Green Paper consultation events – Carmarthen 12 November 2015

Comments made by participants and themes captured

Chapter 1: Co-production and changing shape of health services

1. What are the main barriers preventing collaboration and joint working between organisations and services?

Separation of Health and Social Services: the continued separation of Health and Social Care in terms of roles and funding is detrimental to collaboration and joint working.

Lack of Shared Vision: organisations and departments are too inward looking, with no shared vision. Working together as partners with a sense of trust and common purpose is required.

Lack of Resources: a lack of resources or proper management of resources is a barrier.

Information Systems: better/ shared IT systems for better information sharing and communication between organisations.

Public/ Individual Responsibility: the responsibility patients and staff have for their own health and relieving pressure on the NHS.

Lack of Accountability: health boards are not looking to improve or collaborate with others.

Other: there is nothing wrong with “expert” or “paternalism” in the right situation.

2. What can we do to improve the opportunities for collaboration and joint working between organisations and services?

Involve Staff and the Public: health services should actively involve and engage, and work with the public and staff on the ground, who have valuable experience in providing direct patient care and support in both health and social care settings.

Improve Collaboration: leaders should meet to look to improve collaboration, not just across departments but also across sectors, with champions for change.

Joint Planning: need for joint planning with links to wider services.

Other: training staff.

3. How can we ensure citizens are more engaged and involved in the planning of health services?

Make Information Accessible: information needs to be more accessible, tailored to individual needs (e.g. sensory loss), in order to engage them and assist understanding of and involvement in the discussions and decisions being made. Also need to use variety of mediums to engage; a mix of media and open meetings/ forums.

Involve Patient Representatives: health bodies to more actively involve patient representative groups in decisions, with raised visibility and access to these groups for the public.

Evidence Engagement: health bodies to provide evidence of effective engagement.

Respect and Listen: health bodies to show respect and listen to the public's views.

Encourage Citizens Ownership: citizens should be educated and encouraged to take responsibility for engaging with health bodies.

4. What would successful engagement look like?

Open Public Engagement: clear lines of communication and fixed structures for engaging with the public, through open and accessible means, tailored to individual needs.

Public Awareness: high levels of public awareness of health services related issues would indicate successful engagement.

Greater Transparency: greater transparency with services planned around users as opposed to system convenience.

Improved Advocacy: improved access to advocacy services.

Budgets for engagement: ring fenced budgets for service user involvement.

5. What part should Minister's play in decision making about service changes and should different arrangement be put in place?

Facilitate Partnerships: the Minister should drive collaboration and partnerships through different mechanisms.

Accountability: the Minister to be responsible for making ultimate decisions, given that they are elected representatives of the public and had access to expert/ professional advice.

Independent Decisions: decisions to be made completely independent of political agendas.

Public engagement: the Minister to represent the public and base decisions on public and staff feedback/ experience.

Other: Ministers to deal with poor services and for any expert panel to involve frequent users and carers.

Chapters 2 and 3: Quality and Standards

1. What are the main issues impacting on the quality of healthcare services in Wales?

Resources: a lack of, or mismanagement of resources as impacting on the quality of services.

Staffing: staff shortages, work pressures on staff, and retaining staff with the necessary qualifications, as key issues impacting on the quality of services.

Bureaucracy: bureaucracy, red tape, reports, and legislation as negatively impacting on quality.

Lack of integration: lack of integration between health and social services, as well as a lack of joint working with the third sector, as impacting on the quality of healthcare in Wales.

Focussing on Wrong Issues: focus needs to be redirected away from targets towards outcomes, becoming a proactive organisation instead of a reactive organisation.

Lack of learning/ patient perspective: healthcare providers are not learning organisations, specifically when it came to utilising patients' perspective and experience to improve the quality of services.

IT Systems: inconsistent and outdated IT infrastructure as an issue impacting on the quality of services.

Lack of patient responsibility: need for patients to take responsibility for their own health in improving the quality of healthcare

Other: waiting times, the subjective nature of the term "quality" and healthcare professionals assessing the quality of care they provide, are issues impacting on quality.

2. What can we do to help staff focus on the quality of services they provide?

Peer review: peer review/ providing time and opportunities to staff to share and learn from experiences, with constructive feedback which reflects on standards and patient experience.

Patient Focus: importance for staff to focus on the patient and their individual needs, as well as communicating and making decisions with the patient in the most accessible way (tailored to individual needs).

Supporting staff: staff to be supported in providing quality services, a culture where leaders focus on quality and safety of services and listens to and reacts to staff concerns.

Training staff: providing ongoing training for staff, with a focus on quality.

Reduce Complexity: a reduction in bureaucracy/ administrative actions required, with a shift to focusing on patient.

Other: the need for a Welsh Government legal strategy for British Sign Language users (similar to that for Welsh language).

3. What can we do to ensure leaders and boards focus on the quality of services being provided both in planning the services and in delivering them?

Quality focus for boards: the expectation for board meetings to focus specifically on quality, and that every board member should be responsible for ensuring quality.

Hold accountable: leaders to be made accountable for the quality of services and hold them responsible for failures in quality. Some suggestions included regulations or guidelines setting out expectations and then sanctions for not meeting them.

Learn from staff and patients: leaders to learn about quality of services directly from the experiences of both staff on the ground and patients.

Learn from outcomes: patient outcomes to be considered of the same importance as financial matters by leaders.

Other: closer working with the third sector, planning services around protected groups (rather than the “majority”), and taking a human rights approach.

4. How can we best set out the level of quality we expect to be provided across all healthcare settings?

Learning from experience: opportunity for learning from experience, particularly patient experience; seeking to engage with the public on the quality of services and how to improve, with systems for gathering information and reflecting on both good and bad experience/ practice.

Monitoring Standards: standards to be monitored, inspected, with findings published and standards enforced where quality is lacking, with sanctions for staff.

Common standards interpretation: common standards to incorporate those standards set by professional bodies, and to be interpreted across different settings and the potential need for still issuing more specific quality standards under a common standards theme.

Resource Driven: quality to be improved through the better management of resources, including a pooled budget for Health and Social Services.

Introduce common standards: common standards to be introduced, so as to ensure a consistent level of quality/ expectation of consistent quality across services

Other: working better with the local population and keeping services local, and using quality improvement plans.

Chapters 4 and 5: Openness, Honesty and Sharing Information

1. What can we do to ensure organisations and individuals are open and honest about performance?

Include patients: including patients in discussions, with clear knowledge of their patient record, and being more open to questions, and proactively seeking feedback.

Lead a culture of openness and honesty: building a culture of honesty and openness, with leaders of health organisations promoting and rewarding honesty, with a shift away from a blame culture, whistleblowing, and fear of repercussions.

Define Openness/ Honesty: openness, honesty, and transparency to be explicitly defined so that staff and patients know exactly was expected.

Publish information honestly: monitoring or auditing the performance of services and openly reporting back to the public in an accessible way.

Single Information System: a single system/ database for recording and sharing patient information.

Other: Audio/ video recordings of meetings between health professionals and service users; “Fit and proper persons tests” for senior leaders; NMC/GMC already provide joint guidance on Duty of Candour

2. What responsibilities do you think should feature as part of a duty of candour?

Accountability for Organisations: Duty of Candour to only cover organisations, rather than healthcare professionals (who already have a duty of candour).

Culture Change: a duty of candour should not be implemented at all as legislation cannot be used to change the culture around openness and honesty; a duty of candour should not be introduced until the culture has changed through other means first.

Co-production: involving patients in all aspects of their care and decisions which impact on them as well as making them aware of their rights as a service user.

Complaints: the complaints process needed to be strengthened with more support for those involved.

Other: How would a Duty of Candour be monitored for compliance? Mediation is important; Appears to be a fantasy that leaders are not held to account, when evidence would suggest otherwise.

3. What are the barriers preventing healthcare bodies from sharing patient information?

IT Systems: a lack of consistency in the use of, and the effectiveness of IT systems. There were calls for a single IT system containing patient information and for health professionals' notes to be recorded electronically as opposed to handwritten.

Fear: a lack of confidence and understanding of data protection legislation and fear of making mistakes as acting as a barrier.

Patient Understanding: a lack of patient understanding about how, when, why, and with who their information is shared, with a need for patients to have more understanding and control over their record.

Other: Section 251 of the Health and Social Services Act could be used to make provision for sharing information for other purposes (such as research); counselling records are considered more confidential than others and are unlikely to be shared; lack of trust between Health and Social Services; devolve powers over these rules to Wales

4. What should be the most important factors and considerations when sharing information?

Consent/ Confidentiality: serious consideration needs to be given to maintaining patient confidentiality while sharing information, with more clarity as to when consent is required. .

Patient Ownership: importance of patients having ownership rights over their own information and it only being shared with their consent.

Accuracy: accuracy and quality of information being shared was key.

Single IT System: a single IT system to be adopted across organisations.

Outcome Data: the need to record and share information on patient outcomes as a means of testing the quality of services.

Other: Patient notes should be non-biased and should not be handwritten; the Data Protection Act should be embraced, not cause fear; sharing information for other purposes is key for future generations but should not be done without patient consent; Information should be shared safely and securely.

Chapter 6: Checks and Balances

1. Do you think we need to make any changes to enable Healthcare Inspectorate Wales to most effectively operate?

Change Inspection System: system for inspection should be reviewed and changed, moving to a more proactive assurance model rather than simply inspection, and considering how HIW can become more involved in other settings such as nursing care homes.

Increase independence: HIW to have greater independence and autonomy, citing the importance of independence in conducting work with full trust of the public and the patients.

Increase Powers: HIW to have more legislative powers to enable it to address and take action when any negative issues/ failings are identified within its inspections of services.

Increase Awareness of HIW: the need for greater public awareness of HIW's role, work carried out, and recommendations from inspections. This included making the information accessible to all e.g. British Sign Language

Working with others: potential merger of HIW and CSSIW, with the need to reflect upon merging improvement agencies as well.

Staffing: improving the level of professionalism, relevant experience, and expertise of staff working for HIW, including the need to improve recruitment processes.

Existing systems: increased independence might decrease HIW's accountability and reflected on existing systems and questioned a move towards a similar system as in education, and what the role of the Wales Audit Office would be.

2. What would be the advantages or disadvantages of creating a single inspectorate covering the roles and responsibilities of Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales?

Advantage: Promote integration: merging the inspectorates would benefit from more joined up working and a more integrated approach to considering the quality of health and social services, especially in nursing home settings.

Disadvantage: Lack of integration: Health and Social Services to be merged in line with the Inspectorates.

Advantage: Slimmer Resources: financial implications of merging the inspectorates and suggested savings could be made as part of the merger.

Disadvantage: Merger not beneficial: a merger would not work, with one citing it would be too large and unwieldy, and another reflecting on the work of Care Quality Commission in England.

Advantage: Clearer understanding: merging the inspectorates would enable the public to better understand the system and inspectorate's role.

Advantage: Common Standards: merging would benefit both the inspectorates and services by creating a consistent approach to inspecting with common standards expected across both health and social care settings.

Other: merging would provide more power to the inspectorates; learning from HIW - not punitive measures; a merged inspectorate could help reduce duplication; patient outcomes and service delivery require inspection, not facilities.

3. What action can we take to strengthen the patient voice in Wales?

Direct Patient Involvement: service providers to be more accessible to patients, patient groups, and patient representatives wishing to represent views. This included involving under-represented groups such as children and young people, and British Sign Language Users. There were also suggestions to use more inclusive means of communication; social media and websites as opposed to just meetings.

CHC Reform: Community Health Councils functions and recruitment to be reviewed and reformed, suggesting a single focus on patient voice (rather than inspection or service planning), with recruitment of members to be reformed in order to strike a better balance of representation.

Joint Working between HIW and CHCs: need for better joint working between HIW and CHCs, with an emphasis on patient representation.

Evidence of listening: importance of health bodies providing evidence of learning from patient concerns and complaints.

Other: need for Welsh Government to take responsibility for final decisions.

4. Are there any key activities that Community Health Councils should be focussed on in order to best represent the patient voice?

Expand to cover Social Services: CHCs to expand their role to representing patients in Social Care settings as well as Healthcare settings.

Advocacy: CHCs' advocacy role to be strengthened.

CHC Recruitment: recruitment process of CHC members needs to be revised in order to ensure they are patient led and have a better balance of representation e.g. British Sign Language users.

Service Change: CHCs need to continue engaging on and representing the patient voice when it comes to service changes/ planning.

Continue with visiting rights: CHCs to maintain their right to visit and inspect healthcare settings, from an independent, patient perspective.

Chapter 7: Finance, Functions and Planning

1. Should we change the law to give health boards borrowing powers?

No: concerns about building up unmanageable debt and who would be responsible; Health Boards already are in deficit so borrowing powers would only increase their deficit; no need for separate borrowing powers if Welsh Government can borrow.

Yes: within limits; only if there is a prospect for appropriate borrowing opportunities; NHS Wales needs to obtain more capital to facilitate service change but no spare money in system – borrowing may make change possible; only borrow to save later; only borrow to shift emphasis to prevention.

Repayment/overspend: how will they pay back given their consistent overspend; how will cutting services to pay for borrowing be tolerated by the public; need safeguards on any borrowing so don't just accrue large debts

Miscellaneous: it is not clear why health boards should be different to NHS Trusts, which do have borrowing powers.

2. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?

No: here seems little value in preparing summary accounts if they are not read; individual accounts provide financial control.

3. Should legislative changes be made to provide greater flexibility regarding summarised accounts for NHS organisations in Wales, reflecting NHS structural and government financial reporting changes?

Probably yes: Should there be a duty to publish and explain financial position of health board in a way that is accessible and understandable? It makes sense for them all to be responding to the same requirements with flexibility to allow for the differences.

4. Should there be an equivalent statutory planning duty for NHS Trusts as we have for health boards?

Mixed views: not convinced it would make any positive difference. Current practice acts as if the duty exists for Trusts.

5. Should we review NHS (Wales) Act 2006 planning duties to avoid duplication and improve alignment with the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015?

Yes: any proposed legislation should seek to align, remove contradictions and work with other new / existing legislation.

Miscellaneous: essential to find a way of funding which enables services to meet needs e.g. if services are funding via an attachment to beds/wards/directorate how are they made accessible to people who are in other places e.g. primary care to access therapies; avoidance of duplication should be encouraged and facilitated.

Chapter 8: Leadership, Governance and Partnerships

Health and Trust Board membership

1. What are the barriers preventing local health board and NHS trust boards from operating effectively?

Size/constitution needs revision: current membership is not right but if it is made too small you will not be able to drill down to services; there is too much clinical representation and this needs to be reduced in favour of a more social model; there needs to be more lay representation; a core membership should be considered with some mandatory membership requirements e.g. frequent users/carers, lay majority, lay chair, mental health and primary care. Above that you could have some flexibility; need the right people to deliver the task. Determine the tasks and then who is needed to make decisions

Need for proper clinical representation: the prime purpose of the health board is to provide a clinical service, and therefore all clinical professional groups require to be represented equally at board level i.e. medics, nursing, therapies, health science and public health

Role and purpose of boards: too big an agenda to manage – need to empower directorates/divisions etc. and trust them to make right decisions and to escalate appropriately; health boards are being asked to micro-manage from a macro-level. Welsh Government is better placed for strategic oversight and health boards should be responsible for delivery and implementation

Disagreement that boards not performing effectively: not aware that boards were being prevented from working effectively. What is the evidence to support change

Appointment process/pool membership drawn from: unclear about the performance management of directors; boards are not diverse enough; too much professional recycling; public sector nominations are generally dominated by academics and professionals who know how to meet the application/competence criteria

2. What changes could be made to make boards more effective including any legislative change?

Change to Ministerial appointments: independent appointments commission may be beneficial to remove panel from Minister

Workload/information consideration: boards either need less information or more specific information to provide focus and effectively scrutinise & quality assure

Change in role/function of board: relationship to Welsh Government must be re-defined as most of the real power is held by government e.g. procurement decisions and capital spend, ultimate reconfiguration, accounting officers. Could create hospital boards to manage operational and local planning/flow, then have strategic Health and Social Care Boards to look at public health and longer term planning and engagement.

Committees: boards may be unable to have eyes on full range of quality and service issues. Perhaps they should be strategic and use sub committees to be operational. Role of sub committees e.g. Quality and Safety Committee to feed up specific, serious issues to full board, but board relies on sub committee to filter and act on. Sub committees should be relied upon to feed board appropriate level of information.

3. Should there be flexibility on board membership, either partial or complete, for individual boards or a blanket approach applying across all boards in Wales?

Mixed views: there should be full flexibility; flexibility to recruit to suit local needs could be beneficial, but also risks a less streamlined service provided by boards; there should be some fixed and compulsory roles on each board and a number of flexible roles; having a variance in board structure may cause problems and overall the ratio of exec to independent members should not be open to change, keeping the balance in favour of greater independent members.

4. What action could be taken to achieve greater citizen involvement in the boards and to ensure they are held to account?

Make Boards more open to citizen involvement: timings of meetings; access to papers; accessible locations etc.; Boards should hold regular public engagement events with the public that are accessible, help support people to engage via paying expenses and use inclusive formats/materials.; non-executive members could be sought from a more diverse pool to include people with disabilities, from different groups etc. – positive action in recruitment; Invest in more public engagement events and opportunities

Appointment of patient experience representatives: have a required number of patient experience engagement facilitators per head of population.

Appointed community members: how would ‘community member’ be defined? Is there a risk it would attract former NHS professionals? Perhaps it should be an elected role.

Appointed user members: should be a legal requirement for appointed and paid frequent users and carers; there should be citizen representation on the board perhaps via CHC or third sector representatives on behalf of protected-characteristics

Greater accountability on boards: holding the board to account – not the citizens. Greater frequent user and frequent carer membership of board.

Board secretary role

1. What are the barriers preventing board secretaries from operating effectively? Is legislation change required to address this?

In conflict with Chief Executive: board secretary's role could be in conflict with the Chief Executive who is the accountable officer.

Clear requirements/skills for role/professional qualification: no agreed professional framework for board secretaries so you can not change powers without this.; needs a greater professionalism of role – clear requirements in terms of knowledge, skills, capability required.

Need for legal qualification for board secretaries: they should be qualified lawyers.

See no problem with the role: what is the evidence base that board secretaries are prevented from working effectively? What could legislation bring to support that person that good employment process and raising concerns guidance cannot currently provide

2. Do additional corporate responsibilities compromise a Board secretary's independence? If so, how could board secretary independence be enhanced?

Requirement to perform other duties: the board secretary role has become blurred by having other duties such as management/communications, etc. It should be a designated role.

No affiliations with pressure groups/political affiliations: must not have affiliations with pressure groups and must be non-political

3. What should happen if a Board secretary's governance advice is disregarded?

Note and report concerns for investigation: reasons should be duly noted and investigated with appropriate action taken following; same as any other process reported via appropriate route

Report concerns direct to Minister: ultimate action for board secretary would be to report board/CHC/CEO to Minister. In such circumstances relationships would be fundamentally broken and Ministers would have to decide who stays.

4. How important is indemnification of the role of Board secretary having regard to the existence of other protection such as whistleblowing?

Important: It is difficult to maintain objectivity and independence in that position.

Advisory structure

1. Do you think there is a need to reform the current arrangements? If so, why?

Yes, there seems to be a case for reform: too many statutory advisory committees – better to have task and finish groups. Minister should be free to take advice from anyone – he is accountable and is scrutinised via committees and NAfW. Why are there no advisory committees for social care? How do we access advice from the relevant sector for integrated services?

Yes, but what is the alternative: Happy to discuss statutory alternatives to advisory mechanisms – but straight abolition of current mechanism is not helpful; 32 groups and no patient voice on any seems excessive particularly with duplication and expensive resource. However it would be important to better understand what might be put in their place should they be abolished

Patient carer voice: Increase frequent user and carers involvement in all advisory groups

Miscellaneous: Must be careful to avoid reverting to old boys network and the ‘usual’ suspects of power; what are NSAGs and what do they do? Very difficult to see and challenge; How often are the NSAGs and advisory committees reviewed to ensure quality and that they are the correct committees or are there any missing? Are there any gaps in expert knowledge?

2. Is there a need to provide for any sort of advisory group in legislation instead of just relying on routine liaison with the service and stakeholders?

No: There would be no need to move to a single group, if the current NSAGs work well. Moving to a single group or committee would not be effective because of the need to receive multidisciplinary advice. A single advisory group would also be no different to the Bevan Commission.

Yes, but requires careful consideration of what is expected and what needs to be achieved: While there is scope to merge NSAGs, networks, and delivery groups, independent advice must be retained. If expert professional / clinical advice is required, then that must be from the right people. Generalised advice is ‘interest’ based. The Minister must be required to seek, consult and hear the advice but also have the right to make own determination (as long as justify if need to ask why he didn’t act on it.

Possibly: Introducing legislation for two types of liaison; with multiagency and frequent user & carer involvement.

3. If the situation is left as flexible as possible, what advantages or disadvantages could you foresee?

Advantages: So long as checks and balances are in place to ensure that flexibility doesn’t lead to lesser expertise. Useful to pilot new structures before rolling out changes – flexibility would allow this – or could be regulated.

Disadvantages: Need some consistence, need to ensure frequent user and frequent carer involvement. Independent advice matters. Flexible arrangements will be ignored and misguided.

4. Should legislation be used to ensure that policy development is based on expert professional advice? If so, how?

Yes: Through existing Advisory structures – the vital importance of statutory requirement to take advice cannot be understated. The advisory committees ensure advice is taken from a wider range, not just the usual strong voices. The statutory committees are mostly very effective. The non-statutory committees are less transparent.

No: There are too many statutory committees. Abolish all advisory committees and set up task and finish groups instead.

NHS workforce partnerships

1. Do you agree, as a point of principle, that the position reached in the devolution journey calls for decisions about the NHS Wales workforce to be ratified and signed off in Wales?

Yes: Partnerships and workforce regulation could follow the model in social care. There is a good opportunity for Wales to be different.

No: Withdrawing from arrangements is high risk and costly. Long-term it could disadvantage the Welsh NHS. Wales cannot sustain its own workforce; our medical schools are weak and post graduate arrangements are struggling to compete with England. We need to remain within UK Arrangements for workforce planning and education. Opportunity to four countries discussion would prevent isolation. There is a UK workforce and a UK market of workers; it should be possible to import and export to the strength of NHS Wales. Could also have a negative impact on pay levels in Wales, which could impact negatively on staff retention.

2. Would you be supportive of changes (including legislation) to the existing level of variation possible under the agenda for change framework to be made in order to achieve this?

No comments

3. Do you think that in this general area the same rules should apply to all NHS Wales organisations (i.e. is there any reason to distinguish between Trusts and Boards)?

Yes: The same rules should apply across Trusts and Boards.

Depends: This has to depend on funding levels and financial scrutiny available for such ventures.

4. If changes were made that gave Welsh Ministers a clearer final say on agreements that had been arrived at through partnership working, what else should be done to ensure that strong links at a UK level are maintained?

No comments

Hosted and joint services

1. **Where a hosted service is bigger than its host, what types of issues may this cause, to both host and hosted organisation, and how might it be addressed?**

Issues identified: The hosted services cannot be over-ruled because they are bigger than the host, leading to issues with accountability.

Suggestions for addressing the issue: Create a framework, or provide all-Wales guidance on appropriate and consistent hosting arrangements, or go as far as developing a new organisation which manages shared services and shared decision making.

2. How can we ensure that there are appropriate and consistent hosting and governance arrangements in Wales?

Governance: needs to include frequent users of services and frequent carers

3. How can we equip NHS Shared services to take on a wider public sector shared services?

Shared services: Mixed calls for shared services to either apply only across the NHS or for it to extend its services across both health and social services, or even right across the public sector.

4. Do you think that NHS Wales should have the freedom to act in the same way as universities in areas like research, intellectual properties, spinout companies and commercialising products and services?

Yes: NHS bodies need maximum freedom to act. Patient interests must be prioritised and research should be shared; NHS research should benefit all. LHBs should be able to set up joint ventures with equal rules.

Concerns: Would be concerned by the intellectual property.

5. Do you think that NHS Wales should have the freedom to generate additional revenue, for example for commercialisation or for delivering expert services outside Wales?

Yes: Generation of additional revenue and commercialisation should be allowed but run ethically. Could this be pursued through the duty to collaborate under the future generations net. Perhaps private healthcare could purchase NHS services, but without having priority.

6. Do you think that in this general area the same rules should apply to all NHS Wales organisations (i.e. is there any reason to distinguish between Trusts and Boards)?

No comments.