



# **The Healthcare Commission and Wales 2004-08**

**A report to the Healthcare Commission on how we have  
discharged our statutory responsibilities in relation to  
Wales, working in partnership with others**

**November 2008**

# Summary

In addition to being the independent watchdog for healthcare in England, the Healthcare Commission has a modest set of functions relating to Wales. This report describes how we have fulfilled those responsibilities over the past four and a half years, including our work with Healthcare Inspectorate Wales (HIW) and other bodies. It also summarises our contacts with regulators elsewhere in the United Kingdom and the Republic of Ireland.

## Our functions in Wales

HIW is responsible for regulating NHS organisations (and, since 2006, independent healthcare) in Wales. Its role, as well as our own, was set out in the Health and Social Care Act 2003. In summary, our functions relating to Wales are:

- A duty to cooperate with the Welsh Assembly Government “for the efficient and effective discharge of any relevant function”.
- Undertaking national reviews that extend to England and Wales.
- Publishing an annual report on the state of healthcare in England and Wales.
- Publishing data relating to the provision of healthcare by and for NHS bodies.
- Reporting to the Assembly Government if, in our view, there are significant failings by or for a Welsh NHS body.

## What we have done

The main features of our work have been:

- Maintaining, from the outset, mutually supportive links with Welsh partners, including sponsoring officials in the Welsh Assembly Government.
- As a signatory of the concordat between bodies inspecting, regulating and auditing health and social care in Wales, playing a full part in its development and implementation, drawing on our experience in England.
- Reporting annually on the state of healthcare, taking account of advice and data from Welsh partners.
- Managing, until March 2008, the national clinical audit programme, which covered both England and Wales.
- Working cooperatively with the Wales Audit Office in its management of the acute hospital portfolio in Wales.
- Working cooperatively with Welsh partners on reviews of services that are similar in content to those in England (for example, learning disabilities and maternity).
- Sponsoring, with the Mental Health Act Commission and others, the annual ‘Count me in’ census of the ethnicity of all inpatients in NHS and independent mental health and learning disability hospitals in England and Wales.
- Joint working with HM Inspectorate of Probation and others to inspect youth offending teams in England and Wales.
- Presenting to Welsh partners and policymakers the results of our work in specific areas (notably public health).
- Launching the cardiac website, which covers the whole of the United Kingdom.
- Launching, with the National Patient Safety Agency, the charter for the safety of patients, of which HIW and our counterpart in Northern Ireland were signatories.
- Identifying expert advisors to assist with HIW’s work.

- Obtaining approval for our Welsh Language Scheme from the Welsh Language Board and publishing our main strategic documents in Welsh.
- Completing some studies in Wales that were begun by our predecessor, the Commission for Health Improvement.
- Establishing, with other regulators of healthcare in the United Kingdom and the Republic of Ireland, the 'five nations' group, which has met regularly since 2005.

### **The future**

The Healthcare Commission will be replaced in April 2009 by the Care Quality Commission, whose functions for the regulation of health and adult social care relate only to England. However, under the Health and Social Care Act 2008, the CQC will have a duty of cooperation with Welsh Ministers (and, by extension, HIW). There are also certain provisions about information and the reporting of significant failings that have cross border implications. This report considers these issues and others affecting future cooperative working.

# 1. Background

1.1. Wales is just over 8,000 square miles in area, roughly a sixth the size of England. The population is just under three million, compared to about 50 million in England, five million in Scotland and 1.7 million in Northern Ireland. Wales has more people than several sovereign nations of the European Union.

1.2. After 1969, the Welsh Office exercised much of the responsibility for health services in Wales. As a result, arrangements in England and Wales moved apart in a number of respects. However, the establishment in 1999 of a National Assembly and a government to exercise the Assembly's executive powers fundamentally altered the political and administrative landscape.

## The strategic context

1.3. Since 2000, when the Assembly Government published its first strategic plan for Wales, the provision and development of healthcare have been influenced by a series of major initiatives. These have included the strategic agenda, *Wales: A Better Country* (2003), which highlighted the improvement of health – not just the treatment of ill health – as a major goal, and, in 2006, the *Healthcare Quality Improvement Plan*<sup>1</sup>, which emphasised the need for the NHS to have simple, clear objectives and good systems of management. More recently, *One Wales: A progressive agenda for the government of Wales* (2007)<sup>\*\*</sup> contained a series of specific commitments relating to health. These included reviewing the configuration of the NHS (see below) and changes to the financing and management of the service, including an end to the internal market.

1.4. A more detailed summary of demographic, epidemiological and strategic features is in Appendix A.

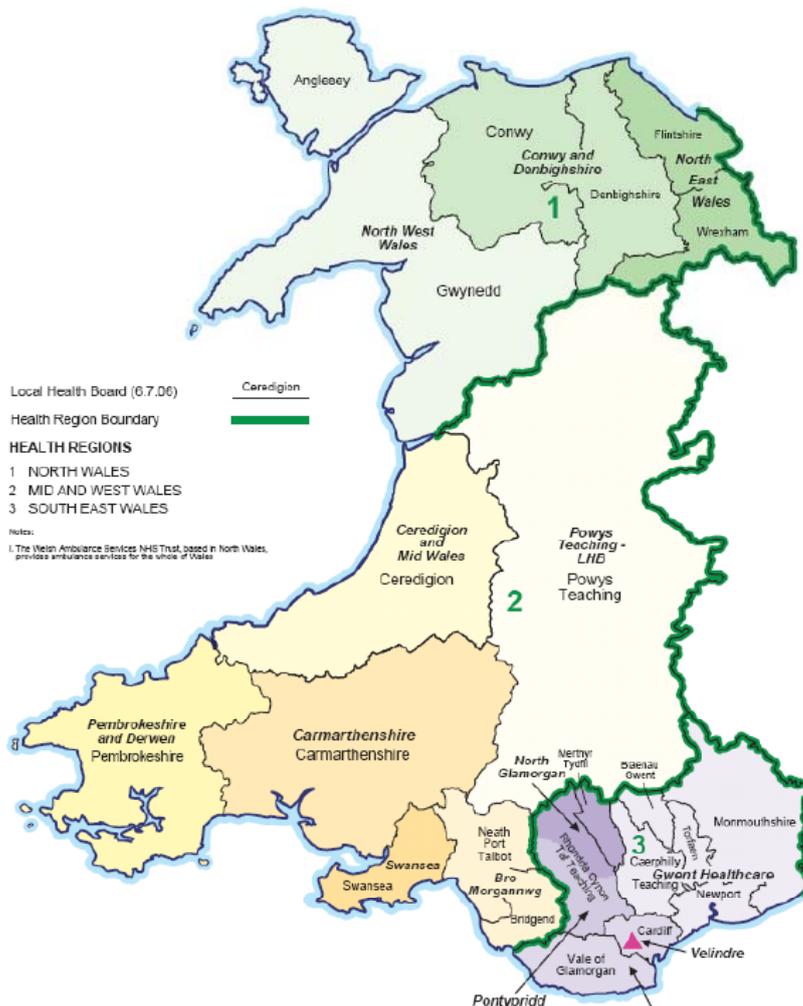
## The organisation of health services in Wales

1.5. Proposals for major changes to the structure of the NHS in Wales have recently been announced: see paragraph 6.7. Currently there are nine **trusts** providing hospital and related services. Their number has reduced, through amalgamations, from 14 in 2004. Seven trusts relate to particular areas of the country. Of the other two, the Velindre NHS Trust, based in Cardiff, provides a range of specialised services, while the Welsh Ambulance Services NHS Trust is responsible both for ambulance services throughout Wales and, since 2007, NHS Direct Wales, which provides advice and information about health to members of the public.

\* The Government of Wales Act 2006 has since clarified the respective roles of the Assembly and the executive and placed each on a distinct legal footing.

\*\* An agreement in June 2007 between the governing Labour and *Plaid Cymru* groups in the Assembly.

## NHS trusts in Wales



*Courtesy of Healthcare Inspectorate Wales*

1.6. Twenty-two **local health boards**, which plan health services and negotiate their provision by trusts, primary care practices and other organisations, share the same boundaries as local authorities. Unlike England, Wales has no foundation trusts\* or primary care trusts, while **community health councils**, initially replaced in England by patient and public involvement forums\*\*, have been retained and are to be strengthened: see paragraph 6.7. There are three **regional offices** for health and social care (North, Mid & West and South & East), which have a role in managing the performance of NHS bodies.

1.7. The NHS is the largest employer in Wales, with almost 90,000 staff<sup>2</sup>. About 40% of these are nurses, midwives or health visitors. As in England, about 30% of NHS spending is on primary care<sup>3</sup>. Eighty per cent of all contacts with the NHS take place outside hospital<sup>4</sup>. At 31 March 2007, there were 70 registered providers of independent healthcare across Wales<sup>5</sup>.

\* In England, NHS foundation trusts, of which there were 99 on 30 June 2008, have greater freedoms and flexibilities than other trusts in the way they manage their affairs.

\*\* Patient and public involvement forums were introduced in England in 2004 and replaced by local involvement networks (LINKs) in 2008.

## Current arrangements for reviewing healthcare

1.8. The current arrangements for reviewing healthcare in the NHS in Wales derive from the **Health and Social Care (Community Health and Standards) Act 2003**. Prior to that, the former Commission for Health Improvement was responsible for reviewing systems of clinical governance in NHS bodies in England and Wales, as well as national studies of particular types of healthcare.

1.9. Under the 2003 Act, the **Healthcare Commission** (known legally as the Commission for Healthcare Audit and Inspection) became the principal regulator of both NHS and independent healthcare in England. Broadly similar functions relating to the NHS in Wales were given to the **National Assembly for Wales** which, in turn, vested them in **Healthcare Inspectorate Wales** (HIW). Both the Healthcare Commission and HIW became operational in April 2004. HIW has since added certain responsibilities to its brief, including in 2006, regulating independent healthcare and the statutory supervision of midwives\*.

1.10. One feature of these arrangements is that, while the Healthcare Commission and HIW have a common legislative base, their legal status differs. The Healthcare Commission is an independent statutory body in its own right, with a Chairman and Commissioners appointed under provisions in the Act. By contrast, HIW is a division of the Welsh Assembly Government. Its operational independence is ensured by having full delegated authority for its activities and findings.

## The Healthcare Commission and Wales

1.11. Complementing the provisions relating to the Welsh Assembly (and, therefore, HIW), the 2003 Act gave the Healthcare Commission certain functions extending to both England and Wales and some specific responsibilities in relation to the latter. In summary these are:

- A **duty to cooperate** with the Assembly Government\*\* “for the efficient and effective discharge of any relevant function”. This report cites many examples of how that duty has been fulfilled.
- Undertaking **national reviews** that extend to England and Wales: see section 3.
- Publishing an annual **report on the state of healthcare** in England and Wales: see section 4.
- **Publishing data** relating to the provision of healthcare by and for NHS bodies, prime examples being those from the national programme of clinical audits and web-based information about cardiac surgery: see paragraphs 3.4 and 3.9.
- Reporting to the Assembly Government if, in our view, there are **significant failings** by or for a Welsh NHS body. (The Assembly has a reciprocal duty to report failings by an English body to the Secretary of State for Health.)

1.12. In Wales, the Independent Review Secretariat considers **complaints** about the NHS that have not been resolved locally. The Healthcare Commission, which currently has a similar function in England\*\*\*, is responsible for handling any unresolved complaints about

\* From 2002, the regulation of independent healthcare was the responsibility of Care Standards Inspectorate Wales, whose residual functions relating to independent social care passed to Care and Social Services Inspectorate Wales in 2007 (see paragraph 6.3). HIW took over the supervision of midwives following the abolition of Health Professions Wales. On 31 March 2008 there were 1,684 practising midwives: see Healthcare Inspectorate Wales, *Local Supervising Authority Annual Report to the Nursing and Midwifery Council 1 April 2007-31 March 2008*, September 2008.

\*\* Although the 2003 Act referred to the National Assembly for Wales, in practice, the Commission's relationship has been with the Assembly Government, whose constitutional role and that of the Assembly itself have since been clarified by legislation: see footnote to paragraph 1.2.

\*\*\* In April 2009, the Health Service Ombudsman will take on this role in England.

special health authorities with a remit in both countries. Similarly, although the Commission's powers of **investigation** generally relate only to England, there are exceptions where:

- Special health authorities have cross-border responsibilities.
- An English NHS body is providing services under contract in Wales.
- Services are being provided in Wales on behalf of an English NHS body.

1.13. These various functions have required us to recognise the distinctive features of Wales, including its system of healthcare and the Welsh language, in our policies and programmes of work:

- A constructive relationship with our **sponsoring officials** in the Assembly Government<sup>\*</sup> has helped the Commission to maintain a clear understanding of the direction of policy and other developments in Wales. The Chairman met the two previous Ministers for Health and Social Services, Jane Hutt AM and Dr Brian Gibbons AM, in September 2004 and September 2006 respectively.
- The principle of '**no surprises**' has meant that Welsh Ministers or other regulators are ready to respond to any of the Commission's findings that affect Wales or those which, though confined to England, may nevertheless prompt questions about aspects of healthcare in Wales. The Commission's investigations into learning disability services in Cornwall and maternity services at Northwick Park have been among those that aroused particular interest in Wales: see paragraph 3.17.
- The **mutually supportive links** with HIW and other partners, notably through the **concordat** between bodies inspecting, regulating and auditing health and social care in Wales (see paragraph 2.11), have enabled the Commission to carve out a distinctive role in Wales that adds value within a broader regulatory framework: see, for example, paragraphs 3.17-18.
- Three of the Commission's four operational regions adjoin Wales. Activity **across the border** varies: for example, patients from North Wales have often received specialised care in north west England, while significant numbers of students and business people commute between South Wales and Bristol. The closure of independent services in England may sometimes have implications for the continuing care of Welsh patients who have been placed there. Regional staff manage the regulatory implications of such issues and liaise as necessary with HIW and other Welsh bodies.
- In 2008 our **investigations** team assisted HIW to carry out an independent review of a homicide committed in Wales by an individual who had previously received care in an NHS mental health trust in England. We used our powers under the 2003 Act to gain access to the relevant health records and visited the trust with HIW so that it could review the information<sup>6</sup>.
- **The Commission** has received **regular reports** at its meetings in public of activities relating to Wales. Since the Commission's transitional days in 2003, a Commissioner has been designated to maintain a special interest in Wales. Initially this was Dr Sharon Hopkins, who was succeeded in 2008 by Mr Charles Goody. A small team of the Commission's staff, led by the Head of Clinical Quality and Welsh Affairs and including a

<sup>\*</sup> The Commission is party to a management statement and associated financial memorandum, which define its relationship with its governmental sponsors in England (the Department of Health) and Wales. Among other things, the management statement sets out the Commission's purpose and functions, the process for agreeing its strategic direction and how it is held to account for its performance.

development manager who lives in Wales, has combined the coordination of Welsh affairs with other duties. HIW has made facilities available to the Commission at its offices in Caerphilly.

- The Healthcare Commission's transitional team was represented on the project board for the **establishment of HIW** in 2003/04.

## The future

1.14. From 1 April 2009, the **Care Quality Commission (CQC)** will be the new independent regulator of health and adult social care in England, replacing the Healthcare Commission, the **Mental Health Act Commission (MHAC)** and the **Commission for Social Care Inspection (CSCI)** (see paragraph 6.7). The CQC will have no responsibilities in Wales, although there will be a statutory duty of cooperation with Welsh Ministers\*. The work of the MHAC in Wales will devolve, through Ministers, to HIW.

## The Welsh language

1.15. The Welsh and English languages have equal official status in Wales. Welsh is spoken by just over a fifth of the population.\*\*

1.16. Under the Welsh Language Act 1993, public bodies such as the Healthcare Commission are required to prepare a **Welsh Language Scheme** for approval by the Welsh Language Board. In operating our scheme, which was approved in 2006, we have ensured that reports relating to healthcare in Wales are published in both Welsh and English (and that, as required, translations are available in a number of other languages). There are pages in Welsh on our website. When the Commission held a meeting in public in Cardiff in 2004, a simultaneous Welsh translation of its proceedings was available and some business was presented in Welsh.

**Where external bodies publish their reports, they do so in ways that are accessible to those affected by them, as well as to the wider public.**

**External review bodies publish reports in accordance with their Welsh Language Scheme and, where appropriate, in a range of formats (including other relevant languages).**

*Concordat Between Bodies Inspecting, Regulating and Auditing Health and Social Care in Wales, practice 7.4*

1.17. Obligations concerning the Welsh language are reinforced by commitments in the concordat and the Assembly Government's statement of policy in *Dyfodol Dwyieithog: A Bilingual Future* (2002).

1.18. The Commission has received no complaints from the public about the operation of its Welsh Language Scheme.

\* This formulation – ie with Ministers rather than the Assembly, as in the 2003 Act - reflects the delineation of responsibilities in the Government of Wales Act 2006.

\*\* According to the most recent survey by the Welsh Language Board, 21.7% (611,000) of people aged three and over could speak Welsh, compared to 20.8% in the 2001 census. Of these, 62% spoke Welsh daily. See Welsh Language Board (2006) *2004 Welsh Language Use Survey: the report*.

## 2. Working with partners

### The Healthcare Commission and HIW

2.1. In October 2005, HIW and the Healthcare Commission concluded a memorandum of understanding (MoU). This has provided a formal basis for our cooperative relationship and a point of reference for keeping its various aspects under review. By the time the MoU was signed, we had already established arrangements for regular liaison and were both signatories of the Welsh concordat (see paragraphs 2.8-11), which has underpinned relationships between regulators of healthcare in Wales.

2.2. Among other things, the MoU established some principles of joint working (see Appendix B) and anticipated cooperation in such areas as:

- **Coordination and exchange of information**, subject to relevant law and codes of practice.
- **Planning programmes of work**, including national studies and investigations.
- **Advice to Ministers in Cardiff or Westminster or to the National Assembly for Wales.**
- **Training and guidance.**
- **Contributing to annual reports.**
- **External communications.**
- **Sharing resources generally.**

2.3. We agreed to review the MoU annually. The first such review, at the end of 2006, identified a number of practical ways in which cooperation had been positive<sup>\*</sup>:

- Greater involvement of HIW in preparing the annual **report on the state of healthcare** (see section 4).
- The use by HIW of specialist **external advisors** associated with the Healthcare Commission (see paragraphs 2.12-13).
- Sharing experience relating to the implementation of the Welsh and English **concordats** (see paragraphs 2.8-11).
- Planning **reviews** in Wales and England, notably those of services for people with learning disabilities, maternity services and ambulance services (see paragraph 3.17).
- **Early warning** of findings whose publication might have an effect on the other's responsibilities.

2.4. As indicated above, other sections of this report describe these aspects of our work in more detail. A provision in the MoU for reconciling disagreements has, happily, never been invoked.

### Working with other partners

2.5. A number of other statutory bodies have some responsibilities for the review or audit of healthcare services in Wales. Some of these, notably the MHAC and the **Postgraduate Medical Education and Training Board** (PMETB) (a UK-wide body), have a specialised remit, while that of others, such as the Wales Audit Office (see below), ranges quite broadly. We have MoUs with several bodies, including the MHAC, PMETB, the National Institute for Health and Clinical Excellence (NICE) and the General Medical Council (GMC), that also have a role in both England and Wales.

<sup>\*</sup> See half-yearly report on Wales to the Healthcare Commission, 25 January 2007

## The Healthcare Commission and the Wales Audit Office

2.6. **The Public Audit (Wales) Act 2004** established the Wales Audit Office, replacing the Audit Commission in Wales and the Welsh 'arm' of the National Audit Office. The WAO was formed in 2005 and undertakes work on behalf of the **Auditor General for Wales**, who is responsible for auditing the National Assembly for Wales, its sponsored bodies and the NHS, as well as appointing auditors for local authorities. We have developed good strategic links with the WAO, having previously, at the Commission's meeting in Cardiff in 2004, presented a jointly agreed framework for working cooperatively in Wales with the Audit Commission and the National Audit Office<sup>7</sup>. It is worth recalling that the latter, which, among other things, welcomed the Assembly Government's commitment to initiate consideration of a Welsh concordat, identified the following opportunities:

- Making best use of collective resources.
- Avoiding duplication of activities.
- Giving consistent messages.
- Working with those providing services to streamline the implementation of reviewing bodies' recommendations.

2.7. There are various provisions for cooperation between the Healthcare Commission and the Auditor General in the 2003 Act and the Public Audit (Wales) Act. These are concerned mostly with the provision of information (see paragraph 6.4 regarding relevant provisions in the 2008 Act for the Care Quality Commission and the Auditor General). We concluded an MoU with the WAO in March 2008, the main features of which are exchange of information and joint working, including, in particular, cooperative arrangements relating to the **acute hospital portfolio** in Wales (see paragraphs 3.7-8). One practical feature of our relationship has been a series of strategic tripartite meetings with senior staff of the WAO and HIW. Studies by the WAO into aspects of health and healthcare have included such areas as **waiting times** (see Appendix D), **ambulance services** (see paragraph 3.17) and levels of **physical activity**<sup>\*</sup>.



The Auditor General for Wales, Jeremy Colman, and the Chief Executive of the Healthcare Commission, Anna Walker CB, signing a memorandum of understanding. March 2008

<sup>\*</sup> Levels of physical activity in Wales are low, with nearly 45% of adults leading a sedentary lifestyle in 2004/05. Wales Audit Office, *Increasing physical activity* (June 2007) recognised the ambition and investment in the Assembly Government's 'Climbing Higher' strategy (2006), but highlighted the need for a more coherent approach and more effective evaluation and management of performance.

## The concordat

2.8. In 2004, the Assembly Government published plans to improve the delivery of public services generally in Wales. *Making the Connections: Delivering Better Services for Wales* emphasised the need to maximise efficiency through economies of scale and sought more effective coordination and cooperation between agencies. Consistent with the principles of *Making the Connections*, a *Concordat Between Bodies Inspecting, Regulating and Auditing Health and Social Care in Wales* was concluded in May 2005 by the main regulators of health and social care in Wales and some other bodies with an interest in good regulation.

2.9. The concordat (see objectives in **Appendix C**) aims to promote a coordinated and targeted approach to review that is in proportion to the level of risk involved. A formal plan for implementation, which has been led by HIW, was published in June 2006.

### Signatories of the Welsh Concordat (May 2005)

#### Full signatories

Care and Social Services Inspectorate Wales

*[CSIW was formed in April 2007 from Care Standards Inspectorate Wales and Social Services Inspectorate Wales, both original signatories of the concordat]*

Board of Community Health Councils

General Medical Council\* *[since September 2006]*

Health and Safety Executive\*

Healthcare Commission\*

Healthcare Inspectorate Wales\*

Mental Health Act Commission\*

Postgraduate Medical Education and Training Board\*

Wales Audit Office

Welsh Risk Pool

*\*Also a full or (in the case of HIW) an associate signatory of the concordat in England.*

#### Associate signatories

Academy of Medical Royal Colleges in Wales\*\*

National Leadership and Innovation Agency for Healthcare *[since July 2008]*

NHS Delivery and Support Unit *[since November 2006]*

School of Postgraduate Medical and Dental Education, Cardiff University\*\*

Welsh Health Estates

Welsh Local Government Association

Welsh NHS Confederation

*\*\*The Academy of Medical Royal Colleges is an associate signatory, and the Conference of Postgraduate Deans (COPMeD) a full signatory, of the English concordat.*

2.10. Both the content of the concordat and its implementation have drawn on the experience with the similar concordat for the regulation of healthcare in England, whose development and implementation have been led by the Healthcare Commission. As such, we have been well placed to contribute to the arrangements in Wales: for example, the online 'scheduling tool', launched at the conference of the Welsh NHS Confederation in November 2006, was based substantially on the English model and has helped to improve coordination of reviews and sharing of relevant information between signatories.

2.11. A report by the signatories on implementation of the concordat was published in November 2007<sup>8</sup>. This noted considerable progress in delivering the objectives, while recognising that there was room for improvement and that a number of additional actions were planned. The report acknowledged the role of the Healthcare Commission in helping to shape the programme of implementation and highlighted the following specific examples of good practice involving the Commission:

- Helping to develop the scheduling tool (as above).
- Representation on all relevant working groups.
- Organising seminars to highlight issues from the Commission's reviews and investigations (see paragraph 3.18).
- Working with HIW and other partners in relation to reviews of maternity and learning disability services (see paragraph 3.17).
- Developing a charter for the safety of patients (see paragraph 5.9).
- Developing approaches for measuring the quality of clinical services (see below).
- Cooperating with the WAO to manage the acute hospital portfolio (paragraphs 2.6-7 and 3.7-8).

**“Implementation of the Concordat in Wales has benefited from the experiences of implementation of the concordat in England. Certain aspects of implementation, particularly the development of the Scheduling Tool, have made rapid progress because of close collaborative working with the Healthcare Commission in England. The Healthcare Commission is represented on all of the working groups developed to take the Concordat forward in Wales and this close working relationship has facilitated a broadly consistent approach to implementation in both England and Wales. This is beneficial because several bodies are signatories to both concordats.”**

*Concordat Between Bodies Inspecting, Regulating and Auditing Health and Social Care in Wales: Report on Implementation Progress 2005-2007*

## **Working with clinicians and other experts**

2.12. The Healthcare Commission and HIW both take specialised advice from external experts, mostly clinicians. Such advice has been used in reviews, investigations and the development of measures to assess the quality of healthcare.

2.13. The Commission currently maintains a database of some 1,500 advisors (formerly know as ‘associates’). Advisors come from a wide range of disciplines and specialties, and can be called upon to assist with relevant activities<sup>\*</sup>. HIW has its own list of over 200 external reviewers, but also has access to the Commission's sources of expertise – one very tangible aspect of our MoU. On average the Commission has identified roughly 50 advisors annually to assist with aspects of HIW's work. We understand that HIW will have a continuing need to draw on such expertise after April 2009, including, when it takes over the responsibilities of the MHAC in Wales, advice currently provided to the MHAC by Mental Health Act Commissioners and second opinion approved doctors<sup>\*\*</sup>.

<sup>\*</sup> The Commission's most common use of clinical advice (about two-thirds of all occasions) is to consider complaints about the NHS in England.

<sup>\*\*</sup> This will be an issue for the Care Quality Commission: see section 6.

2.14. As described in the following section of this report, clinical audit has been an important way of engaging clinicians directly. We have also addressed with HIW and partners elsewhere in the UK (see section 5) the opportunities to work more strategically with clinicians and clinical bodies: for example, to help ensure that we measure the things that matter to them in their care and treatment of patients and that schemes to accredit services, such as those being run or developed by some of the medical royal colleges, operate in ways that complement wider regulation of healthcare. We are arranging a joint seminar with HIW to share learning and approaches in this area, including the implications for regulation in England of the *Next Stage review* of the NHS, with its strong emphasis on the quality of healthcare and the importance of making international comparisons<sup>9</sup>. With the latter in mind, we have emphasised to the Department of Health and others the opportunities that exist within the British Isles.

## **Patients and the public**

2.15. Our assessments of healthcare in England pay careful attention to the views of patients and the public, and we have systematic, inclusive arrangements that enable that to happen. When members of the public in Wales raise with us issues or concerns about local services, we usually explain the limited nature of our role and, with their permission, ask the relevant Welsh body to follow up the matter. If a letter or email is in Welsh, so is our reply. As already noted, a number of our reports of English services have attracted interest in Wales and our main strategic documents are published in both English and Welsh. The meeting of the Commission in Cardiff in 2004 was well attended by the public and we sought to deal constructively with points that were raised on that occasion and afterwards. However, in proportion to our functions, our active engagement of the Welsh public has been fairly limited.

2.16. The first of the 32 standards of healthcare for Wales (see the following section) requires healthcare organisations to take into account the views of users and carers in planning and delivering health services. HIW and other partners do, of course, have arrangements of their own for involving patients and the public in their work (for example, as described in HIW's *Annual Report 2006/2007*). A number of relevant initiatives were summarised in last year's report on implementation of the concordat (see paragraph 2.11). There is public and patient representation on a reference group that assures the quality of 'tools' developed to assist signatories of the concordat to meet its objectives.

## 3. Reviews, audits and data

### Standards of healthcare

3.1. Since 2005, NHS bodies have been required to take into account the *Healthcare Standards for Wales*, published by the Assembly Government. The 32 standards are grouped within four domains: the experience of patients, clinical outcomes, the governance of healthcare, and public health. They are aimed at improving levels of care and treatment and, as with those published by the Department of Health in England in 2004, have provided the basis of the regulatory assessment of the NHS. From the outset the standards have been aligned with themes of clinical governance that were promoted in earlier Welsh guidance.

### Reviews by HIW

3.2. HIW has the prime responsibility for regulating healthcare provided by NHS organisations\* (and, since 2006, independent services) in Wales. Since April 2007, NHS organisations have been required to undertake self-assessments against the standards and to make an annual public declaration about their performance. HIW tests and validates these returns, using a risk-based analysis, against a range of data. This approach has some obvious similarities with that underpinning the Healthcare Commission's annual health check in England. In November 2007, HIW published a review of progress against the standards, based on its analysis of organisations' submissions for 2006/07<sup>10</sup>. A report of its review against standards for 2007/08 will be published in November 2008.

3.3. HIW has also undertaken a number of thematic reviews of services covering the whole of Wales. There has been cooperative working and other links with the Healthcare Commission in certain areas where we have undertaken similar work in England (see paragraph 3.17. HIW's work is summarised in its annual reports and, in more detail, in reports of specific reviews.

### Clinical audit

3.4. The Healthcare Commission has the power to conduct national reviews covering both England and Wales. In practice we have exercised this principally in relation to the national programme of clinical audit and patients' outcomes, for which we were responsible until March 2008. These audits (see below) have been managed under contract by professional bodies, often royal colleges, and are an important way of involving clinicians of all disciplines in the measurement of their performance. A number of audits have covered the whole of the United Kingdom.

\* Defined as Welsh NHS bodies, independent contractors and other organisations, including the independent and voluntary sectors, which provide or commission healthcare for individual patients, services users and the public: see Healthcare Inspectorate Wales (2007) *How Good is the NHS in Wales?*

## National clinical audits covering Wales 2004-08

Subject	Component	Coverage
<b>Cancer</b>	Bowel	UK
	Head and neck	E/W
	Lung	E/W
	Stomach	UK
	Mastectomy and breast reconstruction	UK
<b>Child and maternity</b>	Neonatal intensive care	UK
<b>Heart</b>	Adult cardiac surgery	UK
	Congenital heart disease	UK
	Cardiac interventions (eg, angioplasty, opening up heart artery)	UK
	Myocardial infarction	E/W
	Heart rhythm management	UK
	Cardiac ambulance services	E/W
	Heart failure	UK
	Patients' pathways and outcomes	E/W
<b>Long term conditions</b>	Diabetes	E/W
<b>Mental health</b>	Violence in MH settings	E/W
<b>Older people</b>	Stroke (hospital)	E/W/NI
	Preventing stroke	UK
	Falls	E/W

NB: This table excludes scoping studies, planned reviews and registry/network commissions. Some audits are continuing.

### Key:

E/W: England and Wales

NI: Northern Ireland

3.5. A major part of the Commission's funding for work in Wales was devoted to clinical audit\*. Responsibility for the national programme, which still covers both countries, has since passed to a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and the Long-Term Conditions Alliance known as the **Healthcare Quality Improvement Partnership (HQIP)**. HQIP is currently seeking tenders for studies relating to asthma, primary care as part of the "pathway" of stroke patients, and dignity in hospital. The latter will take account of indicators identified through the **Fundamentals Of Care** programme\*\* (which, in turn, are linked to implementation of the *Healthcare Standards for Wales*) and those relating to "Essence of Care", which has been spearheaded in England by the Royal College of Nursing.

3.6. Looking forward, both the Care Quality Commission and HIW will require cooperative relationships with both HQIP and the recently-established **national clinical audit advisory group**, so that findings from audits, as well as information about levels of participation in such studies, continue to inform wider assessments of healthcare.

\* The Welsh Assembly Government makes an annual contribution to the Healthcare Commission's grant in aid from the Department of Health. Since April 2008 the Assembly Government has funded the Welsh element of the programme managed by the Healthcare Quality Improvement Partnership.

\*\* Welsh Assembly Government (2003) *Fundamentals of Care: Guidance for Health and Social Care Staff*. Indicators of practice from this programme have concerned such aspects as communications and information, respecting people, ensuring safety and preventing pressure sores.

## Acute hospital portfolio

3.7. From 2000 to 2004 the Audit Commission managed the “acute hospital portfolio” (AHP) in Wales, England and Northern Ireland. This was a series of reviews that measured the performance of NHS trusts in specific areas of healthcare, balancing quality of care with service costs to assess value for money. Responsibility for this programme passed in England to the Healthcare Commission, which, under the 2003 Act, took over aspects of the Audit Commission’s work relating to effectiveness, efficiency and economy in healthcare, and in Wales to the WAO on its formation in 2005. As noted at paragraph 2.7, our MoU with the WAO provides for cooperative working in relation to the AHP.

3.8. Areas of the AHP carried out by the WAO in Wales and the Healthcare Commission in England have included **accident and emergency departments, staffing on wards, diagnostic services** (pathology, imaging and endoscopy), **maternity services** and the **management of medicines**. In each case, every participating trust has received an assessment of its performance, based on a comparison of national data. More recently, the elements of the AHP in England have been absorbed into the Healthcare Commission’s wider programme of service reviews, but the WAO continues to manage the AHP in Wales.

## Cardiac website

3.9. Rates of survival following cardiac surgery at Morriston Hospital, Swansea and the University Hospital of Wales, Cardiff (the only cardiac units in Wales) have been included on the website, *Heart surgery in the United Kingdom*, which was launched in 2007 by the Healthcare Commission and the **Society for Cardiothoracic Surgery in Great Britain and Ireland**<sup>\*</sup>. This pioneering site includes data for each hospital and individual surgeons in three categories: bypass operations, aortic valve replacements and all cardiac surgery. Taking into account factors that increase the risk of not surviving an operation, the overall survival rate for both Welsh hospitals in the three years to March 2007 was 97.5% (compared to 96.6% in the UK as a whole).

## Mental health: ‘Count me in’ census

3.10. In England and Wales there are about 200,000 admissions to hospital annually due to mental health problems<sup>11</sup>. About one in five of these is subject at some point to an order for compulsory detention under the Mental Health Act 1983<sup>\*\*</sup>. At any one time there are over 2,000 inpatients in Welsh mental health or learning disability services, of which the latter account for fewer than 200<sup>\*\*\*</sup>. In 2005 13,500 people with learning disabilities were registered with a Welsh local authority<sup>12</sup>.

3.11. Since 2005 the Healthcare Commission, the MHAC, the Care Services Improvement Partnership and the National Institute for Mental Health in England have sponsored an annual census of inpatients in mental health services in England and Wales. Learning disability services were added in 2006. The purposes have been:

- To obtain robust figures of such patients (whether detained under the Mental Health Act 1983 or admitted voluntarily).

<sup>\*</sup> <http://heartsurgery.healthcarecommission.org.uk/index.aspx>

<sup>\*\*</sup> As amended by the Mental Health Act 2007.

<sup>\*\*\*</sup> On 30 March 2007 there were 2,137 mental health and 190 learning disabled inpatients in NHS and independent services in Wales: Healthcare Commission *et al*, *Count me in 2007*. (The figure for learning disabilities includes patients with autistic spectrum disorder or Asperger’s syndrome.)

- To encourage accurate records of patients' ethnicity to be kept.
- To assist implementation of the Assembly Government's **race equality action plan** for adult mental health services (2006), which is directed at developing the evidence base, designing suitable and responsive services, training and recruiting staff, and managing performance, monitoring and audit<sup>13</sup>.

3.12. One very obvious strategic implication of the figures derived from the censuses has been the growth of the **independent sector** in the three years to 2008. During this period the number of independent providers in Wales rose from 7 to 16 (and in England from 98 to 141), while the number of patients in independent hospitals more than doubled.

### **Patients with mental health problems or learning disabilities in independent hospitals in Wales 2006-08**

	<b>2006 census</b>	<b>2007 census</b>	<b>2008 census</b>
Mental health	155	262	355
Learning disabilities	10	36	41

*Count me in censuses 2005-08*

3.13. Over the same period the number of inpatients in NHS services in Wales on the date of the census fell from 1,962 to 1,892 (mental health) and 164 to 143 (learning disabilities).

### **Youth offending teams**

3.14. Between 2003 and 2006 **Her Majesty's Inspectorate of Probation** led a series of joint inspections of youth offending teams (YOTs). This programme involved the Healthcare Commission (the Commission for Health Improvement until 2004), HIW and several other bodies, including the former **Social Services Inspectorate Wales** (SSIW)<sup>\*</sup> and **Estyn** (HM Inspectorate of Education and Training in Wales). It covered 50 YOTs in England and Wales<sup>\*\*</sup>, including five of the 17 in Wales.

3.15. Reports of each inspection were published, together with a general report in 2006 on healthcare services for young offenders<sup>14</sup>. The latter made a number of recommendations for health services, relating, for example, to the development of good protocols and service level agreements, adequate and flexible resourcing, better sharing of information and improving the monitoring of health outcomes. The report also drew attention to the statutory requirement for each YOT to have a healthcare worker and the importance of access to good quality mental health services, as outlined in the *National Service Framework for Children, Young People and Maternity Services in Wales* (2005).

3.16. The inspection of Welsh YOTs has continued, with a full cycle due to be completed during 2008/09. Responsibility for assessing aspects relating to health has transferred from the Healthcare Commission to HIW.

<sup>\*</sup> Merged with Care Standards Inspectorate Wales in 2007 to form Care and Social Services Inspectorate Wales: see paragraph 6.3. SSIW was responsible for inspecting local authority social services.

<sup>\*\*</sup> There were then 155 YOTs in England and Wales (157 by 2006). YOTs were established under the Crime and Disorder Act 1998 primarily to divert and prevent children and young people from participating in offending behaviour. Teams include representatives from social services, education, probation and health.

## Assisting our partners

3.17. A distinctive aspect of the Commission's work in Wales has been the advice and support we have provided to HIW and other bodies on reviews of services that are similar in content to those in England. This has represented an efficient use of resources and expertise, while leaving to our Welsh partners the responsibility for developing or adapting suitable methodologies and carrying out and reporting the outcomes of reviews. Areas in which HIW has drawn on our experience have included **learning disabilities** (notably our investigations in Cornwall and Sutton and Merton<sup>15</sup>), **maternity** (the investigations at Northwick Park hospital and New Cross hospital, Wolverhampton<sup>16</sup>) and **infection control** (in particular, concerns about decontamination of shared equipment and linen highlighted by our investigation at Stoke Mandeville hospital, the report of which was published while HIW's review was being planned<sup>17</sup>). In 2006 our advisor on **ambulance services** and emergency care contributed to both the Auditor General's inquiry into the Welsh Ambulance Services NHS Trust (undertaken at the request of the National Assembly) and HIW's closely linked special review of the trust<sup>18</sup>.

3.18. We have shared a number of our approaches and findings with groups of leading policymakers and regulators of healthcare in Wales. Seminars have covered such areas as **public health** (notably our work on the control of tobacco and misuse of substances), the **acute hospital portfolio** (jointly with the WAO), and **clinical quality**. A reciprocal meeting with Assembly officials and the Wales Centre for Health considered approaches in Wales to **life saving interventions**\*. There were also regular meetings with Assembly officials and others to discuss coverage in Wales of the national programme of clinical audit.

## Review of defence medical services

3.19. In 2008 the Healthcare Commission undertook for the Ministry of Defence an assessment of defence medical services in the UK and overseas. This programme included a visit to the dental service at Royal Air Force St Athan in the Vale of Glamorgan.

## Residual work from the Commission for Health Improvement

3.20. In its first year, the Healthcare Commission completed a small number of reviews in Wales initiated by our predecessor:

- A clinical governance review of Gwent Healthcare NHS Trust.
- Thematic reviews with SSIW of:
  - services for children with a disability
  - communication, assessment and decision-making relating to the social care of patients in acute hospitals.

\* Drawing on the approach of the Institute for Healthcare Improvement in the United States which, through interventions based on evidence, had been aiming to save 100,000 lives in 18 months: see Welsh Assembly Government (2006) *Healthcare Quality Improvement Plan*.

## 4. Reporting the state of healthcare

4.1. The Healthcare Commission is required to publish an annual report on the state of healthcare in England and Wales. The first such report appeared in July 2004 and the fifth and final one is due to be published in December 2008. From 2009 there will be no statutory requirement for a report on the state of healthcare in Wales\*.

4.2. Due, in part, to the differing nature of our functions, we have developed, through our assessments, a much fuller overview of healthcare in England than in Wales. In addition, the systems of healthcare in England and Wales have increasingly diverged. Therefore we have worked closely each year with our regulatory partners in Wales, notably HIW and the WAO, as well as the Assembly Government, to collect information and findings that are relevant to the state of healthcare in Wales.

### Setting the scene

4.3. As the Chairman of the Healthcare Commission indicated in his foreword to the first report, “the NHS is very large and complex. It does not lend itself to some general judgement”. Therefore the reports have not made assertions about the general state of healthcare in Wales. Rather, they have concentrated on particular themes – in some instances, recurring ones like waiting times (see paragraph 4.9) – and often linked these to actions by the Assembly Government or regulators to examine the issues further or to bring about improvements.

4.4. Selected themes (see paragraphs 4.9-11) have typically been addressed for both England and Wales, while recognising differences of approach and organisation, as well as particular factors that affect health or healthcare in either country or regionally. ‘Higher-level’ statements about healthcare have mostly concerned trends or circumstances that have been demonstrated quite widely and raise major issues for planning, provision or cooperative working. For example, as highlighted in the *State of Healthcare Report 2004*:

- Health is influenced by a wide range of issues, such as age, economic status, education and ethnic origin (factors recognised in the Assembly Government’s consultative document, *Well Being in Wales*, in 2002).
- England and Wales have an ‘ageing’ population and life expectancy of women is higher than that of men.
- People from black and ethnic minorities (who make up 2% of the population in Wales, compared to 9% in England) are likely to have worse access to services and poorer health than those from white communities.
- There are wide demographic variations in deaths from cancer and stroke is the largest single cause of severe disability.

\* The Care Quality Commission will be required to publish reports on the provision of NHS and adult social care, and to carry on regulating services in England (Health & Social Care Act 2008, section 83). The new National Quality Board will publish an annual report to the Secretary of State for Health on the state of quality in England: *High Quality Care For All: NHS Next Stage Review Final Report* (Cm 7432, June 2008), paragraph 4.33. The Commission for Social Care Inspection currently publishes an annual report on the state of social care in England.

4.5. For the most part, such issues had already been reflected, in one way or another, in the **Wanless review** of health and social care in Wales. The report of that study (2003)<sup>19</sup> offered some cautionary words about arrangements for healthcare in Wales, including that:

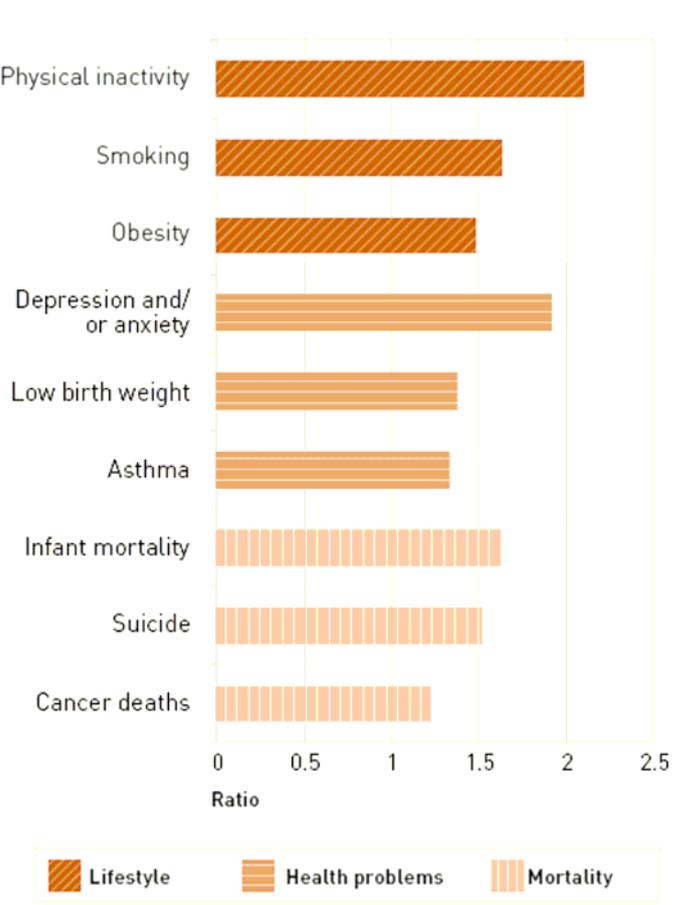
- Demand for health and social care services in Wales could overwhelm the system of provision and the workforce.
- Health and social care organisations would need to improve performance and modernise services to justify increases in resources.
- Services would need to be realigned to focus on prevention and early intervention.

4.6. The wide-ranging conclusions of the Wanless report were a strong influence on the Assembly Government's objectives in *Designed for Life* (2005)<sup>20</sup> to improve health and reduce inequalities and on the *Healthcare Quality Improvement Plan* (2006) to deliver those objectives. In the meantime the Assembly Government had already taken action to address inequalities, including the use of targeted funding, as informed by Professor Peter Townsend's detailed work on resource allocation for healthcare in Wales<sup>21</sup>. In this regard, the *State of Healthcare 2005* acknowledged Wanless' conclusion that Wales was ahead of the rest of the UK in terms of its approach to addressing inequalities in health through joint action across areas of policy.

4.7. In turn, the *State of Healthcare 2007* drew attention to the Assembly Government's recognition of the need to take action to improve people's health and specifically to the plans in *Designed for Life*. The report also highlighted the national initiative, Health Challenge Wales, which was launched in 2005 to provide a focus for individuals and organisations wishing to contribute to that process.

4.8. In summary, therefore, we have sought not only to present annually a picture of the state of healthcare and to draw attention to particular issues or challenges, but to take account of wider strategic considerations and to recognise and track action taken to tackle problems from year to year.

**Indicators of health and lifestyles in the most deprived and most affluent fifths of the Welsh population (2004)**



State of Healthcare 2005  
 Source: National Public Health Service for Wales (2004) *Deprivation and Health*

**Issues covered in the reports**

4.9. **Appendix D** is a case study of how the reports on the state of healthcare have covered **waiting times** in Wales, including the trends, actions and improvements made in this area since 2004.

4.10. Other Welsh issues addressed or highlighted in the state of healthcare reports are summarised below. They have been divided into five broad themes, although some of these overlap (such as sensitivity to individual needs and improving quality). Most issues were considered in conjunction with relevant aspects of healthcare in England. The increasing availability of findings and data from reviews, notably those of specific services in England by the Healthcare Commission and in Wales by HIW, was a significant feature of the more recent reports.

## Reports on the state of healthcare 2004-07: Issues relating to Wales

<p><b>Learning from patients' experiences</b></p>	<p><b>2004</b></p>	<ul style="list-style-type: none"> <li>• Extant guidance on involving patients and the public: for example, tracking complaints and aggregating data, and plans for public involvement in health services.</li> <li>• Transferring learning across health and social care: training and support for patients and carers of people with learning disabilities.</li> </ul>
	<p><b>2005</b></p>	<ul style="list-style-type: none"> <li>• Significant progress in setting up arrangements for involving patients and the public.</li> </ul>
	<p><b>2007</b></p>	<ul style="list-style-type: none"> <li>• Experiences of people using mental health services, including those over 65.</li> <li>• Experiences of people with learning disabilities: HIW about to report on review of services.</li> </ul>
<p><b>Sensitivity to individual needs</b></p>	<p><b>2004</b></p>	<ul style="list-style-type: none"> <li>• Waiting times: see Appendix D</li> </ul>
	<p><b>2005</b></p>	<ul style="list-style-type: none"> <li>• People detained under the Mental Health Act 1983.</li> <li>• Communicating with people with disabilities, including people with hearing problems.</li> <li>• Waiting times, including the "second offer" scheme for faster treatment at an alternative hospital</li> </ul>
	<p><b>2006</b></p>	<ul style="list-style-type: none"> <li>• Arising from a review of mental health services by the WAO, the challenges faced in closing the remaining "Victorian-style" hospitals by the end of 2008; the involvement of patients and their carers in the planning of care; the continued availability of advocacy services; some encouraging initiatives regarding people's management of their own conditions.</li> <li>• Waiting times</li> </ul>
<p><b>Safety of care and treatment</b></p>	<p><b>2005</b></p>	<ul style="list-style-type: none"> <li>• Launch of Welsh Assembly Government's strategy for tackling healthcare associated infections (HCAIs) in NHS trusts.</li> </ul>
	<p><b>2006</b></p>	<ul style="list-style-type: none"> <li>• NHS staff reporting errors that could have caused harm to patients or staff.</li> <li>• HIW's plans for "spot checks" of how hospitals deal with HCAIs.</li> </ul>
	<p><b>2007</b></p>	<ul style="list-style-type: none"> <li>• Rate of MRSA about half that in England and decreasing faster.</li> <li>• Prevalence of <i>clostridium difficile</i> lower than in England, though rates are not directly comparable: see Appendix A, paragraph 2</li> <li>• Findings of HIW's spot checks: evidence of good practice but more needing to be done.</li> <li>• The WAO's report on minimising HCAIs: development of frameworks by NHS trusts and screening of patients; more could be done to improve collection of information and arrangements for reporting.</li> </ul>

<b>Public health and inequalities</b>	<b>2005</b>	<ul style="list-style-type: none"> <li>• Variations in health and lifestyle between the most deprived and most affluent parts of Wales: see figure above</li> </ul>
	<b>2006</b>	<ul style="list-style-type: none"> <li>• Review of sexual health services underway, including development of quality requirements.</li> <li>• Increased life expectancy and lower infant mortality over the past 20 years.</li> <li>• Leading causes of premature death in England and Wales before the age of 75 (cancer, circulatory diseases and respiratory diseases), including international comparisons.</li> <li>• Health and lifestyle, including smoking (ban in public places and cessation services), and obesity (sport and physical activity) and prison health (application of healthcare standards).</li> </ul>
<b>Improving quality and clinical effectiveness</b>	<b>2006</b>	<ul style="list-style-type: none"> <li>• Assessing the suitability of patients for day surgery.</li> </ul>
	<b>2007</b>	<ul style="list-style-type: none"> <li>• Main features of <i>Healthcare Quality Improvement Plan</i>.</li> <li>• Greater proportion of patients with heart problems receiving clot-dissolving drugs.</li> <li>• Recognition by government and clinicians that stroke services need to be improved following late launch of national service framework in 2006.</li> <li>• Review by HIW of maternity services: safe and effective overall, but some areas for improvement (application of All-Wales Clinical Pathway for Normal Labour, “escalation” policies to deal with increased activity, staffing levels, policies for reporting incidents, development of national data set).</li> <li>• Ambulance services: major reports by HIW and the WAO following adverse incidents and public debate about efficiency and effectiveness of all-Wales service.</li> </ul>

4.11. The report for 2008 will focus on improvements in healthcare in England and Wales in 2007/08 and, more generally, since 2004. It will emphasise the importance of personalised care and of “pathways” of care for patients. The main subjects covered this year will be safety of healthcare, community services, maternity, children, learning disabilities and mental health.

## 5. Working with regulators elsewhere in Great Britain and Ireland

5.1. Many of the issues of interest to HIW and the Healthcare Commission are similar to those affecting regulators elsewhere in the United Kingdom. One measure of this was HIW's decision to commission our Scottish equivalent, **NHS Quality Improvement Scotland (QIS** – established in 2003), to conduct a review of the effectiveness of its assessment against the *Healthcare Standards for Wales* in 2006/07<sup>22</sup>. A number of other bodies with which we work closely, such as royal colleges, the GMC and PMETB, operate across either Great Britain or the UK as a whole. Therefore, there is a wider dimension to some of our work and the external relationships that help to support this.

### The five nations group

5.2. To optimise these various contacts, we established, with our main counterparts in the UK and the Republic of Ireland, the 'five nations' group, which, since 2005, has met typically about four times a year. Our other partners in this group are HIW, QIS, the **Regulation and Quality Improvement Authority (RQIA** – established in Northern Ireland in April 2005) and the **Health Information and Quality Authority (HIQA** – established in the Republic of Ireland in May 2007<sup>\*</sup>), together with the **Commission for Healthcare Regulatory Excellence**, whose functions to ensure best practice in the regulation of healthcare professions are UK-wide. Other bodies, including NICE and the PMETB, have attended some meetings by invitation.

5.3. The secretariat for the group, which now rotates with the responsibility for hosting it, was provided initially by the Healthcare Commission and HIW. Recurring themes have included:

- **Independent healthcare**
- **Public health**
- **Mental health**
- **Safety of patients**, including management of healthcare associated infection
- **Measuring clinical quality and effectiveness**
- **Regulation, training and education of healthcare staff**
- **Managing regulatory change**
- **Research and evaluation** of topics associated with the regulation of healthcare (see below)
- **International work**, including links with the **European Partnership for Supervisory Organisations (EPSO)** and the **World Health Organisation**, and the development of indicators of primary care by the **Organisation for Economic Cooperation and Development**.

5.4. In 2005 the Healthcare Commission commissioned Professor Kieran Walshe, of the Centre for Public Policy and Management at the University of Manchester, to review differing **systems of regulation** and their impact on performance in seven sectors, including health and social care. The five nations group subsequently adapted Professor Walshe's approach to identify the main similarities and differences between our organisational functions. The areas covered included organisation and governance, responsibilities, policy purpose, standards, regulatory powers, regulatory regime, type of regulation, performance

<sup>\*</sup> Earlier meetings were attended by the interim authority.

management, complaints, investigations, arrangements for healthcare arrangements, the role of the public, and current issues. The findings were discussed at our meeting in June 2007.

5.5. Special meetings in September 2006 and May 2007 respectively addressed issues to do with clinical quality and the regulation of independent healthcare. We discussed some of the UK-wide implications of the former with the Academy of Medical Royal Colleges at its meeting in April 2008. The MHAC and its counterparts in Scotland and Northern Ireland attended the meeting of the group in September 2008, which included a session on the regulation of mental health services. We were also joined on that occasion by a representative of the Danish National Board of Health.

### Meetings of the five nations group 2005-08

Date	Host	Location	Main subjects	Also present
August 2005	Healthcare Commission	London	Inaugural roundtable	NHS Confederation
January 2006	QIS	Edinburgh	Strategies and programmes of work  Regulatory change  Evaluation of Healthcare Commission's annual health check  Review of ISQua conference (Vancouver 2005)	
May 2006	HIW	Cardiff	Research projects  Approaches to review, assessment and clinical strategy  English and Welsh concordats  Planning for ISQua conference (London 2006)	
September 2006	Healthcare Commission	London	Special meeting on clinical issues	NICE
November 2006	RQIA	Belfast	Independent healthcare  Regulation of healthcare professionals	

March 2007	Healthcare Commission	London	Controlled drugs/medicines in social care  Independent healthcare  Public health  Regulation of healthcare professionals  Research and evaluation	NICE
May 2007	Healthcare Commission	London	Special meeting on independent healthcare	
June 2007	HQIA	Cork	Approaches to regulation  Safety of patients, including working with World Health Organisation  Independent healthcare  Regulation of healthcare professionals  Influencing government policy	NICE
December 2007	QIS	Edinburgh	Independent healthcare  Regulation of healthcare professionals  Work of PMETB  Healthcare associated infection (HCAI)  Clinical quality and effectiveness  Role of the 5 nations group	PMETB

April 2008	HIW	Cardiff	Safety, including control of HCAI and Republic of Ireland's framework for quality and safety  Measurement of clinical quality  Learning from investigations  Controlled drugs	CSSIW (for pre-meeting event)
September 2008	Healthcare Commission	London	Clinical quality, including accreditation of services and European work  Regulatory change, including mental health and establishment of Care Quality Commission  Medical training and education	MHAC  Mental Welfare Commission for Scotland  Mental Health Commission for Northern Ireland  PMETB
(January 2009)	(RQIA)	(Belfast)	(Integration of health and social care regulation)	

**Key:**

CSSIW: Care and Social Services Inspectorate Wales

ISQua: International Society for Quality in Healthcare

MHAC: Mental Health Act Commission

NICE: National Institute for Health and Clinical Excellence

PMETB: Postgraduate Medical Education and Training Board

5.6. Before the meeting in June 2007 there was a presentation and discussion about the accreditation of health services, led by HIQA. Other meetings over the past two years have been preceded by a presentation by an eminent guest:

- November 2006: Professor Kieran Walshe (see paragraph 5.4)
- December 2007: Professor Phil Hanlon (Professor of Public Health, University of Glasgow).
- April 2008: Dr Jonathan Gray (Director of Healthcare Improvement, Wales Centre for Health).
- September 2008: Professor Sir Ian Kennedy (Chairman, Healthcare Commission).

## Related activities

5.7. In 2006 there was a joint five nations workshop on success in inspection and review at the annual conference in London of the **International Society for Quality in Healthcare** (ISQua), hosted by the Healthcare Commission.

5.8. In 2008, following discussion by the five nations group, a cross-border group on the regulation of **controlled drugs** was established. This has met twice: in Belfast in May 2008 and in Edinburgh in September 2008.

## Charter for the safety of patients

5.9. In 2007 the Healthcare Commission and the **National Patient Safety Agency** launched a charter for the safety of patients, to which 36 bodies and leading figures in the field of health also committed themselves. This was an early collective response to the report, *Safety First*, which was commissioned by the Chief Medical Officer for England and made a number of recommendations for embedding the safety of patients in the NHS<sup>23</sup>. HIW and RQIA were among the original signatories of the charter. Associated with this initiative were two national 'summits' in London in 2007 and 2008 and a workshop at which signatories shared approaches to safety under the broad headings of regulatory models, standards and guidance, investigations, influencing policy and practice, strategic purchasing and sharing of information.

### **Extract from a charter for the safety of patients (2007)**

**We ... have separate but linked responsibilities for key aspects of the provision of healthcare and recognise that:**

We must offer leadership which will accelerate change. This will call for close cooperation, energy, passion and clear direction.

A culture of commitment to safe care must be fostered and embraced by all those involved in providing care so that protecting patients from avoidable harm becomes an accepted feature of "the way things are done about here".

Safety is at the core of clinical practice and patient care: we all have a role to play in ensuring that the safety of care is continuously improved.

We need to revitalise our approaches for improving the safety of care, to eliminate suffering, avoidable harm and care of poor quality.

## 6. Looking ahead

6.1. Over the past four and a half years the Healthcare Commission has developed a mutually supportive relationship with HIW. We have also worked cooperatively with the WAO and various other bodies responsible for reviewing or auditing healthcare in Wales, as well as the Assembly Government and partners across the UK and beyond. We have been active participants in the development of the Welsh concordat, drawing on our experience in England.

### Changes in regulation

6.2. As noted, the Commission will be replaced in April 2009 by the Care Quality Commission, which will in effect bring together in England the work of three bodies: the Healthcare Commission, the Commission for Social Care Inspection (an England-only body) and the Mental Health Act Commission.

6.3. Since 1 October 2008 HIW has been managing the process to ensure that, by April 2009, Welsh Ministers, through HIW, will be able to carry out the statutory functions that rest currently with the MHAC (see paragraph 1.14). Social care in Wales will continue to be regulated by **Care and Social Services Inspectorate Wales (CSSIW)**.

### Cooperation under the 2008 Act

6.4. The CQC will not have any functions in Wales, but a few provisions in the Health and Social Care Act 2008 anticipate a continuing relationship with Welsh bodies:

- The CQC and Welsh Ministers (and, by extension, HIW and other Assembly-based bodies) must “**cooperate with each other** for the efficient and effective discharge of their corresponding functions” and may **share information** for relevant purposes (section 69).
- Following a special review or investigation, the CQC must inform Welsh Ministers if it considers there are **significant failings** on the part of a Welsh NHS body and may recommend Ministers to take special measures (section 51). This is similar to the current obligation on the Healthcare Commission, and HIW will continue to have a reciprocal duty under the 2003 Act in respect of English bodies.
- The **Auditor General for Wales** (see paragraph 2.6) must, on request, supply the CQC with information to make comparisons between English and Welsh NHS bodies that the Commission reasonably requires for studies of efficiency, economy or effectiveness (section 71).

6.5. The CQC, the Assembly Government and HIW in particular will need to decide how best to manage the statutory duty of cooperation. Given what we understand to be the wish of our Welsh partners to maintain similar levels of interaction as there have been with the Healthcare Commission, the existing arrangements for maintaining constructive links could no doubt be adapted to the new circumstances. These include regular meetings; our memoranda of understanding with HIW and the WAO, which identify points of contact and areas of shared interest; and the facility for the Commission to identify expert advisors to assist HIW (and to re-charge accordingly) (see paragraph 2.13).

## The concordat

6.6. The Healthcare Commission, by virtue of its limited functions in Wales, has a direct role in relation to the Welsh concordat that goes beyond its leadership of the English concordat and its duty under the 2003 Act to coordinate reviews of health and healthcare in England. Since the CQC will have a statutory role in England “to promote the effective coordination of reviews or assessments carried out by public bodies or other persons in relation to the carrying on of regulated activities”, arrangements that enable relevant experiences to continue to be shared with Welsh partners (and *vice versa*) may bring some mutual benefit. In any event, HIW remains an associate signatory of the English concordat and, in both Wales and England, the various partners are considering how the practices of the respective concordats and the learning of the past four years could be applied in the future. Naturally any continuing links between Wales and England will need to take account of developments.

## Changes to the NHS in Wales

6.7. The major changes planned to the organisation of the NHS in Wales<sup>\*\*</sup>, following consultation earlier this year, are likely to have corresponding implications for how HIW undertakes its work. In summary the main features are:

- The eight hospital trusts and 22 health boards will be replaced by seven bodies that combine primary and secondary care.
- There will be a unified public health service.
- The Velindre trust (see paragraph 1.5) will continue to provide specialised services, although some of its functions, such as screening services, will become part of the public health service.
- A national advisory board, to be in place by April 2009, will have independent membership and be chaired by the Minister for Health and Social Services.
- The Chief Executive of NHS Wales, who will be a member of the advisory board, will lead a delivery group responsible to the Minister for the operational performance of NHS organisations.
- The role of the Health Commission Wales, which commissions specialised services, will be reviewed.
- There will be consultation on a strengthened role for community health councils, which share the same boundaries as local authorities.

## UK issues

6.8. Under the 2008 Act **Northern Ireland Ministers** may make arrangements for the CQC to undertake relevant work relating to their functions<sup>\*\*\*</sup>.

6.9. The CQC will need to decide whether to retain the Healthcare Commission’s involvement with the five nations group. The group will be considering at its meeting in Belfast in January 2009 whether to seek a closer alignment with the “**Celtic Network**” of social care regulators. The latter does not – by definition – include CSCI, but since the CQC, in common with RIQA (Northern Ireland) and HIQA (Irish Republic), will cover both health and social care, there may be advantages in a single multi-national group to bring together both elements. In the case of Wales, that might imply the involvement of both HIW and CSSIW. In **Scotland** social care is regulated by Care Commission Scotland, whose functions

<sup>\*</sup> Section 67 of the 2008 Act

<sup>\*\*</sup> Assembly statement by the Minister for Health and Social Services, 30 September 2008.

<sup>\*\*\*</sup> Section 74 of the 2008 Act.

in that area the Scottish Government intends to merge with those of the Social Work Inspectorate Agency and, in relation to the protection of children, Her Majesty's Inspectorate of Education (HMIE) to form a single body to look at care and social work.

6.10. The latter proposal is part of a wider realignment of scrutinising bodies north of the border. The Scottish Government plans also to establish a new body to scrutinise health. This would bring together the functions of QIS, the Mental Welfare Commission and the Care Commission's work relating to independent healthcare<sup>24</sup>.

### **Cross-border healthcare**

6.11. All members of the five nations group have an interest in the **draft European Union directive** on patients' rights to healthcare in other member states (July 2008). Some of the implications were discussed at the meeting of EPSO, attended by the Healthcare Commission and HIQA, in Copenhagen in October 2008. The UK health departments are currently consulting on this to inform the UK's negotiating position. If the proposals were adopted, there would inevitably be regulatory implications for the CQC, HIW and their counterparts. For example, Article 5 of the directive would require member states to define "clear quality and safety standards for healthcare provided on their territory" and the European Commission, in cooperation with member states, would develop guidelines relating to such standards in order to facilitate healthcare across borders. The consultation closes in December 2008.

### **Healthcare Commission November 2008**

# Appendix A

## Demography, epidemiology and strategy

1. Wales is just over 8,000 square miles in area. In 2006 there were 2.97 million people. Births currently exceed deaths and are increasing\*. The largest centres of population are in the south eastern part of the country (an area that includes the cities of Cardiff, Swansea and Newport), around Wrexham in the north east and along the north coast between the seaside resorts of Llandudno and Prestatyn.

## Demography and health status

2. Wales has a higher proportion than England of people over 65\*\*, as well as a higher percentage with a longer-term illness<sup>25</sup>. Survival rates for some forms of cancer are slightly better in Wales\*\*\*, although mortality rates for circulatory and respiratory diseases are higher. Wales has the lowest rate of elective admissions to hospital among countries of the United Kingdom, but the highest rate of emergency admissions\*\*\*\*. In some respects the quality of healthcare compares very favourably with the rest of the UK: rates of MRSA bacteraemia (bloodstream infections) in Wales are the lowest, and those of prescribing statins to prevent cardiovascular disease the highest<sup>26</sup>. Estimates in 2006 suggested that the prevalence in hospitals of *clostridium difficile* was about half that in England\*\*\*\*\* (although rates in England of both *c. difficile* and MRSA continue to decline\*\*\*\*\*).

3. Over half of the population of Wales is overweight and almost one in five is obese\*\*\*\*\*. As noted in section 2, over 40% of adults have a sedentary lifestyle<sup>27</sup>. Just under one in four of the adult population smoke tobacco, about the same as in England\*\*\*\*\*. However, since a ban on smoking in public places was introduced in 2007, three months before that in England, the proportion of people reporting regular exposure to other people's tobacco smoke has fallen from two-thirds in 2005/06 to 42%<sup>28</sup>. As in England, there are certain

\* In 2006 births per 1,000 population (11.3) exceeded the number of deaths (10.5). 33,628 live births were registered, an increase of almost 1,000 compared to 2005: see Healthcare Inspectorate Wales (2008) *Local Supervising Authority Annual Report to the Nursing and Midwifery Council 1 April 2007-31 March 2008*.

\*\* In 2003 the number of people at or above the age of retirement in Wales was projected to rise by 11% over 20 years, compared with 3% overall in the rest of the UK: *The Review of Health and Social Care in Wales*: report of the project team advised by Derek Wanless (June 2003).

\*\*\* For example, five-year survival rates for patients diagnosed with breast cancer between 2000 and 2002 were 77.8% in England and 78.4% in Wales. However, both are lower than those of most other European countries: see Healthcare Commission, *State of Healthcare 2007*.

\*\*\*\* Comparison by CHKS: see *Health Service Journal*, 28 August 2008. In recent years, the rate of increase in emergency admissions has been smaller than in England.

\*\*\*\*\* Healthcare Inspectorate Wales (2007) *How Good is the NHS in Wales? – All Wales Review of Progress against Healthcare Standards for Wales: 1 April 2006-31 March 2007*; Healthcare Commission, *State of Healthcare 2007*. However, rates between the two countries are not directly comparable as those in England are based on patient bed days, while Wales uses patient admissions.

\*\*\*\*\* See, for example, Healthcare Commission (2008) *The Annual Health Check 2007/08* regarding year-on-year reductions in levels of MRSA in English hospitals. According to the Health Protection Agency, the number of cases of *C. difficile* in England in April-June 2008 was 18% per cent lower than in the previous quarter.

\*\*\*\*\* In 2007 57% of adults were classified as overweight or obese, including 21% who were obese: *Welsh Health Survey 2007*.

\*\*\*\*\* 24% in both countries: see *Welsh Health Survey 2007*; Healthcare Commission, *State of Healthcare 2007*

marked inequalities in health: for example, for average life expectancy between local authority areas. In some areas a combination of geographical and socio-economic factors affects travelling and access to services: for example, only 45% of people in the valleys have the use of a car and those that do not tend to be young or older people, or on low incomes<sup>29</sup>. A plan for rural health is being developed (see paragraph 6). One consequence of geography is that people in mid-Wales and the north have often tended to look to English centres such as Shrewsbury or Liverpool for hospital treatment. Over the past five years the needs of immigrant communities have had an increasing impact on the planning and provision of healthcare in many parts of Wales<sup>30</sup>.

## Strategic developments

**The Labour Party has been in government in Wales since 1999 and has provided the First Minister (initially, First Secretary) throughout that period. From October 2000 to May 2003 and since July 2007 there were coalitions with the Liberal Democrats and *Plaid Cymru* respectively. These dates are obviously relevant to references in this report to the Welsh Assembly Government.**

4. The Welsh Assembly Government published its first strategic plan for Wales in 2000. In 2003 the government's strategic agenda, *Wales: A Better Country*, drew on the Wanless review of health and social care<sup>31</sup> to highlight the improvement of health as a major goal. It noted that reported levels of poor health were higher in Wales than the rest of the United Kingdom and were associated with patterns of deprivation. However, Wanless also acknowledged action by the government to tackle inequalities through joint work across areas of policy<sup>32</sup> (see paragraphs 4.5-6).

5. Wanless found a mixed picture of performance in health and social care, including areas of under-performance associated with systemic defects. Consequently, the government's *Healthcare Quality Improvement Plan (2006)*<sup>33</sup> (from which the previous sentence is taken) emphasised the need for the NHS to have simple, clear objectives and good systems of management. It sought also to strengthen the focus on quality of healthcare. This approach built on the strategy for health and social care services, *Designed for Life (2005)*, which identified the main challenges for the NHS in Wales in the period to 2015 as an ageing population, rapid technological change and upgrading the infrastructure.

## One Wales

6. More recently, *One Wales: A progressive agenda for the government of Wales (2007)*<sup>\*</sup> emphasised the values and "world-class" aspirations of the NHS in Wales and contained a series of specific commitments to "a healthy future". These included:

- Reviewing the configuration of the NHS (see paragraph 6.7).
- Changing the financing and management of the NHS (including an end to the internal market).
- Developing and improving health services in areas such as family nursing, "well being" centres, palliative care, mental health, dentistry, public health and sexual health.
- Improving the experience of patients.
- Improving access to healthcare: for example, by reducing waiting times (see Appendix D), improving access to "drop in" centres and pharmacies, and developing a plan for rural health.

\* An agreement between the governing coalition parties in the Assembly.

# Appendix B

## Principles of joint working between the Healthcare Commission and Healthcare Inspectorate Wales

### Extract from memorandum of understanding (October 2005)

The Healthcare Commission and Healthcare Inspectorate Wales will work together following the principles of the *Concordat Between Bodies Inspecting, Regulating and Auditing Health and Social Care in Wales* and will seek to ensure its effective implementation. In particular, all decisions about collaborative working between the Healthcare Commission and Healthcare Inspectorate Wales across the NHS\* will be subject to the following general principles:

- The Healthcare Commission and Healthcare Inspectorate Wales will respect each other's independent status and will cooperate when necessary or appropriate.
- The working relationship of The Healthcare Commission and Healthcare Inspectorate Wales will be governed by the need to deliver maximum benefits to those using health and other public services.
- The Healthcare Commission and Healthcare Inspectorate Wales will work together in undertaking their respective functions when this contributes most to improvements in healthcare services.
- The Healthcare Commission and Healthcare Inspectorate Wales will work together to encourage the development of consistent, high quality, accurate information in the NHS and will rely on intelligent data to focus and support their work programmes.
- The Healthcare Commission and Healthcare Inspectorate Wales will be open and transparent in their decisions about when and where it is considered appropriate for them to work collaboratively.

\* HIW did not take over responsibility for regulating independent healthcare in Wales until April 2006.

## Appendix C

### **Objectives of the concordat between bodies inspecting, regulating and auditing health and social care in Wales (May 2005)**

Each objective is underpinned by several shared practices (for example, in the case of objective one, defining and explaining the remit of reviewing bodies to ensure clarity and effective coordination; using existing sets of data; sharing information with other bodies; planning and coordinating external reviews; and relying on the findings of other reviewing bodies).

**Objective one:** External reviews are coordinated with other reviews and collections of data.

**Objective two:** External reviews of health and social care focus on the experience of patients, other service users and carers.

**Objective three:** External reviews support improvements in quality and performance.

**Objective four:** External reviews continuously improve their methods.

**Objective five:** External reviews are independent, consistent and fair.

**Objective six:** External reviews are targeted and proportionate.

**Objective seven:** External reviews are transparent and accountable.

**Objective eight:** External review bodies use coordinated and proportionate methods of enforcement.

**Objective nine:** External reviewers are suitably qualified, trained and skilled.

**Objective ten:** External reviews continuously monitor their practices in line with the concordat.

# Appendix D

## Coverage of waiting times in reports on the state of healthcare 2004-07

1. The *State of Healthcare Report 2004* was clear that patients in Wales tended to wait longer than those in England for routine treatment. On the other hand, the Audit Commission had found in 2001 that waiting times in accident and emergency departments in Wales were lower than for any English region<sup>34</sup>. There had also been reductions in waiting times for heart surgery and hip and knee replacements. Therefore, the picture of healthcare was mixed. The *State of Healthcare Report* speculated that the differences between England and Wales were due to a combination of factors, including differences in the population and a less strong emphasis in Wales on targets for reducing waiting times. At the time the latter were generally less ambitious than those in England (for example, 18 months for a first appointment as an outpatient, as opposed to 17 weeks in England), although they have now been reduced significantly: see paragraph 6.

2. The *State of Healthcare 2005* made reference to a study by the National Audit Office (NAO) of NHS waiting times in Wales<sup>35</sup> to support the view that, while the gap between waiting times in Wales and England was widening and a tenth of the population of Wales was on a waiting list, there had also been some improvements: for example, numbers waiting for longer than 18 months for admission as an inpatient or a day case were falling. There was other evidence that, between December 2004 and March 2005, those waiting more than a year for admission as an inpatient or for an outpatient appointment had, in percentage terms, fallen dramatically\*. In addition, almost 11,500 people had taken up a “second offer” of faster treatment at an alternative hospital.

3. The 2005 report referred again to the lesser emphasis on targets in Wales, while the NAO’s report noted that the NHS in Wales had met some, but not all, of the Assembly Government’s targets for waiting times for day and inpatients. More positively, the former drew attention to the Government’s commitments in *Designed for Life*, published in May 2005<sup>36</sup>, to strengthen prevention and to reduce waiting times.

4. Coverage of waiting times in the 2006 report ranged more widely than in previous years. For example, the report noted that, although access to primary care in the UK was broadly in line with that in five other developed countries examined in a survey by the Commonwealth Fund, slightly fewer (56%) people in Wales than in England (60%) were able to see a GP within two days. There was concern about access to some specialised community services in both England and Wales, including waits of up to six months in Wales for psychological therapy and counselling services<sup>37</sup>. However, the average wait for a hearing aid in Wales had fallen from 93 weeks to 50 weeks since 2004, with a target of 36 weeks set for 2007\*\*. As regards hospitals, data from the NAO showed that, on average, accident and emergency departments in Wales saw 90% of patients within four hours of their arrival.

5. The *State of Healthcare 2006* emphasised, as had the NAO in its report the previous year, that the length of time that people have to wait for care has a major effect on their overall perception of a service. With that in mind, it noted that:

- People were increasingly making use of newer ways to gain access to advice and support, including via walk-in centres and such facilities as NHS Direct Wales (which has

\* The number of people waiting more than a year for an inpatient appointment fell from 6,293 to 840 (86.7%) and those for an outpatient appointment from 6,270 to 28 (99.6%): *State of Healthcare 2005*.

\*\* By contrast the waiting time for a hearing aid in England had increased since 2004 from 40 weeks to 47 weeks (three weeks fewer than in Wales).

been linked organisationally to the Welsh ambulance service since 2007: see paragraph 1.5).

- Most patients were seeing improvements in the way that their care was delivered and that, in both England and Wales, waiting times for appointments in hospitals were continuing to fall.

6. As part of the wider programme in *One Wales* (2007) to improve access to health care (see Appendix A, paragraph 6), the Assembly Government committed to reducing waiting times to a maximum of 26 weeks from referral to treatment. This included waits for therapy or diagnostic tests. The targets for March 2009 are lower still, including ten weeks for a first appointment as an outpatient, 14 weeks for treatment as an inpatient or as a day case, eight weeks for specified diagnostics and 14 weeks for therapy or audiology.

7. The *State of Healthcare 2007* highlighted a number of issues about access to particular services, including waiting times, but supporting data for the latter related mostly to England. Sections of the report about Wales were concerned principally with the safety and quality of care.

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- <sup>2</sup> Healthcare Commission, *State of Healthcare 2007*.
- <sup>3</sup> Healthcare Commission, *State of Healthcare Report 2004*.
- <sup>4</sup> Healthcare Commission, *State of Healthcare 2007*.
- <sup>5</sup> Healthcare Inspectorate Wales, *Annual Report 2006-2007*.
- <sup>6</sup> Healthcare Inspectorate Wales, *Report of a Review in respect of Ms A, and the Provision of Mental Health Services, following a Homicide committed in October 2005*, paragraph 1.23, May 2008
- <sup>7</sup> Healthcare Commission/Audit Commission in Wales/National Audit Office (Wales), *Working Together to Maximise the Benefit of External Inspection and Audit in Wales*, September 2004.
- <sup>8</sup> *Concordat Between Bodies Inspecting, Regulating and Auditing Health and Social Care in Wales: Report on Implementation Progress 2005-2007*.
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- <sup>10</sup> Healthcare Inspectorate Wales, *How Good is the NHS in Wales? – All Wales Findings of a Review of Progress Against Healthcare Standards for Wales 1 April 2006-31 March 2007*, 2007.
- <sup>11</sup> Healthcare Commission, *State of Healthcare Report 2004*.
- <sup>12</sup> Healthcare Commission, *Count me in 2007*.
- <sup>13</sup> *Raising the Standard: Race Equality Action Plan for Adult Mental Health Services in Wales, Count me in 2007*, October 2006.
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- <sup>16</sup> Healthcare Inspectorate Wales, *Maternity Services in Wales – Findings and Themes from the All Wales Review*, paragraphs 3.1-3.2, August 2007.
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- <sup>20</sup> *Designed for Life: Creating World Class Health and Social Care for Wales in the 21<sup>st</sup> Century*, May 2005.
- <sup>21</sup> National Assembly for Wales, *Targeting Poor Health: Professor Townsend's Report of the Welsh Assembly's National Steering Group on the Allocation of NHS Resources*, 2001; Welsh Assembly Government, *Inequalities in Health – The Welsh Dimension 2002-2005*, 2005.
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- <sup>23</sup> Department of Health, *Safety First: a report for patients, clinicians and healthcare managers*, December 2006.
- <sup>24</sup> Statement to the Scottish Parliament by the Finance Secretary, 6 November 2008.
- <sup>25</sup> Healthcare Commission, *The State of Healthcare Report 2004*.
- <sup>26</sup> Welsh Assembly Government, *Healthcare Quality Improvement Plan: Designed to Deliver*, 2006.
- <sup>27</sup> Wales Audit Office, *Increasing physical activity*, June 2007.
- <sup>28</sup> Welsh Assembly Government, *Welsh Health Surveys 2005/06 and 2007*
- <sup>29</sup> Welsh Consumer Council, *Access to Cash*, 2008.
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