



From Our Irregular Correspondent

Back where we started from – Reflections on 22 years in NHS Wales –

One in a series of occasional papers on health and social care topics by Terry & Monica Dennis of Healthcare Alliances. Our aim is to be thought provoking with a touch of devil advocacy. They are based mainly on our experiences of work, mentoring and training. They contain the occasional reference. This paper has been written by Terry Dennis.

“In the beginning there were area health authorities and the area health authorities were with the Minister”

14 years before I set up the consultancy practice of Touche Ross (now Deloitte) in Cardiff, there were 8 area health authorities (AHAs) in Wales responsible for primary, community and secondary care. 22 years later there are 7 local health boards responsible for primary, community and secondary care. Two differences are that:

- Betsi Cadwaladr University LHB encompasses Clwyd and Gwynedd AHAs
- The Assembly Health Minister has replaced the Secretary of State for Wales as the politician responsible for health in Wales

In summary, over the 36 years there have been:

- 8 area health authorities (AHAs)
- 9 district health authorities (DHAs)
- 2 special health authorities
- 8 family practitioner committees (FPCs)
- 31 (old) NHS trusts
- 8 family health service authorities (FHSAs)
- 5 health authorities (HAs)
- 22 local health groups (LHGs)
- 14 (new) NHS trusts
- 22 (old) local health boards (LHBs)
- 7 (new) local health boards, 2 (old-new) NHS trusts and 1 (new-new) NHS trust

In addition:

- The NHS Staff College Wales morphed into the Centre for Health Leadership Wales (CHLW) which morphed into the National Leadership and Innovation Agency for Healthcare (NLI AH)
- We have had the Health Promotion Authority for Wales, the National Public Health Service and now Public Health Wales

The summarised timeline for these changes is as follows

Year	Event	Health sector funding	Accountable politician	Director of NHS in Wales	
		Secondary care (HCHS ¹) Primary care (GMS ²)			
Before Life in Wales					
1948	NHS established	Welsh Board of Health	Aneurin Bevan ³		
1964	Welsh Office established		Ken Robinson ⁴		
1969	Responsibility for health devolved to Welsh Office		Jim Griffiths ⁵		
1974			8 AHAs ⁶ established (with FPCs)	John Morris Nicholas Edwards	
1979		9 DHAs ⁷ 8 FPCs			
1982					
1983	Griffiths Report				
1984	General management				John Wyn Owen
1985					
1986					
1987				Peter Walker	
Working in Wales					
1988	Welsh Health Planning Forum	31 NHS Trusts ⁸ 8 FHSAs GP fundholding			
1989	Strategic Intent and Direction				
1990				David Hunt	
1991					
1992					
1993	Caring for the Future			John Redwood	
1994					Peter Gregory
1995				William Hague	
1996					
1997					
1998	Putting Patients First		Ron Davies Win Griffiths ¹⁰		
1999	National Assembly of Wales		Alun Michael ¹¹ Jon Owen Jones ¹²		
2000			Jane Hutt ¹³		
2001	NHS Wales Plan	14 NHS Trusts ¹⁴		Ann Lloyd	
2002					
2003					
2004					
2005	Designed for Life		Brian Gibbons		
2006					
2007			Edwina Hart		
2008					
2009		7 ¹⁶ (New) Local Health Boards and 3 NHS Trusts		Paul Williams	

The purpose of this paper is to set out some personal reflections on the NHS in Wales since 1988.

In the beginning: 1988

After graduating in law, I qualified as a chartered accountant with, what is now, KPMG. I was appointed financial controller at JCB and moved onto the corporate headquarters of British Aerospace (now BAe Systems). In 1986 I joined Touche Ross Management Consultants (now Deloitte) in Manchester. Early in 1988 I was asked to set up the Cardiff management consultancy practice – the same year that the Department of Health and Social Security was split into two.

So, on 1 April 1988 the removal van left Altrincham in South Manchester for St Hilary near Cowbridge followed by Monica, Christopher, Alistair and myself. 23 days later Claire was born – which, I now realise, was cutting things a bit fine!

Initially, the consultancy practice in Cardiff was mixed – public and private sectors, health and local government, multi-nationals and owner managed businesses. Colleagues who have remained as friends since then include Geoff Thomas and Chris Davies.

In Manchester, I had been heavily involved in healthcare assignments. Income generation, value for money and costing commissions being fashionable (some things never change!). I had also been involved with the Institute of Health Service Management (IHSM – previously the Institute of Health Service Administrators) and the Health Finance Management Association (HFMA) in the North West and Mersey Regions. Consequently, I had an affinity with healthcare and that became the focus of the consultancy practice.

In 1988:

- Westminster MPs determined health policy, mainly through the Department of Health.
- The Welsh Office had 3 Conservative ministers; one was the Secretary of State for Wales, Peter Walker.
- Wales had 9 district health authorities (DHAs) and 8 family practitioner committees (FPCs) based on the then 8 counties. Dyfed was split into 2 health authorities: East Dyfed and Pembrokeshire. This might have had something to do with the Secretary of State for Wales (Nicholas Edwards - now Lord Crickhowell) being the sitting MP for Pembrokeshire when the health authorities were established in 1982.
- General management (the Griffiths report – a letter in reality) was being implemented.
- Financial budgeting had just been introduced (does anyone remember the Arthur Young management budgeting system?).

In 1988 FPCs were mainly administrative; DHAs had the power. The district general managers (DGMs) appeared to have virtually unfettered powers of hiring, promotion and firing. They were all male and most had a drinks cabinet or fridge in their office – not acceptable today, but in those days an hour or so in the DGMs' office was a good time to network, share thoughts and discuss ideas.

NHS Directorate: Too few staff, or too much to do

One of my first assignments in 1988 was for the NHS Directorate of the Welsh Office. John Wyn Owen was the first director, having been in post since 1984. His appointment caused much discussion because he was not a civil servant, but a NHS manager, with experience of managing St Thomas' Hospital in London. Most of the discussions centred on how the civil service coped with someone who was not grounded in its culture, and vice versa.

Apart from John Wyn Owen, the NHS Directorate was staffed by career civil servants. Heads of divisions included Colin Williams, David Pritchard, Denzil Jones and Neil Thomas.

The Directorate had around 110 staff and the brief was simple: “was the staffing level sufficient?” At the time, Welsh health policy was largely led by the Department of Health which was staffed by thousands of staff in London, and then subsequently Leeds (in 1994 as the NHS Management Executive). The Welsh NHS Directorate:

- had to implement much of the UK policy
- was responsible for operational matters
- had the remit for developing service strategies – most notably mental health and health promotion

Our conclusion was as simple as the brief: “there were either too few staff to meet the agenda, or the agenda was too large for the staff to deal with”.

There is a similar dilemma today: how can the relatively small health system in Wales ever match the resources that are allocated to policy development in England?

Although there were resource limitations, the period of the late 1980s was perhaps the most effective in terms of policy and direction in Wales, despite the ever present tension between operational management and the political agenda. The Secretary of State for Wales had a wide brief; health was only one of the post holder's responsibilities. As a result policy development was left largely to the Director of the NHS in Wales, which meant that it tended to reflect health needs rather than the politician's agenda.

The barons of district health authorities

In the late 1980s we were asked to tender to prepare a business case for a new hospital. The hospital was to be funded by “unconventional finance” (the forerunner to PFI). We made our presentation to the district health authority’s district general manager (DGM) and his team. After we had made our presentation, the DGM said that payment of our fees would be dependent on approval of the business case by the Welsh Office. This condition was not included in the written brief. We considered that the condition would affect our independence and, therefore, we withdrew from the tendering process.

The point of the story is that the DGMs wielded fairly unlimited power in their health authorities. Performance management was many years away and there was little interference from the centre. They were known colloquially and collectively as the “barons”. Each had his own unique character and included Gordon Harray in South Glamorgan, Jeremy Hallett in Gwent, John Taylor in East Dyfed, George Boulton in Mid Glamorgan and, Dr David Jones in Clwyd (who was possibly the first clinician in senior management in Wales). The DGM we presented to is not included in this list.

This was a time when DHAs were at the top of a planned system with a chain of command running from the ward to the DGM. There was a focus on service and capital planning, with an emphasis on efficiency savings and staffing levels. There was an active management services department in South Glamorgan with responsibility for those matters. Gwent and other DHAs had similar departments.

There were weaknesses with the system:

- The virtually unfettered power of the DGMs meant that cliques developed, particularly in the DHA headquarters.
- There was little incentive for change and innovation, unless the DGM was that way inclined.
- DHAs had institutional cultures and norms of social behaviour, hierarchy and ways of working.

On the other hand, there were advantages:

- There was good staff development; the DGMs moved staff around to give them a broad range of experience.
- Networking around Wales was excellent. The DGMs used to meet regularly, each taking it in turn to host the meeting (quarterly, I think). This helped to reduce the Cardiff-centric influence of the Welsh Office. It also gave a platform for other professions to meet and network. For example, because the District Treasurers (today’s Finance Directors) met at the same time, the Health Finance Management Association (HFMA) used to hold their meetings either preceding or following the Treasurers’ meeting. As did the Chief Administrative Nursing Officers (today’s Directors of Nursing) and the Institute of Health Service Management (now the Institute of Healthcare Management).

Numbers are constant and so are the accountants

In the late 1980s, the London office of Touche Ross had undertaken several reviews of paymaster services (creditor payments and payroll) of health authorities. As a result, we were commissioned by several of the treasurers (now finance directors) of the nine district health authorities (DHAs) in Wales to review their paymaster services. Other projects included costing the transfer of the burns service from St Lawrence Hospital in Chepstow to Morriston Hospital.

At that time, DHAs were responsible for what was known as the HCHS (Hospital and Community Health Services). This included all secondary, community, mental health, tertiary and specialist services. Primary care funding at that time was through the FHS (Family Health Services) budget administered by the eight family practitioner committees (FPCs) in Wales. They were responsible for reimbursing the four contractor professions: GPs, pharmacists, dentists and opticians. They had little discretionary budget – making payments to the contractors according to the “red book”.

The treasurers, like the DGMs were characters. People like Nigel Towns in East Dyfed, Kelvin Redwood in Gwent, Roger Wood in South Glamorgan, Brian Jones in Clwyd, Bill Owen in Gwynedd and Chris Grimes in West Glamorgan. They kept a watchful eye on the purse strings and were often the most influential member of the health authority after the DGM (and sometimes the chairman). Today, there are so many funding streams that the mapping of expenditure to income has been lost – I am not sure what the treasurers would make of that.

The debate about, and restructuring of, central services such as finance and IT still exists in 2010. Today's corporate support organisations such as the Business Service Centre, the North Wales Business Support Partnership, Welsh Health Estates, the National Leadership and Innovation Agency, Health Solutions Wales, Breast Test Wales, the Artificial Limb and Appliance Service, Welsh Blood Service, Welsh Health Legal Services, etc can all trace their roots back to the Welsh Health Common Services Authority (which itself was preceded by the Welsh Health Technical Services Organisation: WHTSO) – a special health authority established under the NHS Act 1977 to provide a range of specialist professional, clinical and technical services for the NHS in Wales. It was dismembered by John Redwood in the mid 1990s – see the Redwood Stage section later in this paper.

Where's SID?

One of the lasting marks of John Wyn Owen's tenure as director of NHS Wales was the establishment of the Welsh Health Planning Forum in 1988. For the first time Wales was seen as taking a lead in health policy in the UK and was recognised worldwide for developing the pioneering concept of health gain and protocols of investment for health gain. Its landmark publication was known as SID. Not the 1987 BT campaign to attract private investors on privatisation, but *Strategic Intent and Direction*. Famously known at the time for its strap line of "adding years to life and life to years". The Welsh Health Planning Forum is attributed with the first use of the term "health gain" in the UK.

Founder members, in addition to John Wyn Owen, included the Director, Morton Warner. Other members over the years included Jan Williams, Tony Beddow, Deirdre Hine, Mike Ponton and Patrick Coyle supported by a secretariat which included Marcus Longley, Chris Riley and Jeremy Felvus.

Although we did not know it at the time, this was a golden age for policy and planning in the NHS in Wales. Intellect and resources were committed to developing guidance and protocols long before NSFs. The Planning Forum's publications from 1989 to 1995 included Protocols for Health Gain such as mental health, primary care, diagnostics, genetics, nutrition, cancer, public health, quality, maternal health, dental health and respiratory disease which fed into the local strategies for health. In addition, the Planning Forum published a series of ad hoc papers on topics that were considered to be strategically important for the future planning of the NHS, for example, a study on endoscopic surgery and the future of day cases. The Forum became a WHO collaborating centre and provided consultancy services across Europe. Today, in 2010, I wonder who now has the remit for this type of clinically led, strategic planning in NHS Wales?

The purchaser / provider split

In the early 1990s the Conservative government in Westminster, led by Margaret Thatcher and Kenneth Clarke, introduced the "NHS reforms". *Working for Patients* set out the key elements, the heart of which was the purchaser/provider split (internal market), based on the establishment of NHS trusts, independent of the district health authorities.

Initially Wales did not embrace the changes. There were no Welsh trusts established in the "first wave" in 1990. The Welsh "first wave" was in 1991 when Pembrokeshire NHS Trust was established, more as a defensive measure against merger with neighbouring provider units – although the first chief executive did not do his colleagues any favours by being photographed by the Western Mail getting out of his shiny red sports car outside his holiday cottage! It fuelled criticism of fat cat pay packets of NHS managers – similar to the public perception of bankers' pay in 2010.

Despite some resistance by the health authorities, especially in South Glamorgan, all the provider units became NHS trusts over the next few years – helped by the unexpected re-election of John Major's Conservative Government in 1992 which meant that the reforms continued.

Around the same time (1991) the 8 family practitioner committees (FPCs) became family health service authorities (FHSAs) reflecting an increase in their discretionary funding and more involvement with the management of primary care – particularly GP fundholding (GPFH) and the old “new GP contract”. Some effort went into implementing GPFH, particularly in Gwent and parts of Powys. It was, however, often resisted by some of the trusts and health authorities; for example, by 1997 the population covered by fundholding ranged from 42% in Bro Taf to 73% in Dyfed Powys. Despite the resistance, this was the period when locality planning and commissioning were pushed hard – providing the foundations for what were to become local health groups (LHGs).

There were 31 NHS trusts in Wales at their peak – and I helped 27 of them with their application. Even then there were mutterings about sustainability because of their small size: there were 5 ambulance trusts; Derwen NHS Trust was in effect St David's Hospital in Carmarthen; and the University Dental Hospital in Cardiff was independent of the University Hospital of Wales. Budgets were small by comparison to today, even after allowing for inflation. The budget of the largest trust in 1995, University Hospital of Wales Healthcare NHS Trust, was £101m; the budget of the largest LHB in 2010, Betsi Cadwaladr University Local Health Board, is £1,170m.

Many of the incumbent unit general managers became the chief executive of the new organisations: Margaret Foster in East Glamorgan; Martin Turner at Glan Hafren (Newport); John Richards in Velindre; Paul Williams in Bridgend; Norman Mills at Llandough, David Williams at Swansea (Singleton); Mike Naylor at Morriston; Gren Kershaw at Glan Clwyd; Laurie Wood at Clywdian Community; Norman Whitehouse at the Dental Hospital; etc.

The five ambulance trusts also had characters at their helms: Keith Goodall in South and East Wales; Stephen Harray in Mid Glamorgan; Jim Butcher in West Wales; etc.

The situation was different with the chairs of the trusts. They came from a diverse range of backgrounds: banking; electricity supply; motor trade; publishing; manufacturing; property management; accountancy; Post Office; farming. Only a few had management experience of the NHS, although some of those that had, had been the DGM of the predecessor DHA, which led to some interesting relationships. They were all self-taught and had to find their own way through the thicket of national policymaking and local politics.

This was a time of energy, innovation and development – despite the introduction of capital charging. Although the policy was clear, details of implementation were light. The local focus, freedom from the bureaucracy of the health authorities and the relatively light hand of the Welsh Office meant that trusts felt autonomous and things got done. Premises were modernised, staff felt committed and services were developed. Despite ever present funding problems, a dislike of the contracting/purchasing/ fundholding environment and the inevitable variability that came from 31 independent trusts, it was an exciting time. It couldn't last.

The Redwood stage rides into town (1993 – 1995)

I have tried to be apolitical in this paper. The exception is the period 1993 to 1995 when John Redwood was Secretary of State for Wales – a nightmare. The iconic public memory of him is his unsuccessful attempt to mime the Welsh national anthem. However, of more lasting significance to the NHS in Wales (and the public sector generally) was that he:

- returned £100m block grant to Treasury, thereby reducing funding available to Wales in subsequent years.
- started the process of re-organising local government, creating 22 unitary authorities some of which, even then, were considered to be too small – and which also laid the foundations for the relatively short-lived 22 local health boards.
- initiated the break-up of the Welsh Health Common Services Authority (WHCSA – see above) and, according to Hansard, was quoted as saying that the staff should “find work in the private sector”.
- stopped central planning processes, including the Welsh Health Planning Forum. This was a major backward step. It took the NHS in Wales years to recover from the lack of central direction and coordination.

It now seems strange that amongst all this devastation, I worked with George Boulton to prepare the business case for the establishment of the NHS Staff College Wales, which was set up in 1995 headed by Stephen Prosser.

During John Redwood's term in office, John Wyn Owen left for a post in Australia. It was a great loss to Wales and there were rumours that his resignation might have been related to differences in style between himself and Redwood.

With John Wyn Owen's departure, went the sense of corporateness in NHS Wales which he had engendered. He was replaced by Peter Gregory, a career civil servant. Although not to everybody's liking within the NHS, Peter fulfilled his task well of serving the will of the minister. This period perhaps marked the beginning of the politicians and the civil service becoming much more involved in the day-to-day operational running of the NHS in Wales – something that lasts to today.

Apparently, on the day Redwood left the Welsh Office a senior civil servant was seen in his office, leaning back in his chair with his feet on his desk – puffing on a cigar and a clear sense of relief on his face!

The lull before the storm (1995 – 1997)

In 1995 William Hague replaced John Redwood. Initially, there was concern as Hague's image as an ultra right wing Tory preceded him. However, in practice he was easy to work with and sympathetic to the uniqueness of Wales. He also showed an interest in the experience and well being of patients which was a marked contrast to his predecessor.

In 1995 the Calman-Hine Report was published – a policy framework for commissioning cancer services. Deidre Hine had been chief medical officer in Wales.

The Welsh Office document, *Fresh Start*, in 1996 led to the major structural change during Hague's term, which was the merger of the 9 district health authorities (DHAs) and 8 family health service authorities (FHSAs) into 8 health authorities (HAs – thereby losing the “district” element of the name”).

The first of many trust mergers was in 1997 when Pembrokeshire and Derwen NHS Trust was established.

Other than the health authority changes, which did not impact greatly on the provider trusts, this was a relatively quiet time in NHS Wales. Most people were anticipating a change in Government in the May 1997 elections, which labour duly won with a landslide victory.

The winds of change (1997 to 2000)

The merger of health authorities in 1996 had mirrored England. However, the advent of a labour administration in Westminster in 1997 and the promise of devolution gave the impetus for the Welsh Office ministers to begin the process of developing a different approach in Wales.

Ron Davies was Secretary of State with Win Griffiths, and subsequently Jon Owen Jones, as the Welsh Office minister with responsibility for health. In addition to changes in the chairs of Welsh health organisations (reflecting political leanings), there was an initial spate of enforced trust mergers. In 1998 the five ambulance trusts merged to become the Welsh Ambulance Service and the following year, in April 1999, the remaining 25 trusts were reduced to 16, mainly through the merger of acute and community trusts – for example Gwent Healthcare NHS Trust from Gwent Community, Glan Hafren and Nevill Hall trusts and Conwy and Denbighshire NHS Trust from Glan Clwyd District General Hospital and part of Clwydian Community.

When I asked a senior civil servant the rationale for the changes, I was told that the civil servant had recently asked the ministers the same question. The alleged answer was “to show them who's in charge”.

This period saw policy developments that were common in both England and Wales:

- The National Institute for Clinical Excellence was established in 1997.
- In the same year, the Caldicott confidentiality guidelines were published.
- GP fundholding was abolished in 1998
- Also in 1998, quality rose towards the top of the policy agenda with the move from medical audit through clinical audit to clinical governance (*A First Class Service: Quality in the New NHS*).
- The Health Act 1999 established quality as being a legal duty on NHS organisations – when has that ever been enforced?
- And in 2000, the first National Service Frameworks (NSFs) were published.

During this period I established Healthcare Alliances with Monica, my partner and wife. Not as a direct result of the changes, but perhaps symptomatic of society and business. I was glad of some of the policy initiatives as my first two consultancy assignments were baseline clinical governance reviews for Velindre and Gwent Healthcare trusts. I also played a key role in the publication of the Institute of Health Service Management's (IHSM) policy document on clinical governance: *Clinician Heal Thyself*.

At the time I was Honorary National Treasurer of the Institute of Health Service Management (IHSM). The moral support I received during this period from members of the Welsh Divisional Council (Katie Norton, Daniel Phillips, and Graham Alexander) helped me to get through a difficult patch. I have found the networking of the IHSM (now the IHM) to be helpful and rewarding over the last twenty years – and one of my current aims is to try and reinvigorate the Institute in Wales.

A more coordinated and coherent strategy emerged in Wales with the publication of *Putting Patients First* in January 1998 and *Better Health, Better Wales* in May 1998. These were the last two health policy documents issued by the Welsh Office. The principles underlying the plans included closer working between the NHS and social services and support for primary care. The agenda in Wales was beginning to be different from that being set in England, which was starting the process of introducing a more business oriented model (and which would lead in due course to tariffs, payment by results, patient choice, independent treatment centres and foundation trusts).

The most visible difference in Wales was the establishment in April 1999 of 22 local health groups (LHGs) as committees of the health authorities– their boundaries being coterminous with local authority boundaries. Although the functions of LHGs were initially designed to be similar to Primary Care Groups (PCGs) in England, there were significant differences in their structure with, in particular, a wider range of representation on the LHB board. The Labour administration's (and impending National Assembly's) focus on the Welsh Way would eventually lead to LHGs (and the subsequent LHBs) to be different from the English PCGs/PCTs. LHGs in Wales were tasked with partnership working and commissioning; whilst PCGs in England were embracing commissioning and a business-like approach with vigour.

The focus in Wales on local needs and equality (which could be tracked back to the John Wyn Owen era) was reflected in my consultancy work in the period, which included local needs assessments in communities such as Upper Cwm Nedd, South Cefn Caeau, Llandovery, Merthyr Tydfil and Tregaron.

Sir Graham Hart's 1998 internal management document, *The Health Responsibilities of the National Assembly for Wales*, noted that under the Conservative administration, led by John Redwood, the Welsh Office had adopted a hands-off approach to NHS administration, leaving the initiative to the NHS Trusts on the ground. The result was lack of leadership at the all-Wales level and an absence of a strategic approach. Sir Graham said that "the NHS in Wales now requires greater leadership from the centre"

Despite the Hart Report, the beginnings of a Welsh Way and an agenda different from that being developed in England, the Welsh Office Policy Unit's report to the Assembly in 1999, *Stocktake of NHS Wales*, noted that staff numbers in the health division had reduced from 200 in 1994 to 145 in 1999.

At this time Wales was in the vanguard of telemedicine and ehealth. Being a founder member of the UK eHealth Association meant that I was heavily involved in many of the telemedicine projects in Wales, which included:

- TEAM (Tele-education and Medicine) which unlocked the thinking about the potential for telecare and telemedicine.
- KCL (Keeping Care Local) which demonstrated that telemedicine was operationally proven and clinically acceptable.
- TLC (Transforming Local Care) which built on the principles of KCL and applied them to a specific speciality, diabetology, in one geographical area.

Sadly, this momentum does not seem to have been maintained and Scotland is now recognised as being at the forefront of activity on ehealth and assistive technologies, which is a shame given the rurality of Wales.

The girls are back in town (2001 to 2006)

The thinking about the Welsh Way was pulled together in the NHS Plan for Wales (*Improving Health in Wales: A Plan for the NHS with its Partners*) which was published in February 2001 and promoted jointly by the Assembly's Health Minister, Jane Hutt, and First Minister, Rhodri Morgan.

It laid the foundations for the abolition of the 5 health authorities in 2003, which were replaced by 22 autonomous local health boards (LHBs) based on the existing local health groups. Powys NHS Trust ceased to exist when Powys LHB was established. 3 regional offices were also set up.

The NHS Plan also emphasised Jane Hutt's focus on partnerships and joint working with the establishment of local health alliances (sometimes confused with our business which had been established in 1988 – Healthcare Alliances). Many staff in the NHS, social services and the voluntary sectors in Wales concurred with the principle of closer working and there was a focus on needs led services.

There was a plethora of well-intentioned policy aimed at reducing inequalities and addressing poor health, for example Health, Social Care and Wellbeing strategies and Children and Young people's plans.

There have always been excellent examples of joint working and innovative service developments in Wales. However, the partnership policies were not matched by robust and resourced implementation plans and the rhetoric was not defined. This meant that the best practices of partnership working and needs led services never became widespread as organisational boundaries, budgets, differences in size of organisations and personalities got in the way.

Despite these difficulties with the realities of partnership working and the concept of needs led services, the profile and influence of the voluntary sector increased. One of the advantages of devolution has been that the voluntary sector has been more involved in contributing to policy development.

When Jane Hutt was Health Minister, Ann Lloyd replaced Peter Gregory as Director of the NHS in Wales in 2001, and Christine Dawes was appointed Head of NHS Finance in 2003. In addition, Dr Ruth Hall was Chief Medical Officer and Helen Thomas was Head of Social Care. At that point, all the key leaders of the NHS in Wales were female. Very different from the Barons of the 1980s.

The last "big strategy" (my emphasis) for Wales was *Designed for Life*, published by the new health minister, Dr Brian Gibbons, in May 2005. It is perhaps remembered more for the protests against community hospital closure plans in places such as Builth Wells and Llanidloes, than for its 10 year "Vision 2015 based on three 3-year Strategic Frameworks". Its primary author, Geraint Martin who was Head of Health and Social Care Strategy, set in motion a series of supporting strategies (Designed for This; Designed for That, etc) and then left when he was appointed Chief Executive of Counties Manukau District Health Board in New Zealand.

Its vision was "By 2015, through the efforts of the Assembly Government, the NHS, local authorities, their partners, the community and individuals, Wales will have minimised avoidable death, pain, delays, helplessness and waste." Perhaps not quite as snappy as SID's "adding years to life and life to years".

However, it did promise a “sharpened incentives and sanctions regime”. This did come to pass, but not perhaps in the way envisaged. The style of operational management was different from anything experienced before in NHS Wales. Some long serving, able and committed staff in the Assembly and the NHS left because of the change in management style and I remember more discussions about the colour of the shoes of the Director, than service development.

It was during this period that the talk of differences between Wales and England began to take shape in a practical way – clear water between the two systems began to emerge. For example, Wales retained CHCs which were abolished in England in 2003 and Wales did not adopt either Payment by Results (2003/4) or the foundation trust model (2004). The Wales Centre for Health was established in 2005 (and then abolished in 2009) tasked with, amongst other things, acting as an advocate on public health issues.

The *Review of Health and Social Care in Wales* (Wanless), published in 2003, called for people to take better care of their own health and warned that the current position was not sustainable. It also cautioned that demands for health and social care could swamp the system and stressed the need for greater integration. *Beyond Boundaries: Review of Local Service Delivery* (Beecham) was published in 2006. It recommended a transformation of public service delivery based on citizen engagement, delivery, partnership and challenge. It also recommended that there should be no major reorganisation of structures, although there should be a review in 2011¹⁷. It seems bizarre that three years after Beecham there would be the biggest shake-up in NHS structures in Wales since the early 1990s.

The Assembly published its response in 2006: *Making the Connections*. It set out plans for Local Service Boards – but whatever happened to the health component?

In 2001 the NHS Staff College Wales changed its title to the Centre for Health Leadership Wales and in 2005, when it combined with the Assembly’s workforce development function and the Innovations in Care team, the National Leadership and Innovation Agency for Healthcare (NLIAH) was established. The Assembly’s Clinical Governance Support Unit has recently transferred to NLIAH.

Also in 2005, the Assembly announced that a total wait target of 26 weeks from primary care referral to treatment was to be achieved by December 2009 (Access 2009) and the Delivery and Support Unit (DSU) was set up.

My consultancy work during this period was predominantly the preparation of business cases, reflecting the increased autonomy of the Assembly and the appointment of Joe Flanagan to develop the business case process to replace the Capital Investment Manual. Business case projects included endoscopy services, renal, diagnostics, IM&T (God bless IPCS!¹⁸), electrical infrastructure, diabetes, community hospitals, etc.

The move to all-Wales screening services also resulted in costing projects for ante-natal screening services, Breast Test Wales and diabetic retinopathy screening services.

Another strand of work was mapping of services across health and social care and the voluntary sector, such as children and young people's services, mental health and older people.

This lady's not for turning (2007 to 2009)

Edwina Hart, the Health Minister at the time of writing this paper, was appointed in May 2007. Her appointment heralded a more direct political involvement in operational aspects of the NHS in Wales than ever before. By comparison, Paul Williams' appointment as Director of the NHS and Social Care Department brought an unrivalled knowledge and understanding of the NHS in Wales to the Assembly.

Edwina Hart started the process of the last wave of trust mergers, for example creating Hwyl Dda and Cwm Taf. However, through a process of consultation (likened in some quarters as turkeys voting for Christmas) a view emerged from the chief executives in Wales that reconfiguration should extend to the merger of trusts and local health boards together with the formal abolition of the internal market and commissioning. Hence, the current organisational map in Wales from October 2009 of 7 (new) local health boards (nLHBs) – virtually the same as the configuration of area health authorities that existed from 1972 to 1984, the slight difference being one organisation in North Wales, Betsi Cadwaladr, encompassing both Clwyd and Gwynedd. Back where we started from!

In addition, there are three NHS trusts: Welsh Ambulance Services, Velindre and Public Health Wales. On the other hand, there is (as yet) no single, central support services organisation (à la WHCSA).

The outcome was probably inevitable, but the process was painful. For example, some staff in north Wales had to apply for their jobs three times as, firstly North East Wales NHS Trust merged with Conwy and Denbighshire NHS Trust to become North Wales NHS Trust; secondly, North West Wales NHS Trust merged into North Wales NHS Trust; and, thirdly, North Wales NHS Trust merged with the six old LHBs (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham) to become the Betsi Cadwaladr University Local Health Board.

It is difficult to evaluate the benefits of reorganisation. For example, the Health Service Journal published an article in August 2008 about the differences between the 4 health systems in the UK. Although wide variations in elective admissions, emergency care and readmission rates were reported, the HSJ and other commentators found it hard to draw conclusions about quality. Similarly, the Nuffield Trust published a report in January 2010 which stated that the NHS in England spends less and has fewer doctors, nurses and managers per head of population but has higher levels of activity. Despite this, there was nothing to suggest major variations in quality of care or differences in levels of patient satisfaction between Wales and England.

If I had to pick out one current key problem in Wales, it is that the vision has not been clear for several years. Despite ongoing innovative local service developments and the pioneering work of Informing Healthcare and NLIAH, it is sometimes difficult to perceive the “Welsh Way” as being anything other than organisational restructuring and rejection of the Blairite business orientated approach (ie payment by results, commissioning, choice, foundation trusts, etc). People working in the NHS have an overwhelming feeling of “What’s it all for?” or “Why are we doing this?” We are still waiting for a meaningful sense of purpose, a vision of where it is all going and a rallying cry for the NHS in Wales. If we are inspired, we will motivate ourselves.

Another issue is how performance management has not had as big an impact as expected. There is not much that is measured and managed now that was not measured fifteen years ago. There might be more focus now, but the emphasis still seems to be on processes, activity and outputs rather than outcomes.

However, one clear change from the early years is that the preferences and experiences of Assembly health ministers can influence policy directly. Having an empathy with what the general population is looking for from health services is crucial – if Aneurin Bevan had not understood the problems that people had with accessing health services, we would not have the NHS. But developing policy based on personal experiences, not linked to an appreciation of need, is something completely different.

The “Welsh Way” is clearly distinctive. However, I would prefer the approach to be based on a positive, evidenced based “Best Way”, rather than an approach which I perceive as having its roots in doing something different from England, laced with a touch of local politics.

The Teenies – a new decade of uncertainty

From the initial changes in 1991, the key people still in senior positions are Paul Williams, Margaret Foster at Cwm Taf and Jan Williams at Cardiff and Vale – Margaret Foster being, in effect, the only person to have been in the same post throughout the period.

The ideal now would be a long period of stability in NHS Wales. However, there are factors which suggest that this might not be the case:

- The Westminster elections in early 2010 might result in, for the first time since devolution, a different UK government from that in Wales; that could lead to wider policy differences.
 - The Assembly elections in May 2011 could lead to a change in the balance of power and almost certainly in a change in political lead for the NHS in Wales.
 - Any change in the Director of the NHS in Wales could lead to changes in policy.
 - Public finances are tight.
 - Changes in local government structure in Wales are being mooted; if so, this could impact on the structure of the NHS.
 - There are also rumours of discussions about linking health and social care closer, possibly within the same structure.
 - Finally, there are already mutterings that the seven LHBs are too large.
- The “Welsh Way” will also be affected by the talent pool of politicians in the Assembly, which, as several politicians have told me recently, “is not the largest in the World”!

End Piece

Over the last 20 years of working alongside the NHS in Wales we have moved from 9 district health authorities (DHAs) and 8 family health service authorities (FHSAs) to 5 health authorities and 32 NHS trusts, then to 22 local health boards (LHBs) and 17 trusts. We now have 7 (new) local health boards.

Specialist services went from DHAs to the Specialised Health Services Commission for Wales (SHSCW) hosted by Dyfed Powys Health Authority to Health Commission Wales (HCW) and now back to SHSCW by another name – the Welsh Health Specialised Services Committee, supported by Cwm Taf LHB.

In the same period we have also had 10 Secretaries of State for Wales – 5 labour; 5 conservative – two of whom have had 2 separate periods of office (Peter Hain and Paul Murphy). We have gone from Welsh Office to National Assembly for Wales and the Welsh Assembly Government with 3 First Ministers/Secretaries and 3 Health Ministers. We have had no market, an internal market and now a National Advisory Board to help the Minister prioritise decisions. We started with unconventional finance, then PFI and now no PFI. Over in England there have been 11 Secretaries of State for Health since 1988: Keith Joseph, William Waldegrave, Virginia Bottomley, Stephen Dorrell, Frank Dobson, Alan Milburn, John Reid, Patricia Hewitt, Alan Johnson and Andy Burnham.

The history of policy making in the NHS in the UK appears to be a series of strategies published by people who think the world changes by publishing a strategy (when, in practice, the strategies make no difference at the front line unless they are resourced) and frequent systems change because politicians need to show they are doing something. The complete opposite of what Miles Davis said about jazz: “The best musicians are those who know when not to play and what notes not to play when they are not playing”.

With each change a new power base emerges with its followers, adherents and hangers-on. Policies and priorities have been developed and then abandoned. New ones have emerged, often trying to ditch the remnants of the preceding policy, but then retaining elements of policies from two or three previous political and/or managerial generations. Career civil servants have had to adapt to a devolved administration that is very different from a Westminster department, and career health service managers in the Assembly are having to learn how to manage ministers (that is to become Sir Humphreys). We hear a lot about a citizen centred approach in Wales, yet it feels as if most patient involvement activities play lip service to the rhetoric. That might be because the public does not want to be involved or it might be that managers and professionals do not know how to engage the users of their services.

Despite all the above, there is a backbone of senior managers in the NHS in Wales who have been through – and survived – the changes. One of the great unsung advantages of the NHS in Wales is that “everybody knows everybody else”. Although diluted by new recruits and people moving in from other health systems, there is still a sense of history associated with being part of the NHS in Wales.

Although some senior managers with extensive experience of the NHS in Wales have left or are on gardening leave, the vast majority of staff are getting on with their day-job, phlegmatic, shoulder shrugging and thinking “We’ve seen it all before.”

So, reflecting as I bring this paper to an end, I would categorise the main periods of the NHS in Wales as being:

1948 – 1983	The Incremental Years
1984 – 1990	The Intellectual Period
1991 – 1995	The Reforms
1995 – April 1999	The Watershed
May 1999 – date	The Age of Re-disorganisation
From here onwards	The Decade of Uncertainty?

I feel privileged to have been involved in NHS Wales at the tail end of its legacy of Aneurin Bevan, Archie Cochran, John Wyn Owen and Tudor Hart. There is no doubt that it is because of them that Wales still has a focus on public health: the trail of organisations and programmes includes the Health Promotion Authority, Heartbeat Wales, Breast Test Wales, National Public Health Service, Wales Centre for Health, Health Challenge Wales and now Public Health Wales. However, I lament that we do not appreciate the value of this legacy.

I like NHS Wales. The people I work with and meet are as committed as anywhere in the UK and there is a sense of neighbourhood and community that seems to have gone from England.

I have learnt, however, that I cannot change the system. From 1991 the NHS has been in a continuous state of re-organisation (not my phrase). It would be good if there was evidence that the organisational changes had benefited patients and users and clients. But it's never been left alone long enough to tell. I cannot see the nature of politics changing in Wales in the foreseeable future, so the nature of the NHS in Wales and its management will have to.

I worry that managers might perceive that they are rewarded more by adherence to centrally determined policy and corporate processes than by concentrating their efforts on building and maintaining good relationships with patients, users, clients and carers. I worry also that personal relationships and a caring environment are undermined because of systems, processes and targets.

These type of reflective papers tend to end with a rallying call – so my plea is that we should put real effort into learning from the changes by identifying what has worked, what hasn't and why. This will require politicians and policy makers to accept that they do not know all the answers, to listen to evidence and to start observing in a more structured way.

The phases of my consultancy work over the last 20 years have included value for money, financial planning, contracting, needs assessments, costing partnership working, ehealth, business cases and service mapping. My current focus of helping individuals to develop through training and mentoring is worthwhile and rewarding. I wonder what the next ten years will bring.

The final word

"I like the destination Labour aims for; but I dislike the process of trying to get there; I don't like the aims of the Conservatives, but the journey was a lot more rewarding".

(loosely based on a quote I heard several years ago – if anyone knows the source, please let me know).

We would like to thank all the people we have worked with since 1988 for sharing their time with us. We would also like to thank our friends and colleagues who commented on early drafts of this paper – for obvious reasons of confidentiality we cannot name you, but you know who you are.

We welcome comments on this paper which:

- disagree with us
- agree with us
- amplify the points we make
- give a different perspective

Please send your comments to:

correspondent@healthcarealliances.co.uk

All *From Our Irregular Correspondent* papers and comments can be accessed directly by [clicking here](#), or by following the links to information services from the home page of our website: www.healthcarealliances.co.uk

Notes

¹ Hospital and Community Health Services

² General Medical Services

³ Secretary of State for Health for Health

The subsequent secretaries of state were as follows:

- Hilary Marquand (17 January 1951 - 26 October 1951)
- Harry Crookshank (30 October 1951 - 7 May 1952)
- Iain Macleod (7 May 1952 - 20 December 1955)
- Robin Turton (20 December 1955 - 16 January 1957)
- Dennis Vosper (16 January 1957 - 17 September 1957)
- Derek Walker-Smith (17 September 1957 - 27 July 1960)
- Enoch Powell (27 July 1960 - 20 October 1963)
- Anthony Barber (20 October 1963 - 16 October 1964)

⁴ Secretary of State for Health

⁵ Following Jim Griffiths, who was the first Secretary of State for Wales, these were the holders of the post:

- Cledwyn Hughes 5 April 1966 5 April 1968 Labour
- George Thomas 5 April 1968 20 June 1970 Labour
- Peter Thomas 20 June 1970 5 March 1974 Conservative

⁶ 8 Area Health Authorities

- Gwynedd
- Clwyd
- South Glamorgan
- West Glamorgan
- Mid Glamorgan
- Powys
- Dyfed
- Pembrokeshire
- Gwent

⁷ 9 District Health Authorities:

- Gwynedd
- Clwyd
- South Glamorgan
- West Glamorgan
- Mid Glamorgan
- Powys
- East Dyfed
- Pembrokeshire
- Gwent

Note: There was one FPC for Dyfed. However, it was split into two DHAs – Pembrokeshire and East Dyfed.

⁸ This is the list of the 31 NHS trusts (and their 1995 budgets). They were established over several years. The “first wave” in Wales (when England was into its “second wave”) consisted of one trust – Pembrokeshire. The others followed over the next few years (and although Cardiff Royal Infirmary had a desire to become a trust, it never made it):

- University Hospital of Wales Healthcare NHS Trust (£101m)
- Glan Hafren NHS Trust (£61m) [Gwent]
- Bridgend and District NHS Trust (£47m)
- Gofal Cymuned Clwydian Community Care NHS Trust (£46m)
- Pembrokeshire NHS Trust (£45m)
- Derwen NHS Trust [merged with Pembrokeshire]
- Glan-y-Mor NHS Trust (£45m) [Neath and Port Talbot]
- Morriston Hospital NHS Trust (£42)
- Gwent Community Health NHS Trust (£41m)
- North Glamorgan NHS Trust (£39m)
- Gwynedd Hospitals NHS Trust (£38m)
- Cardiff Community Healthcare NHS Trust (£38m)
- Glan Clwyd District General Hospital NHS Trust (£38m)
- Llandough Hospital NHS Trust (£38m) [merged with part of Cardiff Community]
- Cardiff Community NHS Trust [part merged with Llandough Hospital]
- Wrexham Maelor Hospital NHS Trust (£35m)
- Gwynedd Community Health NHS Trust (£34m)
- Swansea NHS Trust (£33m)
- East Glamorgan NHS Trust (£33m)
- Powys Health Care NHS Trust (£30m)
- Nevill Hall and District NHS Trust (£29m)
- Carmarthen and District NHS Trust (£26m)
- Rhondda Health Care NHS Trust (£21m)
- Llanelli Dinefwr NHS Trust (£20m)
- Ceredigion and Mid Wales NHS Trust (£16m)
- South and East Wales Ambulance NHS Trust (£12m)
- North Wales Ambulance NHS Trust (£9m)
- West Wales Ambulance NHS Trust (£7m)
- Velindre NHS Trust (£7m)
- Mid Glamorgan Ambulance NHS Trust (£6m)
- University Dental Hospital Wales NHS Trust (£5m)

⁹ 5 Health Authorities:

- Gwent Health Authority
- Bro Taf Health Authority
- Dyfed Powys Health Authority
- North Wales Health Authority
- Iechyd Morgannwg Health

In addition, there were two special health authorities:

- Welsh health Common Services Authority
- Health Promotion Wales

¹⁰ Junior Minister: Health

¹¹ First Secretary of Wales

¹² Junior Minister: Health

¹³ Assembly Minister for Health and Social Services

¹⁴ This is the final list of 14 NHS Trusts (they did not merge at the same time. For example, Llandough Hospital and Cardiff Community merged early in the process, followed closely by Pembrokeshire and Derwen):

- Carmarthenshire NHS Trust (Carmarthen & District + Llanelli/Dinefwr)
- Ceredigion & Mid Wales NHS Trust
- Pembrokeshire NHS Trust (Pembrokeshire + Derwen)
- Pontypridd and Rhondda NHS Trust (East Glamorgan + Rhondda Health Care)
- Conwy & Denbighshire NHS Trust (Glan Clwyd + Clywddian[part])
- Gwent Healthcare NHS Trust (Glan Hafren + Gwent Community + Neville Hall)
- Bro Morgannwg NHS Trust (Glan-y-Mor + Bridgend and District)
- North West Wales (Gwynedd Hospitals + Gwynedd Community)
- Cardiff and Vale NHS Trust (University Hospital of Wales + Llandough Hospital + Cardiff Community + University Dental Hospital)
- North Glamorgan NHS Trust
- Swansea NHS Trust (Swansea + Morriston Hospitals)
- Velindre NHS Trust
- Welsh Ambulance Service NHS Trust (the 5 ambulance trusts)
- North East Wales NHS Trust (Wrexham Maelor + Clywddian[part])

¹⁵ 22 Local Health Groups:

- Isle of Anglesey
- Gwynedd
- Conwy
- Denbighshire
- Flintshire
- Wrexham
- Powys
- Ceredigion
- Pembrokeshire
- Carmarthenshire
- Swansea
- Neath, Port Talbot
- Bridgend
- Vale Of Glamorgan
- Cardiff
- Rhondda, Cynon, Taff
- Merthyr Tydfil
- Caerphilly
- Blaenau Gwent
- Torfaen
- Monmouthshire
- Newport

¹⁶ 7 (New) Local Health Boards (and their 2010 budget):

- Abertawe Bro Morgannwg University LHB (£973m)
- Aneurin Bevan LHB (£955m)
- Betsi Cadwaladr University LHB (£1,170m)
- Cardiff and Vale University LHB (£874m)
- Cwm Taf LHB (£559m)
- Hywel Dda LHB (£647m)
- Powys Teaching LHB (£212m)

In addition, there are three NHS trusts:

- Public Health Wales (£80m) [NHS Wales Governance Manual]
- Velindre NHS Trust (£75m) [estimate based on 2005/6 less PHW]
- Welsh Ambulance Service NHS Trust (£112m) [2006/7 annual report]

¹⁷ Beyond Boundaries, 2006, page 56

6.12 The traditional response to the capacity problem would be to re-organise units of service delivery with the aim of concentrating leadership and managerial capacity in a smaller number of local organisations.

6.13 Although many people told us that the number of small organisations is a problem, very few argued for the kind of major structural change that took place in 1996 and 2003 [Abolition of health authorities and creation of local health boards coterminous with local authorities]. Most acknowledged that re-organisation of this kind would be very disruptive and expensive, and would risk being seen as an alternative to the more fundamental change which is needed.

The risk would also be that re-organisation could diminish capacity - if experienced leaders and innovative managers decided to leave Wales.

6.14 More importantly, there is no evidence that simply changing structures would achieve the changes in inter-organisational relationships, organisational cultures and individual behaviour that are needed. Indeed, the record of previous structural re-organisations across the world suggests that it may well have the opposite effect. Nor is there any clear correlation between size and performance - some of the smallest authorities in Wales provide some very good services, whilst some of the largest councils have struggled to achieve acceptable standards in some key services.

¹⁸ IPCS: Integrated Patient Care System – a joint venture by Conwy and Denbighshire NHS Trust and North East Wales NHS Trust to replace their PAS systems. Despite several years of development, the business case was not approved.