6.5 days
Percentage of non emergency admissions admitted as daycases	18%	43%	33%
Outpatient return to new ratio	2.41	1.92	2.21
New outpatients / 1,000 catchment population	33.49	37.31	36.74
Consultants / 100,000 population	3.0	2.57	2.68
Number of junior staff / consultant	1.33	0.98	1.12
Total inpatient & daycase waiting List / consultant	192	201	257
% Inpatient & daycase on waiting list 12m+	10%	7%	12%
New outpatients / consultant	1,115	1,449	1,373

11 Commission for Health Improvement - Report of NHS Direct Services in Wales and England

On 10 November 2003 the health watchdog the Commission for Health Improvement (CHI), published a report into NHS Direct services throughout Wales and England, which clearly recognises that the service is highly successful and well regarded by the public. This is the first assessment of NHS Direct since it was set up in early 2001 (late 2000 for most English Regions) and the report highlights how successful the service has been in it's first three years. CHI's report is based on individual reviews of 20 of the 24 NHS Direct sites in Wales and England, although Welsh statistics have been excluded from the report as the specific Welsh NHS Direct clinical governance review is not due to be published until December.

NHS Direct is a nurse led 24 hour helpline which now handles over half a million telephone calls and half a million internet enquiries every month, with demand continuing to grow. The majority of calls are outside the working hours of GP surgeries and cover a wide range of health issues, with a quarter relating to children under 5 years.

CHI recognises that NHS Direct services are highly valued by the public with 90% of callers completely or partially satisfied with the way that their phone call was dealt with. The report highlights the hard work and commitment of staff to ensure the highest possible quality of care for service users, and notes that staff are proud to work for the service. The report identifies some areas however, that NHS Direct services across Wales and England need to address. These are primarily around strategic direction, self-assessment and responsibilities etc, and associated with the fact that as a new organisation, attention has been focussed on the setting up and development of new services. This timely report, along with the individual reviews, will help guide the future development of NHS Direct, but I am sure that the Committee will want to join me in congratulating the service on what has been achieved.

12 Consultant Contract

I am delighted with the outcome of the recent ballot on the amended Consultant Contract for Wales where on a turnout of almost 65%, 94% of consultants and specialist registrars voted in favour. This heralds a new era for consultants in Wales and is the first real change to their working terms and conditions of service since the NHS was first established in 1948. More importantly this change has been negotiated in Wales, by representatives of NHS Wales and the Welsh BMA at the instigation of the Welsh Assembly Government.

This contract is good for patients and good for consultants. Improved morale within the workforce will undoubtedly improve the quality of care patients receive.

13 National Clinical Assessment Authority (NCAA)

I formally opened the NCAA's office in Wales at a launch event in Cardiff on 11 November. The NCAA, which was established as a special health authority in April 2001, has in effect been offering

advice to NHS Wales since day one, but with the opening of its office in Cardiff will now be able to offer the full range of its services.

By helping the NHS in Wales to deal with performance concerns of individual doctors and dentists as early as possible, the NCAA will assist employing organisations in resolving any issues before they become crises.

14. Updates

14.1 Domiciliary Care Agencies (Wales) Regulations and Standards

At the last HSS Committee meeting on 5 November I stated that this report would include briefing on how it was proposed to implement domicilliary care regulation in Wales. Care Standards Inspectorate for Wales (CSIW) are currently consulting with providers and key partners on the implementation arrangements for the regulation of domiciliary care in Wales (including the implications of staff training). I therefore defer this matter until the first meeting of the Committee in 2004.

14.2 Delayed Transfers of Care

As an immediate response to 'The Review of Health and Social Care' (advised by Derek Wanless) I announced an additional £4m to reduce delayed transfers of care sustainably and promote alternatives to acute hospital admission. This is consistent with the underlying principle of releasing capacity within the acute/secondary care sector outlined in the Question of Balance report. I took the decision to channel this money through the Local Health Boards, as brokers between acute and social care. The funding is being allocated on the basis of performance and need.

On 12 November I published the September census figures for delayed transfers of care in Wales (1116). These figures include (separately) delays related to mental health that up until the introduction of the new data collection system had never before been counted. The next publication of census figures (ie for December) is due for publication in early January 2004.

However, the October results are coming through and we are now confident that the first £2.7million of this investment will have released more than 100 beds in Welsh hospitals by the end of October. That is 100 beds which would otherwise not have been available for use as we go into the winter period. During the month ahead, further scrutiny will be undertaken of the way in which this money has been put to use. In most parts of Wales I have been heartened by the way in which results have been secured. Where performance has fallen short of plans submitted and approved, the money provided will be reclaimed.

14.3 Waiting Times

Second Offer Scheme

In line with continued efforts to reduce the length of wait for treatment, I have asked officials to put in place a programme whereby any patient likely to wait over 18 months is guaranteed a reasonable and timely offer of treatment. This will mean that every patient in Wales will be guaranteed a second offer of treatment to ensure they wait no longer than 18 months for in-patient or daycase treatment. If a patient has not been given a firm date for their treatment during the final three months leading up to the 18 months maximum wait, then they will be offered the opportunity of having their treatment with an alternative provider.

I will be making available funding to assist the NHS with this second offer scheme for a limited period of time, after which, I will expect the NHS in Wales to continue to guarantee that nobody will wait for more than 18 months.

Jane Hutt
Minister for Health and Social Services

Annex 1 Draft GMS Legislation

THE HEALTH AND SOCIAL CARE (COMMUNITY HEALTH AND STANDARDS) BILL

SUMMARY OF THE NATIONAL ASSEMBLY FOR WALES DELEGATED POWERS IN RESPECT OF MEDICAL PRACTITIONERS

Clause	Description of power	Likely content	Replaces
	Section 16CC is inserted into the 1977 Act by this amendment. Section 16CC sets out the LHB duty in respect of primary medical services		
170	Power in new section 16CC (3) to make regulations to prescribe what information a LHB must publish about the primary medical services for which it makes provision.	LHBs will publish details of the primary medical services that are available in its area, together with details of providers, to improve the information available to users of the service. The requirements will inevitably change over time as providers abilities to provide information improves. For example, in the	New power on the face of primary legislation but regulations will replace existing similar, but less detailed, provisions in regulation 8 of the National Health Service (General Medical Services)

		future it may be a requirement to make available certain statistical information that providers currently do not record. Further, the regulations will contain a level of detail that justifies a regulation making power.	Regulations 1992 (S. I. 1992/635
170	Power under new section 16CC(5) for regulations to prescribe what should or should not be regarded as primary medical services.	The regulations may be used to clarify whether any particular service is or is not a primary medical service which a LHB has responsibility to provide. For example, this could be used, if necessary, to maintain a national range of primary medical services across all LHBs. It is therefore not intended to exercise this power on implementation with the new GMS contracts provisions.	New power, but currently regulations under section 29 of the National Health Service Act 1977 prescribe what general medical services are.
	Sections 28Q – 28W, inserted into the 1977 Act by this amendment, govern the terms and content of the new General Medical Services (GMS) contract.		
171 Section 28R	Section 28R - power to set out in regulations the primary medical services that a GP must provide, under a GMS contract	The regulations will set out those services referred to in the NHSC/GPC agreement as essential services (paragraph 2.8) They are firstly the management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally expected, for the duration of that condition, including relevant health promotion advice and referral as appropriate, reflecting patient choice wherever practical, secondly the general	Replaces similar powers in section 29 of the 1977 Act which gave rise to the National Health Service (General Medical Services) Regulations 1992 (SI 1992/635) which will be revoked.

		management of patients who are terminally ill and thirdly the management of chronic disease in a manner determined by the practice, in discussion with the patient.	
171 Section 28S	Section 28S - Power to prescribe the conditions under which an eligible person may enter into a GMS contract must meet as anticipated in paragraphs 7.7-7.10 of the NHSC/GPC agreement	Section 28S sets out the persons with whom a LHB may enter into a GMS contract. Regulations under section 28S(1) will be used to set conditions that those who are party to a GMS contract must meet. Conditions might be, for example:- • that any individual practising in partnership does so on his or her own account and not for the benefit of a third party; • that a contractor is not be disqualified by a professional body from practising their profession or convicted of a serious offence in the UK; • that any party to the contract who is a medical practitioner will have to be included in the proposed GP Register (established by article 10 of the General and Specialist Medical Practice (Education, Training and Qualifications) Order, when in force.	These regulation making powers will replace the complex regulatory structure executed under the powers in sections 29, 29A, 29B, 31 and 32 of the 1977 Act and under the National Health Service (Service Committee and Tribunal) Regulations 1992 (S. I. 1992/664) (also made under section 29 taken with section 17 of Health and Medicines Act 1988) to regulate the provision of GMS through, for example, the medical list, statutory processes for the filling of vacancies, and associated disciplinary matters.

		The details of any condition to be prescribed will be discussed with the NHSC and the GPC as part of the implementation process. Section 28S(2)(b)(iv) permits those who are already providing services under a GMS/GDS contract or a PMS/ PDS agreement to enter into new GMS contracts. It allows regulations to prescribe that this ability to enter into a GMS contract can be retained for a prescribed period during which the individual might not be providing services. The purpose of the provision is to cover a situation where a person is a provider of such services under a GMS contract or a PMS agreement, but the contract terminates before a new or replacement contract is agreed. The exercise of the power will allow such a person to enter into a new contract for a prescribed period of time notwithstanding the fact that he is not currently a provider.	

171 Section 28S(4)	Section 28S(4) – power to set out in regulations in respect of a GMS contract the effect of a change in the membership of the partnership that holds the GMS contract	Regulations may be used to allow a contract to continue despite routine changes in partnership such as career change or retirement. The use of the regulations will save the bureaucracy which may be involved in terminating a contract and replacing it with a new one each time there is a routine change in the membership of the partnership. This provision contributes to the continuity of contracts envisaged in paragraph 7.13 of the Agreement	This regulation making power also contributes to the replacement of the existing complex regulatory structure set out above, in particular the statutory process for filling practice vacancies
171 Section 28T	Section 28T - Power of direction in relation to payments to be made under a GMS contract.	This power allows for payments in respect of any particular matter under the contract to be set on a national basis. Directions may relate to payments to be made by a LHB to a GMS provider or by a GMS provider to a LHB. Payments will be set out in directions, for example, payments in relation to the new quality framework (see Chapter 3 of the NHSC/GPC agreement).	Replaces existing system under which the Secretary of State sets out entitlements to payments to GMS contractors by a series of determinations (The Statement of Fees and Allowances made under 34 & 34A of the NHS (General Medical Services) Regulations 1992). The Statement of Fees and Allowances will be abolished.

171 Section 28U(1)	Section 28U(1) also gives the National Assembly for Wales the power to by directions place limits on the drugs that can be prescribed by a person providing GMS.	These Directions will provide for two lists of drugs, one list that cannot be prescribed and one where the listed drugs can only be prescribed in certain circumstances.	These directions will replace Schedules 10 and 11 of the NHS General Medical Services) Regulations 1992 (S. I. 1992/635) which will be revoked.
171 Section 28V(1)	Section 28V(1) – power to prescribe the provision that must be made under a GMS contract	Examples of the areas that will be covered by the regulations are: - • the right of patients to choose the person from whom they are to receive services; • the manner in which, and standards to which services are to be provided; • the persons who perform services; • contract variation and enforcement; • the adjudication of disputes;	Regulations under this section will cover areas that are similar to those set out in Schedule 2 to the NHS (General Medical Services) Regulations 1992, which will be revoked.
171 Section 28V(3)	Section 28V(3) – power for regulations to set out the relationship between a contractor and their patients. These are covered in Chapter 6 of the NHSC/ GPC Agreement.	The regulations will: - • Provide a framework to allow patients to register with a contractor; • allow a contractor to refuse a patient registration (for example a violent patient); • provide a framework under which a patient	The delegated powers replace those in section 28F of the 1977 Act which are repealed and will in turn repeal the National Health Service (Choice of Medical Practitioner) Regulations 1998 (S. I. 1998/668).

		can be assigned to a particular contractor; • provide for the termination of a contractors responsibility; • require all contractors to have in place systems that allow patients to choose the medical practitioner who will treat them.	
171 Section 28V(4)(a)	Section 28V(4)(a) will allow regulations concerning contract variation to make provision about the circumstances in which a GMS contract variation may be imposed, subsection (4)(b) allows the regulations to make provision about the suspension or termination of a duty under the GMS contract of a prescribed nature. Subsection 28V(5) allows the services prescribed under subsection (4)(b) to be prescribed by reference to the manner or circumstances in which they are provided.	Regulations under subsection (4)(a) will deal with variation where, for example, a failure to reach an agreement would prevent the LHB from fulfilling its statutory duty. Regulations under subsection (4)(b) will, for example, define the services that GMS contractors may opt out of providing and detail the procedures through which the opt out can be effected. – this is likely to be the six "additional services" (cervical cytology, contraceptive services, vaccinations and immunisation, child health surveillance, maternity services and some minor surgery procedures) defined in the NHSC/GPC agreement (Chapter 2).	New Powers required to implement the new service definitions in the new GMS contract

171 Section 28W(1)	Section 28W(1) – Power to make regulations to cover the resolution of disputes concerning the terms of a proposed GMS contract.	This power will enable regulations to provide for pre-contract disputes to be determined on the same basis as those that relate to actual contractual terms. It reflects the text of the NHSC/GPC agreement – paragraph 7.51	These are new powers that reflect the existing power in section 28E to resolve disputes involving PMS agreements. They reflect the need to have procedures to resolve disagreements in a fair manner. The pre-contract dispute process will be modelled on the National Health Service Contracts (Dispute Resolution) Regulations 1996 (S. I. 1996/623) made under section 4(5) of the Act which will probably be amended accordingly.
171 Section 28W(3) to (5)	Section 28W(3) to (5) – power to make regulations to set out the circumstances under which a contractor may be regarded as a Health Service Body for contracting purposes.	To limit the need to renegotiate contracts following routine partnership changes section 28W(4) allows regulations to provide for the maintenance of such status despite routine changes in the partnership within a GMS contract. This will contribute to the continuity of contacts envisaged in paragraph 7.13 of the Agreement	These are new powers that will allow the new "GMS" contracts to be treated as NHS contracts for the purpose of resolving disputes. This adopts the same principles that currently apply to Personal Medical Services contracts under section 28E(3)(b) of the 1977 Act

172	Power to by order make transitional provision in relation to the circumstances in which persons have a right to enter into a GMS contract for the provision of medical services.	The order will cover such issues as - the rights, and associated terms, of existing providers of GMS to be offered a new GMS contract, the circumstances in which an existing provider of GMS must be offered a default contract where it has not been possible by the relevant date to conclude negotiations in respect of a new GMS contract, for the resolution of disputes, for the backdating of terms and conditions.	New transitional provision which is needed to ensure that medical practitioners moving from the existing agreements with the LHB for the provision of GMS, (based on an individual basis), to the new practice based contract set out in the NHSC/ GPC agreement can be offered appropriate and necessary protection.
175 Section 28X	Section 28X provides for regulations for LHBs to prepare a list of those who can perform primary medical services	Medical regulations may cover, for example, • the documents/ information that a practitioner will be required to submit with his application • Matters such as the grounds on which a LHB may or must refuse an application for inclusion in a list; • grounds on which a LHB may suspend or remove a person from a list and the procedure for doing so, • making payments to or in respect of suspended practitioners. • the disclosure by LHB to prescribed persons of specified information	Rationalises the existing principal, supplementary and services lists into a single medical list at LHB level. In doing so it will replace the existing list provisions in the National Health Service (General Medical Services) Regulations 1992 (S. I. 1992/635), National Health Service (General Medical Services Supplementary List) Regulations 2001 (S. I. 2001/3740 and the prospective medical list provisions to be made under 8ZA of the National Health Service (Primary

		about applicants for inclusion in a list as well as refusals of applications and suspensions and removals from lists. • Disqualification from the list, contingent removal from the list, suspension from the list, review of LHB decisions, appeals and national disqualification. The criteria to be used will continue to be based on suitability, efficiency and fraud. The regulations may also provide for an appeal, by re-determination, to the Family Health Services Appeal Authority against any discretionary decision by a LHB to remove, or contingently remove, a person from a primary care performers list or to apply conditions on a persons inclusion in the list.	Care) Act 1997 and section 28DA of the 1977 Act.
180	This is a schedule of minor and consequential amendments which includes:-		

180 at parta 22 inserts sections 45A and 45B into the 1977 Act	at paragraph 22 inserts sections 45A and 45B into the 1977 Act. Sections 45A (7) and 45B(7) allow the National Assembly for Wales to make regulation that require LHBs or to consult Local Medical Committees (LMCs)and Local Dental Committees (LDCs)	The NHSC/GPC agreement provides for a number of roles for the LMC, for example in the list closure/patient assignment arrangements in Chapter 6. Where appropriate such roles may be provided for in regulations	Sections 45A and 45B separate out the roles of these committees from the existing provisions in sections 44&45 of the 1977 Act, the new regulation making powers simply replace those in section 45(1) in respect of LMCs and LDCs.
180 para 25 a regulation making power is inserted into section 54	at paragraph 25 a regulation making power is inserted into section 54 (Sale of Goodwill). We have taken this power to ensure we achieve ECHR compatibility and coherence in the light of the changes to LHB commissioning patterns, for example the potential to have individual contracts just for additional services and/or out of hours services if the LHB has to re-provision those services following opt-outs.	The NHSC/GPC agreement (paragraph 7.21) agrees that the existing ban on the sale of goodwill needs to continue, and we will discuss the details of the subsequent regulations with the GPC and the Confederation.	A new power to deal with revised commissioning patterns allowing the LHB to commission from any one they see fit and to reflect that not all providers of primary medical services will be providing all services