Driving change together

Establishing the new NHS Wales Executive as a clinically led, patient-centred organisation with a collaborative approach from clinicians, managers, patient groups, national charities, royal colleges and professional bodies

Discussion paper

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Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

In a nutshell

We are calling on the new NHS Wales Executive to:

- **Share leadership responsibilities** – ensure new national networks are led by clinicians working with patient representatives.
- **Give everyone a voice** – develop standardised co-production guidance on third sector and patient involvement in running the NHS.
- **Ensure no health condition is left behind –** implement consistent governance arrangements and comprehensive programme support across all networks.
- **Recognise that knowledge is power** – publish service specifications and local treatment pathways online in a central hub, making the patient journey easier to understand.
- **Learn from Senedd committees** – publish work plans and meeting papers online in an accessible, open and transparent way.

The third sector[1] in Wales can add a tremendous amount of value to the work of NHS Wales. Not only do many of our organisations deliver people-facing services, but we also develop policy ideas and recommendations that are based on good practice and can be shared more widely. We represent many thousands of patients, families and health and care professionals across Wales. We can support NHS organisations to improve clinical standards and address wider strategic pressures by working in partnership with clinicians and listening to the voice of lived experience.

The new NHS Wales Executive (NHSWE) should encourage an open and outward-looking approach to NHS governance based on mutual trust and respect between the voice of lived experience, clinicians and policy/operational expertise, knowledge and skills.

This partnership approach should be embedded in the leadership style and working practices of the new executive from the very beginning, and as a working model, it should be mirrored at a local level for the adoption, adaption and implementation of national policies in local communities at scale and pace.

[1] The Welsh government third sector scheme (1.11–1.13) definition includes community associations, self-help groups, voluntary organisations, charities, faith-based organisations, social enterprises, community businesses, housing associations, development trusts, co-operatives and mutual organisations. Royal colleges and professional bodies are national charities.

Our recommendations

- **Every strategic clinical network and national programme in the NHSWE should have a leadership group that includes a network director/manager, clinical lead *and* a third sector lead** (eg chair of a relevant alliance of external organisations). This would help to ensure a patient-centred, clinically led approach, placing patient and third sector groups alongside clinicians and network directors/managers in driving service change. This will help to improve transparency and accountability, raise standards of care and improve the patient experience.

- **Clinical networks and national programmes should publish their forward work plans online.** Information about how to engage with individual pieces of NHSWE work (eg quality statements, service specifications) as well as the contact details of leadership groups, clinical reference groups and task-and-finish groups should be accessible, open and transparent. External stakeholders and organisations should be able to choose freely how and when they engage with specific pieces of work, as with Senedd committee inquiries. Meeting papers should be published ahead of time and shared with all network members, then made available online following the meeting.

- **NHSWE papers (eg quality statements, implementation/action plans, service specifications) should be reviewed by the NHS Wales chief executive and medical director peer groups** as a way of improving accountability and delivery.

- **NHSWE should work with the third sector to develop standardised co-production principles and guidance on third sector and patient involvement,** which are followed by all clinical networks, national programmes, implementation groups and the NHSWE itself in developing national plans. This would reduce variation and ensure lived experience is included. This should be the output of a task-and-finish group that reports by the end of 2023.

- **Clinical networks and national programmes should have consistent governance arrangements and programme support.** Clinical leads should have funded sessions and be appointed through a competitive process, receiving a job description and annual appraisal reviews.

- **NHSWE and health boards should publish pathways, service specifications and local delivery plans online.** This would improve transparency and give patients more control over their treatment pathway. Performance data, peer review reports and quality improvement information should be freely accessible and available to all stakeholders, including patients. NHSWE should consider hosting these resources online for all the health boards and trusts in a central hub, ideally accompanied by further explanation and analysis.

- Although national programmes and strategic clinical networks are set out as separate entities in the national clinical framework (NCF), it is unclear how they will co-exist, interact and collaborate in the new NHSWE. **The principles and recommendations in this document and in NCF implementation workstream documents should apply equally to strategic clinical networks and national programmes.**

Background and context

On 15 November 2022, more than 50 people joined a meeting between national clinical leads and third sector organisations, patient groups, royal colleges and professional bodies. The aim was to establish a dialogue between stakeholder organisations and clinical leads to discuss how we could improve collaboration and engagement, share good practice and create a consistency of approach.

Emerging themes

Key themes that emerged from the discussions included the importance of supporting the workforce, investing in innovation, data and digital, ensuring regional working and consistency of approach. We identified five potential cross-cutting work areas to be prioritised by the new NHSWE in its first year:

- informatics, data and digital
- workforce development and support
- whole system planning and delivery across public health, primary, community and social care
- early and rapid diagnosis with timely access to appropriate, innovative care
- regional working across organisational boundaries.

The new NHSWE should also look at what has been achieved over the past decade through the work of the implementation groups and evaluate where and why things have gone well, and where things have been successful, so that good practice can be continued or spread more widely across other networks in a value-based way. Tackling health inequalities should underpin the work plans of all national programmes and strategic networks, as should collaborative working across specialty and professional boundaries, and networks should be supported and encouraged to develop a joint working approach.

Closing the implementation gap

There is often a disconnect between national policy and local delivery in Wales – the so-called 'implementation gap'. Policy leads working in the third sector can help to bridge this gap with a clear understanding of the experience of our stakeholders in the context of national legislation and policy set by the Welsh government. Many third sector organisations can offer cross-government department expertise that could reduce silo thinking and lead to innovative delivery of services.

The four cornerstones of policy development

Policy leads working for national charities and membership bodies can offer pan-Wales (and sometimes UK-wide) understanding of the broader policy and legislative context and stakeholder priorities. This, combined with lived experience (patients/carers), clinical leadership (health/care professionals), and academia and research (HEI and industry) can provide a rounded understanding of how NHS change will affect patients and clinicians, and how we can ensure it improves lives.

> 'We need equity of voice, action and accountability, across a team with a common goal, all with the necessary skills and knowledge. These voices need to come together in a forum that is capable of open debate and balanced decision-making.' – clinical lead

In other words, we need to find a balance between the patient voice (*why* we need change), the clinical voice (*what* we should change) and the operational voice (*how* we should change it). Obviously, the reality is more complex and interlinked than this, but this is a good starting point.

Every clinical network should also have a digital and data lead that works closely with both Digital Health and Care Wales (DHCW) and other NHS organisation digital leads. This person's role would be to inform, support and facilitate strategic discussion about technologies and data analysis.

> 'Network leads will be acting on behalf of a stakeholder group (patients, clinicians, managers) and should have credibility and strong connections to their community of practice. They should work not only *within* a clinical network, but *across* clinical networks.' – clinical lead

However, we need more clarity around terminology, expectations, plans and outcome measures. The vision for the future of NHSWE needs to be easily understood by everyone, especially patients and the public. Until we have clarity around what's expected both locally and nationally, it is very challenging to make recommendations around the structure and resourcing of co-production.

Ultimately, we need more detail about the structure, timelines and leadership of the NHSWE. It is also notable that the third sector was not asked to comment on the workstream documents that set out proposals for the strategic clinical networks. These were kept internal to the NHS, despite the Welsh government's long-held and public commitment to co-production.

Lessons learned: Senedd Health and Social Care Committee

In developing this paper, we spoke to Senedd committee clerks about how they engage with stakeholders during scrutiny inquiries. They told us they take an integrated approach to seeking evidence, designing a bespoke model of consultation for each inquiry. The first planning meeting for every inquiry includes not only committee clerks, but also members of the translation, legal, communications, engagement and research teams. They actively seek out a diverse range of voices to provide evidence, and as a key principle, all consultations are open to everybody, as accessible as possible and all information is published online as soon as possible.

The third sector in partnership with clinicians and the NHS

The third sector in Wales can offer expert advice across a range of interconnected issues on behalf of clinicians and patients. Organisations routinely work together to develop detailed policy and legislative recommendations with shared messaging across a variety of complex subject areas, and many of them are in fact service providers that can draw on first-hand experience of the system.

> 'Co-production beats consultation beats engagement beats informing.' – clinical lead

> 'Our clinical network would fully support a formalisation and professionalisation of the lived experience voice within the NHS Wales Executive and strategic clinical networks.' – clinical lead

The third sector is an often-under-used resource, full of expertise, knowledge and insight that could support real transformative change if we can develop a system of co-production that works.

National charities, royal colleges, professional bodies and patient advocacy groups can provide invaluable information about the health and care workforce, service users and local delivery models that could enable useful comparisons within and between service providers, facilitate learning and disseminate good practice.

> 'I fully support third [sector] involvement in decision making around the direction of travel of strategic clinical networks.' – clinical lead

While the new Citizen's Voice Body should be in place by April 2023, the risk is that without active third sector involvement, patient involvement will be, at best, tokenistic. While the Citizen's Voice Body will certainly have a part to play in the new NHSWE, this should not be to the exclusion of lived experience within the third sector.

> 'We need to work more closely with the third sector to look at the whole patient pathway. Working collaboratively and making decisions together in a more joined-up way adds value.' – clinical lead

> 'Roles at a national network must be about solution focused, system thinking that takes account of all perspectives.' – clinical lead

At a time when many organisations are struggling with staff and resource capacity, it makes sense to pool resources and work in partnership to:

- develop strategic priorities and improve performance
- reduce variation across different clinical specialties and geographical areas
- share good practice and facilitate learning
- connect directly with stakeholders, including clinicians and patients
- develop more inclusive, accessible and effective health and care services
- develop standardised structures, governance and working practices for third sector and patient involvement across the whole of NHSWE.

The third sector can support the public sector to:

- develop shared messaging, understanding and priorities
- make progress towards closing the implementation gap
- share the workload through appropriate collaborative working.

NHS clinicians and managers can spend a great deal of time firefighting. The third sector can support strategic thinking, underpinned by the lived experience of patients, stakeholders and members.

> 'Change is slow, laborious and painful. There needs to be more focus on holding health boards to account on performance and regional working.' – clinical lead

> 'There should be clear and visible commitments to co-production with patients and the third sector at every level in the NHS Wales Executive, including decision-making, outcome measures and oversight. This does not mean 'arms-length' stakeholder groups; it means full, equitable (and resourced, where appropriate) involvement at those tables.' – third sector policy lead

A transparent and open approach to designing pathways and service specifications would build trust. The third sector can ask questions and challenge the status quo, bringing true co-production into the health and care system. As well as a role in the leadership group, the third sector should feed into the clinical networks through reference groups and task and finish groups.

> 'We are facing a rapid transformation of healthcare services and we need to bring patients and the public, professionals and organisations along with us. We need to collaborate on cultural change to understand expectations and make some difficult decisions together: this is about strategy, service design and implementation of change on the ground.' – clinical lead

> 'In my specialty we have long-standing, very constructive and positive two-way relationships with patient organisations. If we want to put the patient and public voice at the centre of the system, we need better integration between the NHS and the third sector.' – clinical lead

> 'Often, a more joined up, integrated approach to advocacy would lead to more effective change.' – clinical lead

This cannot be a tick-box exercise. The third sector can bring wider expertise to the table in communications skills, influencing change and sharing good practice. Simply giving the third sector a single seat at the table does not guarantee influence; the lived experience voice as a member of the leadership group will help to bring about change, and this role must be supported with training.

> 'We need multiprofessional groups (including national clinical leads and third sector colleagues) to influence the delivery of services in a formal arrangement where we are able to hold health boards to account.' – clinical lead

> 'The lived experience voice [must be] professionalised to ensure they are representative of the patient population and not only their own journeys.' – clinical lead

> 'We will need mechanisms and support to ensure that lived experience leads are able to represent their stakeholder group appropriately.' – clinical lead

The draft NHS Wales Duty of Quality Statutory Guidance 2023 and Quality Standards 2023 defines quality as 'continuously, reliably, and sustainably meeting the needs of the population that we serve' (p19). This 'requires involving people in decisions that affect them' (p6).

> 'Engagement is often not tailored to meet diverse and marginalised people's needs. If we keep using the same (often inaccessible and largely unpublicised) engagement methods, we will keep hearing the same voices … service-users [should be] in the room as equal partners, sharing the decision-making as advocates with lived experience [and] wide networks, supported and resourced to maintain dialogue with their communities' – third sector policy lead

Lessons learned: Wales Kidney Network

'Quite simply, we couldn't do all we do for patients without the support and inputs from our charity partners. Each of our main charity partners is represented on our network board – this enables them to feed into the network about all the good work that they undertake and identify the synergy with network priorities. It also provides a forum for robust challenge and debate in relation to network plans and strategic direction. We are a commissioning network, and we hold the budget for specialised renal services in Wales as a delegated responsibility from Welsh Health Specialised Services Committee. Through service specifications, we can 'direct' health boards to deliver services. We monitor delivery and quality, and we work collaboratively with health boards to ensure unwarranted variation is minimised.'

A consistent, transparent approach to engagement

> 'The system should be standardised and transparent. It takes detective work to find out how to engage with the networks and their plans. If I was a patient, how would I ever find out?' – third sector policy lead

Every clinical network and national programme should have an up-to-date online presence that sets out a forward work programme, minutes, agendas, meeting papers, contact details and ways to engage. When a new piece of work is started, a task-and-finish group should be established, and a consistent process followed (the same process for all networks), which includes a call for evidence (based on terms of reference developed by the network) and a call for expressions of interest that is shared with key third sector stakeholders, including the Welsh NHS Confederation who can cascade this information.

This would give third sector organisations a more level playing field, providing everyone with the same opportunities to feed into policy development, improve diversity and inclusion and allow both individual patients and clinicians to provide feedback. Meeting papers should be published ahead of time and shared with all network members, then made available online following the meeting. Furthermore, all NHSWE work should be subject to consultation with patients and the public.

> 'This isn't done consistently or in an accessible way at all in the current set up. We receive the agenda the day before, which means we can't meaningfully engage or suggest agenda items, and there's no easy way to look at past meeting papers.' – third sector policy lead

Lessons learned: Women's Health Wales

'Fair Treatment for the Women of Wales (FTWW) is a patient-led, grassroots organisation, made up mostly of volunteers who can articulate their lived experience in a very powerful way, both to policymakers and in the media. We've developed strong working relationships with clinicians over the years, which has put our campaign in a strong position. We've also worked with national charities like the British Heart Foundation to collect stories, build the evidence base and develop stakeholder and influencer networks. The patient voice is absolutely central to the campaign, which means it's impossible for politicians to ignore our message. We share a common goal, which makes the coalition very strong.

'Initially it was the Senedd Health and Social Care Committee that recognised the importance of women's health. This added weight to our calls for the Welsh government to develop a women's health plan. Both Scotland and England had already announced women's health plans, and we didn't want patients in Wales to be left behind. The minister for health and social services has been very supportive, and of course, a co-produced women and girls' health plan with measurable outcomes that makes a real difference would be an impressive legacy from her time in post.

'Challenges remain. The Welsh government staff team developing the plan is small with many competing demands. There is no overarching clinical lead for women's health, which can sometimes make communicating and resolving pan-Wales clinical issues more difficult, and we understand that this has been problematic for clinicians as well as patients and the third sector. We very much look forward to structures being in place that will enable all of us to work collaboratively, consistently, with patient advocates and the third sector represented and involved in all levels of decision-making and oversight.'

> 'We understand that timelines can shift; but the more information we have, the more we can factor projects into our own work plans. The more we are seen as partners in service design, the more warning we get, the more valuable our contribution will be.' – third sector policy lead

> 'As an organisation, we experienced good engagement on our quality statement, but we were told it would not go out for public consultation at all. We would have loved to have captured real life experience in a structured way, which did happen with other quality statements. That was not offered to us; we weren't told that was a possibility. Other groups have been promised action plans; we've been told no. It's inconsistent. We worry that this inconsistency will spill into the implementation and some quality statements might be seen as more important by health boards because there's been more resource and consultation attached to their development.' – third sector policy lead

Having high-quality and well-resourced programme support staff will be key to the success of strategic clinical networks and national programmes. Where staff time is shared between networks and programmes, this should be made clear to network members, and monitored to ensure that all networks are receiving an adequate level of support.

Clinical leadership as a key principle

> 'We must be pragmatic and lead change. It's on us to lead our colleagues, networks and communities, and work with the third sector, professional organisations and industry partners.' – clinical lead

Clinical engagement means having an active dialogue, shaping the conversation, taking a strategic approach and discussing issues before arriving at a consensus or shared conclusion.

> 'Genuine consultation does not mean simply sending a newsletter once a week. If people don't feel engaged with a process, it doesn't matter whether you've sent a thousand emails, the process has failed.' – third sector policy lead

> 'From a wider perspective what worries me is, "Where's the clinical voice?" I'm not sure we're all being listened to.' – clinical lead

> 'I think we are losing the clinical voice. It's not as respected as it's been in the past. We need to be on the same page and have a shared message. Otherwise, it's just distracting.' – clinical lead

> 'A collective, coherent clinical voice could improve the quality and accessibility of data, planning framework and finance. It's hard for us to do that when we do not have a collective work programme.' – clinical lead

While recognising that much of this work is ongoing as part of the NCF implementation workstream, clinical leads felt it was important to:

- develop a stronger collective clinical voice
- ensure clinical engagement, not endorsement
- standardise appointment, job planning and appraisal processes.

Clinical leads should be responsible for engaging with specialty societies, royal colleges and clinicians on the ground. They should provide an independent clinical perspective on service planning, which would avoid any conflict of interest with health board appointed clinical leads, and they should be accountable to the Welsh government and the NHS Wales Executive leadership.

> 'Health boards would say the clinical voice comes from their medical director, specialty clinical directors or clinical board members. Quite reasonably, they might ask what is our role as national clinical leads? Who appointed us? Who do we speak for? Our legitimacy in the future will depend on having a place within the formal structure of the system.' – clinical lead

The introduction of a standard approach to recruitment and appointment is crucial. Some clinicians have been through a competitive application and interview process; they have a job description, annual appraisals and funded secondment arrangements in place. Others told us

that they have no clear job description, wrote their own job title and were appointed by a self-selected sub-group.

> 'The new executive gives us an opportunity to strengthen the clinical voice. We need a shared common language to make a persuasive case to health boards; this means ensuring the next generation of clinical leaders have those skills and knowledge.' – clinical lead

> 'The clinical voice is starting to feel quieter now in Welsh government and it needs to be louder. There should be a dual role for clinical leads: both as experts in our own specialty, but also as a collective voice where appropriate. As a group, we struggle to get traction because we remain in our own little silos.' – clinical lead

Networks and programmes in the NHS often grow organically, depending on new pots of money, or third sector pressure, or government priorities. This has resulted in a complex set up. To give these roles legitimacy, it's important that people go through a competitive process, receive a job description and annual appraisal reviews with objectives and deliverable actions for the year. Having funded clinical lead sessions will be essential. Professionalising these roles would demonstrate their value to the Welsh government, their NHS employer, and the wider specialty. This, in turn, would give them legitimacy and allow their network or programme to hold them to account.

> 'The networks will be clinically led with resourced job planning and funded sessions.' – NHS manager

> 'Clinical time is precious. Backroom support should enable clinicians to add value with their expertise and knowledge.' – NHS manager

There was solid agreement that the voice of lived experiences and of clinicians needed to come together to improve communication, support clinical leaders to influence change, develop national strategy and inform service delivery. Working in partnership within the strategic clinical networks would be a constructive way forward. Primary care team members must be an integral part of clinical networks from the very beginning; the health and care system can no longer be neatly divided with each half working separately.

> 'Some clinical leaders are perceived to be spokespeople for their own opinions, as opposed to leading a body of networked clinicians. This can lead to a dismissive attitude about their importance and how much weight their opinion is given to influence policy. The third sector could support leaders by providing constructive feedback/training on the leader's effectiveness in influencing and leading.' – clinical lead

> 'The networks could help to frame some of the planning guidance that supports the development of the integrated medium-term plans (IMTPs). Many of the wider strategic ideas that could get us out of the current NHS crisis don't feature in IMTPs.' – NHS manager

To support succession planning, clinical leads felt it was important to recognise and value the work done at a national level with staff, resource and funding for administrative support, supported by wider communities of practice. This should include resource for maintaining websites and keeping an online presence up to date, which will help patients and health boards to access information more easily.

> 'Regional and national clinical leadership is not always recognised or valued by NHS delivery bodies. Recruiting into non-remunerated clinical leadership roles is increasingly difficult.' – clinical lead

> 'We need to support and encourage others to become involved as clinical leaders. Succession planning needs much better support.' – clinical lead

> 'The new set of networks will be informed by what is evidenced as the burden of disease in the population together with known service pressures. Every clinical lead wants a fully resourced network, but that's not affordable. So how do we reconcile demand with reality? Nothing will be fixed. There will be space to reorganise networks as medicine changes.' – NHS manager

Clinical leadership isn't just about doctors. The NHS and social care workforce is made up of many different professional groups and all of them should be given the opportunity to lead change.

> 'It's vital to recognise the contribution that other clinical leaders make.' – NHS manager

A major theme that emerged during the session was the need to reduce variation and increase regional working and collaboration. This is something that must change under the new NHSWE. Clinical leaders should be offered targeted support and training on effective collaboration.

> 'Every quality statement should (and must) have a national implementation plan. Otherwise, it becomes meaningless, just a collection of vague expectations and hopes from Welsh government.' – third sector policy lead

> 'Nationally, it's almost impossible to hold local NHS organisations to account on the delivery of services; trying to get health boards to work together is very frustrating. We were told that the NHS Wales Executive would change this, but we know now that it won't have any more authority or funding than the old system. So how are we going to get things done?' – clinical lead

> 'At a local level, senior NHS managers are incredibly busy with day-to-day operational firefighting. Meeting agendas are already packed. It is hugely challenging to get people locally to think outside of the box on those wider, national strategic issues like digital healthcare and workforce development. DHCW and HEIW can only do so much without powers of enforcement.' – clinical lead

> 'Health boards are only held to account for service delivery and performance against very narrow metrics. System leadership and delivery is weak in Wales. Nationally we're not able to direct health boards to deliver services in a certain way, which leads to variation.' – clinical lead

> 'The stronger central guiding hand we were promised in 2016 (and many times since) hasn't materialised. Regional, collaborative working between health boards is encouraged, but nobody has the power to make it happen.' – third sector policy lead

> 'Regional working is currently entirely dependent on goodwill. However, the new networks will be supported to focus on national strategy and implementation, and they will be enabled to hold health boards to account using data and evidence-based interventions. But we will need to think in a different way. The existing networks do such a mix of things that it's no wonder they struggle to make progress or improve outcomes.' – NHS manager

This applies equally to cross-NHSWE working between strategic clinical networks and national programmes, which should be strongly encouraged and incentivised with joint funding.

> 'We need to exploit where common approaches and working across network boundaries will be more likely to effect meaningful change.' – clinical lead

> 'Investing in digital is clearly the way forward, but we need to standardise the approach. It cannot be that everyone uses different digital solutions – that will create chaos.' – clinical lead

Lessons learned: Respiratory Health Implementation Group

'In respiratory medicine, we've worked with specialist partners to develop digital tools including a respiratory toolkit. This includes national guidelines, patient-facing apps, quality improvement and educational standards. We've presented at conferences and there's international interest. During the pandemic we were able to implement a national approach at scale and pace.'

Holding health boards to account

> 'There is a role for the clinical community to support the third sector to interpret published data and challenge the system. But any unpublished data are still held by public bodies. That information should be in the public domain; peer review reports should be accessible and published online. We know the majority aren't, and those that are available are buried away on health board websites, making it very difficult for external organisations to hold them to account.' – clinical lead

> 'We are behind the curve on digital innovation. We should be using digital resources to create expert patients who can manage their conditions better.' – clinical lead

> 'Through a Getting It Right First Time (GIRFT) review, we've found that data collection in Wales isn't good enough to identify good practice and create new policies. That's massively disappointing. Without an evidence base, it's difficult to encourage people to change. There simply isn't enough of an emphasis on accurate coding, which means we can't rely on the data.' – clinical lead

> 'We need massive investment in data collection to make the argument, but we also need the authority to make change happen. With accurate data, we could make significant cost savings and improve patient outcomes.' – clinical lead

> 'Data should be transparent and accurate. We need to be able to communicate the results in a language that the public understands – and that's where the third sector, and others, can come in. There is no point collecting data if it makes no difference to the outcomes patients see. Perhaps we need a joint piece of work on data, coding, transparency and communication.' – third sector policy lead

> 'HEIW cannot make health boards publish vacancy data, so we have no idea where the workforce gaps are. Anecdotally we know everybody's overstretched but we have no evidence.' – third sector policy lead

Service change at scale and pace

Not every quality statement will be accompanied by a national implementation plan. However, there is a risk that some quality statements will be seen as 'more important' than others because of this. The link between quality statements, implementation plans, and health board IMTPs must therefore be strengthened to enable effective scrutiny and accountability.

> 'The national clinical framework is about setting a national direction, national standards and national expected outcomes, which should be implemented by health boards.' – clinical lead

> 'We don't need another year without focus where all the networks are running around trying to review seven different versions of the truth.' – NHS manager

Health boards should use their IMTPs to set out exactly how they will meet the detail of quality statements, clinical pathways and service specifications set out by the NHSWE. These IMTPs should follow a nationally agreed template, co-produced with the third sector. Health boards should co-produce these plans with local third sector and patient groups: a national set of guidelines should be developed for how they do this to ensure consistency of approach.

> 'The IMTP planning guidance has already gone out, which is another missed opportunity for clinical involvement and engagement.' – NHS manager

> 'Quality statements have been published at random intervals over a very long period. Where is the guarantee that they will be available in time to be included in IMTPs?' – third sector policy lead

> 'So much is interdependent. Any major change to patient flow has an impact on the ambulance service and other specialties and clinical pathways. Workforce shortages are a major issue and there's no national recruitment process to fill medical posts from outside Wales. Tackling delayed transfers of care would release more capacity, but there's no political will to address the social care crisis. Again, regional and collaborative working would help, but it's not doable because of budgetary and operational constraints. Health boards are not willing to share the financial load with their neighbours by accepting patients from elsewhere.' – clinical lead

This paper is endorsed by:

1. Asthma + Lung UK Cymru
2. Brain Tumour Research
3. British Dietetic Association
4. British Liver Trust
5. British Society for Heart Failure
6. Crohn's & Colitis UK
7. Fair Treatment for the Women of Wales
8. Genetic Alliance UK
9. Macmillan Cancer Support
10. Marie Curie
11. MS Society Cymru
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13. Royal College of General Practitioners
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18. Stroke Association
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