House of Commons

Welsh Affairs Committee

THE DRAFT NATIONAL HEALTH SERVICE (WALES) BILL

Third Report of Session 2001–02

HC 959

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Third Report of Session 2001–02

Report, together with Proceedings of the Committee, Minutes of Evidence and Appendices

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The Welsh Affairs Committee

The Welsh Affairs Committee is appointed by the House of Commons to examine the expenditure, administration and policy of the Office of the Secretary of State for Wales (including relations with the National Assembly for Wales).

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Contacts

All correspondence should be addressed to The Clerk of the Welsh Affairs Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 6189; the Committee's e-mail address is: welshcom@parliament.uk.

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THIRD REPORT

The Welsh Affairs Committee has agreed to the following Report:

THE DRAFT NATIONAL HEALTH SERVICE (WALES) BILL

SUMMARY

The publication in May of the first ever draft Bill for Wales, the draft National Health Service (Wales) Bill, is warmly welcomed. The Committee hopes that it will become standard practice for clauses in England and Wales Bills which have particular implications for Wales (paragraph 6). The Committee also welcomes the NAW's commitment to provide for public consultation on the regulations to be made under the Bill prior to its eventual enactment (paragraph 13).

The Committee notes the diversity of provision now being made in the various parts of the UK and suggests that there may in due course be a case for some mechanism to ensure that the full potential benefits of this diversity are realised (paragraph 16).

The Committee has sought to ensure that the new-look Community Health Councils (CHCs) to be retained in Wales fulfil their potential. It calls for review of some of the detailed provisions in the Bill to ensure that neither the National Assembly for Wales (NAW) nor the CHCs are unduly constrained in the exercise of their duties, while also recommending some amendments designed to make the Bill clearer. It also addresses the issue of central performance management of CHCs by the new Association of Welsh Community Health Councils.

The Committee's principal concern over the proposed Wales Centre for Health is that its intended independence should be more plainly enshrined in the Bill (paragraphs 55 to 57). It also calls for urgent and concerted action by Government to solve the problems currently confronting the collection of medical data for public health purposes (paragraph 60).

The Committee recommends some restriction on the proposals in the Bill which would give excessive latitude to the NAW to confer unspecified additional functions on Health Professions Wales (paragraphs 71 to 72).

THE DRAFT NATIONAL HEALTH SERVICE (WALES) BILL

1. INTRODUCTION

Publication of draft Bill

1. The Government announced its intention to publish a draft Bill dealing with health in Wales in the Queen's Speech in June 2001. In November 2001 a written answer confirmed that there would be such a Bill and that discussions on its contents were continuing.[1] The Secretary of State for Wales published the draft National Health Service (Wales) Bill and accompanying explanatory notes on 17 May 2002[2]. The draft Bill has three distinct purposes:

- the retention and reform of Community Health Councils (CHCs) in Wales
- the establishment of a Wales Centre for Health (WCH)
- the creation of a statutory body, Health Professions Wales (HPW).

Our inquiry

2. It is now the standard practice for departmental Select Committees at Westminster to examine and report on draft legislation. They do this by seeking the views of stakeholders through oral evidence, and through examination of written memoranda, drawing where possible on responses to the relevant department's public consultation process. We have followed this procedure, adapted as necessary to take account of the involvement of the National Assembly for Wales and in particular its Health and Social Services Committee.

3. We held two oral evidence sessions in June, one at the National Assembly for Wales (NAW) in Cardiff when we heard from some of the bodies most directly affected by the Bill, and one at Westminster when we heard from Mr Don Touhig MP, the Parliamentary Under-Secretary of State for Wales, and from Ms Jane Hutt, the Minister of Health and Social Services at the NAW. We were also given a helpful informal briefing on the Bill by officials on the Bill team. We are most grateful to all who gave evidence, and in particular to those who provided us with written memoranda to a very tight deadline.

Written responses to consultation

4. We invited written evidence from a number of those also consulted by the Wales Office, and print these with this Report. We acknowledge the assistance of the Wales Office in forwarding to us a summary of the responses received. The "Dear Colleague" letter accompanying the draft Bill stated that comments received would be made available by the Department to "both Committees and to the public after the end of the consultation". This undertaking was confirmed in oral evidence to us.[3] We will be reviewing the results of the Department's written consultation to see if there are fresh matters raised there which we consider should be drawn to the attention of the House.

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[1] HC Deb, 6 November 2001, col 158w

[2] Cm 5527–I, henceforth "Draft Bill", and Cm 5527–II, henceforth "Explanatory Notes". A draft Regulatory Impact Assessment (RIA) was published on the internet at http: //www.walesoffice.gov.uk, henceforth "RIA".

[3] Q 106

Cooperation with NAW

5. We have sought throughout this brief but relatively intensive exercise to co-operate as closely as possible with the Health and Social Services Committee (HSSC) of the NAW, which is charged by the NAW with scrutiny of the draft Bill. The HSSC debated the draft Bill on 29 May, on the basis of a series of amendments proposed.[4] The Chairman and three of our other Members were able to attend the meeting. Several members of the HSSC attended the oral evidence session we held in Cardiff. We have exchanged papers as appropriate. We understand that the HSSC will consider this Report and the results of the consultation exercise and may well come to its own conclusions later in the year, as well as being free to comment on the Bill as finally presented. Although we have not the power to hold formal joint meetings, we have continued our practice of informal meetings of various sorts.

6. **We warmly welcome the publication of this first ever draft Bill for Wales, and hope that it will in due course become the standard practice, not only for stand-alone "Wales-only" Bills, but also for clauses in England and Wales Bills which have particular implications for Wales.** We note that the recently published draft Communications Bill, currently being examined by a specially appointed Joint Committee of both Houses, includes some provisions exclusively affecting Wales. We have commissioned an external expert assessment of the implications for Wales of the draft Bill. We intend to draw on the lessons of this inquiry, and our work on the draft Communications Bill, when we come to examine the legislative process as it affects Wales.

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[4] http://www.wales.gov.uk/healthandsocialservicescommittee: Minutes 29 May 2002

2. GENERAL

Scope of Bill

7. The Queen's Speech on 20 June 2001 included the announcement that "legislation will be drafted to reform the provision of health services in Wales". The accompanying note from the Wales Office described the draft Bill as providing "a legislative framework for the development of health policy in Wales.... This Bill would reform the NHS in Wales in line with the NHS plan for Wales agreed by the National Assembly". In addition to the establishment of HPW and WCH, as in the draft Bill now published, it was announced that the Bill would establish Local Health Boards and strategic partnerships: both significant pieces of the jigsaw of NHS reform in Wales. There was no reference to provisions on CHCs.

8. In the event, the clauses creating Local Health Boards and strategic partnerships were included in the National Health Service Reform and Health Care Professions Bill, introduced in November 2001, which received Royal Assent on 25 June 2002. The Ministers told us that space had been found in the NHS Reform Bill for those provisions originally destined for the draft Bill which required relatively swift enactment.[5] Local Health Boards can therefore be set up to operate from April 2003, whereas the draft Bill is unlikely to be an Act until July 2003.[6] The CHC provisions were evidently added so that Welsh CHCs could be given additional powers and responsibilities to those provided under the 1977 Act. The draft Bill which appeared in May 2002 is therefore substantially different to that apparently envisaged a year earlier, and somewhat thinner.

Timing

9. Time for examination has been short. The Department's consultation period has run from 17 May 2002 to 5 July 2002, slightly below the standard 2 month minimum period allowed for in central guidance to Departments. Stakeholders were not directly consulted prior to publication, but the substance of the principal proposals have been extensively discussed over recent years.[7]

Wales Office and NAW sponsorship

10. The Bill was presented to Parliament by the Secretary of State for Wales. We established in oral evidence that the drafting instructions to Parliamentary Counsel had come from NAW officials acting in theory on behalf of the Wales Office. Both Ministers involved—henceforth referred to in this Report as " the Ministers"—confirmed that they and the officials concerned had an excellent working relationship.[8] It was apparent throughout the oral evidence session that a joint view had been taken on issues of significance, no doubt helped by the shared objectives of both sides.

Process of legislation

11. The 17 May "Dear Colleague" letter from the Wales Office announced that the Welsh Grand Committee would "convene to discuss the draft Bill and the Report (if it is available) of the WAC", hopefully in mid-July 2002. We have regarded it as our prime responsibility to have a Report ready for that debate, to be held on 16 July. Mr Touhig told us that Ministerial decisions would be taken in early August 2002 on how to amend the Bill. In October 2002 the Legislation Committee of the Cabinet can thus be offered a Bill ready and

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[5] Q 103
[6] RIA, para 15
[7] Q 105
[8] Q 104

waiting to be presented as early as possible in the new session.[9] The intention is that it would then go through the standard legislative process at Westminster.[10]

Nature of our scrutiny

12. The draft Bill is essentially an enabling measure: much of the crucial detail will be in secondary legislation to be made by the NAW. Our detailed scrutiny of the text of the draft Bill has focused on seeking to be able to assure the House of Commons, to whom we report, that

- the primary legislation is appropriate and effective
- the balance of primary and secondary legislation is right
- the powers given to the NAW are broad enough to ensure that their objectives, and the reasonable aspirations of stakeholders, are met, while not giving scope for unexpected or unreasonable exercise of those powers
- there is no readily foreseeable requirement for the NAW to have to return to Westminster to seek a slight amendment of statute because of oversight or excessively restrictive drafting .

Regulations

13. It is now standard practice for a draft of significant secondary legislation to be made under a draft Bill (or a Bill once presented) to be exposed for public consultation during the passage of the Bill. In this case, it is for the NAW to make such secondary legislation, and it must therefore be for them to publish it. Although the House of Commons can have no role in criticising or seeking to amend such draft secondary legislation, the passage of the founding primary legislation may well be smoother if those involved have a clear idea as to how regulation-making powers are likely to be used. Publication can also reveal hitherto unobserved failings or drafting weaknesses in the primary legislation. In evidence to us, the Ministers agreed to seek to have draft regulations available for consultation at Standing Committee stage in Westminster, while a parallel process of consultation was being conducted by the NAW.[11] **We welcome the commitment by the NAW to provide for public consultation on the regulations to be made under the Bill prior to its eventual enactment.**

Long and short titles

14. The short title of the Bill is "National Health Service (Wales) Bill". The long title begins with the phrase "to amend the law about the National Health Service in Wales" before reciting the three principal components of the draft Bill; and ends with the time-honoured phrase "and for connected purposes". As at present drafted, it has to be said that the Bill does not amend the law about the NHS in Wales other than in relation to the three areas covered, and that there are no "connected purposes". It has also been pointed out that the provisions go beyond the NHS in Wales and have an impact on the private health sector as well.[12] **We recommend reconsideration of the long and short titles of the draft Bill.**

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[9] Q 107
[10] Q 108: see Ev 25 and Q 83
[11] Qq 109–110
[12] Qq 31–32

Diversity of provision

15. It is noticeable in examining the Bill from the perspective of the UK Parliament at Westminster how, not unexpectedly, the constituent parts of the UK are finding different ways of meeting largely common objectives.[13]

- *Wales* is retaining CHCs, with extended powers and responsibilities: *Scotland* has Health Councils, similar to CHCs but different: *England* will have Patients Forums, local authority scrutiny and separate advocacy services: *Northern Ireland* retains its network of regional Health and Social Services Councils.

- in *Wales*, there is to be a statutory Assembly Sponsored Public Body (ASPB) covering all healthcare professions and support workers except doctors; in *Scotland*, professional regulatory functions are carried out by a Special Health Board which covers doctors as well as nurses and midwives, but not other healthcare professions or healthcare support workers; in *Northern Ireland*, there is to be a Non Departmental Public Body (NDPB), Northern Ireland Practice and Education Council, which will cover only nursing and midwifery; in *England* there is no national body and quality assurance work is carried out by individual visitors.

16. **Such diversity offers ideal opportunities for discovering what works best where and why.** But proactive steps are required to ensure that it does not simply lead to each country going its own sweet way in blissful ignorance of what others are doing. We were pleased to hear from both Ministers of the extent to which UK and other Ministers meet to discuss such matters.[14] **There may in due course be a case for some mechanism to ensure that the full potential benefits are realised of the diversity of provision among the nations of the UK.**

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[13] Qq 12, 111–112, 114, 146, 167: Ev 57
[14] Qq 111–112

3. COMMUNITY HEALTH COUNCILS

Background

17. Community Health Councils (CHCs) were first set up in 1974, intended to combine the functions of public scrutiny of the provision of local health services, lay inspection of health service premises and support for the patients complaints system. They were placed on a statutory basis in the 1977 National Health Service Act, which also provided for an association of CHCs in England and Wales (ACHCEW). The 20 Welsh CHCs have around 400 members, 50 whole time or part-time employees and cost around £1.8 million.[15] It is estimated that an additional £660,000 will be required as a result of the provisions of the draft Bill.[16]

English and Welsh CHCs

18. In July 2000 the Secretary of State for Health published the NHS plan.[17] Among other proposals, the plan proposed to abolish Community Health Councils (CHCs) and replace them with a new system for public scrutiny and inspection and patient advocacy.[18] The Health and Social Care Bill, giving effect to many of the proposals in the NHS plan, was introduced in December 2000. Clause 15 (1) allowed the NAW to decide whether to retain CHCs in Wales or adopt the new English structure, and clause 14 allowed the NAW to set up a Welsh Association of CHCs. In January 2001 the NAW Minister for Health and Social Services published Improving Health in Wales, a plan for the NHS with its partners. Among other marked contrasts with the English Plan, it proposed the retention of CHCs.

19. The Health and Social Care Bill became law in May 2001, providing for local authority overview and scrutiny Committees to have a role in scrutiny of health services, and for the statutory provision of advocacy services. But the controversial provisions for Patients Forums and the abolition of CHCs were dropped in order to ensure passage of the Bill before the General Election.

20. The National Health Service Reform and Care Professionals Bill introduced in the House of Commons in November 2001 provided at clause 20 for the abolition of CHCs in England, and of the ACHCEW. This left Welsh CHCs still established for the time being under section 20 of the 1977 Act. The Bill received Royal Assent on 25 June 2002, following substantial debate between the two Houses on the PCT Patients Forums which are in part to replace CHCs in England.

Reform of CHCs in Wales

21. In light of the then First Minster's concern at aspects of the role and performance of CHCs, Welsh CHCs were re-organised in April 2000 into an experimental structure of nine federations, ranging from the very loose to the tightly knit.[19] In August 2001 the NAW commissioned After Today Management (ATM) to undertake a review of the experimental CHC structure in Wales and to recommend future structures. The ATM Report was produced in January 2002, recommending that CHCs should be in "line relationship" with the Association of Welsh CHCs (AWCHC), and that there should be 3 federations with line management responsibility for CHC staff. It envisaged the Association as providing "a strong national voice on all Wales NHS strategic issues".[20]

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[15] Q 72
[16] Explanatory Notes, para 41: Qq 121, 126
[17] Cm 4818
[18] *Ibid*, paras 10.17–10.35
[19] Q 114
[20] A copy of the ATM Report has been placed in the Library of the House.

22. The decision to retain and reform CHCs in Wales has put them in the spotlight. There is now a weight of public and political expectation on them to live up to their billing and justify that decision. Ms Hutt emphasised the extent to which CHCs themselves recognised the need to develop and implement a reform agenda. She also recognised that success might well require additional resources for CHCs.[21] **Our examination of the proposals on CHCs in the draft Bill have been based on a desire to ensure that no opportunity is missed for ensuring that the new-look CHCs in Wales fulfil their potential.**

Membership

23. Paragraph 2(a) of the new Schedule 7A gives the NAW unfettered power to make provision about the membership of Councils. The equivalent Schedule in the 1977 Act provided for minimum proportions of members to be drawn from local authorities and voluntary organisations. The Explanatory Notes record the NAW's intentions to move to a more "open" membership, with half recruited through public advertisement.[22] There will no doubt be further discussions on, for example, the role of the voluntary sector, the participation of people from excluded groups and the extent to which steps can be taken, potentially through interviews, to make local authority and other nominees fully conscious of the commitment of time and effort involved in CHC membership[23]: but **we see no reason to constrain the freedom to be given to the NAW to lay down the principles underlying the appointment of CHC members.**

Time off for public duties

24. The AWCHC raised with us in its submission the issue of the rights of CHC members to take time off to attend meetings.[24] Paragraph 5 of the new Schedule 7A would allow for travel expenses and compensation for loss of remunerative time to be paid to CHC (and AWCHC) members, as is currently the case. But employers are not obliged to give their employees (unpaid) time off to attend CHC meetings. Section 50 of the 1996 Employment Rights Act provides that employers do have to give time off to employees to attend a number of broadly comparable meetings, such as health authorities and trusts. The AWCHC suggest that extending this provision to cover CHC membership might make it easier to attract younger CHC members, such as those in full-time employment, who would not otherwise be able, for example, to undertake daytime inspection visits.[25] Such a change could be made by secondary legislation, or in the framework of this Bill. Ms Hutt indicated that she would favour such a change. Mr Touhig suggested that any change should await evidence of a problem.[26] It may also be thought desirable to treat members of Patients Forums in a similar way to CHCs. **We recommend that the Bill be amended to give CHC members the statutory right to time off work for public duties.**

Boundaries

25. The new Clause 20A provides for the continuing existence of currently operating CHCs. It also allows for the NAW to abolish existing CHCs and create new ones, subject to two conditions: that every part of Wales is included in the district of a Council, and that there be no "enclaves". The Explanatory Notes state that the purpose of the powers given to the NAW to determine the number of CHCs in Wales and their boundaries is "to ensure

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[21] Qq 113–114; also Q 126
[22] Explanatory Notes, para 21; also para 41
[23] Qq 42–43
[24] Ev 12
[25] Qq 45–47, 59
[26] Qq 142–44

that Community Health Councils fit with structures and relationships in the NHS in Wales, both now and in the future".[27]

26. Subsection (3) of the new Clause obliges the NAW to ensure that every part of Wales is included in the district of a CHC, and that there should be no "enclave" of one CHC district within another one. But there is no explicit provision obliging the NAW to have any regard to the boundaries of those bodies to be overseen by CHCs, notably Local Health Boards and NHS trusts.

27. A proposal that CHCs should have to be co-terminous with Local Health Boards was debated by the NAW Health and Social Services Committee on 29 May. The Minister rejected the proposed Amendment on the basis that CHCs "had already been through consideration, re-organisation and uncertainty and that the current number generally reflected local health board boundaries". From the evidence given to us by the AWCHC, and by Ms Hutt, it is apparent that their view is that the best way to deal with the complexity of the health map in Wales is to allow for flexibility in coming up with solutions designed primarily with the interests of patients in mind.[28] Patients are not of course primarily interested in LHB or Trusts or indeed national boundaries; as one witness put it:

> *"Wherever you draw the boundary, you are going to have to cross it at some point."*[29]

28. Co-terminosity of boundaries between the newly-created Local Health Boards and the 22 local authorities was, however, one of the animating principles behind the restructuring of the NHS in Wales contained in the NHS Reform Bill. The explicit purpose of ensuring recognisable and geographically consistent boundaries for the Boards was to facilitate effective partnership working between all the main agencies involved in health and social services. Accountability at local level is enhanced by co-terminosity; it makes life simpler for individuals. It would in our view be helpful to give strong steer on the face of the Bill without unduly constraining the NAW. **We recommend adding a third rider to the existing conditions in new Clause 20A, obliging the NAW to have due regard to the boundaries of Local Health Boards and other agencies subject to CHC scrutiny when deciding the districts of CHCs.**

Ambit and powers

29. The new Schedule 7A to be inserted into the 1977 Act extends the existing remit of CHCs into primary care and nursing homes. This includes enhanced visit rights, under paragraph 3, and extended rights of CHCs to be consulted and to consider and report on relevant matters under paragraph 2. It is intended that these rights should include an obligation on trusts, as well as health authorities and LHBs, to respond to reports from CHCs.[30]

30. Several of those who submitted evidence suggested that the ambit of CHCs might be extended, to provide for their being consulted as of right by other bodies providing health services, including local authorities and health promotion bodies.[31] As presently drawn up, NAW regulations covering inspections seem to cover a wider range of such bodies—including local authorities—than does the right to be consulted.

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[27] Explanatory Notes, para 17
[28] Qq 48–50: Q 127
[29] Q 48
[30] Report from NAW HSSC, Amendment 9
[31] eg Ev 11: Ev 23, para 2.10: Ev 52

31. The AWCHC conveyed understandable caution over CHCs taking on more than they would be able to handle, with their given level of staff resources and of member time. Broadening the CHC remit further—for example, into prison health care[32]—would require substantial training as well as other resources, notably member time. Both Ministers felt that the balance was about right and that the NAW did not need more powers to extend the remit of CHCs. Both however also agreed that this might need re-visiting.[33]

32. We do not see the need for fresh primary legislation at Westminster should the NAW wish to extend the remit and inspection powers of CHCs. It would be quite a simple matter to amend Schedule 7A such that the NAW could by order extend the powers of CHCs to cover any other specified place where publicly-funded health care was provided. It would then be for the NAW to decide whether and, if so, how to use these powers. That would obviate the need to return to Westminster for fresh statutory authority. **We recommend that the new Schedule 7A be amended so as to give the NAW power to extend by regulations the scope of CHC powers to inspect premises used to provide publicly-funded health care for the public in their district.**

Visits

33. A prime purpose of the draft Bill is to give CHCs an extended remit to visit primary care and nursing homes: "to visit any premises where NHS care is provided including primary care and nursing home".[34] Consideration will be given to joint inspection of premises licenced under the Care Standards Act 2000[35]; it was apparent from evidence from the AWCHC that CHCs are well aware that such inspections cannot replace the regular professional inspection of such premises.[36] But an occasional "lay" visit, possibly following informal information that all is not as it should be, is indeed valuable. There is some uncertainty as to the exact extent of the enhanced rights of inspection.[37] **In publishing the Explanatory Notes with the eventual Bill, we recommend a translation into plain English of the terms of paragraph (3) of Schedule 7A, and in particular of the arcane language in sub-paragraphs (g) and (h).**

34. The oral evidence from AWCHC laid some stress on the significance of enhanced rights for CHCs to make unscheduled site visits, to private care homes caring for NHS patients in particular, and also to the growing diversity of places where specialised care is provided, such as joint health and social services provision.[38] Paragraph 3(3) of the new Schedule 7A allows NAW Regulations to make provision as to access. In response to our query, Ministers recognised the value of such visits and expressed confidence that the issue of unannounced vists could and would be covered in the regulations.[39]

Information

35. CHCs currently have the right to request information from the health bodies whose work they monitor. The new Schedule 7A does not repeat this provision.[40] The AWCHC and others drew attention to this lacuna, uncertain as to whether it was an oversight or an act of deliberate policy. It is plainly central to the ability of a CHC to fulfil its role that it

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[32] Qq 123, 125
[33] Qq 116–118
[34] Draft RIA, 6(v)
[35] *Ibid*
[36] Q 70
[37] eg Q 67
[38] Qq 59, 64
[39] Qq 130–1
[40] Qq 62–3: Ev 10, 26

should be able to get at the information it needs, whether from a Trust or a private care home.[41] That also applies to organisations outside Wales.

36. We sought to discover from Ministers why the duty on health authorities and others to provide information had not been included in the draft Bill. They confirmed that it had been an oversight which would be rectified in the Bill as presented.[42] **We are entitled to expect publication in the Bill of provisions on the obligations of providers of health services to supply information to CHCs, which should reflect the full range of CHC visit rights, and should include English providers.**

Complaints Advocacy

37. Paragraph 2(g) of the new Schedule 7A allows (but does not oblige) the NAW to provide for CHCs to carry out the independent advocacy services which the NAW is required to provide. This provision, to some extent, formalises a function already carried out by many CHCs, with varying degrees of success. As the draft RIA puts it—

> "While it is arguable that CHCs currently have the power to undertake this function (Schedule 7, paragraph 1(a) and 2(h)) provision of an express power would put the matter beyond doubt."[43]

It is suggested in the Explanatory Notes and draft RIA that this "advocacy role" carried out through an independent advocacy/complaints service would cost an estimated £480,000 per annum, costing each post at around £40,000. Some of this will replace existing NAW or Health Authority funding of pilot projects; there are currently eight patient support and advocacy pathfinder schemes, running for 12 months, including two complaints advocacy pathfinder schemes in Cardiff and Gwent CHCs. The 12 staff apparently envisaged—or their part-time equivalents—may be employed centrally, probably by the new AWCHC.

38. The AWCHC gave a particular welcome to this provision, recording its delight that this task would be properly resourced in the future, and emphasising how CHCs used experience gained in advocacy and the complaints procedure in fulfilling their other roles.[44] In oral evidence, the Chief Officer of Clwyd CHC felt that the resource level referred to was probably a reasonable guess, but suggested that the issue needed further examination.[45]

39. There was discussion in the NAW HSSC on 29 May on the possibility of other bodies providing advocacy services. In evidence to us, the AWCHC emphasised that specialist advocacy organisations, for example for mental health patients or children or particular conditions, were active and would indeed sometimes refer cases to CHCs; but that only CHCs offered the possibility of a universal service delivered to a consistent standard. CHCs also have the advantage of being able to see health services in the round and of being able to see across geographical and institutional boundaries.[46]

40. Ideally, patients should be able to choose an advocacy service. In practice, they follow many routes and will doubtless continue to do so. The draft Bill is appropriately permissive. We sought to establish from Ministers the extent to which the Bill would allow for the NAW, or individual CHCs, to "sub-contract" advocacy to specialist voluntary bodies. Ms Hutt told us that it was the NAW's intention that CHCs should be tasked with advocacy services, but that it would be open to them to commission specialist services to

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[41] Qq 62–3
[42] Qq 128–9
[43] RIA, page 5
[44] Qq 51ff: Ev 11
[45] *ibid*
[46] Qq 55–7; also Qq 91–2

carry out some tasks and to refer people to other organisations. Both the NAW and the Children's Commissioner for Wales are looking into advocacy services for children across the board.[47] **We recommend examination of the terms of paragraph 2 (g) of Schedule 7A, to ensure that it allows for the NAW to provide for CHCs to commission other bodies to carry out independent advocacy services.**

Cross-border treatment

41. Many Welsh patients receive services outside Wales: conversely, not all patients treated in Wales are residents of Wales. Now that only Wales will have the reformed CHC model, it is crucial that there should be no statutory obstacle to Welsh CHCs being able to carry out their functions of representation of the public outside Wales, or where appropriate of non-Welsh patients within Wales. There will plainly need to be some understanding with the Patients Forums being proposed in England. Ms Hutt told us that CHCs would have the same rights vis à vis Welsh patients treated in England as Patients Forums would have on treatment of English patients in Wales.[48] While we welcome that assurance, it may be worth providing for it in statute, for the avoidance of doubt. **We recommend that the terms of the new Schedule 7A be reviewed so as to ensure that Welsh CHCs will not be constrained in the exercise of their functions as a result of Welsh patients receiving treatment outside Wales, and that there will be full reciprocal rights for the equivalent English bodies.**

AWCHC

42. The draft Bill proposes to give the NAW power to establish a statutory Association of CHCs in Wales. The Explanatory Notes refer to "strengthening the role of the Association" and estimate that setting it up "as an overseeing and monitoring authority with increased responsibility and powers" would lead to an additional £10,000 rent/rates per annum and £70,000 in staffing costs. The ATM Report (see paragraph 21 above) sought to give the AWCHC a line management role over CHC federations.

43. There remains some doubt as to exactly what the "increased responsibility and powers" of AWCHC may be. Ms Hutt referred to a strong national body with an enhanced strategic role in standard setting and performance management "in a supportive framework", not least so that the NAW could be confident that such publicly-funded bodies were performing to a consistently high standard.[49] Individual CHCs may not take enthusiastically to having their performance managed from the centre.[50] Their independence is acknowledged as one of their strengths.[51] At the same time, there is widespread recognition that their performance is capable of improvement and is inconsistent over Wales as a whole.

44. Under the Bill, the AWCHC will "support and advise" Councils—following an Amendment moved in the NAW HSSC and accepted by the Minister—and also "assist" them. The AWCHC is likely to engage in training CHC members and staff. It may offer a central legal resource hitherto provided by ACHCEW. As mentioned above, it may in some way manage the independent advocacy service.

45. One possible way for providing for performance management of such publicly-funded but independent and disparate bodies would be to provide for CHCs to make annual reports on the performance of their functions to AWCHC, measured against illustrative objectives,

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[47] Qq 119ff
[48] Q 124
[49] Qq 113, 140–1, 145
[50] eg Q 78
[51] eg Qq 87, 115, 145

and for the AWCHC to draw on these reports in making an annual report to the NAW. **We recommend a review of the terms of Schedule 7A to establish whether it provides sufficient authority for the NAW to provide for a system of reporting by CHCs to the AWCHC, and the AWCHC to the NAW.**

46. The future role of the AWCHC is of course pre-eminently a matter for the NAW to determine. Our only role should be to assure ourselves that the draft legislation under examination is appropriately drawn up. As the draft Bill stands, the NAW can, under paragraph 4(a)(ii) of new Schedule 7A, provide by regulations for AWCHC to "perform such other functions as may be prescribed". That is a very wide power. **We recommend that the power which it is proposed to give to NAW to allocate any functions to AWCHC be constrained by providing that they should be related to its core statutory functions of advice, assistance and support to CHCs.**

CHC staff

47. Similar uncertainty seems to surround the future status of CHC staff, currently inappropriately parked for "technical" reasons as employees of the North Wales Health Authority.[52] We understand that the views of CHC staff will be sought by the NAW Restructuring Group prior to any decision. The NAW is free to make arrangements on this as on other practical matters to do with CHCs, under the new Schedule 7A. **No doubt the NAW will bear in mind the importance of reflecting the emphasis placed on the independence of CHCs in any arrangements made for the employment of their staff.**

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[52] Q 87 & Ev 23, 2.11: Qq 138–9

4. WALES CENTRE FOR HEALTH

Origins

48. In May 1998 the Welsh Office published its consultation document *Better Health - "Better Wales"*[53], one of a number of papers emanating from the 1998 NHS White Paper *Putting Patients First.*[54] The consultation document raised the possibility of a collaborative public health network at National Assembly level.[55]

49. In October 1998 the Welsh Office published a *Strategic Framework,* reflecting the responses to the earlier paper, and setting out the aims and priorities for improving health and reducing health inequalities. The document listed 17 areas where action would be taken, including the establishment of a "multi-disciplinary Wales Centre for Health" as a means of "bringing together the best public health surveillance and advice to support decision-making". The establishment of the Centre was one of 15 priorities listed for 1999-2002.[56]

50. The document listed the functions of the proposed Centre as including

- providing a forum for multi-disciplinary advice on health hazards;
- risk assessment of threats to health;
- disseminating research and other evidence to support decision-making;
- support for multi-professional training in sustainable health; and
- liaison with national and international multi-professional groups.

Proposed body

51. Four years on, the draft Bill now includes two clauses and a long schedule designed to give effect to this proposal. The draft Bill seeks to establish the WCH as a "body corporate", with Members appointed by the NAW, a chief executive and staff. The NAW is given some freedom to regulate the WCH, and can (under paragraph 4 of Schedule 2) give directions on the exercise of any of its functions. The Schedule sets out in some detail how it is to pay members and staff, and other administrative matters reflecting the fact that WCH is a new body.[57] Establishing WCH by statute rather than informally is intended to raise its profile, increase its clout in attracting funding from public and other sources, and help establish its independence.[58]

52. "A shadow" WCH is in train of formation.[59] The intention is that the Centre will have a "real" existence somewhere, as well as what Ms Hutt called a "semi- virtual" existence with a website, library video-conferencing facilities etc.[60] The Explanatory Notes refer to "about 20 whole time staff (or equivalents)" and an already allocated budget of £600,000. In order to maximise the Centre's access to specialisms, many of the staff may be part-time, working the rest of their time elsewhere in the public health service.[61] Some staff will evidently be drawn from among those already in post in other parts of the Welsh NHS structure: the draft Bill, at paragraph 6 of Schedule 2, provides for the NAW to be able to direct the WCH to employ specified people employed by a NHS Trust.

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[53] Cm 3922
[54] Cm 3841
[55] Cm 3922, 6.35–6.36
[56] Strategic Framework, October 1998, paras 1.7 and 1.8
[57] Q 150
[58] Qq 147–8
[59] Q 156
[60] Qq 157, 161–4
[61] Qq 154–5

Independence

53. It is intended that as a statutory corporate body the WCH should enjoy a greater degree of visible independence from NAW control than other APSBs. Its independence is however to be statutorily constrained by paragraph 4, under which it must comply with any direction given by the NAW, and by the extent to which the Assembly is to control the recruitment and pay of members and the chief executive. Several witnesses expressed concerns that the Bill did not give sufficient guarantees of the Centre's independence. They feared that its potential value in giving the public authoritative and demonstrably independent advice and information—as seen recently, for example, in the controversy over the local public health implications of landfill or incineration sites, or over MMR—would be undermined if it was seen to be unduly influenced by the NAW.[62]

54. Both Ministers assured us that they wanted the Centre to be independent of Government and expected it to become increasingly independent as it developed. Mr Touhig suggested that the express determination of Ms Hutt that the Centre should be an independent body should be sufficient assurance.[63] While we do not for one moment doubt their sincerity, such declarations do not have the force of law, and there is unlikely to be another opportunity to enshrine the independence of the WCH in law.

55. The attempt to create a body with the necessary degree of visible independence has not been entirely successful. Although the WCH can, under paragraph 16 of the Schedule, do anything necessary to exercise its functions, it is obliged under paragraph 4 to comply with *any* direction given by the Assembly exercising any function. That could, for example, prevent it from commissioning research, or reporting to the public, on some controversial matter of public health which for whatever reason the NAW did not want it to report on. That cannot be the intention. **We recommend a review of the terms in the draft Bill under which the WCH is obliged to comply with any direction of the NAW, with a view to limiting that obligation to the exercise of its administrative or financial functions.**

56. Paragraph 16 of the Schedule gives three specific examples of things which the Centre can do: co-operating with others in the same field, purchase of land, and entering into contracts. There may be value in listing these activities, although we are surprised that it should be altogether necessary to spell out that a body corporate is free to buy property or make contracts. The provision on co-operation should evidently cover *all* the Centre's functions and not just the provision of information. It would also be useful to enshrine in statute that the Centre is free to embark on, and publish the results of, research into any topic it considers appropriate, and that it may pursue a public information policy of its own making. **We recommend that the terms of paragraph 16(2) of Schedule 2 be revisited with a view to using the sub-paragraph to enshrine the operational independence of the WCH.**

57. Paragraph 22 of Schedule 2 provides for the WCH to make and publish an annual report to the NAW. There could, in our view, be advantage in the involvement of the principal professional public health bodies, including the relevant Royal Colleges, in the process of annual reporting by the WCH. There may well be other and better ways of providing for the Centre's independence. **We recommend further consideration as to how best to provide within this founding statute for the real independence of the WCH.**

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[62] eg Ev 58–9, 61; see Q 159
[63] Qq 147–9

Ambit

58. Evidence from several witnesses, and the first scrutiny of the Bill by the NAW HSSC, demonstrated some sense that its ambit, as set out in Clause 3, may be unduly modest, and that the WCH should be able to go beyond the provision of "information and advice to the public", to a more proactive and participatory role.[64] Witnesses also expressed some concern that WCH should be funded with "new" money rather than at the expense of services for patients.[65] UNISON, for example, gave the WCH a rather cautious welcome and warned that

> *"Unless the Centre can be seen to add value, then it will be open to criticism that it is effectively diverting much need [ed] resources from direct patient care".*[66]

It is plain that such criticism will continue unless the Centre responds to the expectations raised by its creation.

59. It must be for the NAW and the WCH once established to determine the scope of the Centre's work, within the deliberate constraints of the terms of Clause 3. **On balance we are satisfied that the basic statutory function of dealing with the protection and improvement of health in Wales is broad enough to allow for the NAW and the Centre itself to develop its work as appropriate; and we are confident that the desire to see the Centre as a genuinely accessible public resource for the people of Wales is well understood within the NAW.**

Public health data collection

60. Evidence submitted to us by the Welsh Combined Centres for Public Health (WCCPH) addressed in some detail the problems confronting public health bodies seeking to collate and analyse individual medical data as a result of the data protection and human rights legislation.[67] The memorandum noted that "several hospitals in Wales have stopped sending data to databases that are crucial for health surveillance". As a result a number of the Welsh databases—on hospital admissions, cancer, congenital anomalies and accident injuries—have experienced difficulties in obtaining data. WCCPH noted that—

> "the development of the Wales Centre for Health comes at a time when the quality and accuracy of administrative and clinical databases is dramatically improving and consequently it has the potential to contribute substantially to the health and well-being of the people of Wales. However, unless there is urgent consideration and resolution of the issues raised in this letter, the Wales Centre for Health may not be able to carry out many of the intended functions."

This is not, of course, a new problem; it was, for example, commented upon in March 2002 by the Science and Technology Committee in its Report on Cancer Research in relation to cancer registries.[68] Nor does the draft Bill offer the right vehicle for a solution. **The grave difficulties confronting public health data collection will offer an early challenge to the new Wales Centre for Health. Urgent and concerted action by Government, in consultation with all the stakeholders involved, is required to ensure that a proper level of collection of public health medical data can be resumed.**

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[64] Amendments 4 and 5 debated in NAW HSCC, 29 May 2002

[65] eg Ev 51, 60

[66] Ev 23, 3.4 and Qq 94–95

[67] Ev 61–63

[68] Science and Technology Committee, *Cancer Research—A Follow-Up*, First Report of Session 2001–02, HC 444, paras 31–37.

Public health structures

61. The June 2002 Department of Health Consultation Document on creating a Health Protection Agency noted that " historically, public health relationships have been different in Wales". With the proposed Wales Centre for Health, another piece of the distinctively Welsh public health jigsaw will fall into place. From April 2003 the newly established National Public Health Service for Wales, based at Velindre, will provide the public health function to local Health Boards.

62. Ms Hutt assured us that there was a clear distinction between the service functions of the new Public Health Service for Wales and the advisory and training role of the WCH.[69] There is however some risk of overlap with other existing bodies, in particular over training, as revealed for example in the submission from the Welsh Combined Centres for Public Health. The WCCPH was set up in 1993 to support the public health function through teaching, training and research. They have in recent years created a Masters degree in public health. The WCH is apparently already active in developing an "interprofessional fellowship in public health".[70] The WCCPH warned against excessive duplication in the training role envisaged for the WCH. The University of Wales College of Medicine also drew attention to this general point.[71] The statutory language, obliging the WCH to "contribute to the provision and development of training in such matters [ie the protection and improvement of health in Wales]", is suitably modest.

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[69] Q 155
[70] Qq 156, 158, 160
[71] Ev 58, 61, 67

5. HEALTH PROFESSIONS WALES

Origins of HPW

Regulation of nursing, midwifery and health visiting

63. The system of a United Kingdom Central Council and four national Boards, including the Welsh National Board for Nursing, Midwifery and Health Visiting, owed its origins to the 1972 Briggs Report, implemented in the 1979 Act and amended in 1992. The legislation was consolidated in the Nurses, Midwives and Health Visitors Act 1997. In August 1997 the then four UK health departments commissioned a review of the statutory framework for the regulation of nursing, midwifery and health visiting. The Report recommended a smaller and more effective UK-wide body, the Nursing and Midwifery Council (NMC). The Government accepted the recommendations and introduced the necessary legislation by adding clauses to the Health Bill then going through Parliament.

Regulation of professions supplementary to medicine

64. At the same time, it was decided to replace the Council for Professions Supplementary to Medicine established under the Professions Supplementary to Medicine Act 1960 with a more focussed Health Professions Council (HPC).

Establishment of NMC and HPC

65. The two Orders establishing these bodies were approved by Parliament, and made on 12 February 2002.[72] These orders both provide that the National Assembly for Wales "may create or designate" a body with which each Council may enter into arrangements for ensuring that the Council's standards for education are being met. The HPC is consulting on arrangements to be made in Wales and elsewhere.[73] The NMC plainly does intend to use the relevant Welsh body to act as its "agent".

Functions of new body

66. Following the decision to abolish the WNB, a Welsh Review Group chaired by Sir Adrian Webb met to recommend to NAW the structure and functions of a new Welsh body. In June 2000 its recommendations on the body's functions, which included coverage of healthcare support workers, were approved by the NAW HSSC. Further progress was hampered by a range of issues on the type of legal entity of the new body: for example, whether it should be a Special Health Authority. In 2001 a further group, the Change Management Group (Wales), was set up to oversee the establishment of the new body and bring in further functions as agreed. In February 2002 this group recommended that the new body, HPW, should cover allied health professions and healthcare also scientists and technicians and should take on some further functions such as liaison with Healthwork UK (now Skills for Health).[74]

67. The decision was also taken to establish by statute an Assembly Sponsored Public Body. The WNB was to have been wound up in September 2001. It was eventually abolished with effect from 31 March 2002. Since that date, a "shadow" HPW technically within the Assembly, but in fact a continuation of the WNB, has been fulfilling the necessary functions. This shadow body has 23 employees and costs £1.5 million a year.[75] The

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[72] SI, 2002, Nos 253 and 254
[73] Qq 5, 11–12
[74] Recommendations from Change Management Group Wales to the NAW, February 2002
[75] Q 1

provisions in Clauses 4 to 6 of the draft Bill would give it a proper statutory footing and a degree of independence.

68. It is not ideal that these should have to be such an interregnum between the long foreseen abolition of the WNB in March 2002 and the establishment on a proper footing of HPW, which is unlikely to be before the middle of 2003. But it would plainly have been equally undesirable to delay the establishment of the NMC until all the possible other bodies to whom it might delegate functions were in place. The NMC assured us that there had been no practical problems as a result.[76]

Ambit

69. The new HPW has an ambitious agenda, extending some way beyond that of its predecessor body. In particular, it is to take on as yet only broadly defined tasks in relation to "healthcare support workers". The Explanatory Notes gave as an example of such new functions establishing a Code of Conduct for healthcare support workers.[77] Evidence from the shadow HPW referred to "maximum flexibility" should its remit need to be changed, and stated that "the remit for HPW may change further as the modernisation of the Welsh health service is taken forward". A letter sent in May 2002 by the Acting Chief Executive listed 11 "New Functions to be developed ... as funding becomes available". The Explanatory Notes record that the former WNB budget will be transferred to HPW "with the addition of monies to support development initiatives".[78] It seems likely to some observers that the former WNB staffing level of around 20 staff and a grant from the NAW of £1 million a year will prove insufficient in view of its considerably expanded mandate.[79] HPW are currently trying to attract additional personnel to meet those demands.[80]

70. It is for the Assembly to judge how best to task HPW in the years ahead. HPW told us in Cardiff that "Wales is trying to get one step ahead..." on regulation and support of health care support workers, under an impetus from the Welsh Assembly Government.[81] Concerns were expressed to us about this: it was argued that any Code for health care assistants should be UK-wide.[82] The NAW Minister confirmed that Wales was indeed "taking a lead", but emphasised that it was as yet early days and that she was in regular consultation with other Health Ministers in the UK. UK standards were indeed envisaged.[83]

71. The statutory basis for the ambit of HPW's activities is contained in Clause 4. Subsection (1) allows NAW to establish HPW—

> "with a view, *in particular*, to it exercising on behalf of the Assembly functions in relation to (a) health care professions and (b) health care support workers".[84]

Ministers confirmed that the phrase " in particular" was intended to allow for the Assembly to give HPW other functions. Mr Touhig told us that this was intended to avoid the need for subsequent primary legislation should the NAW wish to extend the remit of HPW outside its current ambit: a "belt and braces" phase, in his words.[85] Parliament needs to be confident of the broad ambit of the body it is being asked to endorse. **We consider that**

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[76] Q 2
[77] Explanatory Notes, para 13
[78] Explanatory Notes, para 29
[79] eg Q 99
[80] Q 19; also Q 100
[81] Qq 5, 7; also Q 16
[82] Qq 17, 99: Ev 2, 26
[83] Q 165
[84] Italics added
[85] Qq 171–3

the phrase "in particular" should be removed from subsection (1) of Clause 4, and a third phrase added at the end of that subsection to allow for HPW to exercise functions in relation to "similar matters".

72. **We are uneasy about allowing functions to be conferred on HPW by direction, as a means of avoiding the requirement for consultation and democratic process.** Ms Hutt told us that the power to confer functions on HPW by direction, under subsection (2)(c), as opposed to by order under subsection (2) (b), was intended to be used merely for operational or internal matters not requiring consultation.[86] The power to give directions about the exercise of an existing function is however already in subsection (4) (moderated as we propose in para ... below). That will allow the NAW to deal with the sort of operational matters referred to in evidence to us. The question of extension of the functions of HPW is potentially controversial. We learned in oral evidence that doctors and dentists on a review group led by Sir Adrian Webb had expressed the desire to remain outside the ambit of HPW.[87] The psychologists told us in written evidence of their uncertainty as to whether they were or were not to be covered.[88] There remains anxiety among some smaller health professions.[89] These are matters deserving of an order rather than a mere direction. **We recommend the removal of subsection (2) (c) of Clause 4, under which a function can be conferred on HPW by direction. We also recommend that the Explanatory Notes to be published with the Bill include a full list of those professions whose activities the NAW has already determined will be covered by HPW.**

73. Witnesses also raised the possibility that problems could arise from the power of the Assembly to direct HPW, and that it could cut across the proper performance of its functions carried out on behalf of the NMC or HPC.[90] Ms Hutt assured us that this power was intended to relate to operational matters only.[91] That is no doubt the case. It would therefore be prudent to make it clear on the face of the Bill that the exercise of functions carried out on behalf of the NMC or HPC would not be subject to NAW direction without prior consultation with them.[92] **We recommend that the NAW's power of direction to HPW in exercising a function, as set out in subsection (4) of Clause 4, should explicitly require prior consultation where it concerned functions carried out by HPW on behalf of the HPC or NMC.**

Welsh Language

74. Schedule 3 to the Bill lists various minor and consequential amendments to Acts required as a result of the Bill. We noted that the application of the provisions of the Welsh Language Act to CHCs is to be duly amended by paragraph 7 of the Schedule, and that it is to be applied to the WCH by paragraph 8: but that it seemed not to cover HPW. The former WNB had a Welsh Language Scheme; its most recent Annual Report records the attention devoted to some of the issues arising. Both HPW and Ms Hutt assured us that it was envisaged that HPW would have the same requirements placed on it as any other public body in Wales, and that discussions with the Welsh Language Board had already begun.[93] We assume that it will be possible to add HPW to the list of bodies in section 6 of the Act by notice. **We would welcome written confirmation that it is necessary to have a specific reference to WCH in section 6 of the Welsh Language Act, but not to HPW.**

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[86] Qq 168–170
[87] Qq 167, 174–5
[88] Ev 64
[89] eg Ev 65, para 6
[90] Qq 13–15; 101: Ev 1, 25–6
[91] Q 166
[92] Q 15
[93] Qq 21–22; Q 176

LIST OF CONCLUSIONS AND RECOMMENDATIONS

Draft legislation for Wales

(a) We warmly welcome the publication of this first ever draft Bill for Wales, and hope that it will in due course become the standard practice, not only for stand-alone "Wales-only" Bills, but also for clauses in England and Wales Bills which have particular implications for Wales (paragraph 6).

Publication of regulations in draft

(b) We welcome the commitment by the NAW to provide for public consultation on the regulations to be made under the Bill prior to its eventual enactment (paragraph 13).

Long and short titles

(c) We recommend reconsideration of the long and short titles of the draft Bill (paragraph 14).

Diversity

(d) Such diversity offers ideal opportunities for discovering what works best where and why. There may in due course be a case for some mechanism to ensure that the full potential benefits are realised of the diversity of provision among the nations of the UK (paragraph 16).

CHCs: general

(e) Our examination of the proposals on CHCs in the draft Bill have been based on a desire to ensure that no opportunity is missed for ensuring that the new-look CHCs in Wales fulfil their potential (paragraph 22).

CHCs: appointment of members

(f) We see no reason to constrain the freedom to be given to the NAW to lay down the principles underlying the appointment of CHC members (paragraph 23).

CHCs: time off for members

(g) We recommend that the Bill be amended to give CHC members the statutory right to time off work for public duties (paragraph 24).

CHCs: co-terminosity

(h) We recommend adding a third rider to the existing conditions in new Clause 20A, obliging the NAW to have due regard to the boundaries of Local Health Boards and other agencies subject to CHC scrutiny when deciding the districts of CHCs (paragraph 28).

CHCs: NAW power to extend remit

(i) We recommend that the new Schedule 7A be amended so as to give the NAW power to extend by regulations the scope of CHC powers to inspect premises used to provide publicly-funded health care for the public in their district (paragraph 32).

CHCs: explanation of inspection powers

(j) In publishing the Explanatory Notes with the eventual Bill, we recommend a translation into plain English of the terms of paragraph (3) of Schedule 7A, and in particular of the arcane language in sub-paragraphs (g) and (h) (paragraph 33).

CHCs: rights to information

(k) We are entitled to expect publication in the Bill of provisions on the obligations of providers of health services to supply information to CHCs, which should reflect the full range of CHC visit rights, and should include English providers (paragraph 36).

CHCs: advocacy services

(l) We recommend examination of the terms of paragraph 2 (g) of Schedule 7A, to ensure that it allows for the NAW to provide for CHCs to commission other bodies to carry out independent advocacy services (paragraph 40).

CHCs: cross-border functions

(m) We recommend that the terms of the new Schedule 7A be reviewed so as to ensure that Welsh CHCs will not be constrained in the exercise of their functions as a result of Welsh patients receiving treatment outside Wales, and that there will be full reciprocal rights for the equivalent English bodies (paragraph 41).

CHCs: reporting

(n) We recommend a review of the terms of Schedule 7A to establish whether it provides sufficient authority for the NAW to provide for a system of reporting by CHCs to the AWCHC, and the AWCHC to the NAW (paragraph 45).

CHCs: additional functions for AWCHC

(o) We recommend that the power which it is proposed to give to NAW to allocate any functions to AWCHC be constrained by providing that they should be related to its core statutory functions of advice, assistance and support to CHCs (paragraph 46).

CHCs: staff

(p) No doubt the NAW will bear in mind the importance of reflecting the emphasis placed on the independence of CHCs in any arrangements made for the employment of their staff (paragraph 47).

WCH: independence

(q) We recommend a review of the terms in the draft Bill under which the WCH is obliged to comply with any direction of the NAW, with a view to limiting that obligation to the exercise of its administrative or financial functions. We recommend that the terms of paragraph 16(2) of Schedule 2 be revisited with a view to using the sub-paragraph to enshrine the operational independence of the WCH. We recommend further consideration as to how best to provide within this founding statute for the real independence of the WCH (paragraphs 55 to 57).

WCH: basic function

(r) On balance we are satisfied that the basic statutory function of dealing with the protection and improvement of health in Wales is broad enough to allow for the NAW and the Centre itself to develop its work as appropriate; and we are confident that the desire to see the Centre as a genuinely accessible public resource for the people of Wales is well understood within the NAW (paragraph 59).

WCH: public health medical data

(s) The grave difficulties confronting public health data collection will offer an early challenge to the new Wales Centre for Health. Urgent and concerted action by Government, in consultation with all the stakeholders involved, is required to ensure that a proper level of collection of public health medical data can be resumed (paragraph 60).

HPW: additional functions

(t) We consider that the phrase "in particular" should be removed from subsection (1) of Clause 4, and a third phrase added at the end of that subsection to allow for HPW to exercise functions in relation to "similar matters". We are uneasy about allowing functions to be conferred on HPW by direction, as a means of avoiding the

requirement for consultation and democratic process. We recommend the removal of subsection (2) (c) of Clause 4, under which a function can be conferred on HPW by direction. We also recommend that the Explanatory Notes to be published with the Bill include a full list of those professions whose activities the NAW has already determined will be covered by HPW (paragraphs 71 to 72).

HPW: NAW powers of direction

(u) We recommend that the NAW's power of direction to HPW in exercising a function, as set out in subsection (4) of Clause 4, should explicitly require prior consultation where it concerned functions carried out by HPW on behalf of the HPC or NMC (paragraph 73).

HPW and WCH: Welsh Language Act

(v) We would welcome written confirmation that it is necessary to have a specific reference to WCH in section 6 of the Welsh Language Act, but not to HPW (paragraph 74).

GLOSSARY

ACHCEW	Association of Community Health Councils in England and Wales
ASPB	Assembly Sponsored Public Body
ATM	After Today Management
AWCHC	Association of Welsh Community Health Councils
CHC	Community Health Council
HPC	Health Professions Council
HPW	Health Professions Wales
HSSC	Health and Social Services Committee
LHB	Local Health Board
NAW	National Assembly for Wales
NDPB	Non Departmental Public Body
NHS	National Health Service
NMC	Nursing and Midwifery Council
WAC	Welsh Affairs Committee
WCCPH	Welsh Combined Centres for Public Health
WCH	Wales Centre for Health

PROCEEDINGS OF THE COMMITTEE RELATING TO THE REPORT

THURSDAY 4 JULY 2002

Members present:

Mr Martyn Jones, in the Chair

Mr Martin Caton
Dr Hywel Francis
Julie Morgan
Adam Price
Mr Mark Prisk
Chris Ruane
Mr Bill Wiggin
Mrs Betty Williams
Mr Roger Williams

The Committee deliberated.

Draft Report [The Draft National Health Service (Wales) Bill] proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 74 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Several papers were ordered to be appended to the Minutes of Evidence.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

[Adjourned till Monday 15 July at 1.30 pm in Cardiff

LIST OF WITNESSES

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Monday 17 June 2002

NURSING AND MIDWIFERY COUNCIL

Dr Pam Walter and Janice Gosby . . . . Ev 5

HEALTH PROFESSIONS COUNCIL

Colin Lea and Dr Peter Burley . . . . Ev 5

HEALTH PROFESSIONS WALES

Wendy Fawcus and Thomas Moore . . . . Ev 5

ASSOCIATION OF WELSH COMMUNITY HEALTH COUNCILS

Tommy Morgan, Pat Cadwallader, Robert Hall, Jane Jeffs, Carolyn Theobold, and Clive Barnby . . . . Ev 12

UNISON CYMRU WALES

Dave Galligan . . . . Ev 28

ROYAL COLLEGE OF NURSING WALES

Eirlys Warrington, Liz Hewett, and Greg Walker . . . . Ev 28

Tuesday 25 June 2002

Don Touhig MP, Jane Hutt AM, Bob Oliver, and Joanest Jackson . . . . Ev 33

LIST OF MEMORANDA INCLUDED IN THE MINUTES OF EVIDENCE

Memoranda from:

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