Green Paper – Full Responses

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WGGP001 – Jacques Protic
Tref / Town – Anglesey
Sefydliad / Organisation – N/A

General comments

Recognise the harm the 'Invisible Elephant' (Welsh Language compulsion in Health Services and elsewhere) is ding to Wales. Time to employ people for their skills & competence and no more 'Welsh Language 'Essential' – Simply the best he or she based on job criteria!

It's a fallacy to see Wales as a 'bilingual nation' and Welsh Language services should be only provided where practical and reasonable to do so. Where else in the world a tribal language spoken by the few, imposed on many and irrelevant to most is promoted as a 'national language'?

As a local to the BCUHB I see incompetence first hand and most related to Welsh speakers being Essential!

Equally important is to rename Health Boards with names that people can relate to geographic regions and as Mark Drakeford was advised by the senior medical Consultants working in Wales that he chose to ignore and not that long ago!

Response to specific questions

No response to specific consultation questions.

WGGP002 – Anonymous
Tref / Town – Anonymous
Sefydliad / Organisation – N/A

General comments

Wishes for response to be kept anonymous.

WGGP003 – G. Ramanathan
Tref / Town – Unknown
Sefydliad / Organisation – N/A

General comments

We can introduce JCI (Joint Commission International) (http://www.jointcommissioninternational.org/) to get International recognition for our hospitals and may be way to generate extra fund through International medical tourism. Implementation of ISO 15189 standards are currently happening in our hospital attached clinical labs, but it would be good if we focus our attention on the STANDARDS focusing on the standardisation of Pre-analytical processes (handling patients' samples/collection) and post-analytical processes (handling patients' test results and storage/retrieval of patients' samples).

It would be nice to introduce Tele-pathology/Tele-medicine/Tele-radiology to access remote places within Wales. Right now we are using Air-ambulance to transport Patients. If we have Tele-pathology we can bring the clinical labs/pathology at their door-steps, this can be possible if have mobile labs just like mobile CT/X-rays/MRI. As patient care is our first priority plus considering the spending at the current financial climate, it would be better to harness Satellite technology. In Tele-radiology, X-ray is taken and transferred electronically to the radiology department based at the hospital, so that radiologists will see and provide advice.

Response to specific questions

No response to specific consultation questions.

WGGP004 – Anonymous
Tref / Town – Unknown
Sefydliad / Organisation – N/A

General comments

My major concern is that the thousand of reports, recommendations, policies made, yet we are still coming across poor practise, neglect & abuse in 2015. With an understanding that there are more people in need of N.H.S. services with greater expectations & demands for more costly up to the minute medication & operations. When is common sense & care ever going to be written & practised to avoid the likes of "Death by Indifference" ever repeating itself?

Response to specific questions

No response to specific consultation questions.

WGGP005 – Ahmed Shandall
Tref / Town – Unknown
Sefydliad / Organisation – N/A

General comments

My own view having spent the last year as a Specialist Advisor on the Care Quality commission in England and my perception of HIW is that a similar system with independence, legislative powers is required in Wales. To fully understand the workings of the CQC would require personnel from WG to partake in inspections and view methodology to fully appreciate the rigors of the process which is currently not done in Wales. I would certainly recommend this.

Response to specific questions

No response to specific consultation questions.

WGGP006 – Michael Boyle
Tref / Town – Unknown
Sefydliad / Organisation – N/A

General comments

I strongly object to the views of the HIW, within the NHS Green Paper which proposes that CHCs should be stripped of their rights to enter and inspect NHS premises.

I understand that this proposal is strongly supported by HIW who have been promoting their own "professionalism", criticising the CHC's lay focus and citing the Minister's desire to do away with duplication in the inspection of the NHS.

I feel the minister has, and would continue to get a clearer picture of the quality of NHS services within Wales by allowing the CHC to continue its good work.

The CHC Members have given freely of their time in order to monitor the quality of services from a patient perspective."CHC members undertook over 500 assessments during 2014-15". The HIW do not have the staff to carry out the number of impartial visits the CHC is capable of and only have the interest of the Patients and the delivery of a good Welsh NHS service.

Bryn Beryl is an isolated community hospital dealing with many vulnerable dementia patients. This is a known set of risk factors and although the HIW's own inspection showed many serious problems - HIW appeared to be content with a period between visits of at least seven years. Compare this with the dedication the CHC has to the Welsh NHS, who continue to make regular visits, and who continue to update the minister.

Do we wish to continue to have quality CHC checks, or a HIW system that does not have the time and members to carry out regular inspection?

Response to specific questions

No response to specific consultation questions.

WGGP007 – Anna Stephens – Health Visitors Task and Finish Group, Cardiff and Vale University Health Board
Tref / Town – N/A

General comments

Response to specific questions

Chapter 3: Quality in Practice

Clinical Supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
I would like to comment on Clinical Supervision as I and 3 health visiting colleagues have recently developed a clinical supervision policy to be used for health visitors (although this can easily be adapted for all professionals) within Cardiff and Vale University Health Board. We set up the task and finish group following a meeting with Human Resources on staff moral within the health board. This was a priority and as we are working towards revalidation felt the need to have a consistent level of clinical supervision. We devised 2 policy documents; one for the clinical supervision group members and one for the group coordinator/s, which is the group member copy plus further information relevant to the role of coordinator. Each clinical supervision group will have 2 coordinators / supervisors. As our health visitors are based within neighbourhood teams, the leader of each team will not take the role of clinical supervisor / coordinator for their neighbourhood team members, in order to prevent conflict of interest and to adhere to best practice guidelines. Likewise, there will be no members from the same neighbourhood team within each clinical supervision group. We have included Cardiff and Vale UHB `Values and Behaviours` policy in the document. We have discussed both formal and informal supervision and the differences between the two. We discussed how Barnet Healthcare (1998) addressed the issue of people fearing supervision as it is seen to be more associated with criticism than validation of practice; although it can be difficult when our practice is being looked at, not to take criticism personally. It is recognising the key elements of supervision to be; support, standards setting and skills development.

The framework we will use is to be delivered through the Action Plan Learning Set model and in-house training is currently being organised.
We have addressed how disputes may occur between practitioners within the group and it has been agreed this will be resolved within the group. Ground rules will contain an agreement on resolving `fairly` differences of opinion and how to deal with breakdown, although allowing for free and robust exchanges of views for all.

A supervision agreement will help the group coordinator and members to agree ground rules – essential for the success of the supervisory relationship. Each copy will be signed by all members of the group and a personal copy kept on file.

An attendance sheet will be required for evidence in practitioners annual Personal and Developmental Review (PADR).

Clinical supervision meetings will be held every 2 months, for 2 hours, always on UHB property, maintaining confidentiality.

Group coordinators will keep all information agreed in the supervision session confidential, although if any unsafe, unethical or illegal practice is disclosed by practitioners, appropriate procedures will be followed. *Management supervision will not be part of the clinical supervision session.
A register of all members will be taken along with a record of the agenda, issues discussed and actions to be completed. Each member will have their own individual attendance sheet for their PADR evidence.
An appendix is included with “suggested training requirements” of;

- What is it?
- What are the steps?
- Why do it this way?

And finally a bibliography displaying where all information was sourced is included at the end of the document.

WGGP008 – Prof Dame Carol Black DBE
Tref / Town – N/A
Sefydliad / Organisation – Bevan Commission

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The aim is commendable but unless there is good evidence that legislation would actually strengthen local collaboration in this respect I could not give it great priority. Neither, except perhaps in specific narrow circumstances (such as taxes on tobacco, alcohol, sugar and issues of health and safety) do I see a significant place for legislation in promoting health and wellbeing.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
An example from England might be health and wellbeing boards, which aim to encourage different agencies to work together to meet health and wellbeing needs (However, they lack executive power).

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Yes, perhaps along the lines of 5. but such engagement mechanisms should include authoritative representatives of health professionals.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
It is important that representative groups have a continuing effective voice on or through boards and trusts. Perhaps this can only be assured through legislation.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?

Yes I do. NICE is one such a national expert body and works effectively. It is admired and respected internationally as an expert forum. The Citizens Council provides NICE with a public perspective on overarching moral and ethical issues that NICE has to take account of when producing guidance. The Council's recommendations and conclusions are incorporated into social value judgements and, where appropriate, into NICE's methodology. An expert panel established to resolve differences on proposals for service change might draw on this model.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
I think not. Ultimately the quality of services depends on leadership, skills and motivation – in short, professionalism – buttressed by clear accountability at the level of delivery. This should be set out in contracts and not require legislation. But we expect individuals to be accountable at the appropriate level and this may require better defined legislative means.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Ultimately the effectiveness of legislation depends on its impact upon the behaviour of individuals charged with clearly defined duties and responsibilities with accountability for fulfilling them.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
I agree that concepts such as the “Responsible Individual”, as set out in the Regulation and Inspection of Social Care (Wales) Bill and tests around the “fitness” of senior leaders and others to carry out their roles have been raised (44) and could be debated further. Ultimately the effectiveness of legislation depends on its impact upon such individual behaviour. It would be important to ensure that the notion of “fit and proper” is aligned with existing professional codes.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
It is important that individuals are not held to account for factors and system failures that are beyond their control.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
It seems to me that current means of setting and improving standards of service and practice in healthcare, which are widely shared, are sufficiently rigorous and pervasive.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
See above. I do not think such a new standard is necessary. Contracts can embrace existing standards.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
It would certainly be a good idea to see where accreditation and peer review might be strengthened. Again effectiveness depends on local leadership and accountability for use of these mechanisms.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Health professional registrants must be able to voice their views and there must be mechanisms enabling them to do so with confidence.

17. What arrangements should be put in place for self-employed health professional registrants?
I do not know whether current arrangements for revalidation (at least by the GMC in respect of doctors) are sufficient to be assured of the quality of clinical supervision. A responsibility falls on the suitable person. Here too the Health professional registrants must be able to voice their views and there must be mechanisms enabling them to do so with confidence.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes. Doctors have long had a duty of candour. Secondary care providers registered with CQC in England are subject to a statutory duty of candour.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Organisations providing NHS services in Wales should be subject to a statutory duty of candour. Indeed the Keith Evans' review recommended that a legal duty of candour should be placed on the NHS in Wales, not just on individual members of staff but the organisation as a whole in order to set a clear corporate responsibility and tone for the organisation.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Apart from technical weaknesses in IT systems I believe there remains the question of protecting confidentiality. This becomes problematic as increasing numbers of organisations become healthcare bodies.

22. How can we consider breaking down any barriers?
It is crucial to be clear on who needs to know particular patient-sensitive information.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Patients must give consent to the collection and sharing of such information. This the central issue.

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
It is my understanding that Community Health Councils already listen to what individuals and the community have to say about the health services with regard to quality, quantity, access to and appropriateness of the services provided for them. They then act as the public voice in letting managers of health services know what people want and how things can be improved. In turn, CHCs also consult the public directly on some issues to make sure that they are properly reflecting public views to the Local Health Board, Trust or Welsh Government. Whether or not the election of community representation on health boards would improve transparency, public engagement and accountability in the

health service would depend chiefly on their quality. They should be appointed independently.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Please see 38 below.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
The Commission questioned whether the current arrangements for health board membership provide the required level of challenge and, by extension, the spur to improve service quality. .Accordingly I agree with its recommendation that there should be a review of the current number, representation and appointment process of independent members of health boards. I particularly agree that the overall size of each health board be reduced to improve strategic decision-making and effective scrutiny.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
I wholly agree that to ensure effective leadership with authority in relevant organisations it is important that directors of public health have a strong voice, in particular across NHS and local government partnerships. In my view this can only be ensured through statutory joint appointments.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
I believe engagement and scrutiny would be enhanced were the proceedings to be recorded and published (as are those of CQC).

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
Please see my comments above.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
It is crucial not only that Ministers and NHS leaders can access expert professional and clinical advice, but also that advice should be an inherent part of healthcare policy development, and made public and answered. Only with a committee or organisation with statutory powers can this essential function be properly discharged with professional and public confidence. It is not sufficient that many sources of advice are available, seeking appropriate professional advice should be obligatory.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
One might consider the Academy of Medical Royal Colleges (with its close representative links to the medical Royal Colleges and their expertise) as having the necessary authority and standing to be accorded such a statutory role.

WGGP009 – Geoff Bell – Older People's Advisory Group/ 50+ Forum
Tref / Town – Pontyclun

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
No, but permanent engagement mechanisms should be an essential element of integrated plans submitted by health boards and trusts.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
No, Ministers should consider 'task and finish' groups to make recommendations on specific issues.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
No. Accountability at all levels should be promoted with appropriate training being provided.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
Is not the 'accountable officer' the 'responsible individual'? Broaden the scope of the 'responsible individual' and hold to account.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
The quality of leadership is the issue, not legislation.

Chapter 3: Quality in Practice

Meeting common standards

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes – if social services were also included.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Accreditation could be an appropriate mechanism to promote self worth and accountability in staff delivering services.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Health Professional Bodies (e.g. Royal Colleges) have a greater role to play – linked with new service delivery "mechanisms".

17. What arrangements should be put in place for self-employed health professional registrants?
Accountability and controls which mirror arrangements for NHS health professionals.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Do we have no faith or leadership?

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Confidentiality/ incompatible systems/ data security.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Promote benefits with patients and let them decide.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
Many "patient" journeys involve both NHS & Social Services. If we are patient/ person centred, a single inspectorate would seem to be the way forward.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
Initial training and development of inspectorate staff to equip them. Services are – or should be – changing any way. Sharing skills and experience must be in everyone's interests.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Is legislation the answer to everything?? The patient voice needs to be integral to service delivery. Do not expect too much from an underfunded CHC.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
To meet future service delivery.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Would this be abdication of "central" financial control – or confidence in health board financial management in a changing economic environment?

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
While budgets are “allocated” on the current basis – yes, they are relevant.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Promote high standards of leadership and governance, backed by training. I am not convinced legislation would lead to higher standards.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Balance between executive and non-executive board members must be maintained.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Yes, this would encourage more innovation. Core roles should include medical, nursing and finance directors.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
Health boards should have at least two independent members with a focus on community representation.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
How about joining health boards and social services to provide person-centred services?

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Perhaps a review of criteria and independent member roles together with more flexibility of some executive roles.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
What can be learned from the performance of existing boards?

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
A focus on innovation and leadership development.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Not convinced of the use of legislation – other than legislation totally focussed on patient-centred services.

Hosted and Joint services

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Changes which support the delivery of persons centred care.

WGGP010 – Audrey Prince
Tref / Town – Unknown
Sefydliad / Organisation – 50+ Forum

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Yes.

2. If so, what changes should be given priority?
More transport to get there.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
More advertising events.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
More discussion.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Yes.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
The general public should be involved.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Not always.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Yes

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
More meetings.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

22. How can we consider breaking down any barriers?
No postcode lottery for cancer patients.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
Not sure.

WGGP011 – Anonymous
Tref / Town – Unknown
Sefydliad / Organisation – N/A

General comments

I do not feel qualified to answer the attached questions – I nursed in the 1950s – too long ago! However, I have (alas) been a frequent patient/ visitor during very recent years so if the following statements are relevant to this "response paper" please consider them in the appropriate numbered responses.

1. Staffing levels in EVERY ward must be sufficient to ensure that no ward is completely unattended at any time.

2. Patient lounges must not be used for ward staff to hold their meetings preventing their usage by patients (and their visitors) as, for example, they are often the only place where private conversations can take place or patients told by their consultants to go/ ne taken there, to prevent them becoming "hospitalised" when a long-term patient.

3. Staff members must ensure that when food is brought (hot?) to the ward, patients are able to see/ handle it while it is still palatable – it is only wasted if it becomes too cold/ tepid to be eaten and no alternative is then provided. Not must be officially logged when patients have not eaten their food – and reason. As meals are ordered (still) by previous patient occupying that bed, appropriate food / drink must be provided for the patient currently occupying that bed i.e. diet/ religion.

4. Aprons should be provided ensuring that the will be removed before staff pass from one ward/ area to another thus helping to prevent "cross infection". Should also of course be removed before nurses (male or female) leave the hospital/ clinic to end their shift and go to collect their children from schools etc., go shopping, travel on public transport – taking germs out of… and brining germs into hospitals, clinics, patients, public places!!!

Response to specific questions

Chapter 1: The changing shape of health care

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Yes.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Yes (non union members).

WGGP012 – Dawn Price – RCT People First Ltd/ Maesgwyn Special School
Tref / Town – Aberdare

General comments

Response to specific questions

Working together to give good care

How do you think we could get people to work together better?
Sharing Information with other agencies Sharing information with each other Putting more money towards it Works as a team more Sharing information with each other Sharing information with each other Talk to each other Draw up plans Works as a team Communicate with you Talk to each other Draw up plans Works as a team Talk to each other more Draw up a plan Schedule communication better with us Put more money into the company Sharing information with others Work as a team More school doctors More money More local doctors More money Waiting lists should be improved More local doctor More money People with drug problems should go somewhere else More local doctors More money More local doctors More money More local Doctors More money More local doctors More money More local doctors

More money More local doctors More money in the service The waiting list should be improved

Making changes to health services

The report said that local people should be asked to say what they think about changes. It also said that some changes might need to be looked at by experts. What do you think?
They need to involve us more Include more information on internet / websites Yes (x 5) It should be everyone's choice Yes because they should only keep people in who desperately need it because we need beds They need to involve us more Include more information on internet / website Reduce waiting times They should reduce waiting lists That the should reduce waiting list old people, baby , disabled people main priority They should reduce time for waiting Reduce waiting times Reduce waiting times We are experts of our own health

Good quality care

How do you think we could make good care happen all the time?
The staffing levels needs to be higher enough. Staff training especially about learning difficulties and disabilities Get enough money to run it better They should have more care workers All work together and make it as best as they can More money More nurses More Doctors Needs more money They need more training from people like us More money More training of staff Young people involved in training Look after people Pay nurses and doctors more then people would get more help Buy better equipment The staffing levels needs to be higher

staff training especially about learning difficulties and disabilities And get enough money to run it better People waiting in hospital they get a drink Give what we need to be comfortable They love ones should have they own choice from suffering When people are dying in pain that they should be able to end it When you are in hospital They should be on tap all the time and they should help you all the time Make you feel comfortable when being in hospital Make you feel comfortable when being in hospital Give what you need to be comfortable If someone is in pain the should be able to say what they do with their life

High Standards

We might want to set standards for those people too. Doctors talking to other doctors about the way they do their work can also help to improve standards. Making a new law might help this happen. What do you think?
Yes we need a law and then health workers should share information and good practice Why haven't they made it then Shouldn't have to make a law about it It is their jobs they should give good services at all time and get paid for it So why aint it already happening? People who desperately needs care should stay in and people don't need it should be out More equipment Yes we need a law Health workers should share information and good practice Yes (x 3) They all need to be high standards at all times There should be different treatment centa for people All hospital should work and be in high standard All hospital should be the the same law Everyone should work all the same and at there best Yes it should be made law to have the same standard in every hospital in Wales Yes it should be made law to have the same standard in every hospital in Wales The doctors or the lower ranked should be at highs standards at all times

Telling the truth

We want the NHS in Wales to be honest and tell people if something goes wrong. We also want the NHS to tell the public about whether services are doing well, or not so well. If people are unhappy then it should be easy for them to say so, even if their complaint is about more than one service.

Making a new law might help this happen. What do you think?
There should be more information available on websites / newsletters No They should always tell the truth Yeah make a law so if they don't do it jail them No not to make it law Yes because more people better it will be Make sure every 5 weeks standards are up to dare and equipment Make sure needs have a thorough clean It should be more information available on websites / newsletters Yes (x 2) Yes it should be the law to be honest Yes they should tell people that they messed up Doctors should tell the truth even if they get things wrong Yes it should be law you got to know what I think they should tell you everything you need to know and what's wrong Yes doctors should be always honest with you Yes doctors should be always honest with you Yes they should always say the truth when needed

Sharing information

We want information to be shared if it will improve things for patients. What do you think?
Yes I think they should share information to get people better Yes (x 6) yeah it will improve why not share information I think they should share the information but keep private information away from other people No because its private I think they should tell people how they dealt with problems and keep our stuff private They should share information to get people better Yes its a lot easier Yes because you could be ill when you out and the doctors in the area so they can get treated Share information but only to other doctors Yes it should be shared for the patients

Checking how things are going

We want to know if HIW could do its job better. This could mean making some changes to the way it is set up. It might be helpful for HIW and CSSIW to join up because this might make services even better. What do you think?
I think its important they share the information and they all work as a team

Yes (x 8) Yeah join them up and make it better Yes we could do with their help Yes because they can work together I think it is important they share information and they work as a team Yes it will help a lot more for people Yes they should All make one plan Yes it will help

Making sure people have a say

It is important for people to have a say in the way the NHS is run. Making a new law might help this happen. What do you think?
I think they should share the law for people to get better Yes more people involved the better Because they have no choice to do what right then Yes more people the better Yes (x 5) Yes so they can listen to our views I think they should follow the law I think it should because Yes it should be the law All make one plan Yeah I think it should

Good Leaders

It is important for all of us that the NHS is run properly… making a law might make this happen. What do you think?
Yes it is a good Idea Good idea Yes make a new law so they all have to make a change to the hospital to make it better I think a good idea Yes (x 4) yes more people woking together the better Yes its a good idea I think that people with a disability should be involved Yes to help find more ways of treating people Yes they can have more of an input It will be good Most drugs should be banned and most not Yes they should Yes I think people with disabilities should do it

Listening to NHS staff and experts

The Welsh Government asks many people to help with making laws, making changes and deciding things. It might be helpful to change the way this is done. Making a new law might help this happen. What do you think?
They should follow the plan to help people get better One expert from each one should have a meeting and discuss issues to make everything better because that's what everyone wants Yes (x 4) They should follow the plan to help people That old people and baby and disabled people should be treated first Yes everyone should give their point of view Yes more people should be involved Yes they should

WGGP013 – Dawn Price – RCT People First Ltd/ Self Advocacy Group – Bert Denning Day Centre
Tref / Town – Ebbw Vale

General comments

Response to specific questions

Making changes to health services

The report said that local people should be asked to say what they think about changes. It also said that some changes might need to be looked at by experts. What do you think?
You should visit hospitals and see what happens and make the changes to improve peoples health Need to investigate and find out how disabled people are treated in hospital and make sure things improve.

Good quality care

How do you think we could make good care happen all the time?
Must be fully qualified to provide care. Have cleaner hospitals. Bring hospitals up to standard. Let people decide who they would like to be examined by.

High Standards

We might want to set standards for those people too. Doctors talking to other doctors about the way they do their work can also help to improve standards. Making a new law might help this happen. What do you think?
Yes standards need to improve and standards should be set.

Telling the truth

We want the NHS in Wales to be honest and tell people if something goes wrong. We also want the NHS to tell the public about whether services are doing well, or not so well. If people are unhappy then it should be easy for them to say so, even if their complaint is about more than one service. Making a new law might help this happen. What do you think?
Yes it should be made into a law.

Sharing information

We want information to be shared if it will improve things for patients. What do you think?
Yes, only to health professionals.

Checking how things are going

We want to know if HIW could do its job better. This could mean making some changes to the way it is set up. It might be helpful for HIW and CSSIW to join up because this might make services even better. What do you think?
If it will benefit people. Need easy read. Simple language.

Making sure people have a say

It is important for people to have a say in the way the NHS is run. Making a new law might help this happen. What do you think?
You should visit hospitals and see what happens and make the changes to improve peoples health. Need to investigate and find out how disabled people are treated in hospital and make sure things improve.

Good Leaders

It is important for all of us that the NHS is run properly… making a law might make this happen. What do you think?
Yes.

Listening to NHS staff and experts

The Welsh Government asks many people to help with making laws, making changes and deciding things. It might be helpful to change the way this is done. Making a new law might help this happen. What do you think?
It would be a good idea if these boards have someone with a learning disability on them to help improve the health service for people with learning disabilities “I had 5 different doctors giving me 5 different diagnosis - not ideal”

“When I was in hospital I have male nurses providing personal care I didn’t like this and felt uncomfortable. I should be given the choice on who helps me with personal care” “I should be given the option to have a female doctor”

WGGP014 – Anonymous
Tref / Town – Anonymous
Sefydliad / Organisation – N/A

General comments

Wishes for response to be kept anonymous.

WGGP015 – Llewellyn Morgan
Tref / Town – Pontypool
Sefydliad / Organisation – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Yes.

2. If so, what changes should be given priority?
Public involvement; proper resource allocation; co-location of services based on identified population need; shared budget responsibility.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Co-produced work-stream analysis reports annually, along with a requirement to produce quarterly audit reports.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Statutory requirements with appropriate instruments to govern how this changed is managed. Mandatory reporting mechanisms with 360 degree feedback to be included.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Yes – as populations are often best placed to identify their needs. This would require annually instituted health needs assessments alongside production of relevant health impact reports.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Yes – qualified by a requirement to include 'expert' clinicians in any assessments that are conducted. Furthermore appropriate business case

models and analysis with appropriate health impact assessments. This would require a consensus approach on submission of referrals onwards.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
No, not always.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Appropriate succession planning mechanisms as a regulated function alongside mentoring and role-modelling planning. A requirement to include statutory quality analysis reports.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
Advantage of ensuring quality is at the heart of care. Disadvantage potential for 'lip service' adherence. Potential for significant cost in terms of monitoring, approval and recruitment of said individual.

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
As above. Should apply at Board Level appointment with accountability with the Chief Executive.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Yes, given recent inquiries and reports clearly indicate that this has previously not been a central responsibility.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Yes – should be consistency between all services no matter who delivers that health care. Organisations should be subject of same legislative instruments.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?

Yes.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Annual statutory inspection requirements. Statutory implementation of minimum standard requirements with sanction processes for providers who fail to meet minimum standard requirements.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Regulatory requirements required to ensure this happens and is provided for staff. Statutory requirements with reporting mechanisms to be instituted in healthcare organisations. This would require evidence production and analysis of learning by practitioners – much like the proposed NMC revalidation requirements.

17. What arrangements should be put in place for self-employed health professional registrants?
Revalidation processes similar to that proposed via the recent NMC consultation and pilot sites.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Consultation with professional regulatory organisations regarding its implementation. Statutory requirements to produce public responses to concerns raised. Use of independent reviewing officers to assess extent of outcomes and production of reporting mechanisms.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
As suggested within the relevant consultation section – would require extending legislative powers for PSOW making them statutory.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Lack of appropriate IT infrastructure with shared systems that is centrally managed. Lack of understanding of practitioner information sharing protocols.

22. How can we consider breaking down any barriers?
Addressing the above may assist.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Caldicot Principles need to be applied to each individual situation. Concerns regarding information security, and lack of access to secure networks with which to share information.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
Yes – as identified in Marks review, they need to be explored further.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
No – allowing them full autonomy as an organisation with regulatory powers and reporting mechanisms.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
Ideally, there should be a single inspectorate so as not to duplicate work streams, this would allow for further integration of health and social care. However, this would require a legislative change in order to fully implement.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
Advantage of a streamlined approach to service provision and

investigation/inspection allowing for organisation ownership of investigation and addressing concerns. This would prevent oversight of concerns not being thoroughly investigated. Disadvantage potential delays of investigations etc whilst merger and single processes introduced and established.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Yes – learn from the National Social Services Citizen panel. Additional need to require production of annual reports regarding work undertaken and involvement.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
No – not fit for purpose. The discussion re: National Social Services Citizen panel seems to have merit and may be worth examining the feasibility of including something similar within health.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
No.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
No.

32. 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?
Yes, as described in this section of the consultation. Consolidated accounts would allow for greater transparency re: income and expenditure.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes

34. 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 - the 2006 act requirements have now been superseded by the 2014 and 2015 acts.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Review may need to be undertaken to ascertain what is currently occurring. Board membership review also required. Review of legislation also could be warranted. Peer mentoring and use of lean business models and their application to healthcare organisations may also be worth exploring further.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Qualified yes, based on the individual organisation performance. Membership may need to be revised in light of the 2014 & 2015 acts.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Yes.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
I think that this is currently not utilised enough, but that any elected member should have a level of business experience commensurate with that of existing board members.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Yes.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership

best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
No – should be included or remodelled based upon LHB board membership proposed changes.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
No.

45. How could potential conflicts of interest for the board secretary be managed?
Person employed as board secretary should solely have this role, thus limiting conflicts of interest.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Yes.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
Remove the statutory status of committee's/groups. Strengthen further working and associated legislation around groups discussed in paragraph 133.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
These need further reviewing, however, consideration still need to be given to a Wales only review committee.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
Legislation enacted to separate out their functions from their requirements under host organisations.

50. What changes could be made to provide greater flexibility for NHS Wales

Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
This organisation needs to be established as a body in its own right outside of the current host organisation. This would allow it to further develop to assume its role as a sector-wide service.

WGGP016 – Rhys Meredith
Tref / Town – Swansea
Sefydliad / Organisation – Abertawe Bro Morgannwg University Health Board

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Review of non-medical prescribing legislation. At present too many professional groups are excluded.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
I agree with invest to save but the borrowing should be done at government level to ensure the best possible interest rate. I suspect that local borrowing would incur a higher borrowing rate which would not be the best use of public funds.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
I am concerned about the loss of the DoTHS role (See question 40).

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Aims of prudent health care needs to be supported. This needs to involve developing new ways of working and developing new pathway models Also; recruitment of medical staff, especially GPs likely to be an issue for some time. It is vital that non-medical professions, (scientists, therapists) are given the maximum support and are fully represented at Board level. The DoTHS is a very important role to negotiate the changes that are required for substantial changes in the delivery of health care to success.

WGGP017 – Lindsey Hilldrup
Tref / Town – Barry
Sefydliad / Organisation – HIW (Supervisor of Midwives)

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Yes, most definitely as a statutory mechanism is the means to ensuring continued public scrutiny without simply paying lip service to it.

Chapter 3: Quality in Practice

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Legislation is required to ensure a strong and robust method of providing clinical peer supervision as long as those providing it have the appropriate knowledge and skills. This will require investment in training and CPD opportunities if a quality process is developed to ensure clinical peer supervision is based on sound principles underpinned by evidence based practice and underpinned by NMC standards.

17. What arrangements should be put in place for self-employed health professional registrants?
Enforcing a process of clinical peer supervision will have to incorporate some consideration of this group of health professional. Revalidation will address this to some extent but there needs to be a statutory requirement that ensures health professionals have a 'link reviewer' in the geographical area that is appropriate to their practice. These health professionals will need to take this responsibility to maintain their registration as well.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes absolutely but this will also require some degree of external scrutiny to ensure compliance.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
External scrutiny is the key to ensuring governance is robust, timely and meaningful if the lessons from Morecombe Bay are to be adhered to. Without this level of scrutiny it is difficult to imagine an unbiased governance process with the public at the core.

WGGP018 – Alfred Ford
Tref / Town – Cardiff
Sefydliad / Organisation – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Staff study patient case history to ensure correct treatment to be administered.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Copying what CHC does.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
I would like to think that a Minister would have a unit of intelligent employees who can seek information and write a report for the Minister.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
It borders on necessity seeing that individual is required.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
A definitive framework to cover both sectors will have great impact.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
I would like to think that the foregoing comment – consistent throughout life's process could be of good maintenance with revalidation of issues.

17. What arrangements should be put in place for self-employed health professional registrants?
There should be no separate arrangements for self employed professionals. All must follow the legislated procedure.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes, once it's legally implementable and enforceable.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Prosecutions and reviews.

Chapter 6: Checks and Balances

Representing patients and the public

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
No change or strengthen legal authority to pursue and refocus structure.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
No.

Summarised accounts

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

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Could do. Give more prominence to trusts. No competition required.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Is there a need?

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
The appointment of personnel with ability and success are the important requirement here. Guidelines (not legal requirements) are necessary for directors to have a strong basis for dealing with issues and organisations.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
The appointment of personnel with ability and success are the important requirement here. Guidelines (not legal requirements) are necessary for directors to have a strong basis for dealing with issues and organisations.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
Good idea to have community representations in addition with CHCs.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?

Why?

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
The appointment of personnel with ability and success are the important requirement here. Guidelines (not legal requirements) are necessary for directors to have a strong basis for dealing with issues and organisations.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
Board Secretary should be a single role with an office to support the workload.

44. If so, what aspects of the role should be additionally set out in law?
Board Secretary should be a single role with an office to support the workload.

45. How could potential conflicts of interest for the board secretary be managed?
Board Secretary should be a single role with an office to support the workload.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Ministers are responsible for areas of policy and to determine the effectiveness of the working of these policies – visits to relevant areas should be made unofficially.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
Ministers are responsible for areas of policy and to determine the effectiveness of the working of these policies – visits to relevant areas should be made unofficially.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Secretary of State for Wales should make representation in UK Government to have this anomaly reviewed.

WGGP019 – Sam Rice
Tref / Town – Llanelli
Sefydliad / Organisation – Hywel Dda University Health Board

General comments

I wish to raise an issue around a current patient of ours who is being currently let down by the arrangements. The situation is a patient with severe cerebral palsy, epilepsy and Type 1 diabetes. The patient has full time carers. I look after the patient's type 1 diabetes. The funding for the patient's carers does not relate from their health needs so we have been told that we can no longer teach them to give insulin to the patient. This is turn leaves the patient's parent in significant difficulty and prevents them from having any form of respite and prevents the patient from having days out with her carers.

Response to specific questions

No response to specific consultation questions.

WGGP020 – Richard Ebley
Tref / Town – Unknown
Sefydliad / Organisation – N/A

General comments

The NHS local authorities and the wag need better management.

Response to specific questions

No response to specific consultation questions.

WGGP021 – Anonymous
Tref / Town – Anonymous
Sefydliad / Organisation – N/A

General comments

Duplicate of WGGP014 – wishes for response to remain anonymous.

WGGP022 – Dr David Salter OBE
Tref / Town – Dinas Powys
Sefydliad / Organisation – N/A

General comments

I would be grateful if you could consider this alongside my pro-forma response to the Green Paper consultation. I am writing this in a private capacity and not as Chairman of the HIW Advisory Board.

I believe the following points are relevant:

1. The Green Paper feels like a pastiche of issues with tenuous relationships and no clear statement of the problem that the paper is seeking to resolve.

2. It seems to stand alone, in policy terms. In the absence of a clear long-term Welsh Assembly Government strategic health plan and its implementation, it is difficult to see its place in future planning.

3. Many professionals feel overwhelmed by regulation and legislation. There is a clear need to improve the culture of the NHS, and the introduction of a Green Paper based solely on even more legislation is perceptually counterproductive.

4. To answer the consultation sensibly, respondents would need a comprehensive knowledge of the existing legislative background.

5. The Welsh Assembly Government Health Department has adopted, by default, most of the role of a Regional Health Authority. This has been in the absence of the function at any other level in Wales. The role has not been formally acknowledged and has lead to a number of issues needing resolution. One of these is the clarity of the relationship between the Health Department (with the Chief Executive of the NHS, the Medical Director of the NHS etc.) and NHS Wales itself. This, in part, has lead to the perception of HIW not being independent of Ministers.

6. Some questions are posed in the absence of an analysis of the all the issues that are pertinent. This leaves the respondent without a clear idea of what might be helpful in response. Question 24 is a good example, the question is very broad and not focussed.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
It is clear that a common budget would be needed before effective planning and collaboration can occur. Legislation enabling this is required but this should also require agreed outcomes.

2. If so, what changes should be given priority?
Those enabling independent living.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
There needs to be a requirement for using common data sets and information systems to prevent boundary issues over care. There are huge cultural differences between health and social care services. These need to be addressed by attention to opportunities for joint training, possibly joint contracts.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Yes, to prevent the deliberate publication or public announcements of misinformation or information intended to deliberately deceive. This is particularly relevant to clinicians (often retired) with aberrant views or self - interest agendas.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
The difficulty with this is trying to ensure that such groups are representative of the local population. It might be better to legislate for the mechanisms that should be used in the consultation e.g. with local community council (as the lowest democratically elected unit, using all local media (newspapers, TV, and radio) and using social media. At the same time the local population need to have an independent professional view of suggested changes and any consultation should be required to contain such an assessment.

6. Do you support the idea of a national expert panel to which referrals might

be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
It might be preferable to establish a national expert panel to perform the function suggested in 5 above. If the Panel has provided an assessment, as part of the consultation, any relevant challenges to it should be dealt with by the Panel. There should no need to refer to the Minister. This can be legislated for in the consultation regulations.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
No. This is a cultural, training and education issue. Organisational values are also key to the issue and cannot be controlled by legislation.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
The contract of the CEO (and ? Health Board Chair) should explicitly contain a duty for quality. Each Trust should be obliged to have a publicly accessible web based database of quality measures it has developed and each Trust/Health Board required to use these measures, if practical or necessary.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
It would dilute the importance of this role if it is not the CEO. That is not to say that an individual, at Board level, should assist the CEO in this responsibility.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
The CEO.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Only when current budgetary arrangements interfere with the delivery of quality.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Healthcare standards should be minimum standards and applied to all settings in which Welsh NHS patients receive care. Those settings should be accredited, as fit for purpose, using the standards plus other relevant standards.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
See above.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
This was part of the intention in the setting up of clinical networks and has been used in cardiac surgery and respiratory medicine for years. It is a most effective way of promoting quality. It should be mandatory for all aspects of clinical practice.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Accreditation of health care establishments should be mandatory, as is the case for independent health care. It is undesirable that the NHS should be different. Doctors have to revalidate their ability to practice - so should all health professionals giving direct health care. Use the same type of legislation.

17. What arrangements should be put in place for self-employed health professional registrants?
I am not sure what question is being asked here but they still have to comply with their regulating body in providing care. GPs and Dentists are self-employed health professional registrants working for the NHS. Those in the independent sector should do the same. This would follow 16 above.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes, for individuals and organisations.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Demand publication of agreed standards, of number of complaints/praise and the substance of those complaints.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Legislate for the sharing of information across the sectors and as a first step the funding of joint investigations.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Lack of clarity over who “owns” the information. Differing IT systems. Tendencies to overprotect information to patient detriment and not understand Information Commissioner requirements. Ill founded suspicion between professionals over ability to maintain confidentiality.

22. How can we consider breaking down any barriers?
Allow patient’s to own the information. IT systems that can communicate. Common training of health and social care professionals. Allow patients more say over the transfer of information in advance.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
There are very few. It is a desirable and valuable tool provided that anonymity is preserved.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?

Yes, it cannot put an organisation into special measures on its own behest. This dilutes its influence and delays the change needed - putting patients at risk. It cannot accredit NHS premises (c.f. the independent sector).

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
This is a question which is as much about perception as much as reality. I am not fully convinced that statutory independence is needed but I would agree that it is required to improve the perception of HIW, both of the NHS and of the Welsh Public. However, this is not a stand alone issue and needs to examine the future relationship with CSSIW, CHCs and other regulatory agencies. Despite relative independence at present, it gets its authority mainly from the Minister. Therefore, any future proposals need to maintain that authority - see 24 above.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
Joint sharing of information, common training, budgetary arrangements that encourage joint working. IT that can communicate with each other. Common back office arrangements.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
Common sense says there should be one inspectorate. The patient should be unaware of crossing organisational boundaries in their care pathway. Therefore investigation of problems and assurance of quality should also transcend those organisational boundaries. The ideal would be a common Health and Social Care Board with the the inspectorates working under the Board. They could be a combined agency but an analysis needs to be made of how often and what type of joint investigations are needed. It may be that a relatively small number of staff are needed for joint working. There is no doubt that size aids efficiency (up to a point). There may be skills in accrediting etc, that can be combined.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The present system allows personal agendas to be pursued under the guise of the CHC. It also allows apparent "expert advice" to be given to CHCs when the accepted evidence is contrary to that advice. It seems odd that CHCs and HIW are operating separate systems aimed at the same purpose. CHCs could operate under the umbrella (or directly) of HIW. This could ensure the wider

citizen voice being heard as in 5 above and could provide access to independent advice.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
See 28 above.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Not until they have shown an ability to manage their budgets for several consecutive years.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
There needs to be a comprehensive strategic planning system for NHS Wales that includes the Welsh Government. All organisations need to have effective planning systems in place in order to be successful. However, the 3 Trusts in question have very disparate functions. In my view the Ambulance Trust should be recognised as a clinical service and operated at Local Health Board level, as the community aspect of the Accident and Emergency Service. The Public Health Trust should be supporting the Welsh Government and LHBs in their strategic planning. The Velindre Trust is in someways an anomaly and thought should be given to single management of the type of services provided in Velindre, in other LHBs. This would allow sensible strategic planning (including workforce) of these services across Wales.

34. 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.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
No comment, other than relevant replies above.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Where is the evidence that the present arrangements are wrong or that size is a factor? There is evidence that the size of healthcare organisations effects their efficiency. Boards can only function well if the information they receive is right, this factor needs examination before board reorganisation.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Why specify the numbers - of course they should have discretion.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
Again, this is a question of perception rather than effectiveness. Yes, it would look good but would only effective if the election was non political and arrangements were in place for effective community communication to allow feedback to the community as well as effective representation.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
This is a messy solution. Better to have statutory provision for the provision of public health input to the local authority from the Public Health trust.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Clinical service management needs as much input as financial aspects - this needs to be represented.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed? 42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
See above.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
Yes.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
It is interesting to see how aspects of this Green Paper is about increasing the democratisation of health services and yet this is about decreasing the legitimate influence of the healthcare professionals. Yet again, this ignores the opportunity for culture change and aligning the values of NHS Wales and its healthcare professionals. Yes, Welsh Government has many avenues of professional advice but the advisory committees provide local knowledge plus professional knowledge moderated by an all Wales perspective. In addition, it allows professional opinion independent of organisational agendas - e.g. Royal Colleges, BMA, RCN. To remove the statutory position of these committees could be perceived as a deliberate distancing of Welsh Government from its healthcare workforce.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
If “we” means Welsh Government, why do you need more legislation - in my, considerable, experience expert advice is not difficult to obtain - the independence of the advice is the essential issue and legislation is not relevant. See 28 above for an are where legislation might be helpful.

WGGP023 – Bill Salter
Tref / Town – Cardiff
Sefydliad / Organisation – Cardiff and Vale University Health Board

General comments

I am writing to give my view regarding finance and that this is a view of mine and **not** Unison.

There is millions being wasted on contracts when items can be purchased of the same quality far cheaper.

EG
I needed a pallet truck for my stores we could have bought one from a supplier local in Penarth Road for £199 but we couldn't as we contracted
To someone else this ended up taking a week longer and costing nearly £500.

We also buy Blood pressure machines at a cost £25 each because we supply about 10 a month to home dialysis patients, my colleague found them on Amazon the same make but actually this company provided the batteries where the ones we buy them from does not they were £10.99 each we ordered them but after 2 orders our
Finance stopped us and told us we cannot do this as we have a contract.

It is clear this is happening all around Wales so the cost is a disgrace of public sector money and should be a law that if any trust or dept is proved of wasting Public sector money it should be publicised and punished by the welsh government.

I am a trade unionist and totally against privatisation of any p[public sector I spent 24 years on the railway fighting against privatisation and it would be criminal
For NHS to privatised but one thing that improved with the privatisation of the railways was the spending of money for Hotels travel and the buying of items Required.

Like I said talking to many colleagues in the procurement section they will tell you have money being wasted because of contracts people responsible for
Contracts within of the NHS should talk to the staff involved and check costs of items

Response to specific questions

No response to specific consultation questions.

WGGP024 – Angela Hopkins – Betsi Cadwaladr University Health Board
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Public services in Wales duty to collaborate (Future Generations Bill). Partnership Service Boards emerging- 4 within North Wales. Health and Wellbeing Plan April 2018.

2. If so, what changes should be given priority?
If legislation comes through- Role of Regulator= collaboration enforced through consistent standards. Aligning standards. Consistent focus for planning= Defining building blocks (Primary Care Clusters) Legislating for this.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Enough knowledge of current legislation to know what has worked and variances which we needed to be clear about.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Current variation with engagement and legislation would help the integration and engagement i.e. CHC. Need for prudence. Patient groups - now aligned to H&W Boards.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Legislation for formal consultation. Needs to be in the DNA - statutory or not. Patient panels Leadership is key-hearts and minds, currently the organisation is arrogant regarding positive proactive involvement

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
? National Clinical Forum :- In place. An objective national expert panel would this replace the above and we would support that approach to bring a consistency to the review, focus on system and process of review on behalf of patients/service users.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Multi professional discussion reflected the appropriate accountability already exists through the professional Codes. Consistency in the standard used across health and social care would support integration and co-operation. Resources and training to support leaders in their accountability will be key rather than a legislative approach. The Health and Care standards are clear in their requirements and expectations.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
There is already work with the Staffing bill and a very public drive and official line with regard to staffing requirements, publishing data on staffing levels which supports and underpins Quality. Escalation and whistle blowing where there are concerns are also supported through policy. We need to apply tools which already exist, which evidence professional clarity and support to systems and processes which protect any detrimental impact on Quality. The Health Board is introducing Quality Impact Assessment as a requirement within their Quality Improvement Strategy is one way to do this. Legislation may support clarity on the systems and processes required to support our duty with regard to quality. Building on Integrated Clinical academic Frameworks will support Integrated systems.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Quality of care is dependent upon attitude, behaviours and cultures of Individuals and organisations. Prudent healthcare is Integral to improving health and health services. Legislation around co-production with partners and patient/ service users may help present accountability system. Clear codes- Regulatory framework.

Code of Conduct. Introducing and mandating Quality Impact Assessments to be introduced by all agencies providing health and social care would support consistency of process, place Clinicians at the heart of decision making through legislation.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
Above points with regards to professional accountability, clarity of accountability professionally.

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
NMC/ professional bodies-monitoring through legislation. Values based recruitment. X-Ref to chapter 4-re Duty of Candour being legislated to support openness/mind-sets and behaviours.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
1. Doesn't currently include Quality and Public Views adequately at the moment and needs to be a thread throughout. 2. Quality Impact assessment process will need public and service user involvement 3. Legislation- support re introducing the legislative requirement for the Duty of Candour, as this is already placed in professional codes.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Standards reviewed nationally - framework for monitoring standards, needs to be consistent and guidance provide clarity. Something about who reviews and pulls together the framework do not necessarily need legislation. Quality of production needs to be clear. Having an integrated Inspectorate Body covering health and social care-currently very subjective-CSSIW-lay reviewers not professional input. Not evidenced based.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Better co-production of regulatory framework. Develop core standards together- s/care/N/care. Common outcomes Chapter 1 Common planning: using safeguarding as an example - consistent process outcomes: strength of legislation to support.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Discussion with regard to HSE accreditation as a result of legislation. Already have Medical Revalidation 360°. Midwifery statutory regulatory requirements coming out of statute and concerns on the basis of that whilst trying to propose legislation for team supervision. This approach needs to commence in training - still doesn't ensure. Legislation in this area needs careful consideration and the Consequence of not meeting standards. Evidence of Appraisal - Mandatory training which is legislated for has not resulted in full compliance.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Above points. Legislation not the way to enable Clinical supervision.

17. What arrangements should be put in place for self-employed health professional registrants?
Re concerns re gaps-regulatory one is CMO/CNO/CPO- gap in legislation-HIW and professionals. CD drug prescribing. Note: commissioned service on behalf of HB-evidence to access to clinical supervision, mandatory training.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Completely- a fundamental requirement and the scope of this needs to be explicit and built into other guidance and standards. Support Interagency working and the approach as an Integrated. Board.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Enable us to deliver and be transparent not just on performance outcomes but

on care delivery in real time. Also provide transparency with Co-production, access and information.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Cross border issues would need considering here Cross organisations/ WAST- clear coordination and guidance which supports approach and framework. Lack of public standards, information Governance.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Barriers to providing/sharing patients' info. GPs - GPs/ Nurses-ODH, pharmacy IHR-Trust.

22. How can we consider breaking down any barriers?
PTR- common sense WASPE. Non-public Bodies. Interpretation of Data protection, legislation made simpler. Public bodies having a duty to share with person.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Caldicott Guardian Single patient record – Clear Controls and guidance, No exposure to commercial risk (Business focused 3rd party providers).

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
Yes in the context of capacity given the size of Health Organisations in Wales. A lot of complexity and duplication of effort (HIW and CHC). Context of credibility of regulators at present but an integrated way of reviewing 1 regulatory body for all would support Inter agency standards and co-production.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
I think the changes should focus on integration with CSSIW more so and points above.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
We need one integrated regulatory body working within one framework. It's more than joint working. It needs legislative change. Common standards and common framework Combine clear framework for professional input and independent reviews.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
As above points, consistency in standards and the regulatory framework around holding to account on those standards and an ability to provide clear public and organisational understanding of those.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Considering 1 regulatory framework and patient advocacy at the heart of that would be helpful.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Not currently-need to have effective management and governance from FT mature and more ability. (Earned autonomy). Basic change to framework and accountability i.e. WG funding need money upfront. Broader than funding - more about planning/framework. Need equity-i.e. why Velindre/WAST.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board

summarised accounts still relevant?
Review why NHS Trusts have been borrowing powers What are the benefits? Review evidence.

32. 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?
Summarised accounts.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
The framework should be consistently applied and effected and supervised.

34. 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.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Secondary legislation as outlined in paper.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Public Service Boards. Need to ensure clear holding to account & performance framework throughout organisation.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Yes there should be scope to flex director's roles to meet local context.

38. What are your views about the suggestions made by the Commission on

Public Service Governance and Delivery, such as the election of community representation?
Increased challenge, need to be clear about role. Does this work in reverse eg for Local Authorities.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Joint appointment would be supported.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Best fit with local context.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
Need to ensure structure that support and enable delivery of objectives and clear holding to account & performance framework throughout organisation.

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
Role of independent members is clear in relation to their challenge and scrutiny roles as outlined in HIW reviews.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
Recommendation within the HIW review of governance.

44. If so, what aspects of the role should be additionally set out in law?
Appointment on a term basis, appointment by Welsh Government.

45. How could potential conflicts of interest for the board secretary be managed?
A single role, without other director level responsibilities.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Clarity regarding terms of reference, membership, outputs from groups. Move to more multi-professional, reduce number of committees.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
Would need to know more about what legislation was to be used.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Partnership working should be reviewed to ensure continues to be fit for purpose to reflect changes and devolution.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
Legislative measures that enable better clarity around accountability and governance.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Need to ensure that Shared services can flex to meet demand, with regular reviews of service level agreements to ensure remain fit for purpose.

WGGP025 – Councillor Arfon Jones
Tref / Town – Wrexham
Sefydliad / Organisation – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
No, we have the Well-Being of Future Generations (Wales) Act 2015, The Social Services and Wellbeing (Wales) Act 2014 and the Public Health (Wales) Bill. Existing legislation should apply to Local Authorities AND Health Boards, there is no point (Para 30) where the act 'contains a duty' for LA's and Health Boards must have regard to these purposes, who says they will, scant evidence of joint working up to now The vision behind primary care services are very laudable but only if we have sufficient trained staff to ensure the vision becomes a reality. I still look forward to seeing Health Boards and LA's working together to deliver services through pooled budgets, we have been working on it for at least 15 years to my recollection.

2. If so, what changes should be given priority?
Recruiting more GP's Less reliance on the Welsh Deanery and more on the North West to address shortages in N.Wales Real joint working between health and social services. Prioritising primary services. Wellbeing duties to apply equally to Local Authorities and Health Boards Integrated Health and Social Services

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
No, we have a surfeit of legislation and strategies, what we need is enforcement and the will and requirement to work together.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?

The Community Health Council's should be the lead authority on all engagement and consultation. At the moment there are too many cooks dipping in and out

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
There is a need for a truly independent organisation to undertake engagement and consultation, the Community Health Council's have that independence and are trusted by those who have had experience of their work.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
No I don't; such a panel will be an unelected unaccountable bureaucrats selected by the Minister so he/she can avoid making difficult decisions. I also don't agree with your statement that a referral to the Minister by the CHC is a sign the system has failed. In fact it is a sign of success. This was vindicated by the Health Board withdrawing from the JR over Maternity Services and the lack of consultation and engagement. The Minister had supported the Health Board's stance. CHC's should not be expected to come up with their own costed plans that is not and should not be their role. If we change the power that CHC's have to refer matters to the Minister then the CHC's would be powerless to force change, the fact is that Health Boards regularly ignore CHC's as it is.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
There should be common standards of care throughout the health service

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Common Standards Framework should apply to NHS, Independent Sector and Local Authorities

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?

Have one Governing Body for both Health and Social Care

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Royal Colleges, RCN, RCM etc. should work with NHS Wales to ensure adequate supervision.

17. What arrangements should be put in place for self-employed health professional registrants?
Same, must be members of Royal College etc.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes and should include a duty to report breaches of law and regulations.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Strengthen the Freedom of Information Act and make NHS Wales performance figures more accessible and easier to understand. Publish a scheme under FOIA with links.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Integrate the complaints system of health and social services at present the statutory social services is complex to understand and NHS complaints system is overwhelmed with work. Need a contractual duty on staff to assist and co-operate with investigations. Many delays are due to clinicians dragging their feet. The CHC Advocacy service provides a valuable service to clients trying to access these bureaucratic systems.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient

information?
There should be legislation (if not already) that allows the sharing of information as long as it is necessary and complies with the Data Protection principles.

22. How can we consider breaking down any barriers?
Health Boards and Social Care should have compatible IT systems and patient records should be identical and interchangeable, sorry to harp back but it needs to integrate Health and Social Services with pooled budgets.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Should comply with Data Protection Principles and should be held securely, it should have patient consent for retaining this information for research purposes.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
HIW are not independent of Government and the Health Minister, they are not properly resourced and carry out few investigations and have a low public profile. After recent scandals HIW are low on public confidence. There should be closer working between the statutory inspection regimes and the CHC's who are miles ahead in the numbers of inspections carried out.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
Integration of CSSIW and HIW seems to be the way forward but such amalgamations have not proved successful in the past.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
Cultural behaviour would seem to be the biggest barrier to integration the opportunity to legislate has been missed with the Social Services Act.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?

A better understanding, easier to make a complaint, there is little understanding of how these system's work currently. With two agencies there is a danger that issues fall between two stools and are being missed and information is not being shared.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The Green Paper proposes that CHCs should be stripped of their rights to enter and inspect NHS premises – a right they have held since 1974. This appears to be based on the advice of other bodies who have been promoting their own "professionalism", criticising the CHC's lay focus and citing the Minister's desire to do away with duplication in the inspection of the NHS. The BCUHB Annual Quality Statement for 2014/5 says; *"During 2014 -2015 Healthcare Inspectorate Wales undertook a total of 8 Dignity and Essential Care Inspections across the range of ours services including our main hospitals, community settings and Mental Health Services."* Over the past 3 years there have been many concerns about the quality of care provided by BCUHB and at least five major critical reports. This is the Local Health Board that has caused Welsh Government the most concern and it is the only Welsh Health Board to be placed in Special Measures. Despite this, HIW felt that Betsi Cadwaladr University Health Board warranted only 8 Dignity and Essential Care Inspections in 2014/15. NW CHC felt very differently and CHC Members have given freely of their time in order to monitor the quality of services from a patient perspective . Page 32 of the same report records that: *"CHC members undertook over 500 assessments during 2014-15"* . There has been criticism that this is "too many". However, North Wales CHC does not hear that from Ward Managers and Nurses. They welcome CHC members as it is often the only way they can get problems sorted out. With regard to the idea that 500+ visits is too many, this works out at somewhere around 4 visits per ward per year – certain wards may receive more than this but it will still be in single figures. HIW visiting frequency could be 4 or 5 years or even as long as a decade apart.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
CHCs are the only voice within the NHS having any degree of independence. If a "more integrated system" results in a reduction of independence then this

would be a mistake of the order of the abolition of CHCs in England. Some form of organised independent public scrutiny of NHS Wales is plainly necessary. The only formal check and balance at the moment is the CHC. Successive Ministers and their Civil Servants have looked critically at CHCs to question whether they are good value for money and to see whether the public interest in the NHS, to which the present Government has declared itself dedicated, could be better and more economically served by other mechanisms. It is, perhaps, a coincidence that this critical examination is often connected with CHCs reflecting public opinion that does not accord with Government policy. This unrestrained criticism would be more reasonable if the NHS had other statutory watchdogs or stronger inbuilt mechanisms of accountability and effective public engagement. In their absence CHCs, for all their weaknesses, remain the only body dedicated to representing the interests of patients in the NHS. The right approach must be to strengthen CHCs. Any changes must enhance CHCs capacity and rights to monitor and scrutinise local health services. As for CHC membership there are arguments for and against continuing with local authority and voluntary organisation nominees. On the plus side, local authorities are the only truly democratic input into CHCs and voluntary organisations are close to local communities. On the negative side, the current process of representation tends to be unsystematic, the same organisations get represented and nominees pursue their special interests rather than the wider picture. There are also important issues over training, standardising performance, ensuring national standards and empowering ACHCEW to co-ordinate and enforce common standards.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
No, in the main they have not evidenced good financial management with the WG having to bail out some health boards year on year.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
Should be publicly available in easy to read format, there should be an independent Audit Committee for each Health Board.

Planning

34. 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 this would make sense.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Fed up with the Health Board's no fault, lessons learnt management and leadership and there should be more emphasis on sanctions. Health Board partnership working in North Wales is appallingly bad but the new Future Generations Act should improve that. There is a general consensus of top heavy management in North Wales compounded with the creation of 3 Area Directors. There is a desperate need to flatten the pyramid. Consultants should not be treated as sacred cows and should also be the subject of sanctions if their performance and behaviour undermines the Health Board's Strategic Plan.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Concern that some independent members of the Health Board have little knowledge and experience and are reluctant to intervene and question. There is no scrutiny as such of BCUHB.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
The CHC do this now – WG, LA's and Third Sector have representatives, LA reps are elected. We don't need a further layer or bureaucratic structure.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?

This is a suggestion that could have merit but only if LHB's have coterminous boundaries if and when local government is reformed.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
No.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
No, the BCUHB is far too big and bureaucratic.

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
No.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Not in my opinion, the Health input into the Local Service Boards in North Wales seems to be limited. Also joint working with hospices like Nightingale House is woeful i.e. waiting years for a decision to lease land to expand Nightingale House.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
An opportunity was lost with the new Social Services and Wellbeing (Wales) Act 2014. Lack of joined up thinking by WG.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Unable to comment as I have no knowledge of this Partnership.

WGGP026 – Tony Beddow – Socialist Health Association Cymru Wales
Tref / Town – N/A

General comments

3. SHA Cymru Wales response
Our response is given in two parts. First we set out our broad position on the NHS for Wales. Second the questions that are addressed are those that seem especially relevant or are ones where SHA Cymru Wales has a strong view.

4. Responses to the Green Paper

4.1. General Principles of care
SHA Cymru Wales supports the drive towards lessening the demands made upon the hospital service by: targeted action in a range of preventive programmes and health education; adopting the prudent care approach described in the paper; seeing the creation of health outcomes / health gain as a process of co-production; strengthening the primary care sector (including the creation of publicly owned primary care alternatives to traditional independent contractor models where needed). We see the three lines of defence referred to in the paper being aided by the engagement of citizens and patients.

SHA Cymru Wales also supports the creation of Local Health Boards in 2009 and the removal of the purchaser / provider split. We agree that the required governance and performance management regimes are still incomplete. In particular we feel that the "commissioning" and "providing" roles of Boards is insufficiently delineated, with the latter overshadowing the former. I answering questions 30 -34 proposals are made to remedy this. However we are not convinced that a legislative response to this weakness is appropriate. We agree too that the three lines of defence aimed at ensuring high quality services have been shown to need strengthening but here too we are not persuaded that legislation has a major part to play.

However there is an area that is not addressed which we would wish to place on the record. This relates to any legal opportunities or constraints that hinder a) the development and production of generic medications by the Welsh public sector and b) the eventual development of a programme of research and development aimed at creating new medicines.

We believe there is scope for savings (on 10% of the health budget) if the cost of out of patent medicines could be reduced by direct production. We also see a greater role for Welsh Universities, charities, the Welsh NHS and Welsh companies in collaborating to develop medicines for public benefit rather than mere profit.

We propose that a small expert group be assembled to explore any national and international legal / commercial issues that would need to be addressed were this policy to be pursued.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority? 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
We see no strong case for using legislation unless the following are judged to need legal backing to ensure they occur: a) SHA Cymru Wales regards co-terminousity of health and local government bodies as a major strength and one which is envied by other parts of the UK. SHA Cymru Wales will strongly oppose any move to misalign the boundaries of health and local government bodies. Establishing this principle in law would be beneficial. b) Elected councillors in each current and proposed local authority should have powers to require Health Board and Trust Board members to attend scrutiny committee proceedings where a Council has concerns about plans of any health board / Trust that affect their residents. c) The democratic accountability of any planning machinery covering several Local Authorities, to oversee the care system across local authority boundaries should be clear and both transparent and accessible to the public. We believe that more use should be made of the recognised tools of collaboration and networking that are well documented in the literature. We would particularly draw attention to the value of pooled budgets and shared financial framework, a joint performance management framework and shared staff for planning and back office functions. More could be done to co- locate service delivery. In areas of care that overlap at the operational level, much more attention should be paid to the creation of "boundary spanners" in the delivery of services.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
We see no strong case for this.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
It is understood that current guidance already requires public bodies to co-operate with one another and that this includes plans for service changes. While we see no strong case for converting this to a statutory duty, there is a case (if this power does not currently exist) for relevant Ministers to have the power to direct local authorities and Health Boards to carry out specific actions if Ministers feel that inadequate collaboration exists.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
SHA Cymru Wales would expect that any proposals for service changes that are put before the public should have already been subject to expert assessment and would expect that such expert opinion would have been put fully in the public domain as part of that consultation. Normally it is expected that expert opinion is largely agreed on the merits of any proposals, or that if there is dissent, the nature of such dissent is clearly visible to the public. We see no case for referring difficult proposals to expert panels. Many of the proposals that come to Ministers for decision are either ones where different professional groups disagree about the salience of the evidence or arise when proposals for change locally are made in the interests of the wider Welsh NHS. Both of these are rightly matters for the exercise of political, rather than "expert", judgement.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section? 8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
SHA Cymru Wales is not convinced that further legislation is useful in this area. However, it awaits the conclusion of the current process to legislate for safe staffing levels in the NHS; should an Act be introduced in this regard we would wish the effects of the Act to be formally assessed after three years and that this assessment should inform any further use of such powers to attempt quality assurance via legal means.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales? 11. What would be the advantages and disadvantages of legislating for a “fit

and proper persons" test, and to whom should it apply?
A legal basis for certain post holders could have merit if: a) the list of such posts was precisely and deliberately crafted for specific reasons that are clearly and discretely within the remit of specific posts b) the qualities needed for such posts could be both described, measured through selection processes, and be easily acquired c) the "protected duties" of such posts could be clearly laid out, as much with the intention of giving such post holders legal protection in carrying out their duties as much as with any wish to expose such individuals to undue criticism or pressure. However, we have concerns that specifying the details of this with the precision required will prove difficult in practice given the corporate nature of board governance and see little to be gained by this approach which is not already covered by existing selection processes and role specifications. We also draw attention to increasing employment of nursing and medical assistants without any specific t raining or qualifications. This essentially unregulated ara of recruitment is in need of regulation and quality control.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
We understand that currently there is a requirement for public bodies to co-operate and therefore no requirement for legislation in this regard is envisaged.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set? 14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
There is an argument for being clearer about whether standards set by Welsh Government, or Health Boards as commissioners, or Boards and Trusts as providers -or indeed the extent to which external bodies (professional or regulatory) in effect determine standards. There is also a case for being clearer about whether standards should apply to the level / type of inputs. (nurse staffing levels for example), specified care processes (for example expertly defined diagnostic pathways. or rehabilitation programmes), or whether expected outcomes should be relied upon. Each of these is problematical, not least because the pace of technical and other changes requires such standards to be updated frequently.

Whatever combination of standards is employed, it is suggested that standards should apply to the independent sector where: a) it is providing a clinical service to an NHS patient via a contract with the NHS and thus the relevant NHS standard should apply b) where a regulatory body finds it useful to deploy an NHS standard as part of its licencing /oversight function. We must recognise that the quality of care is directly related to the continuity of care by staff who can then see , and reflect upon, the consequences of their actions. Time pressures upon staff, and high staff turnover obstruct these aims and the ability for staff to deploy the skills they have been taught and the values they hold.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
It is commonly thought that good practice / innovation is not shared sufficiently quickly or systematically across the different care settings in NHS Wales. Accreditation and peer review processes offer a good vehicle for aiding this process by speeding the spread of knowledge of best practice and bulding this into accreditation processes.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how? 17. What arrangements should be put in place for self-employed health professional registrants?
These questions raise issues about the intended boundary between the roles of the employer and the appropriate profession in ensuring that professionally registered staff have accessed adequate oversight / advice. If it is felt that the professions should retain a high level of responsibility for maintaining professional standards, then it might flow that the role of Government and the service (as employers) is to help facilitate the level and type of support that the professions require. In respect of self employed staff, SHA would see this as being a matter for the professions and the individual to arrange.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
If current expectations of professionals who are directly caring for patients

are presently felt to be insufficient in meeting required standards, we can see a case for enshrining this duty in law.

However, the Green Paper makes it clear that the duty of candour has to extend beyond the caring professions to encompass managers and, probably, policy makers. Thus if any such duty were to be enshrined in law, it would be expected that such a duty would need to apply not only to most employees of Health Boards, but to civil servants dealing with aspects of public policy and to corporate bodies too.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
We believe more will be gained from opening up the service to greater (and welcomed) public scrutiny, accompanied by formal support when problems are found. This opens up the service to both constructive advice as well as criticism and we believe the public offers more of the former than the latter.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
The continued separation of health and social care through different delivery bodies (health and local government) and different payment regimes, are but two symptoms of barriers to seeing the care system as one integrated whole. Legislative steps may aid two possible options for improving the handling of complaints about whole system matters. One would be either to require co-terminous health and local government partners to merge their departments that presently respond separately to complaints. Another is to retain separate functions but to require the department receiving any complaint which indicates both health and social care issues automatically to alert its partner service with a view to agreeing whether the health or social care agency implicated would investigate on behalf of both bodies and respond accordingly. However, we recognise that the real differences between health and social care need to be noted. For example, health care is often delivered for the residents of one local authority by hospitals outside the area and thus major hospitals delivering regional services will often be dealing with a number of local authorities. It is likely that making arrangements for the discharge of such patients back to home or other community settings at a distance from the hospital will often be more complicated and have the potential source of justified complaints. Such problems may be eased - but not removed - if the number of local authorities reduces broadly to match the number and populations of Health Boards and, in this eventuality, option one above (shared services) would

have merit.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Incompatible IT systems, legal issues re duty of care/confidentiality, lack of clarity regarding what organisations should be given data, all inhibit the sharing of data. The data guardian arrangements also may cause difficulties – for example, the ownership of bits of data where some professionals see the data they have as theirs to be protected by their own professional codes.

22. How can we consider breaking down any barriers?
There should be restricted transfer of, and access to, personally identifiable data to designated staff groups dealing with direct care. More could be done to ensure the compatibility of IT systems with well designed and protected access arrangements (although this seems increasingly difficult these days) and a more radical option would be to give patient / client / users control over their own integrated data file -making it clear that they must alert staff to the content. There must be clear, in built, and protected audit trails to record the accessing of data.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
We proceed from an assumption that in a public service which makes all scientific knowledge available for health care without charge, people share a moral duty to participate in expanding that knowledge for the benefit of future generations. Those who disagree should be allowed to opt out. We are however unsure that many circumstances exist where data that has been gathered must be personally identifiable in order to be shared for research and would need to be convinced of the need for this. If such circumstances exist, personally identifiable data should only be with bona fide research bodies operating under stringent and legally based UK wide assurance / ethical procedures re a) the research topic and b) the safeguarding of data.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
Advantages - gives an inspectorate across the whole care system; one point of entry for citizens; gives critical mass.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Yes.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
No - Welsh Government should retain oversight of borrowing powers.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
Whatever accounting system is used, the content and layout of financial reports should be common for Boards as commissioners, and also common for Trusts and Boards as providers so that comparative assessments can be soundly drawn. Health Boards should be required by law to produce two forms of accounts - one that reports their work as commissioners of services and another which reports their work as providers. The Board report as a commissioner report should be required to describe: a) the basis on which the proportions of spending on different clinical services and (geographical) populations have been arrived at b) the ethical judgements that have informed choices on spending c) the reasons why the balance of clinical provider bodies (the Board itself, other Welsh NHS providers, other UK NHS providers, UK private sector bodies, and any foreign services is as it is. The Board report as a provider should indicate how spending levels have been arrived at in both clinical and non clinical areas, and also show the levels of investment in building repair, equipment replacement, and staff training and development.

Both reports should also summarise the level of Trust funds held and the use of Trust funds for the period in question.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
No, LHBs as commissioners, along with Welsh Government should remain the main engines of planning as far as clinical Trusts are concerned. However, Trusts should have a legal power to require LHBs to include in their plans and annual reports any concerns which Trusts feel should be placed in the public domain - for example where commissioners have not been able to respond to Trust requests for funding for extant or new services - accompanied by an explanation as to why such requests have not meet met.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
There is a mass of evidence and good practice that addresses this topic which is insufficiently employed within Wales to shape the style of leadership and governance used in the NHS, and the nature of the partnerships it seeks to create. We see little use for legislation here. Rather, means of ensuring the even application of good practice across Wales are required.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
No, need to create "commissioner" and "provider" mechanisms within Boards with the Board itself being the arena within which the resulting tensions are resolved. Three types of Board members are thus needed, those skilled at overseeing the planning / political / engagement roles of the Board, those able to oversee and support the clinical performance of the provider function, and a number of generalist members skilled at leading Boards through complex and challenging tasks. The Chair should come from the third group. There may be merit in having a Vice Chair from a "provider" background and a Chair of the Audit committee from a " commissioner " background who would also oversee the scrutiny function.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Yes, if the changes suggested in Q 36 were adopted. Fixed posts however should be those of Chief Executive, Director of Clinical Care. Director of Finance, Board Secretary, and Director of Commissioning.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
Election to the Board is not supported. However, the scrutiny function should allow for a number of directly elected members from the commissioning catchment who would have full powers to see all papers relating to topics which both the Audit committee and the Scrutiny function chooses to review.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
There should be a legal framework that allows (but does not require) any two (or more) public bodies in Wales to create and fund joint posts and this should extend to certain other agencies such as the police service and Higher Education bodies in Wales. This should also allow for public bodies to enter into joint appointments with not- for- profit agencies.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity? 44. If so, what aspects of the role should be additionally set out in law?
Yes, make "protected" as in local government and list Board areas where his/her advice should be followed

WGGP027 – Paul Sawtell (LLB hons)
Tref / Town – Powys
Sefydliad / Organisation – N/A

General comments

First I am concerned at the 'easy read' pdf: do you really believe that adults in Wales are really no better educated than five-year olds? I remember the BBC2 Play School programme which was more 'adult' than this document.

Moving on; having come to live in mid-Wales from the English west midlands we got a shock at the difference in the quality and efficiency of the Welsh version of the NHS. Having been able to walk into our local surgery and be seen within an hour or so to initially having to wait two weeks, now five or even six, for a routine doctor's appointment was a big change for the very much worse.

Trying to get through to the surgery in Newtown on the telephone is almost impossible most days. And there is a strict time corridor so unless you are lucky you have to wait until the next day, and so on.
And no, you cannot send an email. It appears to me that every step is taken to make everything as awkward as possible; no prescription requests over the phone (that's if you do get through) and the bit that would make me laugh if it were not so serious is the notice at the dispensary saying that in order to improve service they will be closed for an hour at lunchtime - this would be when most working people would be able to go there.

In addition I have received less than professional care on two occasions, both from the same doctor. This is rudeness and professional incompetence, the latter causing me to lose a months' work.

It is clear the NHS system here is broken. I have tried speaking with staff about these concerns but they brush them off with silly excuses.

Heaven help anyone here who is taken ill. There needs to be an abandonment of 'training courses' and 'strict guidelines' and a return to good old-fashioned common sense. I get the feeling staff spend so much time making sure they adhere to arcane procedure and that if this time were spet on assisting patients things would be better.

However it seems obvious that at least here there is a real need for another surgery to take the strain of (they tell me) 14,500 patients.

So, no new laws are needed to add to the bureaucracy - just more people allowed unfettered by nonsense, PVC, or whatever else some idiots in government dream up to enable people like us to get a doctors'
appointment when we need one. Five weeks...? It is a joke and an insult. Besides which I am either naturally cured or dead in that time.

Response to specific questions

No response to specific consultation questions.

WGGP028 – Kate Cubbage – The National Deaf Children's Society
Tref / Town – N/A

General comments

The National Deaf Children's Society (NDCS) Cymru is the national charity dedicated to creating a world without barriers for deaf children and young people. We support and represent the interests of deaf children and young people from birth through to independence. In referring to "deaf" we refer to all levels of hearing loss, including mild, moderate, severe, profound and temporary hearing loss.

Part 1: Quality First and Foremost

Whilst we have considered all areas of the Green Paper we feel that our most valuable contribution relates to chapters 1- 6, which focus on quality.

Promoting Health and Wellbeing

Whilst we recognise and value the concept of prudent healthcare, it is important to acknowledge some of the particular barriers faced by deaf children and young people in accessing health services and health information.

The All Wales Standards on Accessible Communication for People with Sensory Loss were launched by the Welsh Government in December 2013. Research by Action on Hearing Loss Cymru, RNIB Cymru and Sense Cymru, earlier in 2015 indicated that 4 out of 5 respondents requiring communication support were not asked about this. This is partly because health care settings are not aware of the requirements outlined in the Standards and partly because deaf people are not aware that the standards exist and that they confer certain rights.

90% of deaf children have hearing parents and often assumptions are made that parents will talk for their children in many circumstances. One example would be during GP appointments. Deaf young people, like every other young person, will reach a stage where they will want and need to visit the GP independently. Deaf young people face significant barriers when reaching this stage, including lack of deaf awareness in surgeries and lack of knowledge about accessing communication support.

In 2014 the NDCS Youth Advisory Board launched a resource to support deaf children and young people at this important stage in their lives, "My life, my health". We were very encouraged by the support shown by the Health Minister, Mark Drakeford AM, and we are pleased to report that every GP surgery in Wales has received a copy of the leaflet which outlines what health professionals can do to support deaf young people.

This initiative is an example of how third sector organisations can have an impact. However, we believe that this responsibility should be shared across public services with a greater obligation placed on the NHS to proactively ensure that their systems and communication mechanisms are appropriate and easily accessible for all. This includes ensuring that those working within the NHS are deaf aware and sufficiently knowledgeable of the rights of a deaf child or young person to appropriate communication support.

It is worth noting at this stage that there are particular challenges for Welsh speaking deaf children and young people in accessing communication support which need to be addressed.

Continuously engaging with citizens

NDCS Cymru Wales welcomes consideration in the Green Paper of the need to engage with citizens regarding the development and delivery of services.

We acknowledge the potential benefits of Patient Participation groups and welcome their inclusion in the GP contract for 2014 – 2015.

Provision through the Social Services and Well Being Act for citizens' panels is also positive with the potential to utilise such groups at primary care cluster level.

Patient expert groups for LHBs and clear links to CHCs are also beneficial opportunities for citizen engagement.

We would support Welsh Government's suggestion to consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms such as patient panels or participation groups. Although we would caution that such an approach would need to be proportionate and avoid duplication ensuring that such groups are empowered to undertake meaningful work.

In terms of engagement it is extremely important to ensure that any panels are made fully accessible for, and consult proactively with, deaf children and young people. There are particular barriers faced by deaf children and young people within the health service and we would strongly advocate that a deaf child or young person, or the parent or family member of a deaf child or young person, be included on these panels.

To that end, it is particularly important that a range of communication methods are used and appropriately promoted by patient panels and participation groups so as to ensure that deaf children and young people have sufficient opportunities to put their views forward.

In terms of written materials the following key points should be adopted to ensure that they are as accessible as possible:

• Information presented visually with use of images, animation and/or colour
• Broken down into chunks, using boxed out text, sub-headings, bullet points and bold text
• Uses simple language and avoids complex words, jargon or idioms
• Using short sentences

Further advice on making information accessible to deaf young people can be found online at: http://www.ndcs.org.uk/document.rm?id=9325

We would advocate that throughout the health service a variety of engagement methods are used to suit the diversity of communication methods used in communities in Wales.

Response to specific questions

No response to specific consultation questions.

WGGP029 – Professor Jonathan Richards
Tref / Town – N/A
Sefydliad / Organisation – N/A

General comments

1.1 The Ministerial Introduction includes the sentence:

We want to build a culture of continuous improvement, focused on unfailing quality of all services provided by the NHS in Wales.

Is it wise to set an unachievable goal at the outset by using the word 'unfailing'? The National Health Service is not a Customer Service Organisation, it is a Human Service Organisation working in partnership with the people of Wales. Failure is inevitable in a complex organisation delivering services to complex people in complex circumstances. The aims of a Quality Strategy are to minimise the risks of failure and harm and maximise the opportunities for success and achievement.

1.2 There are three categories of failure:

1. Slips and errors. These will always occur. They are an opportunity for learning and development and the Organisation should have measures in place to minimise the risks and harms of each occurrence.
2. Organisational and structural failings. Resources are a key concern in an age of austerity. Are there enough staff available to deliver safe and effective services? Is the equipment that they need available? Have the necessary protocols and guidelines been disseminated and built into routine care processes? Resources for training, education and clinical governance activities have been very limited in recent years.
3. Personal failings. The health and wellbeing of people working in and for the NHS is key to ensuring safe judgement and action. Stress and workload impair this. The personal failings of individuals in many recent scandals are not because the person deliberately chose to make the wrong choices. They were a consequence of system and resource difficulties.

1.3 The questions throughout the Green Paper focus on legislation as a means of changing culture and improving safety. Legislation will not reduce Type 1 events. Legislation may have a preventative effect on Type 3 events. The key question is:

How effective is legislation likely to be in changing the culture of an Organisation and the individuals working within it?

1.5 Richard Grol summarised the different strategies and approaches to Quality Improvement and change in an essay in 1997. He helpfully characterises the different techniques, describing them as either internal or external. Will a "coercive, external" method be effective? Is it being considered because the other methods have not been successful in Wales;

because the resources in terms of money, staff and time are not available to the NHS in Wales in a time of austerity?

Table 1
Approaches to changing clinical practice

Approach	Theories	Focus	Interventions, strategy
Focus on internal processes			
Educational	Adult learning theories	Intrinsic motivation of professionals	•Bottom up, local consensus development
			•Small group interactive learning
			•Problem based learning
Epidemiological	Cognitive theories	Rational information seeking and decision making	•Evidence based guideline development
			•Disseminating research findings through courses, mailing, journals
Marketing	Health promotion, innovation and social marketing theories	Attractive product adapted to needs of target audience	•Needs assessment, adapting change proposals to local needs
			•Stepwise approach
			•Various channels for dissemination (mass media and personal)
Focus on external influences			
Behavioural	Learning theory	Controlling performance by external stimuli	•Audit and feedback
			•Reminder systems, monitoring
			•Economic incentives, sanctions
Social interaction	Social learning and innovation	Social influence of	•Peer review in local networks

Approach	Theories	Focus	Interventions, strategy
	theories, social influence/power theories	significant peers/role models	
			•Outreach visits, individual instruction
			•Opinion leaders
			•Influencing key people in social networks
			•Patient mediated interventions
Organisational	Management theories, system theories	Creating structural and organisational conditions to improve care	•Re-engineering care process
			•Total quality management/continuous quality improvement approaches
			•Team building
			•Enhancing leadership
			•Changing structures, tasks
Coercive	Economic, power, and learning theories	Control and pressure, external motivation	•Regulations, laws
			•Budgeting, contracting
			•Licensing, accreditation
			•Complaints/legal procedures

1.6 It is interesting to review the Health Foundation Report on Quality in General Practice published in 2014 and consider which of the interventions could be amenable to a legislative approach to implementation and assurance (Appendix 1.) Statutory requirements to deliver the changes without accompanying resources to support the additional or improved work are likely to result in gaming of data to meet targets and obligations.

Page 6/7 Paragraphs 8 and 9. The Green Paper proposals follow the lead of the Kings Fund Report with the “three lines of defence”: frontline staff, boards and senior leaders and national bodies. Cwm Taf UHB has developed a comprehensive and effective Quality and Safety Strategy. A key component of

the Strategy is the role of "middle managers" who collect and analyse data and information and then prepare summaries for the board and the senior leadership of the health board. The quantity and complexity of performance data reflects the complexities if a modern health service. There is experience in Wales of problems resulting from the quality and accuracy of the information being fed up to the board and senior leadership through "middle management". It would be wise to learn from these events and occurrences and ensure that there are systems in place to ensure honesty, accuracy and transparency in this aspect of the work of NHS Organisations in Wales.

There is no mention of the role of Quality Improvement and the four Independent Contractor professions in the Green Paper. Quality Improvement activities with general practitioners, dentists, community pharmacists and optometrists do not happen by dictat from Government or health boards. Consideration should be given to the most effective methods of engaging with and contracting with Independent Contractors especially in a time of austerity and increasing demand and need.

Appendix 1

Table 7: Effective interventions for improving quality in general practice

Interventions targeting…	Effective interventions	
Patients	– Improving access – Increased appointment length – Continuity of care – Person-centred consultations – Patient access to records	– Gaining feedback from patients – Patient education – Using technology – Other support tools – Layperson-led services
Professionals	– Training in quality improvement – Interprofessional learning – Audit and feedback / peer review – Prescribing outreach visits – Improvement collaboratives – Extra training for trainee doctors	– Pharmacist-led education – Decision support tools – Nurse-led services – Health educators – Joint consultations – Increased staffing levels
Practices or systems	– Providing a wider range of services – Point of care testing – Quality improvement projects – Telehealth – Pharmacist services in general practice – Guideline implementation	– Clinical audit – Significant event analysis – Electronic medical records – Electronic referral systems – Improving data collection and error reporting

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority? 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
It is hard to identify the effectiveness of legislation in building relationships, changing culture, building motivation and facilitating change, especially in the domains of collaboration between different services and organisations. There is evidence about the factors that increase the likelihood of success: shared budgets and financial frameworks, joint performance management with shared goals and objectives, together with shared staff and management for example. Co-terminosity improves communication and makes planning more effective. How will legislation make a difference if these foundations are not in place?

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
It is hard to think of any examples where legislation would have an impact on service change, given all of the other factors that come into play. A law to say "you must make a cake" will be ineffective if the larder does not contain the ingredients, the kitchen tool drawer is not adequately equipped, the cook has not been trained and the oven is not working properly.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
There has been over 20 years of activity in Wales to establish patient participation groups and other engagement activities. The problems identified from the challenges and failures to achieve the hoped-for successes indicate that legislation will not provide effective solutions. Worked examples or evidence of success would be informative.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Decisions about evidence, about priorities and about lessons learnt are political in nature. An 'Expert Panel' will be influenced by conflicts of interest between different specialities, organisations and regions. Wales should learn

from previous errors, mistakes and failures. In a small country one strong individual can have an undue influence on decision-making and policy. How will the voice of the people be heard at the expert panel? The ideal of Co-Production at a national or strategic level is likely to be impossible to deliver.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Legislative measures are highly unlikely to address the issues of attitudes and behaviours of individuals, the culture and systems of care. They may have a role in influencing the overarching structure and will determine the focus of organisation. It is hard to think of ways in which effective leadership will be enabled or enhanced by legislation. Legislation is likely to have unintended consequences, gaming for example.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
It is hard to see how legislation will address the current challenges with delivering the duty of quality agenda.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
In what ways would legislation add to the mechanisms that are currently in place to ensure that quality is put at the forefront of all decisions? The challenges faced by the NHS in Wales are a consequence of austerity, the rising needs and demands of the people of Wales, technological and scientific advances and resource concerns about safe levels of staffing and service delivery. A statutory duty will have no effect in helping health boards address these issues.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
The concept of a responsible individual is likely to support quality improvement. It was interesting to observe how Local Health Boards developed in Wales as ‘accountable organisations’. The structures in England did not include local accountability and this had a significant impact. How will legislation make a difference if the tools and mechanisms required to support the responsible individual are not in place? (See 2.4)

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
The NHS is a very complex system and it is difficult to see how “fit and proper

persons" test could be applied to one individual in the relevant setting within current structures and systems. Clever managers and clinicians are likely to find ways around this if it was important to the Organisation.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
The NHS Planning Framework and IMTP development in a time of austerity focus on the range of affordable and deliverable services together with improvements. It is hard to see how legislation to promote quality would have any additional benefits or effects over and above the current systems and mechanisms. Is there evidence of failings that should be addressed?

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
The simple answer to this question is yes. The Green Paper acknowledges that there is no legal obligation on providers to comply with the Health and Care Standards. There are a number of ways in which this problem could be addressed. One method that has worked well with Independent Contractors is to embed quality and accreditation requirements into contracts. Could this be effective for the wider NHS?

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
A common standards framework would be very helpful. There are difficulties at the moment in the management of pressure damage in nursing and care homes because standards are different and NHS standards do not apply.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Accreditation and peer review are key mechanisms to raise standards. There are weaknesses at present since the current systems are generally "yes/no tick box, has it occurred?". Explicit requirements would improve the systems. Is accreditation for the minimum safe standard, for the median achievement of a quality group or circle or for the best achievable performance? It is possible to demonstrate the ways in which peer review, and user review, can lead to improved quality and raising standards.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Annual Appraisal should be an effective mechanism for delivering this objective. It may be more appropriate to ensure that the resources required to deliver this for all clinicians and managers are available since increasing legislation is unlikely to address the current problems with capacity and implementation.

17. What arrangements should be put in place for self-employed health professional registrants?
This is a particular challenge in Wales for general practice at present. Under the current Appraisal Programme general practitioners do not have to provide evidence to health boards about their learning and quality improvement activities. These are a personal matter between the practitioner and the Appraiser an annual appraisal. The health board receives the Form 4 but cannot direct the learning or quality improvement activities of the practitioner in any way. Increasing numbers of practitioners are taking up “specialist” or “expert” roles within their Clusters, Networks, Federations and Localities delivering clinical and management services outside the boundaries of their own general practice teams. Clusters and health boards should be able to expect the practitioners to demonstrate that their skills and knowledge are up to date and that they are participating in quality review and improvement activities.

WGGP030 – Jennifer Thomas – 50+ Swansea
Tref / Town – Unknown
Sefydliad / Organisation

General comments

We all agree the Health Service cannot continue in its present form.
I.e. it is too expensive.
increased çare for a bigger population.
more complicated treatments.
ageing population.

Chapter 2. Suggested changes:
1. Training of doctors, nurses, professions allied to medicine (P.A.M.s) would be combined in the early years, to create understanding about other professions.
2. All patients (service users) should carry their own records as 'smart cards'. 'Readers' would be available in all health care facilities and holders know what information is available. Those 'confidential depts.(V. D.) hold their own records.
3.a
Increased community care provides individual, quality care for people in their own home where they feel secure
3b.Combine management of hospital and community services. To prevent ' them and us' mentality. Also saving finance.
4.Ring fence and increase taxes to pay for the N.H.S.

Chapter 4.
1a The. G.P. service should provide a 24hour 7 day a week service in the community, thus diminishing attendance in A and E departments.
b. Abolish the independent G.P. contracts and combine with hospital medical staff grading, pay and updating.
c. Quality of care committees to cover hospital and primary care. Information to be made available from audit figures ,exit questionnaires and staff leaving reports.
2.In nursing, midwifery and health visiting staff numbers should be increased.
a. According to W.G figures consultant numbers have been increased by 50% and nursing by * 5% . If whole time equivalents are used. Is it not realised that more consultants means more work for nurses.
b. Patients perceptions are coloured by the amount of care they receive I.e hands on nursing care.
c. As more nurses become more qualified and experienced they are promoted off the wards which is commendable. However, this means the wards are staffed by junior, less qualified and demotivated staff in some areas.. This should be addressed.
d. Those nurses on night duty and in far flung communities do not get best information and up dating. They should be required to work in areas of good practice for a few weeks a year.

e. Tools to calculate staffing needs and models of care in specialised areas and private hospitals be used regularly to to calculate staffing needs . Mandatory staff numbers should be present on day of duty.
f. Supervisors of midwives check care provided in a locality (including independent practitioners). This model should be adopted and enhanced to support all areas of nursing.
g. All nurses should be required to comply with set standards of education, protocols, behaviour, appearance and retraining or discipline applied where necessary.
h. Good practice should be applauded.

2.H.I.W and C.S.S.I.W. should combine and needs to be independent, bigger and have statutory powers to suspend practitioners, close areas of under achievement and replace services.

3. C.H.C's are made up of citizens who volunteer to check services and give their opinions in reports to Trusts.
a. Guidelines, standards and evidence such as patient questionnaires should be available to them and support to compose a report by paid staff who collect evidence.
b. Service users should be on the council and able to question managers regarding standards.
e. Good practice should be applauded.

4. Health boards should enrol members who have time and energy to involve themselves in the service by questioning service users, staff and managers so their advice to the board is up to date and accurate.

Drs., nurses and P. A. M.s should give advice to government, boards and C.H.C's etc. on their areas of concern.

Response to specific questions

No response to specific consultation questions.

WGGP031 – Katherine Owen – Cyngor Tref Frenhinol Caernarfon
Tref / Town – Caernarfon

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Pawb i dderbyn gofal mor agos a phosib i gartref ond gan deall bod rhaid teithio er mwyn cael arbenigedd mewn ambell maes Everyone to receive care as close to home as possible whilst understanding the need to travel to receive specialst car ein certain fields

2. If so, what changes should be given priority?
Cyfathrebu – pan mae arbenigedd yn angenrheidiol bod angen gwell cyfathrebu rhwng ysbytai i geisio dod a claf yn agosach i adref pan yn briodol i wneud hynny Communication – When specialist care is necessary there needs to be better Communication between hospitals to bring patients closer to home when appropriate to do so

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Dim arbenigedd yn y maes yma - ond yn teimlo yn gryf y dylai BOB arbenigwr sydd yn delio a claf cyfathrebu yn well ac yn glir No Specialism in this field – but i feel strongly that ALL Specialists that deal with a patient must communicate better and clear.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Gweler ateb 3 See answer 3

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Dyla You should

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Yn bendant Certainly

Chapter 2: Enabling Quality

Quality and co-operation

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
Dylai bod bob aelod o staff yn “addas a phriodol “ Every stad member shoud be suitable and appropriate

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Mae wastad lle i wella There’s always room to improve

Chapter 3: Quality in Practice

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Disgwylir gweld goruchwyliaeth ar bob lefel o staff

Staff monitoring at every level is expected

17. What arrangements should be put in place for self-employed health professional registrants?
Disgwylir gweld goruchwyliaeth ar bob lefel o staff- hyd yn oed rhai hunangyflogedig Staff monitoring at every level is expected – even thoes who are self employed

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Methu deall pan bod angen deddfwriaeth i sicrhau gonestrwydd dylai bod hynny yn swydd disgrifiad bob aelod o staff beth bynnag I can't understand the need for legistlation to ensure honesty that should be in the job description of every staff member anyway

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Gwell cyfathrebu rhwng BOB aelod o staff sydd yn delio a claf, a bod corff annibynnol yn edrych i mewn i gwynion Better Communication betweel every staff member that deals with a patient, and that an independant body exits to look into complaints

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Dylid cydnabod y trafferthion presennol a cheisio eu dileu gan bod cyfathrebu clir am claf yn holl bwysig It shoud recognise the personal difficulties and erase them as clear Communication about a patient is essential

22. How can we consider breaking down any barriers?
Dim yn deall digon am y trefn bresennol i ateb ond yn annog unrhyw rhwystrau i gael eu dileu mewn ffordd ddoeth I don't understand the current order enough to answer but encourage the erradication of obsticals in a wise way

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Gyda chaniatâd y claf With patient consent

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Na No

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
Yndi er mwyn tryloywder It is to ensure transparency

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Mae problemau hanesyddol yn profi bod hwn yn adran sydd wir angen sylw ac mae angen camau deddfwriaethol Historical problems prove that this section truly needs attention and Legislative steps

LHB size and membership

38. What are your views about the suggestions made by the Commission on

Public Service Governance and Delivery, such as the election of community representation?
Cefnogi yn gryf gan nad oes digon o arbenigedd busnes ar byrddau Strongly Support as there is not enough Business specialism on boards

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Angen mwy o pobl proffesiynol busnes More Professional Business People needed

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
Tydi'r fformat presennol ddim yn gweithio – angen gwell draws doriad The current format doesn't work – need a better cross section

WGGP032 – Maureen Wolfe
Tref / Town – N/A
Sefydliad / Organisation – HIW

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Consideration would need to be given to appointment process to avoid emotional response to required change within the NHS

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Consideration is required to the appointment process to ensure a full understanding of the public and the Health Board needs.

Chapter 2: Enabling Quality

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Quality needs to be at the heart of the NHS and should be enhanced at every opportunity.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Yes.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
It should enhance the client journey from primary to secondary care and return.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Supervision of Midwives has demonstrated that effective peer review, which incorporates action learning, is invaluable to staff and service improvement. Group supervision has highlighted that the sessions have supported staff with identifying solutions for problems faced by their peers and this has resulted in personal satisfaction and efforts to positively address issues in the workplace, which in turn improves the quality and safety of services provided.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Due to the planned changes to the statutory supervision of midwives, the role of the Supervisor of Midwives (SOM) is open to change. As individuals highly skilled in peer supervision and action learning, SOMs could be deployed into new roles to support not only clients and staff but clinical supervision and the Revalidation process. Whilst there may be an initial cost to this role introduction, when regulation is amended, the funding for supervision will return to its original cost and SOMs could be utilised to ensure all professional registrants have access to clinical supervision; midwives will not lose this valued support and nursing staff will acquire additional, appropriate support. Thought should be given to such posts being managed externally to the Health Board/or as additional internal posts, to ensure time constraints from competing priorities are avoided, ensuring effective supervision. Alternatively this will require investment in training and CPD opportunities if a quality process is developed to ensure clinical peer supervision is based on sound principles underpinned by evidence based practice and underpinned by NMC standards.

17. What arrangements should be put in place for self-employed health professional registrants?
Where contracted to the Health Board, individuals could access clinical supervision and for Revalidation an external Confirmer can be designated. A process of clinical peer supervision will have to incorporate some consideration of this group of health professional. Revalidation will address this to some extent but there needs to be a statutory requirement that ensures health professionals have a 'link reviewer' in the geographical area that is appropriate to their practice. These health professionals will need to take this

responsibility to maintain their registration as well.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes, to influence the current closed shop culture and promote transparency and ensure national learning. A statutory duty of candour would promote a more consistent approach across Wales which would address the current disparity amongst organisations and in different Directorates within an organisation. We believe that in line with the NMC Duty of Candour (2015) a statutory duty of candour would benefit the NHS in Wales. It is important to cultivate a culture of learning as oppose to blame that enables organisations to move the service forward and learn from mistakes. Openness and honesty are fundamental to this culture and are required at all levels, individual through to corporate.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Audit by the public panels and comparison of Health Board audit results. This would help staff have more of an awareness of when to use the Duty of Candour. It would provide a consistent approach across England and Wales in line with the Health and Social care legislation (2014) introduced in England following the Francis report.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
The All Wales model of Supervision has demonstrated the benefit of a robust system of working as a team across Wales to investigate clinical incidents/ midwifery practice. Benefits include • A consistent approach • “Expert” fact finding • External (to health Board)scrutiny • Reduced conflict of interest • A timely investigation process within set timeframes • Prioritising of investigation process within defined role • Standardisation of process and reports • A system of working in collaboration with families • Joint learning across Wales • Identification of themes and trends • Identifying individual and corporate learning

• Highlight need for training • Restoration/action plans produced as outcome • The ability to audit and identify areas for improvement • Working in collaboration. This model of investigation is transferrable across all sectors

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
I.T. issues, Poor communication systems, Reluctance to share information and Data protection Confidentiality Patients choice Lack of public trust in the NHS

22. How can we consider breaking down any barriers?
Immediate action to introduce a national I.T. system which can be accessed in primary and secondary care and is inclusive of a maternity information system. Emphasising the benefits of being open and honest to the public and NHS employees. Discussion with patients about the need for information Listening to concerns Providing evidence that sharing of information will benefit the patient or others Building trust that gives confidence in service Openness and honesty in the consultation process Patient held records

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Informed consent and associated confidentiality. NHS ethical approval Patient consent Patient confidentiality Considered very seriously Ethical framework of the greater good Honourable agreement with the issue of consent as a priority Evidence that there is a benefit to the public

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
External scrutiny is the key to ensuring governance is robust, timely and meaningful if the lessons from Morecombe Bay are to be adhered to. Without this level of scrutiny it is difficult to imagine an unbiased governance process with the public at the core.

WGGP033 – Andy Lancelot
Tref / Town – Unknown
Sefydliad / Organisation – N/A

General comments

I saw this on Twitter and thought I would write as living in the North west it is not really convenient to attend either of the events given the distance.

I am generally concerned that the NHS is being run down purposefully by the Government which has Ministers and MPs owning shares in private health companies and health insurance. They stand to make a killing when they finally declare the NHS isn't working and want to privatise parts of it.

I keep seeing tweets by the Community Health Care Councils asking constantly for concerns from the public about health treatment and experiences by people - never any tweets asking employees about the way the Health Board has been managed.

As an employee of 26 years I recall that the North West Wales NHS operated in the black or balanced the books at least - was very efficient and provided a lot more care than it does now, particularly in mental health.

Since we joined with the North East and became BCUHB we have been dragged down. Closures of support bed units and other services, massive debt and a change over to very inefficient, corrupt, bullying and incompetent management structures.

There are services provided in the East that are not available in the West such as veterans mental health service, bipolar disorder service, counselling for people with gender identity and so on - the community bases for CPNs and CMHTs have been sold off in the West where I believe they are still owned in the East.

It feels like we have been successfully taken over and pillaged.

The merger of the North Wales Health Trusts should never have happened. I believe it happened for political reasons and there should be an inquiry into it. I have never got to the bottom of whose idea it was to merge. Our formerly efficient health service in the North West has been tarnished and our reputations blighted because of this. We have the indignity of being in special measures because of the behaviour of the North East.

It sickens me to think that if we do split up again into North West and North East it is highly likely that we will be saddled with half the debt when we should be responsible for none of it.

I hope your organisation can do something about this pathetic mess. I worked hard in the NHS and am devastated to see it being destroyed by these people. please sort the managers and directors out once and for all will you?

My greatest fear is that as I get older I will have to be looked after by this health board. I am not only an employee but a service user of course.

Response to specific questions

No response to specific consultation questions.

WGGP034 – Professor Derek Gallen – Wales Deanery
Tref / Town – N/A

General comments

The Minister's Foreword outlines the purpose of the Green Paper in describing current systems in place in Wales to ensure quality and patient safety, with a view to considering what additional activity could be considered and implemented to enhance the current systems. There is, quite rightly, a strong emphasis on the effects of culture, organisational ethos and leadership in order to ensure high standards of delivery of the quality and safety agenda. This is a theme that is recurrent and embedded in the text of the Green Paper, both explicitly and elsewhere implicitly. The emphasis providing the right care in the right way at the right time in the right place is clearly the quality and safety goal. Indeed, it is necessary to review and improve existing systems and processes and extend and introduce new ones. Equally, it is important to identify and highlight areas of best practice and share these engendering an ethos of shared ownership across all healthcare sectors.

Reference to the King's Fund paper Preparing for the Francis Report: How to Assure Quality in the NHS (July 2012), emphasises the 'three levels of defence' against quality failures in healthcare.

Comments Specific to the role of the Wales Deanery
The Wales Deanery has an established role in supporting, in different ways, each of these levels. Doctors and dentists in training make up a substantial percentage of the NHS workforce in Wales. They have a high level of input into service delivery which some often reflect as being excessive and in conflict with important aspects of teaching and training. Ensuring application and delivery of the required General Medical Council standards for teaching and training is a crucial part of the Wales Deanery's function and this engages the Wales Deanery at an interface with each of the three levels of defence - trainees and recognised trainers as members of the workforce, Clinical Directorates and Health Boards in the context of their duty to ensure a safe working environment, supportive of the clinical academic and curricular attainment of trainees; at a National and UK level as part of the regulatory process, interfacing with Healthcare Inspectorate Wales, Welsh Government and the General Medical Council. Similar statements apply to those trainees and established practitioners registered to practice dentistry by the regulatory body, the GDC. This includes dentists and dental care professionals (DCPs) such as dental nurses, dental hygienists, dental therapists, orthodontic therapists, dental technicians, clinical dental technicians). Their education and training is quality managed through the Wales Deanery’s dental section.

Regulatory Frameworks which enable these activities are in place and are also subject to regular review, consultation and development. Recent developments, for example the new GMC ‘Standards for Medical Education and Training’, to be applied from January 2016, place a strong emphasis on

the organisational culture, the training environment and the interface between clinical governance and educational governance. The standards apply to medical education and training throughout the continuum of doctors' careers. The emphasis has to be one of continuous improvement and engagement towards excellence, or order to establish Wales as a 'go to' place for postgraduate training and for working within the NHS. For the dental profession in Wales, including those in training, the Wales Deanery is cognisant of recent updates from the GDC on their 'standards for the dental team' and defined 'scope of practice' of all registrants and the impending introduction of a new QA process based on recently published 'Standards for Dental Specialty Education. In addition, the GMC's standards for trainers, developed in conjunction with the Academy of Medical Educators, will increasingly drive the professionalism of training in the hospital sector to match that present in UK General Practice for three decades. A similar initiative, driven through COPDEND and underpinned by their 'Standards for Dental Educators is in place for dental professionals, which has yet to see engagement with the GDC in a similar fashion to that described for medicine.

The Wales Deanery does not believe that additional legislation is required to further advance the activity described above. However there is a need to better embed a positive culture within the currently disparate local training providers in Wales. Learning from best practice is an area that the Wales Deanery is keen to support but this requires an open and receptive posture from those organisations not currently fully engaged with the agenda of excellence in training and education. The attitude is defensive in places and it would be helpful if the Wales Deanery could be better supported by both HIW and Welsh Government in pursuit of its goals. We are by the nature of our role and through our stated purpose, supporting the development of future doctors across all specialties with the aim of providing safe and high quality care for the citizens of Wales. Within dentistry, our provision of high standards of training and education, in partnership with Health Board providers and primary care practices, underpins our delivery of multi-professional continuing education and training supporting the standards laid down by the GDC. In turn, this supports the prudent healthcare agenda – 'right care, right place, right time right way' - through the appropriate skill mix delivery of oral and dental healthcare to the public.

We have provided some commentary on most, but not all issues. Our emphasis is in support of the quality agenda, particularly in the context of medical and dental education and its regulation.

The Wales Deanery welcomes positive reference to continuous professional development both of organisations and individuals. We have a traditional role in supporting dental CPD as well as GP CPD, although the latter has been severely restricted of late. The former underpins the GDC's 'Continuing Assurance of Fitness to Practice' (equivalent to medical revalidation) and is now the subject of the GDC's new 'enhanced CPD rules for dental registrants', which applies to the whole dental workforce, dentists and DCPs. There is now even stronger emphasis on the quality of dental CPD and reflection by the registrant and recording of the impact on their clinical and

professional practice. The Wales Deanery, through its obligation to Welsh Government, provides this key commitment of delivery and managing continuing education and training, in support of the whole dental workforce in Wales, the majority of whom are based in primary care dentistry. Additionally, we support the integration of the SAS grades though CPD leadership and appraisal/revalidation within the MARS system. Revalidation for doctors and annual registration for dentists and DCPs is now well embedded in the structured assessment/monitoring process and procedures for trainees across Wales.

We support the activities of CHCs and shared services and see these as having the potential for enhanced role in an integrated service structure, but most importantly under a new long term strategic plan for health and social care in Wales.

The independence of advice to Ministers, the statutory independence of the HIW and the enhanced role of a new reference board to address CHC concerns are all welcomed in reducing the political burden of the NHS and its currently unavoidable negative effect on planning beyond the political cycle.

For the purposes of much of this Green Paper consultation, the notion of legislative change for the short-medium term is bound to risk distraction from the fundamental need for longer term strategic planning.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority? 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Prudent Healthcare: this concept is now firmly embedded in the policy of Welsh Government, but might not have achieved as much traction as one would expect from a logical approach to health care. Some barriers might be that in order to 'only do what only you can do', there has to be in place someone else to deliver that activity if 'you cannot do'. We are not yet in a position to ensure this and so it remains difficult to delegate 'lower level' aspects of practice. There is also the nature of patient expectation in that there are perceived hierarchies throughout health and social care, with individuals or families harbouring strong views on what sort of healthcare provider they would want to consult. Paragraphs 25 and 29 within the overall principles underpinning the primary care plan, describe a shift from treatment of problems towards future well-

being (the prevention agenda). While there is clearly an increase in preventative work, this runs in parallel with an unrelenting increase in the demand for services to provide treatment. This should be recognised as a major demand on a wide range of health and social care services. It is important to recognise that 'prevention' is in many cases the cornerstone supporting a patient's treatment plan. The public would benefit with provision of more clarity and understanding of the importance of 'prevention'. This is something that should be facilitated in a modern approach to 'our health and our health service'.

We do not think that changes to the law would help deliver this aspect of the proposals, however, local commissioning and a more imaginative approach to employment and job-descriptions, partly through clusters, should be encouraged. But we should not pretend that new activity, at whatever level of health professional delivery, can be viewed as being a substitute for what is currently provided and remains under huge demand.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?

Wales is in a stronger position than most due to the retention of the Community Health Councils, often the envy of other parts of the U.K., especially among the more fragmented patient representation at various levels.
Paragraph 36 describes the duty that Health Boards are already under to involve and consult local people in the planning and delivery of services. The difficulty will always be that people are happy with new or extended services but understandably reluctant to accept change in the other direction. Of the three questions in this section, it seems that a national expert panel to receive CHC referrals would be a positive move in de-politicising the process and hopefully providing expediency to much needed service reconfiguration.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations? 10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales? 11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
We do not agree with the proposal for new legislation in this context. The existing frameworks could be implemented to better effect by providing more clarity around the existing duties and a more explicit acceptance of organisations and leaders of these duties. Reporting to Boards and Regulators in line with activity related to existing duties should be the norm. Where there are Chief Executives or Directors within an organisation, the need for an additional 'fit and proper person' is difficult to establish as the duty already exists. This suggests a further tier of managerial bureaucracy. This comes back to the issue of culture and how internal process reflects that culture. It cannot be legislated for, but we would encourage enhancing the establishment and sharing of areas of best practice. This is a more constructive route to organisational development in this context.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
We recognise the need for this medium term approach, but we are more encouraged by the first recommendation of Mr Mel Evans’ panel in the ‘Review of the Healthcare Education Expenditure in Wales’, which calls for a revised long-term (to 2030) strategy for the NHS in Wales. This strategy should be linked with social care to enhance integration and would be more amenable to legislative change. A 15-year programme reduces the short-term nature of political planning, should have cross-party support. It would be more difficult to derail or delay by repeated 'fringe' policy papers rather than gain no long term traction for the benefit of patients. We are not convinced, in this context, that applying legislative change to a three-year plan is either feasible or indeed likely to be effective.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set? 14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
his is a difficult one. If high-level, the application of common standards would make sense provided they are realistic within current budgetary constraints and that the metrics are sensible and quality-orientated. We do not know the reasons behind NHS providers not needing to comply with the current independent sector standards. Do those reasons still exist?

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how? 17. What arrangements should be put in place for self-employed health professional registrants?
In considering an approach to clinical supervision, Welsh Government would be well informed by existing processes employed in the clinical and educational supervision of doctors and dentists in training. The introduction of the Educational Supervisors Agreement, introduced by the Wales Deanery is an area of good practice supporting the trainer recognition directive of the GMC. Additionally, the elements of supporting information required to be demonstrated through annual appraisal for the purposes of continuous professional development and revalidation are useful sources of reference. The Wales Deanery has significant expertise in these areas and should be pleased to contribute further e.g. in a workshop format, should this aspect of the consultation progress.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales? 19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Given the suspicion of there being a lack of openness in this arena, it could be an area where a duty of candour would be helpful. There would need to be clarity on the level of 'error' that would need to be addressed otherwise we would create an unnecessary level of anxiety and bureaucracy to little beneficial effect.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?

This is a complex and already over-populated area where patients and relatives are confused about what approach to take and what outcome might be achieved. Although complaints in the hospital environment are made to the Health Board, they are invariably about the acts or omissions of individuals making it even more complex to have joint investigations. Nonetheless there may be some instances where there is a logic in applying this approach.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information? 22. How can we consider breaking down any barriers? 23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
There is sometimes a defensive culture to protect or retain good practice and at the same time to deny or underestimate shortcomings. Breaking down barriers is difficult because it depends on leadership within an organisation and trust between organisations. NHS Wales is much talked about but in reality it is a concept, a virtual organization, rather than a visible structure. It needs to become a reality with authority to enable this and numerous other actions suggested in this Green Paper. It should also exist with independent statutory powers in order to reduce political interference. We would be opposed, on ethical and moral grounds, to the collection of patient identifiable information for research all round purposes.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they? 25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW? 26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change? 27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
We would be supportive of statutory independence for HIW. The advantages of a single (HIW/CSSIW) inspectorate would only be achieved if the services are integrated in both planning and delivery. Overall, if achievable, this would

be a good plan, but would also have to link logically to the UK Professional Regulators. This also reflects views expressed above in response to Q12.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice? 29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
Our understanding of the situation is that the shift away from representation of individual patients occurred in the changing role of CHCs within the past 5 years. What were the arguments for that change and is there evidence to revert to that more traditional role? In general we would be supportive of the CHCs in Wales (see above) and would see a strong potential for extending roles of CHCs in relation to an integrated system.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
We would suggest - no. The evidence for strong financial management is not universally good and to allow a borrowing facility to Health Boards raises immediate anxiety about risk.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed? 37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors? 38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation? 39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services? 40. Would you like to suggest any other changes you think are required to

health board membership to ensure they are fit for the future?
We are more concerned with the Health Board agenda content, priorities, engagement and co-operation, than modifying its structure. We have little comment on this section other than to emphasise the need to have education and training as a standing item on board agendas, preferably with adequate internal and possibly external input to represent the education and training agenda in the Health Board.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed? 42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
As in Question 36-40 above with regard to Health Boards.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees? 47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
The important point about advice to ministers is that it should come from the appropriate source to provide the outcome that is 'needed'. This should be the priority, rather than advice being sought from where it is perceived that the right political advice is likely to be given. This ensures that Ministers are advised along neutral lines and should avoid asking those individuals/organisations whose responses they might predict to be the required advice. The use of a favoured few within a common political thinking is not necessarily the best source for the NHS or the citizens of Wales.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
We would refer to Question 12.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services? 50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide

shared services role?
We have been impressed with the development of new roles for shared services but recognise that changes have been mostly reactive and ad hoc. An overview and a strengthened ownership of various functions would be helpful, as well as procedures for further development. Extending the shared services role would again be facilitated by integration and a shared long-term strategic plan.

WGGP035 – Laura Coveney – The Health and Care Professions Council
Tref / Town – N/A

General comments

Overall, we welcome proposals to improve the systems in place that support health and care professionals to deliver services safely and effectively, in line with our standards.

We recently reviewed our standards of conduct, performance and ethics (SCPEs) and consulted with registrants, service users and carers, and other stakeholders on some issues related to those raised in this paper.

Response to specific questions

Chapter 1: The changing shape of health care

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
We support proposals to require health boards and NHS Trusts to establish permanent engagement mechanisms to support continuous engagement with service users. Service users and carers should be at the centre of health and care services. Our registrants are expected to work in partnership with service users and carers, and involve them wherever possible in decisions about the care, treatment and services they receive. Engaging with service users and carers is essential in order to achieve this and we would support continuous engagement by heath boards and Trusts as a way to ensure service users remain at the centre of health and care services.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set? 14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
We would support a common framework covering both the NHS and independent sector. Service users and carers have the same expectations about the quality and safety of services they receive, regardless of whether

they are provided by the NHS or independent sector.

Consistency of standards across public and private settings is important for maintaining public confidence in health and care services. Our standards framework applies to all registrants, regardless of the setting they work in. Standards for organisations should reflect this consistency to support registrants in meeting theirs.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how? 17. What arrangements should be put in place for self-employed health professional registrants?
We are supportive of mechanisms which ensure that professionals have access to clinical supervision. We recognise the importance of clinical supervision in supporting our registrants to practise safely and effectively. Supervision can form an important part of continuing professional development (CPD) which is a requirement for all our registrants. Clinical supervision should enable staff to proactively address issues and learn in order to prevent issues becoming a bigger problem that requires additional action and puts service users at risk of harm or receiving ineffective services. Our registrants include NHS, private sector, and self-employed individuals. We expect all of our registrants to adhere to our standards and would welcome availability of supervision to all health and care professionals regardless of their work setting. Professional bodies and other membership organisations may be well placed to facilitate access to supervision for self-employed professionals.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales? 19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
We would welcome a duty of candour at organisational level to promote a culture of openness and bring about consistency with the duty in place in England. As our standards apply to registrants across the UK, we would also welcome an organisational culture of openness across the four nations. Our recent consultation identified support across all stakeholder groups for standards on being open when things go wrong. Many of those who

responded felt that this duty needed to permeate throughout health and care services, including governance level. Introducing a statutory duty of candour within the NHS in Wales may support individual staff to foster a more open approach ensuring consistency across the service.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Our stakeholders largely also supported new standards for professionals to raise concerns and support service users to do so. Legislation to improve the ability of health and care professionals to carry out this duty would be welcome.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

22. How can we consider breaking down any barriers?
We expect registrants to treat information about service users as confidential and, apart from exceptional circumstances, use it only for the purposes they have provided it for. Our recent consultation found that stakeholders mostly support requirements for registrants to appropriately share information in order to provide effective services. We receive queries and concerns from registrants about sharing information appropriately and effectively at their place of work, which leads us to believe that further support and guidance is needed. We would encourage employers to provide appropriate support and guidance on information sharing to support health and care professionals to meet regulatory standards in line with local policies.

WGGP036 – Sarah Payne – National Offender Management Service
Tref / Town – N/A

General comments

The National Offender Management Service (NOMS) in Wales is responsible for public sector prisons, the National Probation Service (NPS) in Wales and has contract management responsibilities for privately contracted prison HMP Parc and the Wales Community Rehabilitation Company (CRC). The focus of these services is to protect the public, support the rehabilitation of offenders and reduce their risk of re-offending.

We welcome the opportunity to provide comments on the Welsh Government's Green Paper "Our Health, Our Health Service". The alignment of health provision and offender management services at a strategic and operational level is an important part of reducing the risk of reoffending and supporting safer communities. This includes joint needs assessments and working in an integrated way with health, commissioned services and rehabilitative interventions to tackle the health inequalities that are often concentrated in the offender population.

It may be helpful to outline how health services and offender management services interact. In the prisons, Welsh Government is responsible for health services and Prison Health Partnership Boards oversee the commissioning and delivery of services. This requires a collaborative
approach between the prison and the relevant Local Health Board (LHB) in which the prison is located. There is an overarching principle that prisoners should receive equivalent services to the community. Offenders supervised by probation services in the community will access and receive the same health provisions as the general population and collaboration between providers is just as important in this setting.

Identifying and addressing an offender's health and social care needs is critical in supporting an offender to move away from crime. Their offending risks may be linked to a range of health and social care issues such as mental health, learning difficulties and disabilities, substance misuse and personality disorders. We therefore work closely with Welsh Government and health partners to make sure that offender needs are considered in health service delivery and so that NOMS in Wales can best support wider health and wellbeing outcomes.

NOMS in Wales and the Welsh Government are also partners in delivering the Wales Reducing Re-offending Strategy and Delivery plan which provides a vehicle, along with other key partners, to make sure there is an integrated approach to delivering or accessing interventions that can reduce the risk of re-offending. As such, NOMS in Wales support the focus on strong partnership working to develop health service delivery plans as outlined in Part 2 of the Green Paper. These partnerships enable us to work in an

integrated way to address the holistic needs of the offender population and their families in Welsh communities.

We would welcome the opportunity to work with Welsh Government officials to further develop a clear governance framework that would strengthen and encourage this integrated approach across community and prisons. This would be supported by improved information sharing arrangements and health representation at NOMS in Wales strategic boards, the All Wales Criminal Justice Board and Integrated Offender Management (IOM) Cymru: Regional and Local Groups.

As outlined in Chapter 3, NOMS in Wales agree that it would be helpful to have consistent standards of care across health services that are aligned, as far as possible, with social care standards. It may be useful to know that we are exploring, with Public Health Wales, the development of a framework of indicators for health and justice outcomes. This could support commissioners and providers in the delivery of health and justice shared outcomes.

NOMS in Wales is also supporting the Social Services Improvement Agency (SSIA) and Welsh Government with the population needs assessment toolkit for Local Authorities, as part of the Social Services and Wellbeing Act 2014. The data and support we can contribute to these local needs assessments could be helpful in supporting both the Integrated Medium Term Plans and the cluster level needs assessments which are discussed in Chapter 7 of the paper. Please see the attached annex for an outline of the data that could be provided to support these assessments.

Sharing this information could also avoid the duplication and overlap between the interrelated planning duties across health and social care services and we welcome the recognition that there is an opportunity to improve alignment between these areas. As a result of the needs assessments, it may be useful to consider whether the current commissioning models can be improved to tackle the inequalities in health that follow the offender population.

ANNEX - OVERVIEW OF NOMS DATA THAT COULD SUPPORT POPULATION NEEDS ASSESSMENTS

To support the population needs assessments it may be of use to note the data that NOMS could provide.

Around 3,400 offenders are currently housed in Welsh prisons, set to increase in 2017 with the opening of the North Wales Prison (capacity of 2,100 offenders). As there are no custodial facilities for women in Wales, these prisoners (around 250) are held in English prisons. The Wales Community Rehabilitation Company (CRC) has responsibility for the management of around 9,900 low to medium risk offenders while the Wales National Probation Service (NPS) is responsible for managing around 6,700 high risk offenders.1.

Risk Predictor Tools
NOMS uses a variety of tools to assess offenders and effectively target interventions to address an individuals' need(s). Future risk can be predicted for individuals using this information, including the risk of general, violent or sexual reoffending, the risk of serious recidivism, and the risk of serious harm.
Criminogenic and support needs

Using the Offender Assessment System (OASys) and Basic Custody Screening Tool (BCST), which screens every prisoner at the reception stage to identify potential needs and risks. NOMS is able to identify the proportion of the population who may require more structured social support due to their risks, needs or offence type (e.g. sex offenders). Data is recorded against the following areas:

• accommodation,
• education, training and employment,
• lifestyle,
• relationships,
• substance misuse,
• attitudes, thinking and behaviour
• finance,
• health,
• domestic violence,
• children and families and,
• (Female) prostitution.

Demographic Information

NOMS collates key demographic information for the offender populations in prison and in the community, including by home local authority. Monitoring these demographics allows NOMS to look at changes over time and the expected impact of any changes; for example, the prison population is aging, with 1 in 7 prisoners aged 50 and over. NOMS can identify where younger

Welsh offenders (aged 18-20) are located, how many were looked after children and provide corresponding needs and risk data.
Access to NOMS Data
Most of the data and information collated by NOMS, and described is unpublished management information. Aggregated data is published quarterly on the Ministry of Justice website , however this is usually at an England & Wales level only. Future discussions with NOMS could be arranged to discuss data requirements, including how the data would be used and distributed.

1. Note that these population estimates are unpublished management information and as such should be used as indicative information only and should not be used in the public domain. Prison data is provided as at 30 June 2015 while the offender population managed in the community in Wales is provided at August 2015.

Response to specific questions

No response to specific consultation questions.

WGGP037 – Rhiannon Jones – Powys Nursing & Midwifery Team
Tref / Town – N/A
Sefydliad / Organisation

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Further changes to legislation are unlikely to encourage greater collaboration but rather what is needed is co-location of health, social care and 3rd sector agencies with properly joined up infrastructure such as IT and single record to enable joint working.

2. If so, what changes should be given priority?
Partnership boards with imbedded requirements to constitute commitment. Sub groups should reflect multi agency and multi citizen approach at every level – this has worked well to date in Mental Health Services.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
It is not so much about legislation as to the appropriate resource and culture – for example financial and practical support for people who use services to attend – there needs to be a wider network of collaboration. It is essential that people's needs are considered collaboratively to improve pathways and experience, including the third sector and independent sector. The single most important change to legislation needed, to support and promote joint working, is to enable pooled resources for health and social care. This would remove the challenge of identifying who pays for particular aspects of care but rather ensure individuals are assessed and treated holistically according to their needs. Performance monitoring should focus on joined up health and social care planning which demonstrates joint outcomes on health and wellbeing improvement.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Many services already endeavour to ensure participation groups, in maternity this equates to the Maternity Service Liaison Committee. However despite enthusiasm from services, many women and families it remains challenging to bring individuals together and ensure meaningful representation. Ensuring truly representative patient responses requires better support to ensure engagement not legislation. A technological solution across all areas able to use at all points of contact or through social media would seem to be a better solution to ensuring the capture of every voice rather than those interested enough to put themselves forward. Each Health Board should ensure that all its policies and procedures and agreed and signed off by patient user group. Health Boards should have nominated independent members attached to service areas and can represent the patient voice for that area. For example a patient experience volunteer attached to 4 medical wards, working alongside the team to improve the quality and voice for patients. This should centre more on the organisations culture and leadership expectations. Would statutory arrangements enable this mechanism in its true form? Alternative arrangements need to be considered to capture patient experience – participation groups will not work in all services. There needs to be a stronger emphasis on community involvement as well as patients experience – they can represent two very different things Currently patient/user participation is still somewhat ad hoc rather than systematically embedded. One potential barrier to regular and committed engagement is the lack of proper recognition service users can bring to service planning and development in the form of a consistent, well defined job description/person specification or role profile with appropriate and adequate reimbursements for people's efforts. Equally those people from minority groups such as sensory and physical impaired should be encouraged to come forward to participate.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
There is always a risk with an 'expert' panel that the panel may not be truly representative or may not cover all views. To ensure true coverage would make a panel too large and unwieldy. Better use of the current advisory groups/networks, ensuring full profession representation, would provide an opportunity to ensure expertise is available when and where needed whilst

ensuring a whole Wales view. If a national expert panel was to be developed it would need to be truly collaborative with every member possessing equal rights/representation and weight of opinion.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
No because there is already a plethora of strategies, frameworks, dashboards, traffic light system as well as numerous quality measures for the NHS to respond to. Frequently from ward sister roles and upwards managers spend much of their time in meetings planning how to respond and responding to the measures currently in place. This inevitably takes them away form the main business of engaging with users and their carers to gather views and monitor the quality of care.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
The NHS already has responsible individuals in the Chief Executive and the Exec board members who have statutory responsibilities.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
There are already many regulatory requirements set out in standards for those who belong to professional bodies and for medical and nurse/midwives the monitoring of compliance will be confirmed through revalidation and the PADR process. For Exec board members who already hold a statutory duty robust appointment processes and regular monitoring of objectives through the PADR process should be sufficient. However appropriate sanctions should also be in place for executives who do not meet their objectives or contribute to quality improvement.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Legislation itself does not usually bring about change.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
There needs to be a wholesale review of the diverse numbers of standards/reporting all services are reviewed against and a rationalisation, that ensures applicability but also meaningful feedback. Some parts of the health service have the current potential to report to multiple different standards i.e. Health and Care Standards Fundamentals of Care Welsh risk pool National Service Framework – Children Mental health measures Health Boards should be measured against key evidence based quality indicators and held accountable. Whilst there may be some argument for this being linked to financial penalties it remains debatable whether such penalties would ensure quality improvements. The use of publically available dashboards may be a more effective mechanism. There is a need to bring together the many standards and quality measures into a consolidated framework rather than adding further layers to an already complex matrix.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Same framework and expectation for all sectors – health and social care is widely met and the framework should reflect this. It would be difficult to see why NHS, social care and the independent sector should be judged by different standards rather than expecting equity in service provision wherever care is delivered.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Rather than requiring further use of peer reviewers or other measures of accreditation a better definition of what is required of CHCs and other inspectorates such as HIW would provide a better focus for their work. The overarching aim should be to balance reporting on celebrating good practice as well as highlighting areas for improvement.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to

have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Legislation has the potential to become a tick box exercise rather than a meaningful discussion. Early evaluation of group supervision, as part of the statutory supervision of midwives in Wales, conducted by Dr Darra from Swansea University, has shown this to be a very effective means of providing staff at all levels with a valued degree of support. It also offers opportunities for action learning to seek solutions to common challenges and enables learning and sharing of best practice from events and incidents. Staff at all levels report group supervision as being helpful. With the abolition of statutory supervision for midwives and the introduction of NMC revalidation for all registrants' group supervision could be a means of supporting all registrants with their reflective discussion, a pillar of the revalidation process, and support the development of CPD plans. Group supervision could also enhance compliance with the annual PADR process and show organisational commitment to supporting staff with their revalidation. A culture change needs to occur if clinical supervision is to become a normal part of all clinical practice and a concept of best practice standards would be welcomed, embedding within personal development reviews would provide a mechanism. Organisations need to invest in the ethos and expectation of clinical supervision. All clinical staff, irrespective of their professional group, should have access to supervision and feel safe to share and learn. This requires a model of professional leadership, service supervision arrangements, specialist supervision for complex cases (e.g.: forensics, Personality Disorders), training of supervisors, protected time – requirements need to be defined in the operational polices, and Psychological Therapies Committee for example. Training bodies in health and social care should incorporate this ethos and expectation to support staff wellbeing and standards of practice.

17. What arrangements should be put in place for self-employed health professional registrants?
Self employed professionals could be invited to join local group supervision sessions offering them peer support, the opportunity to benchmark their practice and minimise professional isolation.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?

This is already a duty on professional groups. Legislation is no guarantee of improvement, ensuring the full implementation of PDRs is the primary step. Before moving ahead to legislate for the duty of candour should Wales be looking to see what impact, either good or bad, the duty of candour has made in England. If there is evidence it has made a difference for the good then maybe we should consider adopting it in Wales.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Whilst performance measures remain process not outcome focussed legislation will not improve transparency. Outcome focussed performance measures that allow real-time reporting on and ensure patients have the opportunity to contribute to what those measures should be has the potential to improve transparency. It is not legislation that is required but the method in which performance is managed – there needs to be a stronger focus on patient feedback and co-production. A recent co- production event in mental health services achieved more timely and meaningful outcomes than performance targets.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
An opportunity should first be taken to review areas where this already works well to assist in wider learning and to ensure common principles before legislation is considered.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
IT systems unable to link or communicate i.e. Myrddin maternity module now used in 4 health boards in Wales. If a pregnant woman from one health board goes to another all her data has to be re-entered into the system, there is no capacity to retrieve the data from the other system, despite it being the same. Professionals fear that they will be blamed for sharing information wrongly and therefore tend to err on the side of caution. The principles of Information sharing Protocols (ISPs) have been taken too far and rather then developing and all Wales document that sets out the main principles for information sharing there is an industry in devising an ISP for many disciplines and many scenarios 'just in case'. In line with the WASPI guidance it should be possible to have a single document that sets out the exceptions when further guidance

should be sought. The lack of co-location of staff also militates against joint assessment and sharing vital information when individuals have complex health and social care needs. Information sharing could also be enhanced by having a single patient record which would, in preference, be held by the patient themselves. This has worked well for maternity provision for many years so already tried and tested

22. How can we consider breaking down any barriers?
A national integrated health record, accessible wherever the patient presents, community or hospital, not dependent upon their 'home' health board or GP, including test/screening results. Dialogue and debate around the tension between information sharing and complaints about breach of confidentiality.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Level of identifiable data needs to be agreed with the public. Opt out of data being shared, clear rationales shared with public for the reasons for using. There is a massive opportunity being missed with the non-use of data that is already being routinely collected that could contribute to research and improving health. Current requirements for research to find the data independently does not sit well with the concepts of prudent care.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
Independence of both bodies is a crucial element in re-establishing the publics' trust in health organisations. If HIW were to be provided with full independence careful consideration would need to be given as to who would hold HIW to account before such a move was taken.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
One place to go to. One set of processes. Joined up learning across services

However with one organisation there would be a need to ensure that the contributions of professional groups and speciality focus are not diluted. Professional leads may help with this. Potential for confusion if services in local areas are not also integrated. There are economies of scale to developing a single organisation by reducing management capacity and other leadership functions in favour of other staff to enhance the capacity for required work and reduction in duplication.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice? 29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
Has to truly reflect the patients and communities – equal representation.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
There would seem to be a convincing argument that there is no potential for adverse outcomes if this action was taken.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
Again it is suggested that the summary accounts bring no additionality to the annual accounts process. If there is no good reason to prepare them in addition to the full annual accounts then this process should be stopped.

32. 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?
As above which is likely to need a change in legislation

Planning

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

This would seem logical and may help to strengthen the planning process which must include the need for service user input.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Partnership Boards and relevant sub groups at all levels Defined professional leadership structures and frameworks Clinical Leadership Programmes Clinical and professional supervision, mentorship, development, vision Investment into the right culture that threads through the veins of the organisation and partnership model. Governance does require stronger measures to support this – but has to be across all sectors.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Increase independent membership Equity of membership and the professional groups represented (i.e.: not just directorate leads).

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
It is helpful to have consistency across Wales but local determination is also important. It is felt helpful to have a core/consistent number of Executive Directors but have other locally determined Directors without Executive status.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Must not lose the importance of devolution that recognises the value and integrity of localised service models based on demographics and need.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
It is difficult to see why the Board secretary role needs any greater statutory

clarity than any other role just because they offer board's legal advice. It is after all only an advisory role.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
With the ongoing development of networks the role of the networks and the advisory committees should be reviewed to assess whether, where there are networks, the networks are now better placed to provide the expert professional and clinical advice. There would seem to be a strong argument for some rationalising of the 32 advisory committees which often have duplicate membership.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
Clarity does not necessarily require legislation.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Changes have to reflect the service configurations and resources adequately to meet the demands of the wider audience. Ensuring understanding of local services – needs and demands will need to be strengthened to ensure that NWSSP is responsive to all organisations regardless of size.

WGGP038 – Wendy Rees
Tref / Town – N/A
Sefydliad / Organisation – Delivery Unit

General comments

Response to specific questions

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Yes. The current process does not legislate compliance and promotes a passive responsibility where lines of accountability for standards are not clear.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
This mechanism promotes transparency and trust where accreditation is used for constructive feedback and improvement, rather than an investigation and regulation process. Using peers from different health boards to review each other provides a collaborative learning approach.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Clinical supervision should be mandated through the job descriptions and regulated through a similar system used to ensure stat/mand training requirements are adhered to as an employee.

17. What arrangements should be put in place for self-employed health professional registrants?
Through contracts. As a self-employed professional, e.g. GP working on the 'out of hours' service your employment should be subject to a contract which stipulates you adhere to the UHB's policies and procedures, one of these being clinical supervision within a defined framework.

WGGP039 – Christine Lewis
Tref / Town – Haverfordwest
Sefydliad / Organisation – N/A

General comments

This response contained confidential information and as such will not be published.

Response to specific questions

No response to specific consultation questions.

WGGP040 – Bill Parker
Tref / Town – Lampeter
Sefydliad / Organisation – N/A

General comments

In the recent BBC Wales Report programme The Minister stated that some would seek major re-organisation but that he does not support re-organisation. This seems somewhat strange bearing in mind the vast sums that his department spends and the extreme pressure on front end delivery budgets. To believe that pooled funding and legislation will overcome the complex behavioural and practical communication difficulties of any co-operative endeavour seems to be blind to the facts of life. Even more remarkable since he recognizes that public sector organisations should not compete against each other.

Since some wish to see re-organisation should they not have the opportunity to have their views and plans expressed within the consultation. Unless that is the case, in so far as the proposals only seek to give legal force to an organisational structure which is already operational and demonstrably fails to deliver, the consultation simply leads stakeholders and public into supporting inefficient service delivery.

One can only assume that the Minister's political motives override what I believe should be his duty to deliver services as efficiently as possible or that he sees protection of unnecessary public sector administration jobs as more vital to the Welsh Economy than delivery of sustainable health and personal care.
Much of what follows renders many of the consultation questions irrelevant and I make no apology for that. As with many such questionnaires they overshadow any original thinking and therefore partially direct outcomes, to results that support the consulting authority's preferred action.
Transferring Health and Personal Care and appropriate staff,(to continue to deliver the day to day functions as currently delivered by Social Services), to Health Boards is a simple matter .It would deliver the desired integration more quickly and more certainly than any 'co-operation 'could hope for. In my view it should happen without further procrastination.

The rest of my organisational vision may be considered as a route map which could be phased in over time.

I believe that any engagement/ consultation should be in line with The National Principles for Engagement in Wales endorsed by the First Minister on behalf of the Welsh Government in March 2011 which state:

1. Engagement is effectively designed to make a difference.
Engagement gives a real chance to influence policy, service design and delivery from an early stage.

9. People are told the impact of their contribution.
Timely feedback is given to all participants about the views they expressed or decisions or actions taken as a result; methods and form of feedback should take account of participants preferences.

In relation to 1 above I do not recall any previous opportunity to comment upon the co-operation between Health Boards and Social Care and by extension the resultant service delivery. It may be that I missed a published opportunity.

In relation to 9 above, could I please request a response about the views I have expressed and not a collective report relating to all responses.

As part of that I would appreciate a candid statement from the Minister covering the real reasons he has for resisting changes to the Governance and Management Structure of the Welsh National Health Service. THE NEED FOR NEW OR AMENDED LEGISLATION:
The inference is that the majority of existing Government Agencies will be retained and that it would be hoped that legislation will support or force co-operative working between them.
This is clearly to put the Cart before the Horse.
What is needed is an evaluation of existing arrangements.
Do they deliver at optimal effectiveness or could different structures, rationalised organisations, alternative bodies, etc. improve effectiveness at lower costs?
Assuming shortcomings in the outcomes from the current agencies will be found (evidence suggest that will be the case in many, particularly in relation to the inability to reduce costs),remedial reorganisation, even abolition of particular agencies, authorities, and departments will be necessary.
Only when proposals for such reorganisation have been decided upon should new or amended legislation be brought forward to facilitate the changes and ongoing working of the new structure.

I think it will be generally recognised that people from separate organisations, agencies, and cultures work efficiently in carrying out a given task where decisions appertaining to that activity are collectively taken by the members of that working group without the need for reference to superiors.
However it is also clear that if members of that group are accountable to and have direction and control from two or more different organisations(as often occurs in collaboratives) their work is immediately impeded due to the need for extra communication, the self interest of the organisations, workshops, meetings, difficulties in co-ordinating staff presence to say nothing of tensions over budgets.

Since public sector employees generally, in my limited experience, but wider observation, have limited discretion and much governance, effectiveness will be better served by ensuring that single organisations are responsible and accountable for all functions within their remit.

Changing legislation, of itself, will not do anything to improve performance as measured by quality and efficiency in the delivery of care. Put bluntly all that it will achieve is increased governance, increased compliance monitoring, and a further slowing down of action for delivery. In short an increase in governance expenditure, for administration which is so often confused with management.
To achieve optimal organisation I suggest it is first necessary to think clearly about purpose and then ensure that all the component parts needed to achieve the purpose are under the control of one authority. That authority needs to have the highest possible level of skills within it, or the ability to commission the necessary skills directly from the 'owner' of those skills, and to use them directly in order to meet its own objectives.

No Public Sector organisation should be competing with any other Public Sector organisation in an effort to achieve the same functional purpose.

The present co-operative model for Care at Home or Close to Home
Currently it is fair to say that nearly all residents in Care homes have to a greater of lesser degree Healthcare issues. Healthcare is currently a statutory responsibility of Health Boards yet some Care Homes and their Carer staff are controlled by County Councils. The Carer staff will be carrying out the same functions as care support staff in hospitals. The Council has to rely on Health Board clinical staff for nursing care delivery.
The Health Boards, in order to minimise bed blocking in their acute hospitals often need to place patients in Care homes while they await suitable at home care packages to be arranged in co-operation with Social Services(County Council) who directly provide or commission domiciliary care for personal care, and who rely on District Health Teams to provide healthcare.

County Councils are providing services through:
1 their own directly employed carer staff
2 their Social Services Organisations
3 Independent Domiciliary Care Providers

Health Boards are providing services through:
1 Their District Nursing Teams
2 GPs and practice teams
3 Specialised practitioners (physiotherapist, chiropodist, community dentist, opticians etc.)
4 Commissioned Nursing Beds in independent sector nursing homes(to which the Health Board has to commit very considerable resources in order to ensure that safe, appropriate nursing care is being delivered).

Add to this the fact that both lead organisations are working within different governance regimes and seeking to protect their own inadequate revenue allocations and it not surprising that the results from a user perspective fall somewhat short.
The day to day communication effort required to resolve service issues, across multiple organisations with uncoordinated holidays, part time working, flexible working, meetings, workshops, seminars, staff absence through

sickness, if my experience in trying to speak to people within these organisations is indicative, must be a very costly nightmare.

No amount of legislation will create an efficient, cost effective, safe, reliable, and easily managed out of the situation I have just described, where there are two lead organisations (County Council and Health Board) endeavouring to co-operate in the management and commissioning of services from multiple sources.

For the future I believe Local Authorities should not have any authority over any Healthcare or Personal care delivery(who needs personal care unless they have an health problem?),even for the most minor of conditions. Care homes should be removed from their responsibilities and should be under the control of a body under the Healthcare structure (currently this would have to be the Health Board but see the Appendix to this paper).

Social Services should be left with their protection activities, where they would be required to refer clients to the appropriate Healthcare organisation when such care is required.

Domiciliary Care (both health and personal)should be delivered by teams made up of suitably qualified nurses, carers, and if possible relatives and volunteers (to deliver light domestic, conversational, and transport services). These teams should be empowered to formulate care packages for clients(with due reference to GPs and other practice staff and any hospital derived information) ,which meet their health and social needs and as far as possible, wishes. The teams should also be empowered to call upon other community care practitioners (opticians, chiropodist, dentist, as necessary. The teams should also establish there own work patterns to cover theirs clients needs.

An outline of my organisational vision is shown in the appendix attached.
Each major segment of Healthcare delivery would have its own Authority in each case covering the whole of Wales. This model would replace the current geographic boundary distribution of responsibility for all Healthcare functions within a geographic area as seen in Health Boards as they now are.

This approach would automatically lead to standardisation of procedures which It has been suggested would give rise to vast savings in England and it would be reasonable to assume, from that, that proportionate savings could be achieved in Wales.

Budgets would be easier to construct because similar units ,engaged largely in identical activities, should have similar variable costs relative to demand. Attention could much more easily be given to budget differences between units. Accounting officials would quickly develop knowledge of prices and usages across units because they would all be under their control ,rather than being spread around seven Health Boards. Best or poor clinical outcomes would be much more quickly recognisable. Delivery performance would be easily compared at all levels. Staff planning, career development,

forecasting future demands and training needs would all be simplified because all the information for each segment would be within one authority.

The Inspectorate Organisations

I would call into question, the overall effectiveness of some of these. The CSSIW appears to have appropriate powers, yet their operational routines relating to domiciliary care, in my opinion, have room for considerable improvement. Their inspections are based on very few sample patient experiences relative to the total visits, made under the provider contracts, between inspections. Reaction to non compliance issues identified seem to be kid gloved and some shortcomings are not reviewed until the next inspection 12 months later. That fact begs the question; if a shortcoming can be left without further checks for 12 months should it be a compliance issue at all?

It seems to be the case that it is assumed that a supply of suitable caring staff will be available into the foreseeable future ,with little effort being made to forecast future demand or to ensure that sufficient adequately trained carers will be obtainable in order to meet increasing needs. CSSIW believes scoping and forecasting of the market is a Local Authority matter, whilst Ceredigion Council are happy to invite new providers into the area when existing providers begin to express concerns about recruitment Issues and /or contractual capacity. That approach does not seem robust.

The Welsh Audit Office to my mind lacks credibility in examining efficiency within Healthcare environments particularly in delivery of care at home where facilities, house design, geographic locations, patient attitudes, relatives and neighbours influences to say nothing of the vast variety of medical conditions, permutations of them, and treatment regimes will distort any attempt to compare actual productivity with that expected and will tend to invalidate what at first sight may seem to be reasonable comparisons. In addition to ensuring compliance with regulations The Welsh Audit Office would best be left to maintain a high level presence in the administrative areas of Healthcare where objectivity is more easily achievable, where performance comparisons are meaningful, and where there is considerable scope for organisational improvement to facilitate costs savings. They should also be central to the prevention of fraud or financial negligence wherever they may occur within the Health and Social Care organisations. In nursing and caring situations any idea that one size fits all could damage effectiveness as distinct from efficiency of treatment. Only practising nurses and other medical professionals are likely to be able to know the appropriate level of attention for each patient in each particular environment(and that will vary from week to week or even day to day) .Thus the idea that meaningful quantification and comparisons of time attending to patients needs in care at home situations is illusory and I submit beyond the appropriate activities of the Audit Office. Yet such comparisons were suggested during the review of District Nursing Services in 2014.

REFERRAL OF DECISIONS TO MINISTER

It seldom seems to be the case that such referrals are resolved by the Minister, without a panel of 'Experts' first conducting enquiries and then offering their collective view.

To assess the benefits of this method is difficult if not impossible.
Would a panel of 'Experts' who have long practical and recent experience within the functions and environments to be considered offer better solutions than a team of 'Experts' with perhaps higher academic qualifications and recognition but lacking the depth of practical skill development and recent experience?

The Minister may well in good faith appoint a panel comprising both schools of 'Expert' but I offer the view that in most such panels the practical skill experts will defer to the academic and titled experts who are likely to have superior oral communication skills.

Even consensual decisions from a panel will be led by one or a few members that are perceived to have superior knowledge or authority.
The appointment of such review panels ensures the availability of the 'acted on best advice ‘excuse for the Minister in the event of an unsatisfactory outcomes.

I believe that best results are achieved when the operational workforce is challenged with a well articulated problem, and then tasked with designing and implementing appropriate change; provision being made for them to refer to authorities, peer groups, and other parties with additional skills and knowledge, that may be required. Such workforce led organisational development also engenders ready commitment by the workforce to the changes, rather than the resistance that sometimes occurs through top down change management.

Since the Minister is ultimately responsible it is clearly for him to decide what action will be taken and I do not believe in the final analysis, that such decisions should be delegated.

Health Board Size and Membership

Although I fundamentally disagree with the geographic organisation of Health Boards(which probably arose from the Local Government background of the Williams Commission Chair(see my alternative organisation in the Appendix to this paper).On the assumption that the Williams model will be retained I will offer the following comments.

Independent Members
There are already County Councillors serving on the Health Boards, they also serve on the Mid Wales Health Care Collaborative. County Councillors also serve on Community Health Councils one is currently Chair of Hywel Dda Community Health Council and represents it at meetings of the Health Board(including planning meetings).There are also other County Councillors serving on each of the Community Health Council locality committees.

To add Council Cabinet members to the mix while reducing the Boards overall size will further increase political and/or(in the case of non -aligned councillors) parochial interests.

Health Boards are in reality far more accountable than any Local Government, Welsh Government, or even the UK government. Yes each layer of government is subject to an election at four or five year intervals and are held to account at that time.

Contrast this with Health Boards operations which are constantly monitored by Welsh Government centrally, the Welsh Audit Office, the Health Inspectorate of Wales, and Community Health Councils, to these can be added all the Medical Royal Colleges. I think too they are watched more critically and pursued more vigorously by users, their relatives, and the multitude of medical charities. To say nothing of the media.
Boards need more Independent Members not to make them more accountable, the extreme levels of governance if properly followed through will do all that is necessary in relation to that, but to bring that organisational flair, which is precluded by the self protection mentality which cripples the public sector, which can be clearly seen in the political arena at all levels, and which is quite naturally mimicked, for the most part unconsciously, by staff working in those environments.

My previously expressed view that Local Authorities should have no part to play in nursing or personal care and that both should be within the Heath Boards' remit renders any consideration of Social Care Directors sitting on Health Boards unnecessary.

Health Inspectorate Wales should acquire Inspection responsibility over all Health Care and Personal Care providers together with follow up ,escalation and enforcement procedures.

CSSIW should lose responsibility for all Health Care and Personal Care and become Protection Services Inspectorate for Wales dealing with all matters including escalation and enforcement procedures relating to what are currently Social Service Protection services.

In this narrative I have used ' Health Board' to refer to the 'Responsible Body' in the Appendix, the size and make up of each body will depend on the demands of each Segment.

For ease of presentation and clarity I have covered one or two topics within the Appendix.

Appendix

WELSH HEALTHCARE MANAGEMENT BY SEGMENT
Appendix
ACUTE HOSPITALS:
Responsible body:
All Wales Acute Hospital Authority.
Provide all services and levels of care currently available at an Acute General Hospital e.g. Glangwili Carmarthen.
Responsible body undertakes strategic planning for all Acute Hospitals in

Wales, together with service delivery planning and implementation. This will include Integrated Medium Term Planning, Accounting, Human Resource Management and Organisational Development, Estate Development and Management, Catering and Household Services, Governance and Communications.

LOCALITY HOSPITALS:
Responsible body:
All Wales Locality Hospital and Homes Authority.
Provide all diagnostic and emergency patient stabilization services. Delivers less demanding surgical and medical treatments. Delivers ongoing out patient care and monitoring (where this cannot be delivered in the community) following Acute Hospital treatments .Has a number of 'step down' beds available for patients who require in patient care but where discharge from Acute Hospital is desirable.
Responsible body undertakes strategic planning for all Locality Hospitals in Wales, together with service delivery planning and implementation. This will include Integrated Medium Term Planning, Accounting, Human Resource Management and Organisational Development, Estate Development and Management, Catering and Household Services, Governance and Communications.

RESIDENTIAL CARE HOMES Responsible body : All Wales Locality Hospital and Homes Authority
Provide residential nursing and personal care for those where Care at Home is not viable.
Responsible body undertakes strategic planning for all NHS Residential Care Homes in Wales, together with service delivery planning and implementation. This will include Integrated Medium Term Planning, Accounting, Human Resource Management and Organisational Development, Estate Development and Management, Catering and Household Services, Governance and Communications. It will also be responsible for commissioning accommodation in independent care homes as required, and will be responsible for scrutiny and monitoring of Nursing, Personal Care, and Nutrition provided by them.

MENTAL HEALTH HOSPITALS
Responsible body:
All Wales Mental Health Authority
iNTEGRATED COMMUNITY
MENTAL HEALTH CENTRES
Responsible body:
All Wales Mental Health Authority
Responsible body undertakes strategic planning for all NHS Mental health services in Wales, together with service delivery planning and implementation. This will include Integrated Medium Term Planning, Accounting, Human Resource Management and Organisational Development,

Estate Development and Management, Catering and Household Services, Governance and Communications

LOCALITY WELLBEING CENTRES
Responsible body:
All Wales Wellbeing Authority

MINOR INJURIES UNITS
Responsible body:
All Wales Wellbeing Authority

SEXUAL HEALTH CENTRES
Responsible body:
All Wales Wellbeing Authority
Responsible body undertakes strategic planning for all NHS Locality Wellbeing Centers, Minor Injuries Units, and Sexual Health Centers in Wales, together with service delivery planning and implementation. This will include Integrated Medium Term Planning, Accounting, Human Resource Management and Organisational Development, Estate Development and Management, Catering and Household Services, Governance and Communications.

GENERAL PRACTICE
Responsible body:
All Wales General Practice Authority
Responsible body is responsible for employing GPs both under contract as self employed business partners, or as salaried doctors employed by the AWGPA. They will undertake strategic planning for the delivery of GP services to ensure that services are available to all within reasonable travelling time. They will monitor delivery of GP services. They will scope and forecast the future requirements for GPs throughout Wales, and support practices with HR, particularly with recruitment and manpower planning. They will liaise with the Deaneries in an effort to ensure an appropriate flow of student doctors.

OUT OR HOURS SERVICES
Responsible body:
All Wales General Practice Authority
Responsible body will ensure that appropriate levels of out of hours GP services are deliverable by GPs and other practice staff.

DENTIST
Responsible body:
All Wales Dental Services Authority
Responsible body will be responsible for strategic planning of General Dental Services, Community Dental Services, and Orthodontic Services throughout Wales. It will be responsible for scoping and forecasting to ensure adequate

levels of appropriate dental care for all communities delivered by independent providers or directly employed dentists. It will be responsible for monitoring all services to ensure they meet contracted standards. It would monitor and scrutinize payments made under Dentists contracts

INDEPENDENT PHARMACIES
INDEPENDENTOPTICIANS
INDEPENDENT AUDIOLOGIST
INDEPENDENT CHIROPODIST
INDEPENDENT PHYSIOTHERAPIST
The responsible body for all of these would be the All Wales Independent Ancillary Healthcare Provider Authority.

It would maintain registers of authorized practitioners, and monitor their activities to ensure the required standards of service were maintained, it would maintain a directory of all practices for use by the Public, GPs, Care Homes and Hospital Staff. It would deal with any reimbursement matters where appropriate.

This organisational outline may not be comprehensive and would certainly need development, but I think it should convey the essential divisions of authority and the main activities of the controlling bodies. All seven authorities together with the existing Welsh Ambulance Service Trust could report directly to the Deputy Health Minister.

Each Controlling Body could interface with the Board of the Community Health Councils which would participate in their planning and service provision decision making. Locality Community Health Councils would provide advocacy services and take up issues referred by the public with the appropriate local service providers, escalating unresolved issues to their Board for resolution through the Controlling Body. They could recommend service changes through their Board and would be consulted by their Board on changes proposed by the Controlling Bodies.

Response to specific questions

No response to specific consultation questions.

WGGP041 – Rhodri Thomas – The Company Chemists' Association Wales
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The evolution of primary care clusters should see the needs of local populations addressed by professionals closest to home, with funding being made available to address issues identified locally. Legislation should see that the primary care clusters are multi-disciplinary with GPs, Dentists, community Pharmacists and other recognised healthcare professionals participating to reflect a wider local intelligence.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
We believe there is sufficient legislation to ensure that health boards are meeting with both users and providers of healthcare services on a regular basis.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Community Pharmacy Wales is the statutory recognised body that represents community pharmacy contractors in Wales. Arrangements are already in place that allows health boards and CPW to meet on a regular basis.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
We believe that the current criteria are sufficient.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Community pharmacy is monitored by the General Pharmaceutical council. Any additional regulatory or standards requirement could mean duplication of work and possible conflicting standards requirements. The CCA would encourage Welsh Government to use the opportunity of this consultation to put in place formal arrangements for the sharing of information where there is more than one body engaged in the monitoring of healthcare services.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Accreditation is already recognised within the community pharmacy sector as a means to ensure that those delivering services are of a standard required. Self declaration of competency should also be promoted as it is important that we recognise the continuing professional development

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
We agree that a statutory duty of candour is beneficial to protect both the safety of patients and reputation of professionals. The GPhC has published a joint statement, with the other regulators of healthcare professionals, confirming that it will be introducing this requirement into standards in the near future.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
If legislation is introduced then it is important that the information gathered is used to promote best practice and drive improvements in standards and that the data does not serve as a deterrent to candour and openness.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Guaranteeing confidentiality should be the priority in any discussions on patient information. As community pharmacists we have shown in studies that

access to patient information can identify safety issues and lead to improvements in patient care. Fears over the potential for misuse of patient information are totally unfounded and safeguards can be implanted into the access process to ensure that this cannot happen.

22. How can we consider breaking down any barriers?
We have already seen the process of allowing other HC professionals access to read only medical record's with stringent access and permission protocols in place, we support the roll out of this service to all pharmacies in Wales.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
It is important that the privacy and interests of the patient population is placed first, and that there should be no potential for commercial use of this data for the gain of either the NHS or private providers.

Chapter 8: Leadership, Governance and Partnerships

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
There should be recognised forum for debate between NHSWSSP, NWIS and providers of IT services to the NHS and primary care providers in Wales.

WGGP042 – Dr Martin Rolles – Welsh Committee of the Royal College of Radiologists
Tref / Town – N/A

General comments

Finance Reporting – whatever changes are made should have the effect of increasing transparency and be comparable across health boards and trusts. LTA arrangements and some WHSSC block disbursements lack the necessary activity-related detail and transparency.

Financial Planning requirements should be equivalent for boards and trusts.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Wherever possible it is desirable to meet healthcare needs close to home, but this should not be at the expense of quality. Some services require centralisation. This is all prudent healthcare and changes to legislation may be unnecessary. It does however need significant commitment and active management to achieve the realistic ideals. Recruitment of suitably qualified staff in Wales, particularly outside the South East, remains a significant barrier to satisfactory achievement.

2. If so, what changes should be given priority?
For cancer care this includes: chemotherapy delivered at home, in mobile units, or in local DGHs, community or cottage hospitals. This can be facilitated by regionally-commissioned electronic prescribing and dispensing systems as demonstrated in South West Wales by the collaboration between ABMU and Hywel Dda. Currently patient follow-up involves a lot of patient travel time to hospital clinics, and it takes up a significant hospital resource. Rationalisation of follow-up, using telemedicine, should be promoted wherever possible. Radiotherapy is expensive to provide in satellite centres with risks to quality, and will always remain based in a few cancer centres. Decentralisation of Clinical Radiology is less of an issue, apart from serious current and anticipated staffing problems in Wales. It is imperative that radiology IT barriers across Wales are resolved to facilitate remote reporting.

Patients requiring specialist interventional radiology and some specialist imaging techniques (e.g. PET-CT) will have to travel to a relevant centre. The primary-secondary care interface is inefficient. There are frequently barriers to communication and referral between community and secondary providers, which wastes resources and impacts on the quality of healthcare. This particularly applies to referrals for suspected cancers in subsites such as urology and colorectal cancer, which have high-volume Urgent Suspected Cancer screening requirements and low conversion rates. Far too many lung cancers present late or as unplanned emergencies. None of these problems are new, but the solutions are elusive. Discharge back to the community is neglected. There is a perennial disconnect between the needs of hospital/GP, and social services, which greatly reduces the efficiency of discharge, particularly for patients requiring care or nursing home placement. This leads to delayed discharge, with the associated hazards of prolonged hospital admission, and it can cause bed-blocking. There are additional issues for tertiary providers when attempting complex discharges to distant authorities. GP handling of discharges would be facilitated by better communication from hospitals. Investment in community palliative medicine services would seem prudent.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Much greater emphasis on personal and community responsibility in prevention (obesity, smoking, alcohol) and emphasis on the timely use of health services. Harmonisation of the standards, requirements and expectations for social services and LHBs to improve collaboration in respect of patient care in the community, hospital discharge.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Public Health legislation such as minimum pricing for alcoholic drinks, and measures to reduce consumption of refined sugars would likely have significant knock-on benefits in shaping service change.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Formal Patient panels / participation groups in oncology often have a skewed distribution and promote highly motivated individuals from predictable patient

groups to champion certain issues and cancers at the expense of those cancers that are disproportionately derived from lower socioeconomic groups, and rarer cancers. Whilst patient involvement is key and the case for statutory involvement in decision making is strong, novel ways of engaging a wider more representative patient voice that would not necessarily sit on a panel or participation group is needed. CHCs can be useful in this respect. The Wales Cancer Alliance, comprising senior members of the major cancer charities, is also a reasonable surrogate, though it has to be acknowledged that the charities also have their own agenda.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
This idea merits a much more detailed analysis.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section? 8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
Legislative measures may be helpful if properly directed. We are not certain whether the following points require legislation or whether they can be addressed through other means, but they are pivotal: • Quality / Meeting common standards – in oncology the Peer Review system backed by HIW and publically published is already providing this in a developing format. A requirement to participate in the process is reasonable, but to have greater value the process should have greater independence. Within Wales it is hard to divorce drivers for change on quality and political grounds. As such the definition of Peers should be widened to outside of Wales or at least has an oversight by a non-governmental independent body. • Quality metrics are not always easily available (e.g. patient-specific mortality data) or may, arguably, produce perverse, sometimes non-prudent incentives (e.g. cancer SaFF targets) at the expense of more clinically relevant priorities. High quality, prospective data relevant to the entire patient pathway is fundamental: much of this exists but in isolated IT silos, inaccessible and underexploited. Benchmarking of electronic clinical datasets across Wales and with England is important, but sometimes difficult. Integration of public health and primary care datasets with those of secondary care is a basic requirement.

• There is a clear need to foster regional inter-LHB cooperation for cancer services, radiology and other issues. Current financial arrangements (LTAs, WHSSC) between LHBs, NHS trusts are frustratingly opaque, and are a barrier to this. • There needs to be consideration to given to how the needs of equity, quality and cooperation can be ensured, given the 2 different commissioning models currently being developed in Wales for cancer services: South East Wales, compared to South West and North Wales. • Wales compared to the UK and EU. Parochial measures of quality and equity within Wales are useful up to a point, but there has to be explicit recognition that Wales exists as part of the rest of the UK/EU/World in terms of staff training and recruitment, specialist service commissioning, and health outcome measures. The continued divergence of NHS Wales and NHS England presents immediate and growing practical issues.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
See question 7.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Yes. Agree with point 52.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
The HIW cancer peer review programme has matured and proved to be useful. It promotes data transparency and a reciprocal, critical multidisciplinary review of local services by a wider Welsh expert panel. The process could be extended to other services. Accreditation beyond Wales is already required for participation in certain areas of clinical research, and this is a clear driver for service improvement. It is important that Wales should be actively involved in generating the UK-wide peer review and accreditation

agenda, rather than assuming the role of a passive follower.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
All doctors are subject to annual appraisal and 5-yearly revalidation under GMC regulations. Clinical peer supervision and support is more than this however, and professional isolation of medical specialists, often in small departments in District General Hospitals is a very real problem. Isolation makes vacant posts unattractive, and compounds recruitment problems especially in the periphery. Professional guidance and needs will vary between specialties. For Clinical Oncology and Clinical Radiology, the RCR can provide guidance. Whether this needs specific legislation or an obligation to follow RCR (or equivalent) guidance is moot: the work required for medical appraisal and revalidation is already a significant burden for doctors, and we would advise caution if considering adding extra to the current appraisal process.

17. What arrangements should be put in place for self-employed health professional registrants?
Self-employed health professional registrants should have the same standards applied as NHS employees.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
No comment.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Agree with points 68, 69, and 70.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information? 22. How can we consider breaking down any barriers?
This is key for Oncology treatment management and research. The unnecessarily restrictive sharing of data is one of the key barriers to future improvements in outcomes. Whilst necessary protection to individuals is important there should be an assumption of free sharing of medical information between health and social care professionals particularly across primary / secondary care and health board boundaries for the benefit of individuals. 1. Technical. Data silos within LHBs (often between departments) and between LHBs (Radiological images and reports are a prime example.) Basic technical sharing issues can be overcome. It is ironic that there remain severe longstanding problems sharing radiological information between units along the South Wales corridor, which have been solved by a private provider of outsourced radiology reporting based in Australia. 2. Future commissioning of IT systems requires an all-Wales set of standards. Wales has to overcome the legacy of multiple non-integrated systems, some of which are obsolete. 3. More advanced integration of data to permit sophisticated population analysis requires a feed from Public Health Wales, Public Health England, and from primary care, amongst others. At present this is in development through the SAIL project, but this remains purely academic, without a clinical interface. This represents a profound opportunity for intelligent, information-driven service development. Cross-border data sharing issues are a problem e.g. death data administered by the Office of National Statistics. 4. Data security and confidentiality. Whilst this is obviously central, it is frequently misapplied, increasing clinical risk. For example the insistence on using anonymised Fax to transfer radiology reporting between health boards, when nhsWales email is probably safer, and less prone to patient identification error. We question whether Fax is appropriate in the modern NHS at all. 5. Lack of appreciation of the clinical risks and inefficiencies associated with unavailability of information at the point of clinical decision making. For example • Regional MDT review of images from neighbouring LHBs, which often arrive without an attached report. • Admission of acutely ill cancer patients to a DGH who are receiving treatment at a specialist unit elsewhere: lack of access for the acute admitting team to details of diagnosis and treatments for a complex condition, current treatment and possible morbidities, ceilings of care.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the

issues to be considered?
Crucial, within accepted, well-defined research guidelines. For the purposes of research, data should be pseudo-anonymised, but then made freely available to appropriately approved researchers. In a similar way to the Welsh leading the way on presumed consent to organ donation, Wales should lead the way on presumed consent for healthcare data sharing on both the individual patient management level and the pseudo-anonymised research level. These arguments have been well articulated by the European Data in Health Research Alliance (http://www.datasaveslives.eu/)

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
A potential problem with integration is loss of specialist understanding of areas inspected.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Yes, with appropriate safeguards. The Scottish NPD model for infrastructure projects is already being adopted in Wales.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Leadership should be fostered and developed. Any strong leadership of should be demonstrably impartial and without any conflict of interest.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the

statutory status of the advisory committees? 47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
Please see the embedded RCR response to the WAG Review of the Advisory Structure for Health (submitted September 2014)

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
See previous comments. Recruitment and retention of staff is significantly affected by training schemes in England and by comparison of Welsh Terms & Conditions with those of England. Given the increasing divergence of NHS Wales from England, the requirements of NHS workforce partnerships becomes more complex, and it is necessary develop a mechanism to keep this under review, in order to plan strategically and sensibly.

WGGP043 – Dr Steve Boyle – National Clinical Assessment Service
Tref / Town – N/A

General comments

NCAS contributes to patient safety by helping to resolve concerns about the professional practice of doctors, dentists and pharmacists. We provide expert advice and support, clinical assessment and training to the NHS in Wales and other healthcare partners.

NCAS welcomes the opportunity to respond to the Green Paper "Our Health, Our Service". We recognise the importance of a robust structure promoting quality and clear approaches for minimising variations in the standards of healthcare.

NCAS as an operating division of the NHS Litigation Authority has recognised experience in assisting healthcare organisations across the UK in resolving performance concerns. It would be pleased to provide expert professional advice to Welsh Government in addition to its current role with Health Boards.

Response to specific questions

Chapter 3: Quality in Practice

Meeting common standards

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
We would support the introduction of a common standards framework across all sectors providing healthcare.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
This will strengthen continuity of care and enable a more effective monitoring of the care delivered. Peer review is a well- established approach to improve and maintain the standard of care delivered by health professions and mechanisms to extend and embed in practise are to be supported.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Clinical supervision, and associated terms used in various branches of health

care support clinicians and help to minimise variations in the standards of care delivered. An extension of this approach across all professions is to be supported.

17. What arrangements should be put in place for self-employed health professional registrants?
This should also be extended to independent and self-employed registrants as NCAS is aware of the potential for professional isolation in this group.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
The importance of a duty of candour is widely recognised and NCAS would support this being implemented in Wales. Greater openness and strengthened oversight by Boards have been extensively discussed in the Francis Report. Measures to raise the duty of care for Health Boards are to be welcomed.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information? 22. How can we consider breaking down any barriers?
Because the delivery of health and social care is a complex journey for citizens the improved sharing of information across bodies is to be welcomed. A shared IT system, patient held records and other approaches to have a seamless transfer will assist in improving the quality of care delivered.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Any sharing of information should have robust mechanisms to ensure confidentiality.

WGGP044 – Dr David Rea – College of Human and Health Sciences, Swansea University
Tref / Town – Swansea
Sefydliad / Organisation

General comments

I have read the above document with some interest. My major concern is to continued organisational boundaries between health and social care. This is marked in the consultation document's proposals for community representation and community health councils.

My concern is the difficulty service users have in representing their views or in voicing complaints adequately when the organisations, its management, and so many of its professional staff are so powerful, and so well defended. Service users need powerful voices on their side which they do not currently seem to have. The problem is made more acute when we consider that most errors and most lapses in quality occur through failures to pass relevant information from one agency to another or to have that information to hand when care is transferred. People deal with a whole system but all too frequently if anything goes wrong, they need to identify who it was within the system that let them down, rather than the system overall.

Community Health Councils, with their focus on health care, are a case in point. Service users and patients (and carers) need to be adequately represented by a professional and powerful advocate working on their behalf. (An inadequate) £4m is currently spent on CHCs in Wales, and recent research has shown that most members regard their role as tokenistic at best. They say that CHCs serve to deflect criticisms that the NHS and local social services are accountable to the Welsh Government, or to professional bodies, but not to the people they serve. CHC membership is comprised largely of a particular age group and demographic, but they have little voice, are not widely known about, and are not served by sufficient numbers of staff.

Response to specific questions

No response to specific consultation questions.

WGGP045 – Lynda Williams – All Wales Nurse Directors
Tref / Town – N/A

General comments

We have answered the questions in the format response, but have included additional responses to some of the chapters for your consideration.

Appendix 1
Fully endorse the sentiments in the - being of Future Generations (Wales) Act 2015 for public bodies to work together to prevent problems and take a more joined-up approach. This should be interdisciplinary as well as uni-disciplinary.

Both the Public Health (Wales) and the Social Services and Wellbeing (Wales) Act 2014 also endorses the need to consider preventative services and individual's wellbeing. Further emphasis should be placed on this in the training of nurses, medics and Allied Health Professionals (AHPs) as this is key to implementing this legislation and will have the biggest impact in the future on population health. Government, education and schools of healthcare need to address 'social medicine' as part of curriculum development.

It enable the NHS in Wales to support individuals to live healthier, more productive and more satisfying lives the focus has to move away from acute services, with NHS staff recognising the contribution that all nurses, medics and AHPs can play in improving population health. Individuals should not be forced to stay in the acute sector because there is no provision for them in the community. There should be parity in the legislation reflecting the importance of individuals making decisions about their own health.

At an organisational level there needs to be more focus on engaging with other health organisations and social services when developing strategies. This is fundamental to challenge the culture of working in silos. Changes in the law, to support and strengthen the vision of preventative health/ social model of health are applauded. However, consideration must be given to the significant impact this will have on many Health Professionals roles and dialogue between organisations and disciplines needs to start before the legislation is in place in order to consider and plan for the transformation that will be required.

Fully endorse a primary care service based on the principles of prudent healthcare and made up of a wide range of public and third sector organisations. Organisations need to work together for the good of the population/ individual and not work in disparate locations with different agendas. Health and social workforce skills should be enhanced and developed so that primary and community care system are not in a position whereby they support crisis management but early intervention and prevention.

GP clusters are vital to delivering population based services, although there is a need to ensure parity across areas. Nurses, medics and AHPs need to be aligned to the clusters so that a comprehensive picture of the population can be developed with appropriate services delivered by a fully integrated team who are able to meet people's needs locally. New roles should be considered that will support primary care to connect more effectively to community, this could be supported by developing lay health workers, social prescribers, behaviour support worker etc.

The focus needs to be on prevention and wellbeing

Appendix 2

Much is made of the need for co-production. This is the way to gain trust across the public and staff sectors. However, to be skilled in co-production it requires a very different set of skills and ones which are not commonly seen in the NHS. In order to really use this as a strategic method then much emphasis will need to be placed on it and with an accompanying training and development programme and behaviours and attitudes will need to change across NHS Wales.

There is no mention of using shared care as a method to improve clinical partnerships with patients, which will stop the complaints and concerns and possibly some litigation. It is this which we should be developing to ensure patient centeredness and open discussions about care in partnership which could be the future.

Appendix 3

There could be great use of the checks and balances, more regard needs to be paid to the role and functions of other inspectors and regulators rather than just HIW, we are as prescribed by HSE, it is an opportunity to respond to the Marks review and to strengthen the role of HIW including independence and integrations with CSSIW as it makes little sense to have two regulatory bodies particularly as we move further into the integration of health and social care services. Joint working between the two organisations will continue to be piecemeal and sporadic without statutory changes.

CHCs focus on representing the patient voice and as advocates would be helpful, it isn't necessarily legislation but clear objectives and performance management.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The legislation within the Social Services & Well-being (Wales) Act 2014 gives opportunity to strengthen collaboration under section 47 and Part 9. The legislation within the National Health Service (Wales) Act 2006 also gives opportunity to work in collaboration under Part 3 and section 33. However there is a convoluted understanding of what is health and what is care to support well-being that requires understanding of what the definitions are within the legislation within the National Health Service and Community Care Act 1990 and Health and Social Care Act 2001 and subsequent acts such as the National Health Service (Wales) Act 2006. If further changes to the law would make this clearer for interpretation at a operational level to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home then this would be welcomed.

2. If so, what changes should be given priority?
Clear definition of what is a health responsibility and what health inputs are considered to be part of maintaining well-being and can be undertaken as normal activities of life. Within this definition there should also be a clear statement over the individual citizens' choice, personal control and risk enablement.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Put all the legislation in this area within 1 act that replaces all the other acts. (See additional sheet Appendix 1)

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Health Boards are already under a duty to involve and Local Authorities have similar obligations not least due to the mandate of local government. However within an integrated environment of Health & Social Care a joint duty to engage in service change may strengthen this.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Within the modern environment accessing people's time to become members of panels or participation groups can limit membership and create bias within the group. Health Boards are already under a duty to involve and possibly this should be given a technological support rather than a statutory basis to improve engagement. This would need a national solution to enable this but local feedback and engagement and opinion polling.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
A national expert panel may depoliticise some difficult decisions but the independence of the panel would need to be established. This could either be through appointment of a Judge to lead as in commissions or creating access to expert panels externally to Wales. However this would mean the option to refer to the Minister should be removed completely.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
No legislative measures merely outline the process to be taken and do not ensure quality improvement is executed.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
The Social Services and Well-being (Wales) Act 2014 provides legislation on a citizen centred approach and how this can be achieved through partnership and integration. Before further legislation is required it is important to recognise the impact of this act to ensure that it has facilitated a citizen focused integrated delivery of care and that the citizen's are satisfied with this within the coproduction agreements and maintaining prudent health and care. 'The Prudent Citizen'. There are significant numbers of tools to measure quality improvement.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Quality is a time and culture sensitive measure dependent on the culture and values of individuals and organisations. Legislation needs to be able to keep pace with quality development and would it be prudent within the time and

context of the developing future.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
There is already an accountable officer the Chief Executive. The Board members have a collective responsibility and accountability. The Director of Nursing is not only accountable as part of the Board but is also accountable to the NMC as the professional regulator.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
The “Fit and proper persons” test is acknowledged as a principle following failings in NHS on managing patient safety and quality. However, this should not detract from the employers responsibilities to check the person is able to discharge their functions. We currently have employment checks which include professional regulation DBS and financial matters such as bankruptcy. It is envisaged they could apply at different levels in the organisation or to key Board members e.g. Director of Nursing.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
IMTP’s are relatively immature and need time to be developed and deliver. Further to this they need time to see if they really do improve planning and this will take sometime to be demonstrated more than. It is vital that quality improvement is a key component of service planning ensuring care delivery in the most appropriate place by the most appropriate person.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
The health and Care Standards have just been refreshed and these need time to be embedded and to be reviewed, but can be applied across Health & Social Care with appropriate monitoring mechanisms.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Common goals and standards that complement each other and remove perverse incentives and enhance the overall journey and experience for the citizen would be welcome. However, this would have implications for CSSIW

and HIW as regulators across Health & Social Care.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Mandatory accreditation across the sector would require the appropriate resource to support the cost of the accreditation process. Thought needs to be given as to the escalation of services that are unable to meet accreditation across Wales when the infrastructure is not to the accreditation standards. Accreditation ensures compliance to a set standard and should be welcomed.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
The NMC are introducing a new Revalidation process this requires all Nurses and Midwives to have a professional discussion to support the process. There would be no additional benefit in legislating for additional supervision. It is important to recognise the resource implications of clinical supervision. Within Midwifery statutory supervision is changing and a review of this model by the Kings Fund recommended that statutory supervision be discontinued. This has now been considered and supported and statutory supervision will discontinue. Good clinical supervision does improve services and improve staff motivation and self worth but legislation would not ensure the quality of the supervision just that supervision activities have taken place.

17. What arrangements should be put in place for self-employed health professional registrants?
The NMC are introducing a new Revalidation process this requires all Nurses and Midwives to have a professional discussion to support the process

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Putting Things Right, including redress 2011 this needs to be reviewed and any lessons learnt implemented before further legislation is considered. Professional groups already have this duty. Boards could be performance managed on the delivery of this.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Support in how, where and what information is routinely made available, as standard, across the sector eg each Health Boards Web site would be welcome. This information should include outcome data and real time patient experience information.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
This doesn't require legislation to enact – it could be achieved with a localised policy/standard and operational policy eg lead agency, complaint handler and include how this is shared and managed using PTR methodology.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Data Protection Act provides the legal framework for allowing organisations to share information and we have WASPI though this is timely and complicated to navigate and implement any support to simplifying the process would be welcome. It is often lack of knowledge that prevents information exchange both by individuals and organisation.

22. How can we consider breaking down any barriers?
Giving operational teams and middle managers better guidance and training and having explicit and visible WASPI protocols to support operational staff. The single patient record could also break down barriers but give new challenges.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
If it is patient identifiable and it is being used for a purpose it was not intended this is then against the data protection act. However non identifiable data should be used as in the SAIL project to help with research and if Patient Identifiable information is to be used for research then a new agreement with the people of Wales needs to be put in place to allow this to happen. Possibly on an opt out basis like organ donation. It is important that patients in our care have trust in how we utilise their information.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
HIW inspect the provision of health care. CSSIW inspect and regulate the provision of social care. There is becoming a larger population of older people who have multiple conditions and a level of frailty that cross cut both regulators. The advisory committees could support HIW in focussing on where the issues may be or provide expert advisory support as to what to inspect within complex health organisations.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
Full statutory independence could provide the levers to enforce non compliance of a health providers and improve independent regulation. It would be imperative to have regulators with equal status and improvements could be made with one body regulating across health and social care.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
An integrated provider should only have one regulatory framework with joint or common standards to work within and not have both regulators asking sometimes contradicting requests of the provider. Should a provider need dual regulation a lead regulator should be independently nominated to regulate the provider. This would require legislative changes.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
A single inspectorate would enable the inspection and regulation of services that support citizen focused independence and well-being and not just health or social care provision giving clarity and visibility for the public.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to

strengthen the CHCs role as representatives of the patient voice?
In multi-agency multidisciplinary integrated care the CHC should represent the citizens voice and provide advocacy across complex integrated care. Focussing on the whole care continuum. There should be less of a focus on visiting and more on advocacy roles.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
The current CHC model focusses on health issues and has no impact on activities that would support well-being and citizen centred care. Re – focussing the CHC on a citizen centred care providing the citizen voice and providing advocacy across complex integrated care. Ensuring it is timely representative of the population it services.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Giving Health Boards borrowing powers would increase the flexibility of resource across revenue and capital and enable NHS providers to modernise and improve estate at a greater pace than is currently achievable. This needs to be balanced over revenue to pay back any borrowing and requires some form of underwriting to facilitate competitive borrowing rates. There would need to be clear policies and parameters with which this would work and to ensure limited exposure to over borrowing and ability to repay.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
Summarised accounts are important in terms of transparency and accountability to the general public. The timing of publication detracts from the values. It could be argued they would have greater meaning if the health Boards had borrowing powers. There may be an argument that the timetable for Annual Reports and Annual General Meetings should be shortened to create more timely reporting. Crucially, any change in reporting should encourage more meaningful and understandable analysis. There should also be consideration given to the Annual Report as a whole, to ensure that it can become a document which is understandable and accessible by the general public.

32. 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?
Summarised accounts should reflect the structure of the NHS and be coterminous with government financial reporting regimes. There are benefits in changing the legislation as outlined above.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes there should be an equivalent statutory planning duty on NHS Trusts. This would ensure a consistency across organisations ensuring patient pathways to care delivery.

34. 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 the NHS (Wales) Act 2006 does need to be updated to be in line with the full integration and citizen centred care agenda. The Community Care Act 1990 also needs to be fully reviewed and replaced to support integration and citizen centred care.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
The current legislative structure through the Social Services & Well-being (Wales) Act 2014 will strengthen leadership, governance and partnerships. It must be seen if this will deliver this once implemented. It is important to recognise the complexity of governance arrangements (WAO recently).

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Current Health Boards have been in place since 2009 and have faced considerable challenges with finance, performance and quality. The focus should be on the competence of the board members to discharge the responsibilities including scrutiny and decision making.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Yes, the current model could be seen as restrictive it should be for the Board to determine composition and competencies.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
The Health Boards must be accountable and responsive to the populations they serve. It is less about representation and more about leadership and director as Board functions.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
If local government reform delivers coterminosity with Health Boards then this would give opportunities for appointments spanning organisations to deliver on key objectives.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Maintain flexibility by having opportunity to have a Board that reflects the organisation and needs of the local population.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
Membership seems to currently reflect an effective focus on decisions, priorities and service provision.

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
Possibly a further development of the public voice to support coproduction and co-creation of services through possible sub committee structures taking best advantage of the Community Health Council input.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
This could be achieved through standing orders and cognisance of the governance implications of the role.

44. If so, what aspects of the role should be additionally set out in law?
The value and importance of the role does not require legislation. This role possibly should be a re-numerated full time public appointment and not a Health Board employee.

45. How could potential conflicts of interest for the board secretary be managed?
There would not be conflicts of interest if there was role clarity and parameters around the functions. If it were to be a public appointment as outline above this would also give distance.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Many of the advisory committees are made up of uni-professions and do not reflect the multidisciplinary, multiagency nature of the services provided or of the citizen needs. With the move towards on coproduction and co-creation would changing the statutory nature add to the flexibility required to meet on-going and future needs. They do though need regular review of constituents and Terms of Reference and stood down as required. Possibly a steering board is required to agree, set up receive outputs and stand down advisory committees.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
Legislation may not be the best way to make improvements in this area. The steering board possibly would require legislation.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Current partnership working arrangements need to be reviewed to reflect increased devolution, however this must be undertaken in such a way as to prevent Wales from becoming disadvantaged against the rest of the UK within the Health employment market.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
There is a lack of clarity in NHS Wales on these various mechanisms, this gives difficulties with lines of accountability and responsibility.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Opening up Shared services to support the wider public sector and to maximise on its buying power for the public sector in Wales. However, this could dilute its impact for NHS Wales. Legislation may need to change for a 2 way flow of funding rather than the limited section 33 agreement we currently have in place.

WGGP046 – Helen Ward – Wales Dietetic Leadership Advisory Group
Tref / Town – N/A

General comments

Overall, this green paper proposes a considerable volume of potential changes to the way that the NHS in Wales operates and to the legislation underpinning those changes. We have no argument with the proposal to shift emphasis and resource from the current secondary (hospital) based care to that of a preventative model of care. We agree that this is an overdue and certainly, more sustainable approach to funding the NHS in Wales.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Sections 23-31 sets the direction of travel for Promoting Health and Wellbeing and outlines a belief that preventative primary care is the essential component needed to meet this agenda, which requires further development. We do not question the premise that this mode of delivery of preventative work is needed and would suggest that other well established delivery modes should also be considered. As an example, the group Public Health Dietitians in Wales, whose staff largely sit within Health Board structures, have been carrying out this type of work for a decade. In this instance, recognising that Dietitians alone cannot hope to meet the capacity demands for high quality nutrition skills development for disease prevention in the population, the Nutrition Skills for Life (NSfL) programme utilises capacity building strategies through the delivery of structured education to Health, Social Care and Third Sector staff and volunteers. These accredited learners then go on to embed their learning in communities to either directly or indirectly influence the nutrition status of communities and individuals. Perhaps rather than further changes in the law, work force planning arrangements should be focusing more on the preventive primary care model and identifying the shift in requirement for staff working in local communities. This particularly applies to AHP's , including dietitians in supporting and recognising the contribution they can make to public health and prevention, and meeting needs closer to home.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The principle of devolving preventative delivery to primary care and to third

sector organisations must take account of the need to ensure that the preventative agenda and content is fully informed by the most sound evidence; and that the skills development needed to deliver the key messages is equally sound. We suggest reviewing the NSfL programme as a model of good practice in this field, including the full evaluative cycle provided by independent researchers. There are significant opportunities to further embed this model across sectors into national programmes including Flying Start, Families First and Communities First for wider population reach, informing and empowering people to access a healthy, affordable and sustainable diet (a key determinant of health and wellbeing). Furthermore, Dietitians, in partnership with the Care Council for Wales, have developed learning and teaching resources for qualified assessors to support more frontline health, social care and early years workers to complete optional nutrition and hydration units within diploma qualifications. Making these units mandatory for the sector would equip far more frontline staff to promote optimum nutrition and hydration for vulnerable population groups. It is our understanding that the Wellbeing of Future Generations Act (Wales) 2015 already places a statutory duty on local authorities and public bodies, including health boards, to work towards seven national well-being goals. We would support strengthening legislation to ensure mandatory application of Health Impact Assessment by Welsh public bodies to consider the impact on health of decisions made or of policies adopted. The requirement for public bodies to respond to a new accountability framework within WFG will demand greater collaboration and networking and we recommend more should be made of opportunities for a joint performance management framework across sectors utilising the Results Based Accountability methodology.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
As stated in the paper, health boards are already under a duty to consult the public in the planning and delivery of local services. The IMTPs provide an ideal opportunity for local consultation and if strengthened by statute may improve local collaboration.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
We support the establishment of an independent expert panel to which referrals could be made rather than referral to Ministers in the event of local disagreement regarding local service change plans.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
How can you legislate for the public in taking control of their own health? The paper clearly states this requires a change in mind set, behaviours and culture not necessarily legislation. However, legislation can be used to change the environment in which people live in order to support cultural change

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
Health and Care standards and the Governance Framework could be strengthened and linked to the legal requirements of the independent sector.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Quality could be linked to the publication of local well being plans, their well being objectives and goals which are jointly owned by public service boards.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
We agree that there may be a case for changing compliance with healthcare standards to become a legal requirement as in the independent sector.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
A common standard framework for health and social care professionals could aid a partnership approach to care and help focus on improving outcomes for people.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Peer review is considered as a useful tool to promote improved service quality within organisations.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Practice Supervision is part of the governance framework. It should be included in working practices and not considered an 'add-on'. It is integral to delivering a quality service and should be embraced by the practitioner to enhance professional practice and develop not only the practitioner but also the employing organisation Practice Supervision is important for all grades of staff – dietitians, support workers, administrative staff and managers. The focus of supervision will vary depending on the specific role and needs of the practitioner. It is essential that trained clinical supervisors are available for staff to access. Whilst we have no argument in principle with the intent to widen access to clinical supervision, legislating is not, in itself, a solution. Appropriate training for supervisors is complex, resource intense and takes a considerable time. Evidence does show that group supervision, as suggested, can yield benefits; however, there are undoubtedly many aspects and challenges in the workplace which would rather be suited to a one-to-one relationship. Legislating to ensure supervision, at this time, seems premature. To state that clinical supervision is an important facet of revalidation and to make reference to the compulsory "model" of supervision used by midwives which is, rather, a mode of delivery could allow the reader to infer considerable misunderstandings of the purpose of engaging in supervision. Evidence for the evaluation of and particular selection of appropriate models from the vast evidence base would need a high level of expertise followed by a comprehensive implementation plan.

17. What arrangements should be put in place for self-employed health professional registrants?
Self employed registrants should be able to access trained clinical supervisors.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes we agree with the introduction of a statutory duty of candour within the NHS in Wales as in England.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?

Strengthening the Putting Things Right process within the NHS in Wales but maybe through culture rather than legislation.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
We agree with the principle of citizen centred complaints rather than service centred and the introduction of the required changes in legislation to progress this.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Improved, integrated, compatible IT systems across primary care, secondary care and health and social care boards would help this. Spend on hand held devices for staff so that assessments and reviews can be documented electronically immediately whatever the setting. IT can also be used to help educate patients demonstrating evidenced based and high quality l websites/apps such as bolus advisor so that patients are better empowered to manage their own health. Healthcare professionals can be more mobile working within the community not restricted to clinics.

22. How can we consider breaking down any barriers?
An integrated IT system with joint records would be an excellent start to breaking down barriers to enable patient information to be shared.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
As long as individuals consent to the sharing of their information for research or other purposes then this is to be encouraged. Patients must share responsibility to improve the quality of services they receive and ultimately research aids this process.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?

It seems that the current legislation has not kept up to date with the development of innovative services and may not be fully fit for an evolving health and care service.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
We are not aware of any arguments against the provision of full statutory independence for HIW.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
Could look at areas where there is opportunity develop shared objectives and outcomes that apply to both.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
Bearing in mind the integration agenda it seems logical and far less complex to have one inspection and improvement body for citizens covering all aspects of health and social care.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
We believe that if the CHCs refocused their activities in this manner it would service the patient voice in a more effective way than duplicating the inspection process.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
In a more integrated system the CHC would represent the citizen's voice across health and social care.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
We agree with this if it will provide HBs with greater financial flexibility.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
Due to the changes made to the NHS Wales structures, summarised accounts do not seem relevant.

32. 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?
In light of the above, legislative changes supporting the structural and financial reporting arrangements should be considered.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes we believe NHS Trusts should have an equivalent statutory planning duty as health boards.

34. 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 to achieve a more integrated approach to care starts with integrated planning.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
With the need to deliver across Health & Social Care and pressures in one area impacting on the other, combined with the need find the solution to this challenge, we need to work as an integrated system. LHB's working co-terminus with Local authorities to deliver on aligned strategy from WG would support delivery of services to better meet the needs of the population.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how

might health boards be reformed?
Organisational change is often disruptive. LHB's are facing the greatest challenges in the history of the NHS and the priorities to be addressed and work to be delivered on would be difficult to accomplish with less executive director Board members. Portfolios arguably are already too large, accountability is crucial, along with capacity to drive and scrutinise delivery on agreed priorities in a timely way to ensure pace required achieved. Of note is the large number of independent members, scrutiny is vital – however the number required could be considered (in the light of evidence base re effective decision making); whilst recognising the importance of bringing relevant knowledge, experience and specific skills to complement and challenge at Board level. The inclusion of a representative of Social Services may support the integration agenda.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
It is felt that total discretion should not be supported. There needs to remain core 'legislative' responsibilities, supporting clear accountability. This is also vital for sustainability, i.e. development of future Board members. Outside of this some flexibility may be required to align portfolios to best suit skills and experience and deliver on the required agenda. Of particular importance is the need to ensure the Board continues to have clinical balance. The added value of the Director of Therapies and Health science role cannot be underestimated. The NHS is challenged with shifting from a traditional medical model of approach. AHP's bring the perspective of promoting a person centred and empowering holistic approach to health and social care. This brings challenge to thinking and will drive the modernisation agenda required. There is still much more these roles can offer in engaging and giving voice to the innovations and solutions sitting across these services in Wales which already have effective multi-disciplinary and multi-agency partnerships in place. Therapies and Health Sciences are intrinsic to providing the solution to the challenges NHS Wales is tasked with and as a result continue to require representation at executive director level.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
With respect to overall size of Health Boards (refer to Q 36 response). Yes LA and Social Services representation would better represent the needs of the population and support integration. Election of community representation is something that should be explored to ensure transparency and maintain a 'grass routes' level of understanding, supporting effective communication and management of expectations.

39. Local government reform is underway; should there be a statutory

provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
As in Q 35 – possibly yes for Director of Public Health and Director for Social Services.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
We agree with the recommendation regarding the role of the board secretary.

45. How could potential conflicts of interest for the board secretary be managed?
Clarification of the role of board secretary clearly set out in statute.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
No with regard to advisory structures it is very important for there to be a statutory requirement on WG to routinely take and access professional advice. Removing a statute to consult would be concerning but more so using a range of sources in an unstructured manner. Individual 'experts' are not necessarily best placed to provide the translation of the expert opinion to a broad audience without links back to the wider workforce and professional bodies. If it works well at present why change?

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
Therapies including the smaller profession of Dietetics have made a valuable contribution over past years to the WG agenda via WTAC. The WTAC committee is an exemplary model of the interface between NHS management and health and social care services. The committee has strong clinical leadership and works well with the Therapy advisor who has established robust links with the committee members and services and is available for advice and support.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
The Green Paper suggests that legislative change is necessary for the future

healthcare agenda in Wales.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
Higher standards are required for shared services and audits to monitor compliance. Revised standards would help speed up the various processes within e.g. recruitment that can delay new staff starting and delay patient care. A review of all systems and processes around procurement, recruitment etc to make the process leaner across Wales.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
In theory public sector wide services delivered from within the NHS seems an innovative idea but it will require attention to detail and consideration of resource implications especially where different standards apply across current public sector services for example the National Procurement Service looking to take on a National Public Food Procurement Service and trying to align it with the NHS Food Procurement services.

WGGP047 – Deepak Rajenderkumar – Audiology Standing Specialist Advisory Group
Tref / Town – Audiology Standing Specialist Advisory Group

General comments

Response to specific questions

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Health Boards should not be too large. Large organisations are difficult to manage and we are probably at a level where further increase in size may not give further advantages. With the prudent agenda, services which were delivered by doctors/nurses are gradually moving on to therapists and scientists more in the community. This is a welcome development but there should be clear accountability. Services provided in the community may have better accountability structures in the community itself. It is also important such services have clear guidelines and safety protocols.

WGGP048 – Geoff Ryall-Harvey
Tref / Town – Unknown
Sefydliad / Organisation – Betsi Cadwaladr Community Health Council

General comments

My name is Geoff Ryall-Harvey. I am, at present, Chief Officer of North Wales Community Health Council. I have been involved with the CHC movement since 1985. I was the Chief Officer of Chester and Ellesmere Port until 2003, I ran PPI Forums in Cheshire until 2008 and recently set up Healthwatch Cheshire West as the interim Chief Executive. In consequence, I have a unique and unrivalled knowledge of how patient and public involvement in the NHS should work and what the advantages and pitfalls of the alternatives to CHCs may be.

I have concentrated my personal response upon the proposals in the Green Paper that relate specifically to CHCs. The North Wales CHC formal response deals with the entirety of the document.

There is much to be learned from the English experience of radically transforming CHCs and this is well described in the Francis Report;
"Community Health Councils (CHCs) were almost invariably compared favourably in the evidence with the structures which succeeded them. It is now quite clear that what replaced them, two attempts at reorganisation in 10 years, failed to produce an improved voice for patients and the public, but achieved the opposite. The relatively representative and professional nature of CHCs was replaced by a system of small, virtually self-selected volunteer groups which were free to represent their own views without having to harvest and communicate the views of others. Neither of the systems which followed was likely to develop the means or the authority to provide an effective channel of communication through which the healthcare system could benefit from the enormous resource of patient and public experience waiting to be exploited."

The Rt Hon Andy Burnham MP doubted in retrospect the wisdom of abolishing CHCs;
"the abolition of Community Health Councils was not the Government's finest moment … it seems we failed to come up with something to replace CHCs that did the job well".

There have been three iterations since the abolition of CHCs in 2003; Patient Forums, LiNks and HealthWatch. My hands on experience, as someone who worked in the organisations that followed CHCs, is that effective monitoring and scrutiny was lost for a substantial period of time (in some cases as much as two years) following each reorganisation.

I am very concerned that the Green Paper contains some fundamental misconceptions of the functions of CHCs, their role as the Voice of the Patient and their independence.

The Green Paper stated that;
"A review of the operation of CHCs made a number of recommendations relating to their structure, functions and membership and the role of the CHC Board in Wales with a view to clarifying and strengthening the existing arrangements. Several subsequent reports have also made recommendations about CHCs' functions and effectiveness."

The reports from Anne Lloyd, Ruth Marks and Keith Evans comment on their findings in relation to the functioning and effectiveness of one CHC only. These comments have then been applied to all CHCs. The reports cross-quote each other and use these quotes to establish the mis-information they contain as "fact".

There is an expectation on the part of policymakers that CHCs should be able deliver grassroots enthusiasm for change that invariably involves closure of valued local NHS facilities;
"As these reports have suggested, there may be new ways of representing the patient voice, for example through patient participation groups at GP surgery, cluster or health board level as set out in chapter one on continuous engagement. The National Social Services Citizen Panel has been set up to secure a voice for service users and carers and we would wish to explore whether a similar arrangement should be put in place for health services. The role of CHCs may need to be refocused towards some key functions, such as collectively representing the patient voice and providing advocacy for people wishing to raise concerns about care, while stepping back from activities which may be better carried out by others, such as inspections and service change proposals. In addition, the current model of one CHC for each health board area may no longer be the best fit for a service which works increasingly across boundaries and in partnership with other services. CHCs may need to change reflect a more integrated service model. Whether and how CHCs should change to fit the new integrated structure needs careful consideration."

The National Social Services Citizen Panel would seem to be an inappropriate example to use. Although it was announced enthusiastically by Ministers in 2012, it still has no website, no record of proceedings easily available to citizens and the promised evaluation of its effectiveness has yet to be published. Its public profile is extremely low and few have heard of it.

The greatest criticism of CHCs is made by Welsh Government when CHCs do not support plans for significant alteration to the provision of local healthcare or when CHCs use their powers to refer controversial plans to the Minister. In his speech to the March 2015 CHC Annual Conference and in a recent letter to the Chief

Executive of the Board of CHCs, he described use of the power of referral as "always a failure". Criticism is usually centred around CHCs failing to persuade the public that LHB plans are in their best interests. It would appear that the Minister, like many of his predecessors, wants strong independent CHCs – that agree with all of his policies.

At the highest levels there seems to be a failure to understand what CHCs at the grass roots know to be true; that the public is ever more ready to debate whether the right decisions over health are being made, and to challenge them when it considers they are not. People are much more ready to challenge authority, to insist on redress of grievances and to resort to law to pursue their rights. Policymakers can no longer decide what they consider to be the public interest based on only token consultation and expect their decisions to remain unchallenged. This is the reason for the increasing trend towards the challenging of decisions by the use of Judicial Review. Policy makers deceive themselves when they attribute this trend to "greedy lawyers". It is, in fact, a response to a firmly held belief that policymakers are not listening.

Response to specific questions

Chapter 1: The changing shape of health care

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
The recent consultation on Women's and Maternity Services in North Wales has shown that there is a lack of confidence and trust in the Local Health Board and such internally run mechanisms for public involvement would lack credibility for the foreseeable future. There is a need for a truly independent organisation to undertake engagement and consultation. Community Health Councils have that independence and are trusted by those who have had experience of their work.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
There is a risk that such a panel would be seen by a sceptical public as an instrument of the Minister. These panels would lack credibility and accountability. The Green Paper does not give the Panel the duty to produce alternative costed plans – as is the case for CHCs. CHC's should not be expected to come up with their own costed plans; this is not, and should not be, their role. This requirement is impracticable and unworkable. CHCs; are made up of lay people. CHCs are not resourced nor

have sufficient expertise to develop alternative plans. This requirement has always been unreasonable.

The Minister has stated that when a CHC makes a referral, it is “always a failure”. In certain circumstances, it is the only option available to CHCs. In the case of Women’s and Maternity Services in North Wales, the CHC did not oppose the changes; it had tried without success to persuade the Health Board to undertake a consultation. North Wales CHC referred the decision not to consult to the Minister in order to give local people the opportunity to comment on this major change.

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs’ activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?

Much has been made of the claim that CHCs are not representative of the public but those making the claim seem unaware that Welsh Government appoints 50% of CHC members, Local Government appoints 25% and 25% are appointed by the Third Sector. CHCs have no control over the appointment of their members and CHCs, such as Cardiff & Vale CHC, who have suggested that they advertise for members specifically in order to better reflect their local demography have been prevented from doing so by the Public Appointments Commission and by Welsh Government.
There are four basic functions of CHCs;
 Speaking up to protect & improve our health services
 Monitoring & scrutinising our health services to ensure their safety and quality
 Influencing NHS service changes so they reflect what matters most to patients and the public
 Helping patients raise concerns about the NHS when things go wrong
Each function informs the others; particularly so in the case of Advocacy and Visiting & Monitoring. CHCs are the only body that makes truly unannounced visits and the only body that visits and inspects NHS facilities with any frequency (see comparative figures for North Wales provided below).
My experience of PPI Forums, LINks and HealthWatch is that without the full range of functions it is extremely difficult to get a full understanding of the operation of the local NHS.

The Green Paper proposes that CHCs should be stripped of their rights to enter and inspect NHS premises – a right they have held since 1974. This appears to be based on the advice of other organisations who have consistently misunderstood and criticised the CHC’s lay focus and have cited the Minister’s desire to do away with duplication in the inspection of the NHS.
Before accepting these arguments at face value, it would be useful to look at how things work in the real world. When North Wales CHC first visited a local community hospital using its BugWatch regime in the Summer of 2014, CHC

members were concerned at what they found. The Director of Nursing and the Director of Infection Control & Prevention were contacted on the day of the visit and a range of measures, including deep cleaning, staff training and support and extensive repairs to the fabric of the building, were undertaken very rapidly.

North Wales CHC members visited the hospital again in November 2014 and also in February 2015 using the CHC's CareWatch methodology (based on the 12 Fundamentals of Care). They found the hospital much improved but with some issues remaining. The Health Board were notified and they undertook to address the issues raised.

When CHC members visited in June 2015 they found that the problems they identified in Summer 2014 were back again. CHC Officers contacted the Director of Nursing and the Director of Infection Control & Prevention and, once again, the problems were rectified.

Only the local CHC has the capacity and the local knowledge to undertake such a sustained and intensive programme of visiting and monitoring. Having found a serious problem, the CHC lay members did a follow up within weeks and then kept following up using BugWatch, CareWatch. They will continue to visit this hospital very frequently until they see permanent improvements. No other body with inspection duties is able to give this level of commitment.

Over the past 3 years there have been many concerns about the quality of care provided by Betsi Cadwaladr UHB and at least five major critical reports. This is the Local Health Board that has caused Welsh Government the most concern and it is the only Welsh Health Board to be placed in Special Measures. North Wales CHC Members have given freely of their time in order to monitor the quality of services from a patient perspective and we have consistently reported our findings to the Health Board, to the Minister and to HIW.

The BCUHB Annual Quality Statement for 2014/5 states that;
"During 2014 -2015 Healthcare Inspectorate Wales undertook a total of 8 Dignity and Essential Care Inspections across the range of ours services including our main hospitals, community settings and Mental Health Services." During the same period, North Wales CHC members undertook nearly 500 inspections, producing detailed reports of their findings that have been made available to partner organisations and stakeholders.

There has been criticism that 500 inspections is "too many". As the person organizing these activities, I not hear that from Ward Managers and Nurses. Front line staff welcome CHC members, as their visits are often the only way they can get problems sorted out. The Director of Nursing at Betsi Cadwaladr UHB has commended the BugWatch programme and in his evidence to the Public Accounts Committee. Furthermore, the Chairman cited the CHC inspection regime as a clear demonstration of the Board's openness and accountability, something that should increase public confidence. The Minister has commended North Wales CHC for its pro-active inspection programme

and promoted it as an example to other CHCs.

With regard to the idea that 500+ visits is too many, this works out at somewhere around four visits per ward per year – certain wards may receive more than this but it will still be in single figures. Inspection frequency by other bodies could be one visit every 5 years or even longer.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
CHCs are the only voice within the NHS having any degree of independence. If a "more integrated system" results in a reduction of independence, then this would be a mistake comparable in magnitude to the abolition of CHCs in England. Some form of organised independent public scrutiny of NHS Wales is plainly necessary. In the light of the Andrews Report, the Lessons Learned Report, Tawel Fan, the Evans Report, the HIW/WAO Report on Governance at Betsi Cadwaladr UHB and the subsequent Special Measures and the recent report to the Minister on the operation of BUHB by Ann Lloyd, it is not credible to claim that Independent Members of Local Health Boards can fulfill the function of holding the NHS to account. The key formal check and balance is, currently, the CHC movement. Successive Ministers and their Civil Servants have looked critically at CHCs to question whether they are good value for money and to see whether the public interest in the NHS could be better and more economically served by other mechanisms. The experience of the abolition of CHCs in England in 2003 suggests strongly that it would be better to strengthen CHCs than to radically transform them. In relation to the CHC membership, there are arguments for and against continuing with local authority and voluntary organisation nominees. On the plus side, local authorities are the only truly democratic input into CHCs and voluntary organisations are close to local communities. On the negative side, the current process of representation tends to be unsystematic, the same organisations get represented and nominees pursue their special interests rather than the wider picture. There are also important issues over training, standardising performance, ensuring national standards and empowering the Board of CHCs to co-ordinate and enforce common standards. There is a strong feeling with in the CHC movement that CHCs in Wales should be given responsibility to recruit directly - as is the case for HealthWatch in England. HealthWatch England has a robust set of criteria for ensuring Local HealthWatch appoints a diverse and representative membership. Similar arrangements could be developed in Wales.

WGGP049 – Lisa Turnbull – Royal College of Nursing Wales Tref / Town – N/A

General comments

The Royal College of Nursing welcomes the consultation on this Green Paper. The agenda facing the NHS in Wales is immense and there have been significant developments since the last reform to the way that our health services are planned, delivered and governed. These are well-articulated in the Green paper's preamble. We would concur with the Health Minster's assertion that any rethink about our health services "starts with the desire to want to do things right for people and to provide services which evolve and learn in response to people's needs" (Ministerial Foreword, pp 1).

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
It is important that primary and community care services receive the same strategic attention as acute services both in terms of their development, resources and scrutiny of performance. It may be worth examining if the legal duties of Health Board to provide care would benefit from rewording to strengthen this, perhaps including explicit oversight of nursing care currently provided to our older population in the independent sector. It is possible that closer partnership working with social care in local government could be strengthened by legislation of this nature. Furthermore a review of the legislation for LHBs currently being responsible for improving health of the population needs to be cross referenced with the legislative foundation of Public Health Wales and their legal accountability.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
The RCN would concur with the suggestion that the way that the NHS engages with citizens regarding major and significant changes to our health services in Wales requires a radical rethink. Although there have been some examples of relatively successful citizen engagement about significant service change proposals (e.g. the work around the South Wales Programme), there are more examples of poorly planned and conducted engagement (e.g. some

of the changes proposed by Hywel Dda UHB and some of those proposed by Betsi Cadwaladr UHB as reported in the media).

Patient panels and participation groups can be very useful methods of soliciting feedback or engagement on specific matters. It might be useful to specify that certain groups such as children and young people or welsh speakers should be included.

However CHCs are a broader mechanism for representing the public perspective and already exist. Another approach to increase democratic and local involvement would be to invite elected local government representatives to sit on Health Boards.
Another consideration is that for scrutiny of performance and consideration of service change to be carried out effectively the public should have access to better quality consistent information and this could be made a legal duty.

In summary the RCN supports a greater legislative duty for Health Boards to engage with their local populations but does not necessarily see patient panel or participation groups as the only available mechanism.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
The Royal College of Nursing absolutely rejects this approach. The Welsh Government is the democratically elected and representative government of Wales chosen by the people to exercise judgement on their behalf. Abdicating this responsibility in favour of an unelected group of 'expert's is not acceptable. The danger of this approach should be evident. For example expertise in living with a chronic condition, expertise in living in a rural area, medical expertise, nursing expertise and expertise in innovative methods of delivering healthcare are all very different types of expertise. Who would choose these experts and who would they represent? There is no reason to have a single panel and we do not believe any further consideration should be given to such a development. Ultimately decisions should be taken by Ministers after advice is taken and convening a national expert panel to provide advice may well helpful in some circumstances.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues

raised in this section?
The RCN agrees that action needs to be taken to strengthen the ability of the NHS in Wales (and Welsh Government) to optimally enable good, and continuously improving, quality of care and service delivery. Whether legislation is needed to achieve this requires debate. Improving the safety and quality of services is dependent on the efficacy of health service governance from the bedside to the Board (and from the Board to the Welsh Government). Such efficacy is in turn dependent of a "culture" of continuous quality improvement; such healthy culture is not simply achieved by legislative change. Whatever changes emerge regarding the service quality agenda going forward, we would concur that there is merit in rooting our approach in Wales on the King's Fund "Lines of Defence" model. We support the development of some of the approaches mentioned.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
It would seem reasonable to review the wording of the existing statutory duties for monitoring and quality assurance and see if they can be made more specific (e.g. to newer types of services), or more general (to all services). If they can be made applicable to joint provision or applicable to more specified agencies. Can 'quality' and outcomes be more closely or more broadly defined? The expertise in the current systems should be harnessed to improve these.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
A duty to provide the best possible patient care in term of best outcomes and safety and access might be a useful starting place. Without definition the term 'Quality' can in itself become a term that obscures the end goal rather than focusing attention on it. There are client groups that may well require health services to be delivered in different ways e.g. groups with hearing loss or sight loss. Duties need to be strengthened with regard to ensuring their views are heard in the development of services.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
The Royal College of Nursing strongly supports the introduction of a 'responsible individual' in health care which would apply to individuals who are not already accountable to a professional regulator. At a minimum this should apply to all Director level posts in the NHS. Professional registrants are held accountable for their actions on behalf of the pubic and rightly so. This law would be a fair approach to non-registrants and perceived as fair. It would help restore public confidence. It would strengthen the focus of senior individuals on the public good and help to ensure unsuitable persons were not 'recycled' around the NHS system to do more

harm.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
The Royal College of Nursing strongly supports the legislating for a ‘fit and proper’ persons test in health care. At a minimum this should apply to all Director level posts in the NHS. Professional registrants are held accountable for their actions on behalf of the pubic and rightly so. This law would be a fair approach to non-registrants and perceived as fair. It would help restore public confidence. It would strengthen the focus of senior individuals on the public good and help to ensure unsuitable persons were not ‘recycled’ around the NHS system to do more harm.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
The RCN is of the view that the move to the IMPT model has been beneficial. The adoption of a three year planning and financial cycle supports stability within the service, and goes some way towards mitigating service change (rather than service development) scenarios that are predominantly driven by financial pressure. It also serves to enable more sensible timescales for manging service re-engineering. The approach to IMPT needs to be kept under review and developed to accommodate the principles of Prudent Healthcare. It is well-recognised that NHS Planning in Wales (including, and especially workforce planning) is not effective. Something needs to be done to rectify this situation. Legislation may well be needed to drive change on this issue. We would strongly support a 10 year strategic planning cycle to enable service modelling. There may also be scope to enshrine in legislation the duty to provide quality care and define some of the characteristics of this such as safety, quality assurance mechanisms, transparency of process etc. For example how are the IMTPs produced and scrutinised. What content must they contain?

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
The RCN is firmly of the view that standards must be consistent across Wales. These standards should incorporate professional standards rather than seek to reinvent them. Our citizens should expect the same (the best)

standards of service wherever they are in living in Wales. Postcode lotteries of service safety and quality are not acceptable. Performance management systems for the NHS in Wales need to be designed with these principles underpinning them. We are of the opinion that there should be a common standards framework for the NHS and the Independent Sector in Wales (certainly for independent sector providers that are treating and caring for Welsh citizens). These standards must comply with professional UK regulation bodies e.g. GMC, NMC etc. Although accreditation and peer review can be important approaches to safeguarding and quality assurance in health services, more and careful thought needs to be given as to how the use of such approaches can be improved and developed in Wales.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes. The RCN supports exploring this approach. However where research has shown a clear and significant link between input and outcome, this should be covered in the standards. One example of this is professional education and continuous professional development. Another is the numbers and type of staff required to deliver safe patient care with best outcomes.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
In principle the Royal College of Nursing supports this approach and would welcome further discussion including other mechanisms such as patient's surveys and critical analysis and response to patient stories.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
The RCN is delighted to see recognition of the importance of clinical peer supervision in assuring the quality of care services in this green paper. Since the introduction of Agenda for Change, the NHS in Wales has continuously failed to provide frontline clinical staff with the annual appraisals and personal development plans that they are entitled to. Similarly, those staff, practising in the most challenging service landscape, are largely deprived of appropriate formal clinical supervision. Effective appraisal, professional development planning and clinical supervision are cornerstones of safe, effective and efficient services. Action should be taken as a priority to ensure that that frontline staff benefit

from these essential HR/professional processes. The RCN believes that all health professionals should have access to this support to ensure safe quality care. This will require protected time and support for both the activity and training for people in how to best seek and provide such support.

A legal duty on employers to support this approach would be extremely helpful. We would also suggest the Welsh Government commit to the development of online resources for this purpose such as links to already existing best practice and new short (e.g. 15 minute) training videos or programs. The RCN would be pleased to work alongside the Government in developing this. Whilst some resources would need to be profession specific there would also be value in exploring multi-disciplinary approaches. Supportive Forums/networks would also be helpful (whether entirely visual or with a local presence in major health centres).

There is also the related issue of mentors for nursing students. Nursing students spend 50% of their time in practice placements where the role of the mentor in educating the student in the delivery of quality care is crucial yet recent educational reviews have highlighted significant problems with the current mentorship model. Mentors are not given protected time to carry out their duties by the NHS and indeed there have been problems with students not being accorded their proper supernumerary status within the NHS. Mentors often have little preparation for their role or time to reflect on it. Support for mentors is critical.

We look forward to working with other professional and regulatory bodies to develop these proposals.

17. What arrangements should be put in place for self-employed health professional registrants?
There is no reason why self-employed registered nurses could not be invited to join a local NHS network or take advantage of an education online resource. The recent proposed Public Health Bill in Wales discussed licensing arrangements for certain cosmetic procedures with local authorities The declaration or terms of the licence could easily include a reference to clinical peer supervision. It will be important for any arrangements or legal duties to be clear how they apply to nurses employed by independent NHS contractors e.g. GPs.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
The RCN supports the introduction of a statutory duty of candour on the NHS as a whole or on individual NHS organisations such as Health Boards. We

agree this will help set a clear corporate responsibility and tone for the organisation. The RCN expects registered nurses to at all times fulfil a duty of candour according to their professional Code.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Public Statistical information on NHS performance, outcomes and activity is extremely poor in Wales (we are not referring here to administrative data held but not shared by Boards but the publication of regular consistent statistics which follow the standards of the independent statistics authority). This means that the scrutiny of performance, public confidence and the development of national policy discussion on health and social care are severely limited. This, more than anything, inhibits the development of a true co-production of health policy in Wales. The Welsh Government could reform this situation by pacing a legal duty of more consistent information to be regularly publicly released. To provide a specific example of this: Statistics Wales provides information on the numbers of nurses employed by Health Boards in the community. This is very nearly the *only* information we have at a national level on community healthcare. How many patients are being cared for by these nurses? What types of care pathway (e.g. end of life or post surgery?) and patient demographics (e.g. over 80 years olds or under 5's ?) do these represent? What are the outcomes for these patients? We do not know or are not told, yet national discussion of policy on workforce planning, resources, structures and ways of working in the community is expected to carry on regardless without clear evidence to inform the debate.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
The RCN is supportive of any reasonable developments that serve to enable the users of NHS services to raise concerns about their treatment of care experience. Patient feedback (including negative feedback) is crucial for the continuous improvement of health services. The Keith Evans Review arrived at some interesting recommendations about how "Putting Things Right" processes might be improved. These would benefit from further consideration and discussion. The developing agenda relating to the furtherance of health and social care integration provides a significant driver for giving impetus to this discussion. The RCN supports the approach suggested in this section.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

22. How can we consider breaking down any barriers?
It is the view of the RCN that patient information is owned by the patient and the consent of the patient should be the central principle and key to resolving these issues. We support moves to make patient records easily and consistently accessible to patients across Wales. The Welsh Government should consider whether it can develop a mechanism which allows patients to easily opt in or opt out of the sharing of their information across organisations. It might also be helpful to assess the evidence on whether the public *already believe* their information to be shared and are/would be happy with information being shared with the NHS on a presumed consent basis.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Anonymised patient outcome data for research and the development of knowledge to improve service provision and preventable conditions should be enabled.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
Well publicised service and care failings in the NHS in Wales in recent years makes it self-evident that NHS inspection, regulation and scrutiny architecture needs a fundamental re-think. The review undertaken by Ruth Marks into HIW, provides the basis of the beginnings of the debate that needs to take place regarding this issue. The roles and inter-relationships of HIW, the CHCs and CSSIW need to be considered in any review but we do believe HIW should be independent of government and a memorandum of understanding with CSSIW be developed.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
It is important that the democratically elected Welsh Government is able to request inspections e.g. of a particular service or type of service, set a thematic approach e.g. how services respond to a particular group of service users and oversee the methodology of the process e.g. how citizens are

engaged. It seems right and proper that there should be democratic reporting of these issues whilst the inspectorate functions independently. In addition, whilst the need for operational independence and the perception of independence by the public are both important considerations so too is the need for robust performance and overview of the inspectorate itself. A full statutory independence model must ensure accountability and responsiveness to public need.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
This approach may be worth pursuing as it is likely that proposals to merge the functions of CSSI and HIW would be premature at the moment. A public memorandum of understanding should be determined.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
As the RCN we are very strongly concerned that the need for professional nursing assessment as part of the inspection of a service is recognised and delivered. In recent years the employment of registered nurses by CSSIW has declined and alongside this the involvement of a nursing perspective in any assessment of inspection has declined. Care homes for older people is an excellent example of where is this omission can be very significant. Medication errors, poor nutrition and hydration, pressure sores and falls are examples of poor outcomes for older residents. Quality nursing care can help prevent these situations. A nursing perspective in the assessment of the service can reveal whether this nursing care is present as it should be. The RCN would wish any merger or increased joint working to promote the involvement of healthcare professionals in the work of inspection rather than diminish it.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Over the past 40 years the CHCs have provided an invaluable role in representing the interest of the public of Wales and users of NHS Wales regarding their NHS. Community Health Councils are a vitally important mechanism which allow for the public to have a voice in service change proposals. The Royal College of Nursing would support changes that strengthen this ability and increase public engagement with the Councils. We do not support changes to remove the power of the CHC to comment on

proposed service change or the power to require information from the Health Board. Various reviews of recent years have indicated that change is needed, regarding the role and functioning of CHCs (e.g. the Longley Review, the Sir Paul Williams review, Ann Lloyd Review and the Ruth Marks Review). The consensus appears to be that, if CHCs are to remain, they should have less (if any) of a role in service scrutiny and more of a role in "enabling" the voice of the people of Wales (and NHS service users) about their health services. Again, the emerging and developing health and social services integration agenda is relevant when reviewing the future of CHCs. The power to carry out inspections of services is a demanding and specialised function and serious consideration needs to be given as to whether the CHCs should continue to have a role in "scrutinising" NHS services. Their ability to undertake this role has been brought into question in recent years (against the background of significant NHS Wales service failure). If they are to have an ongoing service scrutiny role, the CHCs might better serve to provide a lay/public perspective, as part of the any future NHS inspection/regulation regime. Providing advocacy to the public and support during the complaints process is a specialist area of expertise in itself and is a function that requires a great deal of resource. Perhaps this function could be usefully separated and integrated with other national advocacy services.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
There is no reason why the CHC could not have similar remit over all health and social care services operating within its geographic area. This would solve the issues highlighted neatly. The defined geographic and local nature of the CHC is easily understood and valued highly by the local population. As services increase in complexity it is all the more important to retain this local community voice.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
The Royal College of Nursing doe support this change, provided it is not used as a means to reduce appropriate levels of direct financial support from the government to Health Boards, and enables quality services to be delivered.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
The Royal College of Nursing believes there should be no variation between these two bodies, requirements should be consistent.

32. 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?
The Royal College of Nursing believes there should be consistent requirements.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes. It is well-recognised that NHS Planning in Wales (including, and especially workforce planning) leaves much to be desired. Planning must be undertaken with a recurring ten year timeline. Legislation may well be needed to drive change on this issue.

34. 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 along with the Public Health Wales Act.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
The effective governance of both LHBs and NHs Trusts in Wales is dependent on effective Boards (including having the optimal number of Board members, with clarity about their respective roles and responsibilities). An increase in national training and network events for Board members would assist development – particularly a programme of engagement with professional and public perspectives and communication with other public third sector providers. Board members are appointed following a clear process but too often only the usual suspects' put their names forward for such roles. A programme of development aimed at encouraging the next

generation of Board members could widen involvement from different sectors of society and develop the skills and experience required to successfully carry out this role. This could equally be applied to those wishing to serve on Community Health Councils or other participation fora.

Guidance, possibly statutory could strengthen the ability of the Board members to request information and cover the roles and duties of the Board in greater depth including how they should engage with the public and representative groups such as professional's forums.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
In any future arrangements it is imperative that there are adequate numbers of properly trained and developed Independent Board Members, with clear authority to hold to account the Executive Team of the Board. A review of the evidence base on the effectiveness and the size of Boards may be helpful. However it is important to recognise that the ability to take swift uniform and consistent decisions (often assumed to be synonymous with a Board small in numbers) is no guarantee that these decisions will be well informed, balanced, sustainable or effective. A wider provision of expertise (which may require a larger number of people) can ensure appropriate scrutiny and robust sustainable effective decision-making. Improvements in governance can equally follow not from simply reducing the number of people at the Board but improving the information given to the members, allowing development opportunities for members and re-distributing the business effectively. Welsh Ministers currently appoint a Chair, vice chair and nine independent members. These must include a local authority member, a voluntary organisation member, a trade union member and a person holding a post related to health in a university. The Royal College of Nursing believes it is imperative that one of these posts remains dedicated to **trade union expertise**. Trade unions provide an invaluable perspective on workforce development, current service pressure, health policy, professional requirements and legal obligations of employers to name but a few of their sources of expertise. We believe that having Trades Union member of the Board, under the current arrangements, has been a beneficial and we would be concerned if this Board position were lost in any new arrangements. Expertise from the voluntary sector is also a welcome and necessary addition to Board particularly given the Welsh Government's consultation on expanding the role of social enterprise in service delivery.

With 22 local authorities it may be too unwieldly to appoint a cabinet member from each of the areas covered by the Health Board but certainly there is no reason why one cabinet member could not be chosen (by agreement form the local authorities themselves) and put forward.

Welsh Ministers may currently also appoint three associate members which standing orders suggest should be the Chairs of the Health Board's Healthcare Professionals Forum, stakeholder reference group and a director of social services.

The RCN would suggest that these three Chairs are automatically appointed to the Board as these roles would bring a wealth of experience and a wider perspective.

These suggestion would reduce the number of 'independent' posts from 11 to 8 whilst actually strengthening the breadth of experience and views.

In addition this would also have the benefit of reducing the number of Ministerial chosen appointments from 11 of 11 members to 4 of the suggested 8. This would have the added benefit of counteracting the public perception that independent members are obliged politically to the Welsh Government that appoints them, thus undermining their intended positon of independence.

Within the set nine senior executive members of the Health Board the Royal College of Nursing is very clear, **the professional roles of Medical, Nursing and Therapies Director are vital and MUST be maintained**.

Nursing is the largest professional group in healthcare. Registered nurses and health care support workers (which are part of the nursing family) are responsible for patient care at every hour and stage of the patient journey. Critical aspects of care to patient outcomes from hydration, infection and medication are the nursing remit. Nurse are closest to the patient experience of care and trust or the failure of these. There must be a Director at Board level to inform the Board of the current situation and future direction of nursing care within the service and participate in these critical decisions. The role and significance of the Nurse Director post is critical to patient safety patient safety. This post, provides the crucial "professional conscience" of the Board and will be essential going forward if service safety and quality is to be maintained in further challenging times for our NHS inn Wales.

In addition The RCN believes it is extremely important that there is a Director at Board level with specific responsibility for primary and community care and mental health. It is our view that Health Board business is still too easily focused on the acute hospital sector. It is important that other services are recognised and given adequate attention at Board level.

When the NHS in Wales was last subject to major reorganisation concern was

expressed in many quarters about the risks to mental health and learning disability services as they were integrated with the new large LHBs. There was real concern that these "Cinderella services" would suffer in the new arrangements. These concerns were recognised by the Welsh Government. In response to them, the government ensured that the Vice Chairs of each LHB had specific responsibility for overseeing mental health issues and that there would be specific "Executive" Director to lead on mental health (and primary care) issues. We are concerned that in many LHBs these safeguards are no longer effective (if they exist at all in some LHBs). Recent service failures (and significant feedback from our members suggest that both Mental Health and Learning Disability Services are not being well served by Boards. We recommend that in any review of LHB and NHS trust governance arrangements going forward the role of the Vice Chair vis a vis overseeing Mental Health (and Learning Disability) Services needs to be strengthened. Similarly, there must be an Executive Director of mental health Services on each Board (within LHBs where such services exist).

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Within the set nine senior executive members of the Health Board the Royal College of Nursing is very clear that the professional roles of Medical, Nursing and Therapies Director are necessary and must be maintained. Nursing is the largest professional group in healthcare. Registered nurses and health care support workers (which are part of the nursing family) are responsible for patient care at every hour and stage of the patient journey. Critical aspects of care to patient outcomes from hydration, infection and medication are the nursing remit. Nurse are closest to the patient experience of care and trust or the failure of these. There must be a Director at Board level to inform the Board of the current situation and future direction of nursing care within the service and participate in these critical decisions. In addition The RCN believes it is extremely important that there is a Director at Board level with specific responsibility for primary and community care and mental health. It is our view that Health Board business is still too easily focused on the acute hospital sector. It is important that other services are recognised and given adequate attention at Board level.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
There is a need to strengthen the local public accountability of Health Boards. This could be accomplished by direct election or alternatively by increased participation of locally elected council members as discussed above. Alternatively direct elections to a renewed Community Health Council structure may be the solution. The low turnout and public interest in elected police commissioners may suggest that direct elections are not always the

most useful mechanism to achieve greater local public accountability. Moreover it may be helpful to formally separate the roles of challenge and scrutiny (Community Health Council) from that of corporate decision-making and governance (Board). The RCN would welcome further discussion and proposal on this matter.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
The RCN would be happy to support this measure.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Overall the statutory responsibility for failed services is not always currently seen as the responsibility of the whole Board but only that of professional registrants at Board level. This needs to change to ensure **all** Board members are held accountable for the failure to deliver safe appropriate care and services.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
The RCN believes these regulations should be brought in line with Health Board membership.

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
A Nurse Director role is equally as important on the Board of a Trust as on a Health Board. Indeed the specialist nature of the three Trusts in Wales each relies heavily on the professional role of the nurse to deliver their services. It would assist their governance and decision-making.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
Yes but it does not need to be given independent legal authority.

44. If so, what aspects of the role should be additionally set out in law?
The role as set out in paragraph 128 of this document would be a good basis for this discussion. The three recommendations highlighted in paragraph 130

should also be incorporated into this proposal.

45. How could potential conflicts of interest for the board secretary be managed?
Clear guidance from the Welsh Government may assist, also a network of Board Secretaries could be formed with support from Welsh Government or the Wales Audit Office, local government etc to provide peer advice and support.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
The phrasing of this question and paragraph 133 in the green paper are misleading. The Welsh Ministers and the NHS ***may*** access professional and clinical advice from numerous sources. The point of the statutory advisory committees is that that they are protected by law and indeed obliged to provide a perspective to Welsh Ministers and the NHS. The Royal College of Nursing believes that a professional clinical perspective in policy-making is imperative. It has been known for Ministers to decline to meet with outside bodies including professional organisations and it is clear that in practice at present not all health policy documents emanating from the Welsh Government have had the benefit of a nursing perspective. For the reasons therefore the RCN believes that the statutory status of the advisory committees must be maintained. Moreover we are aware that the abolition of the advisory committee has been prosed by the civil service on a regular basis for at least a decade. It appears disingenuous therefore to discuss 'removing the statutory status of the committees' when this would clearly be an abolition. Given the significant challenges facing the Welsh Government regarding nursing in Wales, it is imperative that a Chief Nursing Officer post is retained at Welsh Government. Similarly, a government level nursing advisory group must be retained. The need for these safeguards is reinforced when the central role of nursing in recent (and very well publicised) key service and care failures in Wales is considered. We oppose the replacement of these Committees by a single Committee giving advice. This proposal is totally unacceptable and would not provide the capability of independent strategic advice.

47. If so, how might we use legislation to ensure that policy and service

delivery is based on expert professional advice?
The RCN does not support the abolition of the statutory advisory committees. However it may be worth exploring whether legislation could clearly set out a duty for the NHS and the Welsh Ministers to consult with the relevant professional bodies and relevant welsh government professional officer.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
The RCN is content with the current partnership arrangements and does not believe they require amending. We agree however that keeping under review national partnership working arrangements for the NHS is a good idea. The challenges of devolution make the need for regular reviews of partnership working self-evident. We are of the view that (notwithstanding the emerging agenda regarding health and social care integration) the need for a specific national NHS Wales Partnership Forum remains. Such a forum should continue to involve: Welsh Government, NHS Wales Employers and the Staff-side. Given the scale and makeup of the membership of the RCN in Wales, we would anticipate that we would have significant representation "at the table" of any future incarnation of the NHS Wales Partnership Forum. The RCN is a UK wide body and we believe that UK wide terms and conditions for NHS staff are advantageous to Wales and allow for professional movement and facilitate recruitment and retention of skilled staff.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
'Hosting' has too often been used as an administrative convenience rather than being chosen as an appropriate mechanism in its own right. We believe it is appropriate to review on a regular basis whether each of the 'hosted' services is more appropriately delivered by a separate organisation, merged directly into an already existing NHS organisation's role or moved to the Welsh Government level.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
The RCN believes NWSSP should be established as an organisation in its own right.

WGGP050 – Alice Warren – The Association of Personal Injury Lawyers
Tref / Town – N/A

General comments

The Association of Personal Injury Lawyers (APIL) was formed by claimant lawyers with a view to representing the interests of personal injury victims. The association is dedicated to campaigning for improvements in the law to enable injured people to gain full access to justice, and promote their interests in all relevant political issues. Our members comprise principally of practitioners who specialise in personal injury litigation and whose interests are predominantly on behalf of injured claimants. APIL currently has around 3800 members in the UK and abroad - 141 of those in Wales - representing hundreds of thousands of injured people a year.

We recognise that many of the questions and issues in this Green Paper are outside of APIL's remit, but we would like to take this opportunity to comment on the questions relating to a statutory duty of candour for NHS Wales. APIL welcomes that the Welsh government is examining options for further enhancing openness, transparency and candour in the Welsh NHS. We agree that a statutory duty of candour should be introduced in Wales, to reflect the situation in England, where a statutory duty of candour has been in place for NHS providers since November 2014, and independent health and adult social care providers since April 2015[1]. A new statutory duty would ensure consistency, and encourage an open and transparent culture across the NHS in Wales. APIL believes that the majority of those injured as a result of medical accidents frequently want nothing more than an explanation of what went wrong and why. They also want to know that lessons have been learned. A statutory duty of candour, with clear guidance issued to health care professionals on when such a duty would apply, would help to achieve this.

Harm threshold
The threshold of harm to which the duty of candour applies must be proportionate, striking a balance between providing the patient with an apology, without requiring the health care professional to divulge every "near miss". We feel that the threshold in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – moderate to severe harm or death – strikes this balance. We recommend that this threshold is replicated in any duty of candour regulation applying in Wales. Telling the patient about every slight incident, even if there was no harm, may result in adverse effects on patients, causing them to lose confidence in their health care providers. This is not to say that near misses and slight incidents should not be taken seriously, reported and addressed to ensure that they do not occur again, but this is a separate issue to the duty of candour.

[1] Regulation 20, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The purpose of a statutory duty is to increase openness between the service provider and user. This can be achieved without the need to cause unnecessary worry to the patient; and without overloading health and social care professionals with an unmanageable administrative burden. If the duty is not overbearing, health and social care professionals are likely to embrace a new culture of openness. This would hopefully lead to more openness and transparency as a whole, not just in those situations as required by the regulations.

Duty to report
It is also important that regulations also contain a compulsion on the duty holders to report accidents that result in moderate to severe harm or death, to a relevant nominated body – such as the Healthcare Inspectorate Wales (HIW). It is important that HIW is notified in all cases, as this will ensure that HIW is fully informed when things go wrong, and plans can be put in place to prevent repeat incidents across the whole of NHS Wales.

Broad scope
A statutory duty of candour should also be broadened to apply to health and social care providers operating independently in Wales. All healthcare providers, NHS, non-NHS, and those providing primary care such as GPs, should be under the same duty to ensure consistency and to ensure that all patients, should anything go wrong, are provided with apologies and an explanation of what went wrong and how it is going to be prevented in future.

We would welcome the opportunity to comment on any draft regulations imposing a duty of candour once these have been drafted.

Response to specific questions

No response to specific consultation questions.

WGGP051 – Dr Ian Garth Higginbotham
Tref / Town – N/A
– North Wales (Betsi Cadwaladr) Community Health Council

General comments

Response to specific questions

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Much has been made of the claim that CHCs are not representative of the public but those making the claim seem unaware Welsh Government appoints 50% of CHC members, Local Government appoints 25% and 25% are appointed by the Third Sector. CHCs have no control over the appointment of their members and CHCs, such as Cardiff & Vale CHC, who have suggested that they advertise for members seldom heard communities or ethnic communities have been prevented from doing so by the Public Appointments Commission and by Welsh Government. There are four basic functions of CHCs; • Speaking up to protect & improve our health services • Monitoring & scrutinising our health services to ensure their safety and quality • Influencing NHS service changes so they reflect what matters most to patients and the public • Helping patients raise concerns about the NHS when things go wrong Each function informs the others; particularly so in the case of Advocacy and Visiting & Monitoring. CHCs are the only body that makes truly unannounced visits and the only body that visits and inspects NHS facilities with any frequency. The Green Paper proposes that CHCs should be stripped of their rights to enter and inspect NHS premises – a right they have held since 1974. This appears to be based on the advice of those who have consistently misunderstood and criticised the CHC's lay focus and have cited the Minister's desire to do away with duplication in the inspection of the NHS. Before accepting these arguments at face value, it would be useful to look at how things work in the real world. When North Wales CHC first visited a local community hospital using its BugWatch regime in the Summer of 2014, CHC members were concerned at what they found. The Director of Nursing and the Director of Infection Control & Prevention were contacted on the day of the visit and a range of measures including deep cleaning, staff training and support and extensive repairs to the fabric of the building were undertaken very rapidly. North Wales CHC members visited the hospital again in November 2014 and

also in February 2015 using the CHC's CareWatch methodology (based on the 12 Fundamentals of Care). They found the hospital much improved but with some issues remaining. The Health Board were notified and they undertook to address the issues raised.
When CHC members visited in June 2015 they found that the problems they identified in Summer 2014 were back again. CHC Officers contacted the Director of Nursing and the Director of Infection Control & Prevention and, once again, the problems were rectified.
Only the local CHC has the capacity and the local knowledge to undertake such a sustained and intensive programme of visiting and monitoring. Having found a serious problem, the CHC lay members did a follow up within weeks and then kept following up using BugWatch, CareWatch. They will continue to visit this hospital very frequently until they see permanent improvements. No other body with inspection duties is able to give this level of commitment.
Over the past 3 years there have been many concerns about the quality of care provided by Betsi Cadwaladr UHB and at least five major critical reports. This is the Local Health Board that has caused Welsh Government the most concern and it is the only Welsh Health Board to be placed in Special Measures. Members have given freely of their time in order to monitor the quality of services from a patient perspective and we have consistently reported our findings to the Health Board, to the Minister and to HIW
During 2014-15 CHC members undertook nearly 500 visits and inspections, producing detailed reports of their findings that have been made available to partner organisations and stakeholders.
There has been criticism that this is "too many". However, North Wales CHC does not hear that from Ward Managers and Nurses. They welcome CHC members as it is often the only way they can get problems sorted out. The Director of Nursing at Betsi Cadwaladr UHB has commended the BugWatch programme and in his evidence to the PAC, the Chairman cited the CHC inspection regime as a clear demonstration of the Board's openness and accountability, something that should increase public confidence. The Minister has commended North Wales CHC for its pro-active inspection programme and promoted it as an example to other CHCs.
With regard to the idea that 500+ visits is too many, this works out at somewhere around 4 visits per ward per year – certain wards may receive more than this but it will still be in single figures. Inspection frequency by other bodies could be once in 5 years or even longer.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
CHCs are the only voice within the NHS having any degree of independence. If a "more integrated system" results in a reduction of independence then this would be a mistake of the order of the abolition of CHCs in England. Some form of organised independent public scrutiny of NHS Wales is plainly necessary. In the light of the Andrews Report, the Lessons Learned Report, Tawel Fan, the Evans Report, the HIW/WAO Report on Governance at Betsi Cadwaladr UHB and the subsequent Special Measures and the recent report to the Minister on the operation of BUHB by Ann Lloyd, it is not credible to claim that Independent Members of Local Health Boards can fulfil the function

of holding the NHS to account.

The key formal check and balance at the moment is the CHC. Successive Ministers and their Civil Servants have looked critically at CHCs to question whether they are good value for money and to see whether the public interest in the NHS could be better and more economically served by other mechanisms. The experience of the abolition of CHCs in England in 2003 suggests strongly that it would be better to strengthen CHCs than either to abolish them or strip them of many of their current roles.

In relation to the CHC membership, there are arguments for and against continuing with local authority and voluntary organisation nominees. On the plus side, local authorities are the only truly democratic input into CHCs and voluntary organisations are close to local communities. On the negative side, the current process of representation tends to be unsystematic, the same organisations get represented and nominees pursue their special interests rather than the wider picture. There are also important issues over training, standardising performance, ensuring national standards and empowering ACHCEW to co-ordinate and enforce common standards.

There is a strong feeling that CHCs in Wales should be given responsibility to recruit directly - as is the case for HealthWatch in England. HealthWatch England has a robust set of criteria for ensuring Local HealthWatch appoints a diverse and representative membership; similar arrangements could be developed in Wales.

WGGP052 – Mark Gardner – Melin Homes

Tref / Town – N/A

General comments

The NHS in Wales is something to be proud of. It has strong political and executive leadership, and at Health Board tables around the country, it is served by talented and committed individuals and teams.

The consultation paper however exposes its 'blind spot' specifically, it makes no reference to where people live, and the positive impact that good quality housing has upon peoples' lives.

Apart from the Minister's opening statement, housing is not referred to as a key partner for health going forward.

There is evidence of good collaboration in the Aneurin Bevan University Health Board region, and a new strategic alliance between Public Health Wales (PHW) and Community Housing Cymru (CHC) is starting to emerge, however, the housing sector generally is still not seen as a natural partner for the health service. This needs to change.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority? 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The challenge for Welsh Government is to ensure that legislation considers the contribution of the whole of the public sector and others that support it (such as housing associations and the voluntary sector) rather than focus upon its own discipline in isolation. Recent examples of legislation in respect of housing and social care are too inward looking and this stance is reflected in this consultation paper too. As a starting point there should be an **expectation** that public service organisations and wider partners should seek to collaborate to deliver services in the future. If Welsh Government considers that the only way to do this is to legislate then so be it, but examples such as In One Place and the Gwent Frailty Programme are reference points where local collaboration can work and make a difference to health and well-being.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
There is no mention of Stakeholder Reference Groups (SRG). Is this an oversight or omission? There should be some assurance given that the commitment to SRGs will remain and that they will be a continued requirement for all health boards.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Health boards should have the ability to borrow subject to appropriate business case approvals. It is suggested that borrowing powers also provide for investment in capital projects that are not owned by the NHS but that will deliver a return on investment to the NHS through efficiency savings. Such projects might include housing accommodation that provide local solutions rather than support high cost out of area placements. Through the In One Place programme, there is evidence that every tenancy created saves the NHS £50,000.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed? 37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors? 38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation? 39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services? 40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
It makes little sense to populate health boards with more politicians when the

general thrust of this chapter appears to be intended to make boards more business-like. At the present time, one place is allocated for a local authority representative which promotes collaboration and information sharing rather than arguing for or against change on a local issue level.
There should be a place on each health board for a housing representative to ensure that health, social care and housing sectors collaborate better in the future. There could be the potential for reciprocal arrangements, i.e. health representatives on housing association boards under such a scenario.

WGGP053 – Bronwen Brooks – Vale of Glamorgan Constituency Labour Party
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The law should make local collaboration in planning and meeting people's health and wellbeing needs closer to home a clear statutory obligation.

2. If so, what changes should be given priority?
The law should strengthen the obligation for regular meetings between relevant agencies to review where collaboration has been inadequate and where it has been successful to extract, apply and share the learning in each case.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The legislation should be examined from the point of view of whether it incentivises agencies to operate defensively in silos, fighting for resources. Where it does, it should be amended to provide incentives agencies to co-operate and deploy common resources in the most effective and efficient way.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
We don't have enough knowledge of the law to go into the specifics, but believe that appropriate legislation may lay the foundation for change. However the wording of legislation should be closely examined to ensure that it is unambiguous, will help achieve intended goals, not be the cause of unintended consequences down the line and will not impose undue rigidity in the face of unforeseen situations.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?

Yes, we believe that health boards and NHS trusts should have a statutory requirement to establish permanent engagement mechanisms. Any specification of how patient panels or participation groups should be recruited should ensure that all relevant interests should be represented and that there is no possibility of domination by any one interest group with their own strong agenda.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
As minister are transient and unlikely to have in depth expert knowledge across the piece, we believe that referrals to a national expert panel is likely to produce better outcomes as decisions about the health service as expert knowledge is often likely to be critical to decision making and resolution of issues. The law should require the existence of such a panel and specify its constitution and how members should be selected. The legislation should ensure the independence of the panel and that it has wide membership across relevant areas of expertise, including 'expert' service users. It should be specified that referral to the expert panel can be triggered by any of the involved parties (e.g. Minister, CHC) where there is a dispute over what needs to be done.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Legislative measures are not the most effective tool to address quality issues. Ultimately, quality at the front line in medicine will only come from effective 'facilitative' leadership and associated training that result in profound changes in attitudes and the prevailing culture and consequently, behaviour. Legislative measures may provide a 'backstop' in specifying a minimum level, below which quality of care is unacceptable. Legislation needs to be written with reference to a desired culture open about errors and orientated to learning from them. It therefore should avoid being overly punitive, particularly in dealing with erroneous actions were made with good intentions.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
The legislation should be written to ensure that the questions asked of any decision are: Will is lead to an improvement in the quality of patient care and thus their welfare and well-being? Will it lead to reduction in the probability of failure/errors in care? Is it likely to lead to better patient outcomes?

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
The advantage of setting out the role of “responsible individual” in the senior management of any service provider would be to clearly establish where accountability lies. However, the legislation would have to ensure that the area of accountability was manageable and fair; that events in that area were fully within the responsible individual’s powers to influence. It would also need to embody the message that all individuals working in a service provider had responsibility for quality in the domain in which they could influence events; they could not just pass the buck to the “responsible individual” if they ‘screwed up’.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
It seemed to us almost naïve to ask this questions as it would seem to us that anyone seeking employment in a responsible position in healthcare should be assessed to ensure that they are a ‘fit and proper person’. We have looked at the specification of the ‘fit and proper’ person test set out by the consortium of the NHS Employers, NHS Confederation and NHS providers and it does not differ too much from the sort of selection procedure used by most significant organisations. Indeed it is a good deal less sophisticated than selection procedures used in many organisations and, in particular displays no appreciation of the need for appropriate rigour in assessing what is called ‘character’. We believe that to ensure that ‘fit and proper’ people are employed in responsible positions a suitably structured selection procedure, with multiple assessment methods should be used. Some people who are talented or even very talented in some areas may have personality traits that lead them to display dysfunctional behaviour in certain circumstances, particularly when stressed under pressure. There are a number of prominent examples of individuals in leadership positions whose dysfunctional personality traits were the major contributor to high profile organisation disasters, in recent years. There are a range of psychometric assessments developed over many year, using a scientific methodology to ensure validity and reliability, that will help assess personality (or character), including areas of vulnerability. A prominent example is the Hogan Development Survey (or ‘Dark Side’ personality assessment). The results from administering these instruments would usually be explored in a probing interview conducted by a suitably trained interviewer to tease out where the individual might display traits unhelpful to leading, motivating and managing peers and reports and to assuring that they meet their responsibilities. We believe that ‘responsible persons’ and any appointments at a senior level should be made on the basis of rigorous, systematic, well validated assessments whether the individual is a fit and proper person. Note: The principal writer of this section is an occupational psychologist with extensive experience of designing and applying assessment procedures and

assessing individual using psychometric assessments. Organisation in which he has worked include many major private and public organisations including the NHS.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
We broadly accept the arguments for common healthcare standards across health organisations put forward in the Green Paper. However, for each type of organisation it should be considered whether there are standards that should be specific to them.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
We believe that common standards should be 'outcome oriented' and cover both the NHS and independent sector so that both are clearly focussed on improving outcomes with effective co-ordination/cooperation where required.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
We believe that appropriate accreditation is important to ensuring that all healthcare professional have the competencies required to deliver a service that meets or exceeds the required standards. Accreditation should include demonstration of key competencies in supervised practice as well as in formal assessments such as exams. Peer review is potentially of great importance for raising healthcare professional awareness of their strengths and weaknesses, to build on strengths and remedy weaknesses. However peer review schemes must be carefully designed and skilfully implemented to ensure that individuals do not retreat into denial and defensiveness regarding their weaknesses rather than striving to remedy them. The use of 360 degree feedback, which can be a very powerful technique in promoting individual learning and development, should be considered, particularly for individuals with managerial responsibilities. Again, its effectiveness critically depends on appropriate attention being given to the design of the process and skill with which it is delivered. On these issues it may be of great benefit to seek the help of external consultants with appropriate expertise (e.g. in occupational psychology). We would expect that all healthcare professional who come under the umbrella of the HCPC (Health and Care Professions Council) should either be working towards registration with the HCPC in supervised practice or already registered. As registrants they would have to demonstrate on a regular basis that they were undertaking appropriate levels of CPD (Continuous

Professional Development) to maintain their registration. However, in the experience of one of the writers, some HCPC criteria may not be considered rigorous enough and accreditation at a higher level with professional bodies might be required.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Appropriately written legislation would lay down a clear marker of the necessity of clinical peer supervision to ensure that health care professionals reach appropriate levels of competence in their speciality and meet quality standards.

17. What arrangements should be put in place for self-employed health professional registrants?
Self-employed health professional registrants should have met the registration requirements of the HCPC and, where necessary, of their professional bodies. Where this is insufficient to meet the requirements of the practice situation, further training should be required, provided either internally or externally. To ensure that standards are met, their work should be monitored through an appropriate supervisory regime and peer review or a 360 feedback process.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
From the history of adverse healthcare events in Wales and the UK generally and what these events have told us about the dysfunctional culture in some institutions/departments, a statutory duty of candour would seem to lay down a strong marker for change to a culture of openness and honesty. It should be understood that the legislation is unlikely to instantly change a culture of denial, secrecy, cover-up and scapegoating to one of openness, honesty and orientation to expose and learn from mistakes. Changing an entrenched culture is a long process requiring leadership deploying facilitatory, coaching and democratic styles, while only resorting to a directive style in extreme circumstances. In some cases, outside assistance may be required.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Legislation should make it mandatory to report adverse events with a full

analysis of what went wrong and what should be done to ensure that there is no re-occurrence. It should also provide for an independent review body, with the power to take evidence in camera, where there is disagreement between parties involved and any suspicion of those involved being less than open. Legislation should also provide strong protection for 'whistle blowers', who risk damage to their career prospects, as dramatically demonstrated in some notorious cases (e.g. Mid-Staffordshire Hospital; BRI children's heart surgery unit).

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
We do not have enough 'inside' information to say much about this. We recognise that patient confidentiality may be an issue, but wonder if this cannot be overcome in most cases by seeking patient consent where sharing of information is critical to the patients ongoing welfare.

22. How can we consider breaking down any barriers?
See above.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
While recognising the great potential value of patient information, particularly for long-term studies on factors affecting patient health (as investigated in the Biobank study), we are sceptical whether there is any need to use patient identifiable information. All long-term studies are statistical in nature and it should be possible to carry them out perfectly adequately using data from individuals whose identity has been reduced to an anonymous code from which it is not possible to trace the identity of the 'real' person.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
If Wales is going to genuinely move towards integrated services with common quality standards that it would seem entirely logical to merge HIW and CSSIW to improve both efficiency and effectiveness and eliminate the possibility of different bodies at odds with each other.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
If it is to be changed to encompass Health and Social Care then it should more broadly represent Health and Social Care Service users voice or even 'citizen's' voice, rather than just patient voice. As the CHCs appear to currently be partly fulfilling an 'inspectorate' function, if this function can be effectively discharged by a merged HIW and CSSIW, this would allow a better focus on representing the voice of service users. The profile of the CHCs appears currently to be rather low, apart from other factors, limiting its potential for representing service users voice.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
In a genuinely integrated system it would seem appropriate to rename it Community Health and Social Care Council (CHSCC). It should be focussed on representing service users voice, as indicated in the previous question, seek to raise its profile and accessibility to service users both with problems to resolve and who wish to become involved on an ongoing basis.

WGGP054 – Dr Del Morgan – One Voice Wales
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
One Voice Wales has no specific comment in relation to this question, although some members have indicated that they are in favour.

2. If so, what changes should be given priority?
One Voice Wales has no specific comment in relation to this question, although some members have indicated that a statutory requirement should be introduced to require that a plan for all patients is prepared before they leave hospital. A copy should be given to the patient and/or their primary carer.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
One Voice Wales has no specific comment in relation to this question, although some members have said that stronger relationships should be developed between health and social services personnel to ensure that they are fully joined up thereby providing maximum benefit to patients.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
One Voice Wales has no specific comment in relation to this question, other than to say that, if such participation groups are established, then serious consideration should be given to the inclusion of community and town councillors on these. Perhaps the engagement of volunteers to undertake patient surveys would be useful, as well as the potential use of a "mystery shopper" approach to test proper and appropriate engagement.

6. Do you support the idea of a national expert panel to which referrals might

be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
One Voice Wales has no specific comment in relation to this question, although some members have indicated that they are in favour.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
One Voice Wales has no specific comment in relation to this question, although some members have argued that legislation is not the panacea and instead greater investment should be made in leadership development and management training supported by an effective performance management system.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
One Voice Wales has no specific comment in relation to this question, other than to agree strongly with the general aim implied in such a consideration.

Chapter 3: Quality in Practice

Meeting common standards

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
One Voice Wales has no specific comment in relation to this question, although the idea is thought to be a reasonable way of improving standards.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
The consensus among One Voice Wales members is that this idea has merit.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of

complaints across the NHS and social services in Wales?
One Voice Wales has no specific comment in relation to this question, but please note the response made to question 26.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
An all-Wales IT platform with a common information system managed by a Central IT bureau is vital.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
Please note the response made to question 26.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
One Voice Wales considers that the health and social care sectors should be brought together as soon as is practicable and that, in the meantime, the creation of a single inspectorate covering both strands would be a positive way forward. The focus should always be on the client and not the specialism.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
One Voice Wales agrees that the activities of each CHC should be strongly focussed on representing the patient voice and on providing advocacy services, but that there should also be far more of a focus on the community element of its title. An approach might be to extend Councils' powers so that their role becomes similar in style and operation to that of the Older Persons Commissioner for Wales

29. Is the current CHC model fit for purpose in a more integrated system? If

not, how would you suggest it needs to be changed?
Representatives from the community and town council sector could contribute much to the shaping of these bodies, having both local knowledge and full and continuous community engagement.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
One Voice Wales has no specific comment in relation to this question, although some members have expressed the fears that doing so could lead to boards building up considerable debt.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
One Voice Wales believes that the inclusion of community representatives on Local Health Boards would greatly enhance the standing and the day to day governance of the Boards and that these representatives should be channelled through the community and town councils in their respective areas. Please note also the response made to question 40.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
Please note the response made to questions 36 and 40.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Please note the response made to question 26, above.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
One Voice Wales is recognised by the Welsh Government as the national representative body for community and town councils in Wales. It represents the sector on the Local Government Partnership Council and over three-quarters of the 735 community and town councils are already in membership, with numbers growing year on year. As well as our representative role, we

also provide support and advice to councils on an individual basis and have previously launched, with Welsh Government support, a modular training programme for councillors, which continues to deliver effectively. We believe strongly that community councils are well-placed to develop the economic, social and environmental well-being of the areas they serve and, as such, are active and proactive in debating key issues such as energy policies, environmental issues and strategic planning as well as those pertaining to health and social care. Our sector will continue to support and wish to increase its participation in the drive to sustain and enhance the various strands of community life across Wales, and as such will wish to engage increasingly with public sector governance in general including aspects of the agenda raised within this consultation. Therefore, it is proposed that serious consideration be given to the inclusion of community representatives on Local Health Boards and that these representatives be channelled through the democratically elected community and town councils across Wales.

WGGP055 – Tom Brooks
Tref / Town – Porthmadog
Sefydliad / Organisation – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
No The Welsh Government cannot define what "closer to home" means. Further changes will simply create more misguided strategic misadventures by health boards and local authorities.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Yes. Establish foundation trusts in Wales so that residents can directly influence actions that health boards take.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Yes Make health boards democratic by adopting an elected director system akin to foundation trusts. It could also help by strengthening the role of the CHCs to make them the lead organisation, rather than the Health Boards in relation to engaging with citizens. It is essential to develop ways that are accepted by the public as effective in engaging people continuously in service planning so the patient and public experience fully informs decision making.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Surely not more tea and biscuit sessions. Engagement is not the challenge for health boards. The challenge is for them to accept and act on what the public and patients evidence and contributions say. The recent consultation on Women's and Maternity Services in North Wales has shown that there is a lack of confidence and trust in the Local Health Board. There was a 'patients' panel' and it met with health board officers but the contributions of members have been reported by them as ignored and frequently omitted from the

minutes. Such Health Board internally run mechanisms for public involvement would lack credibility for the foreseeable future. Certainly in North Wales, the CHC enjoys the reputation for independence and is trusted far more by the public than Betsi Cadwaladr Health Board.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
No The National Health Service (Wales) Act 2006 places the responsibility for providing adequate healthcare with the Welsh Ministers. If any Minister does not feel able to accept that responsibility, he or she should resign. A panel would be seen as a cop out by the Welsh Ministers. In a territory like Wales, where the health needs of the population are not being met by the finance being made available to healthcare, decisions will always be political and the Welsh Ministers should have the backbone to take them personally.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
No If residents had real powers such as with the foundation trust mechanism, further complexities and contortions would not be necessary.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Yes Each health board should be required to publish a comprehensive needs assessment report annually supported by a statement describing how they have commissioned the services necessary to satisfy those needs.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
The standards adopted for Wales should be identical with those in use in England. Differing standards on either side of Offa's Dyke lead only to second rate healthcare being tolerated in Wales.

14. Could a common standards framework, which covers both the NHS and

the independent sector better deliver a focus on improving outcomes and experience for citizens?
A common standards framework with the NHS in England is the real answer.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
No Use the mechanisms available in the Royal Colleges and other professional bodies.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
It is sad that the experience in Wales has identified so many transparency defects in the Welsh NHS that this question has to be asked. It is also regrettable that the linked question “Should all staff have a legal duty to whistle-blow on any issue they are aware of where patient care may have been at risk?”

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Adopt the identical measures to NHS England. Most people in Wales believe in the benefits of the union of the United Kingdom. What is wrong with being able to directly compare with England?

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
None necessary. Do not tinker with organisational change when investigative staff development will provide a more effective answer. Higher numbers and better quality of investigative staff not organisational tinkering is the better approach.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient

information?
In this digital world, patient information held in electronic format is the only effective baseline for sharing. Wales has such an antiquated unique information systems model that electronic patient information sharing in Wales on a par with that existing in developed countries is unachievable. Moreover the publically published plans in Wales indicate that the Welsh NHS has little idea about how to define, design and develop systems for effective patient information sharing.

22. How can we consider breaking down any barriers?
Start learning from England and stop pretending that there is a better 'Welsh' way.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Opposed. It will further undermine patient trust in the Welsh NHS.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
HIW is hopelessly understaffed and is performing far too few inspections.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
HIW should be directed by Ministers and should report to Ministers. It should be the Ministerial watchdog to ensure that Ministers discharge their National Health Service (Wales) Act 2006 duties diligently.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
The Marks review appeared heavy on "change for change sake" but light in its evidence base. A simple non statutory collaboration committee should suffice.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
Merging bodies with an inspectorate or governance compliance role invariably leads to an imbalance between the subsequent focus on the two areas of responsibility. When organisations are merged, effort and attention is diverted

inevitably on to administrative and organisational matters and away from the organisations key functions.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
In North Wales where I live the CHC is only healthcare body that retains public confidence. The major problem in Wales is that when a CHC refers failings in a health service to the Ministerial team, Ministers do not react in a timely manner. Leave the successful part of the current model – the CHC – well alone. The four basic functions listed below are addressed suitably by the CHC in North Wales whose members must get very frustrated when their revelations are so often ignored the health board and Ministers. CHCs: • Monitor & scrutinising our health services to detect failings in their safety and quality • Seek to influence NHS service changes so that they address what matters most to patients and the public • Help patients to raise concerns about the NHS when things go wrong • Speak up as necessary to protect & improve local health services

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
The CHC model combines local knowledge and communication through its local committees with the provision of strategic guidance to the health board through its pan North Wales Executive. It is a pity that Betsi Cadwaladr has had a succession of Chief Executives who have paid limited attention to the CHC. If more attention had been paid to the wisdom, observations and judgements of the CHC, Betsi Cadwaladr would not now need to be in special measures. It is concerning that the Green Paper appears to suggest that CHCs should be stripped of their rights to enter and inspect NHS premises. Without unannounced CHC inspections the situation in North wales would have been much worse. This attempt to reduce the effectiveness of CHCs by restricting their powers appears to be based on the views of those whose failings in the past have been exposed by CHC scrutiny. In my view North Wales CHC ***currently*** has the membership and local knowledge necessary to broaden its role further into social care if that is what the Minister wants. But like all organisations it needs to refresh its membership from time to time. Some CHCs in Wales have considered advertising for members with particular experience and skills but are understood to have been prevent from doing so by regulations. It would be a constructive step if CHCs in Wales were given responsibility to recruit directly - as is the case for HealthWatch in England. HealthWatch England has a robust set of criteria for ensuring Local HealthWatch appoints a diverse and

representative membership. Similar arrangements could be developed in Wales.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Yes Betsi Cadwaladr has a major need to invest large sums in order to development the effectiveness and efficiency that it needs. Capital spending of less than £50m per annum on a revenue spend of £1.3Bn is grossly unbalanced. Old plant and our-dated diagnostic test equipment leads to gross inefficiency in the use of finance.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
Absolutely. If Ministers consider transparency is essential for public confidence, as they claim they do, then maximum visibility of accounts is needed.

32. 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?
Those changes that I have heard floated are likely to lead to Freedom of Information requests and I fear irritation with the media and public.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes It is fortunate for the NHS in Wales that when bodies such as the OECD publish comparative healthcare performance evidence between countries, they treat the UK as one country. If Wales was reported on independently from the other countries, as the NAO has done from time to time, the Welsh Government would be seriously embarrassed. The quality of planning and performance management in Wales must be improved.

34. 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?

Not necessary. As stated in 33 above it is the quality of the NHS planning functions in Wales that need to be improved.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
The key to ensuring that NHS leadership delivers the required results in Wales is to introduce a democratic element into the system as has been achieved in Foundations Trusts in England.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
The evidence base mentioned to justify change is Betsi Cadwaladr. Betsi Cadwaladr has a range of responsibilities integrated into it, a geographic spread and a population base that is too large to succeed. A commercial organisations would break it up with the creation of a number of operating companies each with their own boards so as to achieve appropriate strategic direction and governance. The suggestion that increasing the number of public sector 'independent' directors to the Board and reducing the Board's membership numbers would help is the very opposite of what Betsi Cadwaladr needs. It needs all its existing independent directors each spending at least twice the time supporting the health board than they do at present.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
If any of the officer member roles were removed, the Board is likely to be defective.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
I have already advocated that the Foundation Trust role would be appropriate in Wales.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
The public sector in Wales is underperforming. Merging two underperforming

roles creates one disastrously defective role.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
There is little prospect of Welsh health bodies becoming effective in the digital age without a world class digital infrastructure. Having a person with the ability to guide the Board towards achieving such a goal will be essential and a person with such skills should be on the mandatory list of Board appointments. One size never fist all in the successful segment of the digital world.

NHS Trust size and membership

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
See 40.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
No.

45. How could potential conflicts of interest for the board secretary be managed?
Using common sense.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
No Given the relatively poor state of the Welsh NHS, the multiple sources of advice that the Welsh Ministers have accessed as described in para 133 of the Green Paper seem of questionable quality. Formal as well as informal channels are always beneficial.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
It is naïve to consider that NHS Wales “has its own distinctive identity”. North Wales has much closer links and interworking arrangements with the North West of England than it has with South Wales. Betsi Cadwaladr cannot build

an effective workforce strategy without the flexibility to recognise its cross border relations, unfettered by any all Wales constraints.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
Joint and shared services are frequently uncompetitive and inefficient. Little evidence was tabled by Phil Williams in his report to demonstrate that joint and shared services in Wales delivered value for money.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Betsi Cadwaladr should be given the flexibility to opt out of “all” Wales joint and shared services in recognition of its proximity to the North West powerhouses and the distance from Cardiff.

WGGP056 – Hywel Roberts
Tref / Town – Caernarfon
Sefydliad / Organisation – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Why the emphasis on legislation throughout this document? Much can be done without the need to resort to legislation! One of the big problems is that so much is contained in complex legislation written in legal jargon. What is needed are clear processes written in clearly understandable language.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
It would be good if HBs could have a means to **consult** with patients panels and participation groups. Why is legislation necessary to achieve this?

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Yes it would be better if issues were referred to expert panels rather than the Minister (there could be panels for different fields). DK how the law could be reformed. There should be a clear documented process for referring issues; powers of the panel; criteria for judging and recording the decisions; to whom decisions are sent; powers of inspection to check whether decisions have been implemented.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues

raised in this section?
As I'm not a legal specialist I can't possibly answer these questions on legislative measures.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
Surely everybody working in healthcare must be a "responsible individual" in that every person from the cleaner to the Chief Executive must be appointed against a carefully prepared Job Description and Person Specification which clearly specifies the educational, professional requirements etc.; must be given initial and on-going training relevant to the job and must complete CPD and professional requirements where relevant. Why is it considered necessary to introduce legislation for something which is standard personnel practice in industry and commerce (but not, it is becoming clear, in the public sector)?

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
Everyone employed should be a "fit and proper person" for the reasons given in 10 above. The implication is clear; if some persons are designated "Fit and proper persons" then those who are no so designated are **not** "fit and proper persons"! This logic must be clear to everyone.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
DK about the legal situation but there is certainly a need to improve quality and this will be achieved through the development of robust management systems within each body including the conduct of internal management systems auditing. There must be clear documented processes and procedures covering the interfaces between NHS Bodies and other external agencies. There must be a clear directive from NHS Wales to ensure that robust management systems are developed and operating effectively in all NHS Bodies.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
I assume, as you don't make it clear, that you are talking about numerical standards in this section. I don't have the specialist expertise to comment.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
It would clearly be sensible to have common standards throughout the NHS and the independent health sector.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
In my answer to Q12 I said that it was essential that all health service bodies establish and maintain robust management systems with documented processes and procedures where all interfaces with outside organisations are identified and managed. The system would be subject to regular Internal Management System Audits and the reports, with recommended corrective actions, would be reported to the Executive Team and then the Board. Such Management Systems Audits would have identified the issues that caused the major scandals of recent years before they developed into major scandals. This must be supported by the establishment of a system of accreditation through the conduct of external Management Systems Audits to check and ensure that health bodies have efficient and effective management systems. This is how quality is maintained in the industrial and commercial sector so why isn't it done within the Health Service? Why is it that the Health Service is so slow in adapting modern governance practices which exist in industry and commerce? HIW could possibly undertake this role provided that they recruit additional qualified and experienced Systems Assessors and seek advice and also accreditation from UKAS.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
The supervision requirements, including the requirements of the clinician's professional bodies, and the responsibility for its implementation must clearly be documented together with an effective method of recording. An effective Internal Systems Audit would pick up whether this is being implemented effectively. Why is legislation necessary?

17. What arrangements should be put in place for self-employed health professional registrants?
The same as with directly employed staff especially checking that the professional registrant meets his/her professional body requirements.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes, and this should operate throughout the system. An example of lack of candour was when the Aneurin Bevan HB was fined by the Information Commissioner's Office in 2012. The Board came out with a statement that it was a mistake by one individual. True, but the ICO report went into the true cause of the problem which was the lack of documented processes and procedures and that there was no training. Is it any wonder that the individual made a mistake? The cause of the failure was the failure of leadership by the CEO to ensure that documented processes and procedures existed which were being operated effectively and that training was provided.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
DK but currently there is total lack of transparency regarding the appointment of Independent Members (see Q40), Executive Directors and Chief Executives, Board Chair etc.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
This is clearly necessary but I don't know what legislative steps are required. Also the structure of Local Authorities will be changing during 2016/17

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Lack of clear documented processes and procedures and effective training to ensure that all healthcare bodies are recording information in the same format is certainly one factor. There could also be incompatibility between the IT systems of different bodies.

22. How can we consider breaking down any barriers?
Each Body must have accredited status as outlined in Q15

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?

Data must be made available to genuine research requirements. All such requests must be examined carefully to check that they are from approved sources. The main issue is to ensure that each patient's identity is protected so that it would not be possible for the research person/organisation to know this.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
DK. How can I possibly answer as I'm no legal expert? Why should it be necessary for me to know the entire current legislative framework?

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
No. DK how the law should be reformed. CSSIW should also be considered for the possibility of becoming independent.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
Would give greater confidence in the consistency of approach if there was one agency.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Yes. DK re. legislation

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
The possibility should only be considered for Boards whose management systems are externally accredited and are also considered sound financially by the Welsh Audit Office.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
DK enough about NHS Trusts.

34. 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?
All legislation must be consistent and if changes are required to achieve this, then they must be implemented.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
I refer to answers to Q12 and Q15. The development and operation of effective management systems within each Body together with an external Accreditation system is essential otherwise the quality of "Leadership" is irrelevant as they would not be able to implement their visions and policies effectively. The management system would have documented processes and procedures to identify the relationships with each partnership and the responsibilities for their effective implementation. Paragraphs 112 and 113 in the Green Paper are pathetically weak on this, the biggest issue causing the problems within health bodies in Wales.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Para.115 in the Green Paper states that "the need to separate clearly those who make decisions and those who scrutinise them …" The Board scrutinises the work of the service but the Executive Directors are members of the Board so who scrutinises them? This is a critical question which must be answered.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Who has taken the decision on the named Executive Directors listed in Para 121? The Job Descriptions and Person Specification for these positions must be published on HB websites to ensure transparency.

38. What are your views about the suggestions made by the Commission on

Public Service Governance and Delivery, such as the election of community representation?
Why would such a person (s) be required if the option of setting up a Patients Panel (Q5) is implemented? What would be the Job Description and Person Specification? How would competence to scrutinise the work of the Senior executives and their staff be assessed?

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Local government reorganisation is currently under review but a Bill will not be introduced until after the May 2016 Assembly Elections. If there are major changes then clearly the possibilities mentioned here must be investigated and any recommendations must be open to consultation.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
The role of the Independent Members needs to be fully examined and it is essential that the process of appointment etc should be transparent in order to give public confidence. On each HB website there should be a clear, easy to read, outline of the process for appointing Independent Members which include at least: - How the positions are advertised; - The Job Description and Person Specification; - To whom are applications sent; - Who makes up the panel that selects the short-list; - Who is on the panel that interviews applicants and makes appointments; - Who confirms the appointment; - How the applicants are informed of the outcome of the application. - The induction and on-going training that the appointees will be given and expected to undertake successfully. This information is absolutely essential to ensure transparency and public confidence. There is an urgent need to clarify the role of Independent Members. In June the Nursing and Midwifery Council issued a report which was critical of the nursing and midwifery education programmes provided at Glan Clwyd Hospital. These were provided by Bangor University and the report was critical of both the Hospital and the University. The Head of Bangor's School of Healthcare Sciences is an Independent Member of the HB. How can this person be independent when she is in charge of the training provided? She is effectively a contractor to the Board and is in the same position as one of the Executive Directors. There is a need to clarify this position and the position of Independent Members in general. There should be a requirement that Independent Members declare an interest in any relevant topics on a Board agenda.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
The position of Board Secretary is not listed in Para 121. Is the Secretary a Board employee or is he or she engaged as a self-employed independent person to undertake the role? This is not at all clear and must be clarified. The possibility of conflict of interest is highlighted in Para 130. Para 131 compares the role with that of Head of Internal Audit, which I've taken to mean internal financial audit as people within the NHS and the Civil Service don't appear to understand any audit other than financial audit. The role must also be compared to the Head of Internal Management Systems Audit who will provide formal reports on the effectiveness of the management systems. See answers to Q12, Q15 and Q35.

44. If so, what aspects of the role should be additionally set out in law?
The implications of answers to Q43.

45. How could potential conflicts of interest for the board secretary be managed?
If the Secretary holds another position, then a declaration of interest should be declared and failure to do so could lead to disciplinary action.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
DK – couldn't access the website given.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Clearly all partnership working arrangements must be reviewed to ensure that they are fit for purpose.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
DK re. Legislative requirements. I strongly disagree with the first sentence in Para 143 which states that NHS services are "managed with clear management, accountability and governance arrangements …" This unfortunately is **not true** regarding management and governance! This failure is the cause of the major problems seen in recent years within the NHS.

WGGP057 – Mandy Williams– Betsi Cadwaladr University Health Board

Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority? 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The Health Board recognises the significance of and welcomes the new legislation including the Public Health (Wales) Bill, the Social Services and Wellbeing (Wales) Act and in particular the Wellbeing of Future Generations (Wales) Act in relation to the requirements for closer collaborative working between health and other public services. The totality of the implications of the Social Services and Well-Being (Wales) Act and the Well-being of Future Generations (Wales) Act are not fully understood at present but their introduction will transform the way both the health and social care system and the wider public service operates in partnership. As such we do not currently think that additional legislation is needed specifically to strengthen local collaboration for planning. What will be important is for clear guidance to be available to Health Boards and other public services to facilitate a clear and common understanding of the opportunities and requirements created by the new legislation, notably the Wellbeing of Future Generations Act. This will enable the Health Board and partners to maximize the opportunities around local collaboration. Collaborative planning requires not only the recognition of and adoption of common priorities and outcomes, but a framework and timetable that facilitates joint commitment and resource. Current planning cycles across public service and notably across health and local government are not fully aligned. The potential for this should be explored further in the implementation of the new legislation. The Health Board wishes to highlight that it is important that strengthening collaboration is seen from the outset to relate both to a focus on prevention/ early intervention and the wider determinants of health as well as the

provision of care closer to home. This is not always made clear as evidenced by the wording of this question. Emerging guidance for the new legislation should be strengthened to reflect this, with clear and strong reference to improving health outcomes and addressing inequalities. In particular, our response to the current guidance on Wellbeing of Future Generations recommends that stronger and more meaningful reference to and guidance on an approach of 'health in all policies' should be included. This will facilitate all public bodies to recognise the contribution that they make to population health.
Similarly we have highlighted the need for guidance on 'wellbeing assessment' to include assessment of ' community assets' as well as health needs.

As health, local government and other public service partners increasingly work together to define and deliver against agreed aims and objectives through Public Service Boards, the current governance and management models notably operated by the NHS and local government in Wales may require further change. This would have a direct link with many of the areas under discussion within the Green Paper.

Welsh Government would need to consider whether its current performance management and accountability arrangements would need to change to reflect this. The role of Welsh Government (in its broadest sense) in leading and managing the system going forward is pivotal and would benefit from being made clearer in this context.

Ongoing engagement with the public, patients and partners is critical and determining how this is best managed would require detailed consideration and planning. This would need to include how to facilitate engagement which will help to shape and build the joint plans which likely to be built up from GP cluster/community network level through organisations to the Public Service Boards.

If the Health, Social Care and Well-being Act, the Well-being of Future Generations Act and Williams review have the potential to impact as outlined then further change may be necessary to the current systems. How speedily such change could be achieved and whether or not such changes really require legislative support merits detailed consideration.

Any legislation to be considered as a result of the NHS Green paper should therefore not be developed in isolation and will need to be drawn up to compliment and be consistent with the emerging legal frameworks.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
The continuous engagement of patients and the wider public in the planning

and provision of health services is increasingly important.

Health Board's already have a duty under the NHS Act to ensure that local populations are consulted on service changes and there is already significant case law in relation to the requirement to consult.

Each and every service change proposal needs to be considered on its merits. The duty lies with each organisation and governance arrangements should be robust enough to determine when consultation is required.

The main issue often lies in the interpretation of WG Guidance on Engagement and Consultation – and particularly in relation to the definition of "substantial". It is not therefore felt that further legislation is required but that the guidance needs to be revisited and made more explicit.

However, at a time when partnership working is increasing and the health impact of changes made by all public service bodies needs to be understood it would be beneficial if a similar process could be adopted across health and social care as at present the requirements to consult appear different in local government.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
As the Green Paper states, Health Boards are already under a duty to involve and consult local people and their representatives in the planning and delivery of health services. The option of patient panels has been in operation elsewhere in the UK for some time and there are issues of credibility and legitimacy that need to be considered. The role and authority of such groups would need to be clearly defined – particularly in terms of whether they are advisory or whether their views must be acted upon (the latter then raising questions in terms of the Board's accountability within existing legislation). The other issue relates to the role of the CHC – which later in the Green Paper is put forward as the voice of the public. That premise could seem to be at odds with introducing another statutory group. Health Board's already have Stakeholder Reference Groups acting in an advisory capacity but their constitution often results in "vested interests" being to the fore in discussions on engagement and consultation. Similar issues could arise with another group being introduced with a similar remit. There are a range of tools to facilitate continuous engagement and it should be for each organisation to determine the most appropriate local mechanisms. The conclusion therefore is that further legislation is not needed which could

potentially tie the hands of Health Boards in the use of innovative engagement methods.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
There are a number of considerations in relation to a permanent national panel including local knowledge, authority and accountability (particularly in relation to the outcomes of a formal consultative process), the role of the CHC and the scope of its work. It is felt that a process of referral of issues to the Ministers should remain in place – since this ensures that referrals are not made lightly. The National Clinical Forum undertook some elements of this work previously and the perception was that this group did not always reflect local circumstances and on occasions put forward views which reflected a pure standards driven model without taking account of other factors (e.g.: rurality). It is felt a permanent panel would not have the local knowledge and accountability/responsibility/scope of powers would be a cause for concern. The question would be whether Board's in NHS organisations would become redundant in terms of decision made relating to service change. The notion of an Independent Review Panel is supported but the preference would be for each service change under consideration to have a separate panel appointed. However, it is felt important that the Minister should appoint such a panel when required rather than having a permanent panel.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
There already exists clear lines of professional accountability through Professional Codes. This could be strengthened further by aligning standards used across health and social care to support integration and co-operation. Resources and training to support leaders in their accountability will be key rather than legislative measures. The Health and Care standards are clear in their requirements and expectations.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
We need to continue to build on the existing systems, publishing data on

staffing levels which supports and underpins quality. Escalation and whistle blowing where there are concerns are also supported through policy. We need to apply tools which already exist, which evidence the quality and safety of care. The Health Board is introducing Quality Impact Assessments.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Quality of care is dependent upon attitude, behaviours and cultures of Individuals and organisations. Prudent healthcare is Integral to improving health and health services. Legislation around co-production with partners and patient/ service users may help strengthen accountability. Introducing and mandating Quality Impact Assessments to be introduced by all agencies providing health and social care would support consistency.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
It is difficult to see how any one individual could be held wholly responsible or accountable over and above the existing arrangements.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
Following well publicised failings in managing quality and care standards within the NHS the principle of the introduction of a “fit and proper persons” test is supported. However, this should not distract from the primary responsibility of the employer to check that their Board members are competent in discharging their roles and responsibilities effectively and that they behave in a fit and proper manner and continue to do so for the tenure of their employment. Some questions to consider: 1. How will the test apply to those Directors who occupy a professional as well as corporate role (concern regarding dual regulation) 2. How will the test differentiate between those who are clearly the decision makers vs the responsibility of a Board

<u>Integrated planning</u>

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
It is not felt that we need to strengthen existing legislation further to promote quality through the NHS planning framework as this already makes adequate provision to promote quality. Perhaps what is more important is how this is

embedded in practice at a local level. The development and integration of services has to be progressed through co-production between service users, service providers and the wider population so that they are configured to meet local need. We need to ensure support to local GP clusters to focus and tackle and address openly quality of care in primary and community settings in addition to work to improve quality and outcomes within hospital care settings. Current legislation and specifically NHS planning Framework makes this clear and provides adequate provision to promote quality. At a local level, the focus on developing plans based around GP clusters and Area, Secondary Care and Mental health Team plans will support embedding this into local practice and behaviour.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Royal Colleges and Professional Bodies have specific roles in improving quality and setting standards. These standards need to be appropriately utilised to eliminate confusion within professions and organisations. A more robust and consistent system of inspection would be welcomed so the public could be better assured about the quality and safety of services. Standards need to be reviewed utilizing a common framework for monitoring underpinned by clear guidance.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
A common set of standards would be supported recognizing that this has implications for the role and function of regulators.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Peer review and accreditation systems are important aspects of providing external assurance to the public. There is already a plethora of such systems across professions and services. Whilst a more consistent approach would be helpful, this is not an area that would benefit from legislative change.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Appropriate access to clinical supervision should be integral to lifelong learning for all healthcare professionals. This in turn, will lead to improvements in recruitment and retention. Legislation is not the way to enable Clinical supervision.

17. What arrangements should be put in place for self-employed health professional registrants?
There are a number of regulatory gaps which could be addressed through the requirements for clinical supervision, mandatory training and revalidation.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
The Francis Inquiry Report made 290 recommendations including: • openness, transparency and candour throughout the healthcare system (including a statutory duty of candour), fundamental standards for healthcare providers • improved support for compassionate caring and committed care and stronger healthcare leadership Candour is defined in Robert Francis' report as: 'The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.' 'Prompt apologies and explanations, with a reassurance they will not reoccur, may prevent a claim being brought at all' Mr Francis' recommendation 181 provides that there should be a statutory obligation of candour on healthcare providers, registered medical practitioners, nurses and other registered health professionals where there is a belief or suspicion that any treatment or care provided to a patient by or on behalf of their employing healthcare provider has caused death or serious injury. Provision of information should not of itself be evidence or an admission of civil or criminal liability, but not disclosing the information should entitle the patient to a remedy. Candour (and its close allies openness and transparency) permeates throughout Mr Francis' report. Out of his 290 recommendations, several are drafted with those themes in mind.

Promptly identifying negligence and providing redress for the patient and their family should be encouraged. Doing so quickly and efficiently will reduce expenditure on legal costs and should provide a better experience for the patient and their family. Professional standards across all clinical specialties should generally be sufficient to ensure that there is a tacit duty of candour but clearly failings such as those covered in the Francis Report show that this is often not the case. The proposal is therefore supported – recognising that there will be training and culture implications that would need to be addressed and the relevant professional bodies would also have to recognise such a duty in their own standards. A national standard/policy would ensure uniformity across NHS Wales. This should be supported by safe havens for whistle blowers which will support staff to be open and raise concerns.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Transparency will be greatly enhanced by the provision of real time information as many of the systems in healthcare take an extended period of time to produce meaningful data currently. To ensure transparency is the norm, performance and data systems need to be supported, however, it is unclear how legislation in isolation would improve transparency as this would need to be underpinned by cultural change. The performance management framework for Wales could be used to drive improvement in terms of transparency and openness.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
There are already some well-established good practices in place for the joint investigation of complaints albeit there is variability across Wales. The principle that there should be integration across Health and Social Services is supported and aligns with other legislation. The complaints process should be an integrated process which ensures that the same principles and processes are followed. Health Boards already work across health boundaries and the current system allows for organisations to agree the lead organisation and respond to individual complainants. This could be strengthened either by legislation or requirement for a formal agreement to be in place. There is an opportunity as part of the review of PTR that this also includes primary and social care. It is felt important to ensure that PTR applies to all public bodies and healthcare providers.

Legislation would make the position clear in terms of a shared duty to manage complaints appropriately rather than the current ad hoc arrangements.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
The Data Protection Act provides a legal framework for allowing organisations to share information appropriately taking into consideration the privacy and confidentiality of individuals. However, it is often through a lack of understanding by an organisation or staff through a lack of training that the legislation is used to prevent the sharing. Due to a lack of published national Information Governance Standards in Wales, there is often a lack of trust between organisations to ensure that once their information has been shared, similar systems, processes and security measures will be applied to that information to help prevent damage to the organisations reputation or application of a financial penalty. Organisations need to adopt a culture of sharing information where the benefit is improved care for an individual rather than using consent and other issues as a barrier. An increase in the use of mediation is also helpful in enabling patients to obtain closure. It is not felt that further legislation is required but that a different culture needs to be adopted by organisations in an integrated service environment.

22. How can we consider breaking down any barriers?
The main issue relates to consent and the reluctance to share personal information without explicit consent. However, many serious incident reviews highlight the lack of communications between organisations as a root cause. Organisations already have the ability to interpret Data Protection legislation from a position of wanting to share information rather than withholding information – but often they take a negative approach at the outset. The introduction of published national standards around information governance, security and compliance with WASPI etc. would led to increased confidence between organisations and encourage more effective sharing, ultimately benefiting the patient and the care they receive. The use of a single electronic patient record will help to break down barriers.

23. What are your views on the collection and sharing of patient identifiable

information for non direct patient care, such as research? What are the issues to be considered?
It is vital that our patients have confidence in our ability to protect their privacy, comply with the law and safeguard their personal health data. Data holders within the health service must ensure that they obtain information about their patients properly keep it secure and handle it in accordance with the well-established rules of medical confidentiality and the provisions of the Data Protection Act 1998. In addition, the Caldicott'Report on the Review of Patient-Identifiable Information' identified weaknesses in the way parts of the NHS handled confidential patient-identifiable data and as a result all health boards and trusts were required to appoint “Caldicott Guardians” with a specific responsibility to ensure patient-identifiable data was kept secure and used in accordance with the Caldicott principles. Therefore, All patient-identifiable information, relating to living or deceased patients is confidential and must be treated in accordance with the Caldicott Principles. Research which makes use of existing patient identifiable data (and stored samples) must comply with NHS Caldicott Guidelines and have the permission of the health boards’ Caldicott Guardian. It is also suggested that a “national research governance framework” is adopted to ensure consistent safeguards are in place to protect patient information, ensure the quality of information and appropriate consent models are followed. This could be in the form of local Research Ethics Committees. Researchers should always be able to justify and provide risk assessments for requiring identifiable information. However, where possible anonymised information should always be a preferred option.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
Yes in the context of capacity given the size of Health Organisations in Wales. At times this is further diluted by the duplication of effort of the community health council as their work programmes are developed independently.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
There is support for HIW to have a strong independent presence and be integrated with CSSIW.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
Within Dentistry alone there is a plethora of different Inspectorates and Governance bodies. They all state their aim to be the improvement of standards. For each organisation to devise its own standards leads to unnecessary confusion. We need one integrated regulatory body working within one framework. It's more than joint working. It needs legislative change with common standards and common framework.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
As above, consistency in standards and the regulatory framework around holding to account on those standards and an ability to provide clear public and organisational understanding of those.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The role of the CHC is an important one which should be maintained in some form. However, Health Board's are already required to continuously engage with the local population and consult with the population when appropriate and to take these views into account when making decisions. The role of the CHC in "representing the patient voice" therefore needs to be clarified. If this relates to wider engagement then that would seem to cross over the statutory duty of NHS organisations. If it relates to the complaints/advocacy role then that is wholly appropriate.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
There are two potential options. The first is to amend the current model slightly and retain local CHCs as statutory organisations or to create a CHC for Wales that deploys teams to local areas but with the statutory powers being vested in a single organisation. Any changes would need to address some of the current issues and criticisms

in terms of lack of integration between Health and Social Care at a grass roots level.

In any restructuring, given the economic backdrop, care needs to be taken not to add further complexity and duplication to the system, but to use this as an opportunity to streamline.

The membership of the CHC is drawn largely from lay people and this perspective is important when considering whether service change is for the benefit of the wider population.

The CHC role in terms of scrutiny of healthcare and their links to HIW needs to be addressed. Currently, both organisations work largely independently and revising legislation to make the CHC an agent of HIW merits consideration.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
It would be beneficial for Health Boards to be allowed to borrow, although we understand the risks involved and this would require clear policies to operate across NHS Wales. The benefits of allowing borrowing would be four-fold: 1. Borrowing will give much greater local flexibility; 2. Health Boards could invest in accelerating capital investments, where these demonstrate a clear revenue saving and payback; 3. It will instil a discipline of longer term planning and assessing business cases on a more commercial footing, securing an even greater focus on due diligence even in areas where borrowing is not required; 4. It will clarify current arrangements surrounding finance leases and PFI arrangements where Health Boards do, in effect, borrow to fund future developments. Prudential Borrowing codes as used by Monitor and other public sector organisations won't apply to Health Boards, and careful consideration will need to be given to the NHS Wales policy framework in this area to ensure that Health Boards do not become exposed to over borrowing. System changes may also be required. For instance, there may be a need to review the process of capital charges and cash allocations to Health Boards. Within a commercial context, depreciation revenue charges support delivering operational cash surpluses to repay any loans. This would be challenging within the current arrangements.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
We agree with the findings of the Green Paper that producing separate NHS Wales Trust and Health Board summarised accounts provide very little value and do not reflect the current state of the NHS landscape. A summarised NHS Wales account as a whole will provide a far clearer understanding to the public of the activities of the NHS. Within the Health Board, providing summarised accounts are important in terms of demonstrating transparency and accountability to the general public, although the timing of publication (September) detract from this value. There may be an argument that the timetable for Annual Reports and Annual General Meetings should be shortened to create more timely reporting. Crucially, any change in reporting should encourage more meaningful and understandable analysis. There should also be consideration given to the Annual Report as a whole, to ensure that it can become a document which is understandable and accessible by the general public.

32. 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?
Yes, as highlighted above.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
There should be an equivalent statutory planning duty for NHS trusts as we have for health boards. This would ensure the seamless planning of activities to improve health and for meeting patients' needs across the pathways of care.

34. 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?
It is not felt necessary to review the 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. Public Service Boards will provide leadership and alignment of planning duties to meet our shared aims with our partners.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
In order to strengthen leadership, governance and partnerships the need for clear accountabilities is required, with a route of escalation if concerns arise built on sound principles with clear expectations and outcomes. There is already in place an escalation and intervention process in place for NHS Wales which means that there are clear consequences of how HB's or Trusts are moved into a position of escalation and that this is applied systematically and consistently. In order to strengthen the leadership and governance of organisations, clear principles of behaviours over and above the Nolan principles need to be further developed so that they truly reflect the principles of NHS Wales together with what is expected of all public servants. There also needs to be a greater focus on career development and succession planning. If co-production is truly the way forward then working in partnership with the population is paramount recognising that sometimes this may cut across the views of clinical experts. HB and Trusts would need the latitude to design and co-produce services that truly did meet the populations health needs but also improve population outcomes.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed? 37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors? 38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation? 39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services? 40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
The current Health Boards have been in place since 2009 and have faced considerable quality and safety issues, as well as financial and professional challenges. There is a view that the current size and configuration of Health Board membership inhibits the quality of the Board's deliberations and decision making. Whilst a large diverse membership which includes a broad range of

perspectives can be helpful, a narrower membership would provide a more streamlined focus so that the Board could adapt to more strategic decision making. The Commission on Public Service Governance and Delivery commented that Health Boards must be accountable and responsive, accessible to their local populations and provide excellent leadership and direction to their senior executives (and by extension the rest of the workforce) and hold them to account. The need to separate clearly those who make decisions and those who scrutinise them means that the role of a Health Board's independent members is a particularly challenging one.

The Williams Review suggested that the overall size of the Health Boards should be reduced, however, this does not fit with the recommendation in the NHS Green Paper which suggests appointing appropriate Cabinet Members from each of the new Local Authorities as Independent Members. Whilst the new boundaries for Local Authorities have yet to be agreed, there are likely to be more Local Authorities than Health Boards which in North Wales would mean 2 or 3 Local Authority representatives as Board Members.

When considering views on the suggestions made by the Williams Report on the election of community representation it is difficult to see how this would work in practise within the current governance structures of NHS Wales. Given the diverse communities in North Wales served by the Board it is difficult to envisage how one or two individuals could in reality, respond to and be held accountable to local communities. Perhaps it would be better for Health Boards to have stronger mechanisms for continuous engagement with the communities they serve.

Public Service Boards offer a real opportunity for innovation and placing local Directors of Public Health at the centre of these arrangements which could lead to significant and positive change. The relationship between Public Health Wales and Directors of Public Health is incredibly important in managing and mitigating risk and driving innovation and change, this relationship would need to be built on rather than diminished. There should also be other opportunities to look at a broad spectrum of joint / dual roles across a range of executive portfolios.

Consideration also needs to be given to how a trade union and staff perspective is brought to the board if the current board composition changes. There is a value in having a TU member from the employing organisation at the board – a different internal perspective to that of the Executives. The advantage of having a full board member is that the individual will have been through the full public appointments process and should therefore have the necessary skills and abilities to undertake the role; however there are inevitable tensions when the TU view may differ from that of the board. The alternative is to revert to the concept of Trade Union representatives at Trust Boards that was previously in place, this allows a TU voice at the board but the reps are not part of the board and therefore not bound by corporate decisions. These reps would usually have been nominated/elected by the local staffside but would not have undergone a formal selection process. A third alternative is to have TU representation from full time officers/TUC

however, while the trade union expertise would still be present the local knowledge would be lost. Having local knowledge of the organisation is something that is valued and therefore needs to be built into the final determination. Support should be extended to developing a wide range of potential opportunities for people to develop skills and experience in order to apply for Board membership in the future.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
There is support for greater statutory clarity for the role of Board Secretary. Similar roles exist in other public bodies upon which it could be modelled for example, the role of the Monitoring Officer within Local Authorities which in accordance with the provisions of the Local Government & Housing Act 1989 and 2000 Act which makes the role a statutory requirement for all LA's and given them a legal duty to report on legal issues and maladministration, manage the code of conduct and complaints associated with conduct of Principal officers and elected members, manage the standing order's etc. The Local Government (Wales) Measure also provided a statutory resource to support the Monitoring Officer is undertaking his/her duties, specifically the appointment of a "Head of Democratic Services" role to fulfil the corporate requirements of the role. In an NHS environment the role would need extensive experience of NHS services as well as corporate and governance.

44. If so, what aspects of the role should be additionally set out in law?
Linked to the above response. Additional aspects could include the BS role as a statutory role with a specific job description that would be included in standing orders so as to avoid deviation of duties across different HBs/Trusts. The role would be directly accountable to the Chair of the Board and indirectly to the CEO.

45. How could potential conflicts of interest for the board secretary be managed?
There would not be conflicts of interest if the role is clear, professionally discrete, with no broader operational management responsibilities. The importance and status of the role may also be strengthened if there was a professional head within Welsh Government. Making the role accountable to the Chairman of the Board and providing the role with powers to challenge the Board and CEO team if required, as currently available for Monitoring officers in Local Government.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Yes. There is a disconnect between national groups / committees and local decision making. This includes the lack of focus for health professional forums as advisory committees of Health Boards which have limited value and impact currently.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
This has to relate to the nature and speed of the advice required. Advice from speciality bodies in Wales could be accessed through a reformed clinical network system given that networks engage multi-professional groups service users and members of the third sector. The advice should also be gleaned from other Professional Bodies including Royal Colleges, and National bodies such as NICE. Legislation could ensure appropriate consultation with advisory structures/networks.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
The appropriateness or otherwise of existing partnership working arrangements is dependent upon the policy direction Welsh Government wish to set for pay. Currently, most of the contractual arrangements for staff are either UK agreement or are underpinned significantly be UK agreements with Welsh variations to specific aspects. If Welsh Government were to wish to pursue a Welsh Public Service contract for the NHS, Local Government, Assembly Sponsored Bodies and the Welsh Civil service, then Wales specific partnership working arrangements would be required. The development of a Welsh Public Service contract may offer benefits in respect of mobility in employment across public services, but would face challenges in terms of different terms and conditions, pension arrangements etc. It would also cause challenges in border areas – where staff may choose to work outside of Wales if pay was not comparable - and introduce a form of Regional UK pay which has previously not been

supported.

Whilst there are certain staff groups which are predominately sourced from local labour markets, there are others particularly in respect of medical and dental staff where the labour market is a truly international one.

Whilst the terms and conditions of most NHS staff may be determined or significantly influenced by UK processes, it should be acknowledged that there are other Welsh forums which set policy and seek to address public service issues. Notably amongst these are the:
Welsh Partnership Forum (NHS) which brings together Welsh Government officials, Trade Unions and NHS employers.
Workforce Partnership Council (Public Services) which brings together Welsh Government Ministers, Trade Unions and Public Service employers.

The architecture of workforce partnership needs to reflect the policy framework set by Welsh Government.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
The role of Shared Services in a more strategic context would require a standalone entity, which will assist in ensuring that appropriate governance systems can be enhanced. Any such governance should be strengthened through service level agreements with Health Boards to ensure that the entity is fully responsive to the needs of the service and individual clients and can demonstrate it provides value for money for all customers.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
There is a significant agenda for NWSSP within an NHS Wales context and the service hasn't yet matured sufficiently or demonstrated enough resilience to meet its existing customer demands to extend its reach beyond the NHS to the wider public sector. There are significant risks that a wider expansion will make the service less responsive to the needs of the Health Service, which would need to be carefully managed.

WGGP058 – Cllr Edith Hughes
Tref / Town – Bridgend
Sefydliad / Organisation – N/A

General comments

Managers of hospitals should take the comments of CHC's on board and address their concerns when representatives of CHC's make unannounced visits to hospital wards. There are still mixed wards for example in some hospitals.

The CHC's act as advocates for the community and should be taken seriously.

Response to specific questions

No response to specific consultation questions.

WGGP059 – Anonymous
Tref / Town – Anonymous
Sefydliad / Organisation – N/A

General comments

Wishes for response to be kept anonymous.

WGGP060 – Emmeline Galilee – Health and Safety Executive
Tref / Town – N/A

General comments

Response to specific questions

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Issues raised are embedding a culture of continual improvement and effective leadership – legislative measures are an essential component of a suite of measures to achieve improvements in quality of services. A robust regulatory regime that is properly resourced and appropriately enforced with proportionate penalties sends a clear message about expected standards and the need to meet them.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
The two primary regulators in Wales for the health and social care arena are the Care and Social Services Inspectorate Wales (CSSIW) and the Healthcare Inspectorate Wales (HIW). Provision of a comprehensive set of powers for both organisations would enable them to act swiftly in situations where organisations or individuals have failed to comply with healthcare standards, service users are at significant risk or where failings have caused serious harm or death. The Police and Health and Safety Executive (HSE) HSE/Local Authorities (LAs) have powers to investigate and prosecute either single or multiple incidents, but the criminal powers and sanctions available to HIW and CSSIW are far more limited. To enable it to meet its enforcement priorities HSE has set policies and procedures including incident selection criteria for when it may give consideration to investigating a breach of section 3 of the Health and Safety at Work etc. Act 1974 (HSW). This is the section of the HSW Act that deals with public safety matters. Less priority is given to the enforcement of s3 HSW where other regulators have responsibilities and powers to hold to account. This means that HSE will not in general investigate issues related to the quality of care or matters of clinical judgement as other regulators have responsibilities. HSE policy is that incidents that are reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and that meet published incident selection criteria are investigated. HSE will also investigate incidents that are not reportable under RIDDOR but where there has been a death, (or where incidents may have led to deaths)

that have arisen where clear, established standards have not been met because of serious systemic management failures. A regulatory gap therefore currently exists in respect of certain failures outside these parameters. In such circumstances health or social care providers may escape being held to account even where they have deliberately flouted regulatory requirements or care standards and their failures and the consequences have been very serious. The legislative powers of HIW and CSSIW should be extended so that they have sufficient criminal sanctions and powers to effectively secure improvements in standards where necessary and also hold organisations and individuals to account in appropriate circumstances.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
A comprehensive regulatory framework that enables adequate inspection and investigation by the specialist regulator and that minimises regulatory gaps. The investigation of serious complaints and incidents, including single incidents is acknowledged (Francis Report, Berwick Report,) to be an effective way of uncovering systemic failures in organisations and securing improvements in standards. The introduction of 'responsible individual' and 'fit and proper person' can also play an important role in ensuring competency within organisations.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
The advantage would be that it would provide clear standards and serve the aim of effective leadership. Setting this out in legislation would help improve clarity of role, responsibility and accountability within health bodies. Legislation would provide a framework and clarity on the standards to be achieved which the regulatory body could enforce against (provided it has sufficient legislative powers and the ability to take effective action where the standards are not met.)

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
As above.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
One set of standards that are published and accessible to the public can promote knowledge of expected standards and transparency. One set of standards would also address the issue of consistency of approach.

This would remove the current disparity between the National Minimum Standards which independent providers are legally required to follow, and the Health and Care Standards which NHS providers have no legal obligation to follow.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
A common standards framework would work towards better equality and consistency between the private and public healthcare providers. Whether it would deliver a focus on improving outcomes depends on what issues the framework would cover. It may also provide clarity for the citizens of Wales and address any perception of double standards across healthcare provision.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Setting out how and when concerns will be dealt with and by what regulatory body would allow members of the public to have knowledge of when actions will be taken and will help to keep expectations realistic. This provides transparency and accountability to decision making, allowing those making the decisions to justify them if required. HIW's remit could be changed to enable them to follow up individual concerns or complaints and introduce new powers to take enforcement action against providers when required.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Co-operation in internal investigations could be made a legal requirement as could the requirement to actively provide and share evidence, information and outcomes in relation to incidents. Endorse the setting up of formal working arrangements (e.g. Memorandums of Understanding) between regulators. Both CSSIW and HIW are listed as regulators who may have an interest in working to the principles of the Work Related Death protocol (WRDP) HSE also understands that both CSSIW an HIW have now formally requested that they become signatory bodies to the WRDP.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
Yes, HSE firmly believes that there are gaps in the current legislative framework as outlined in our answer to question 8. HIW has a wide and complex range of responsibilities but does not have comprehensive enforcement powers or sanctions, particularly in the public NHS sector, to deal with them effectively. HSE and LA inspectors have powers to serve Enforcement Notices requiring improvement in standards that may be directly linked to patient safety, e.g. falls from windows, hot surfaces, patient handling. HIW have no enforcement powers in respect of public NHS services. Although there is provision for the issue of a non-compliance notice in the independent healthcare sector it is not clear to what extent these powers can be used to require improvements in specific health and safety standards affecting patients. The Police and HSE/LAs have powers to investigate and prosecute either single or multiple incidents, but the powers available to HIW are far more limited. HIW can take civil action or pursue a criminal prosecution in the independent healthcare sector but current HIW policy appears to indicate that they do not routinely investigate individual cases. HIW cannot take enforcement action against NHS services. There exists a separate NHS Wales Escalation and Intervention Arrangements procedure. HSE will not get involved in matters related to the quality of care or involving clinical judgement and will only enforce where there has been a breach of relevant legislation and the incident falls within its own selection criteria. There is therefore effectively a regulatory gap in respect of failures outside these parameters. In these instances there is currently no regulator which will deal with these matters. Therefore there is the potential for health care providers to escape being held to account even where they have deliberately flouted regulatory requirements and care standards and their failures and the consequences have been very serious. The scope to investigate single and multiple incidents and the ability to take action to secure improvement and hold those responsible to account would be a very powerful and beneficial tool for the specialist regulator. In summary, HSE believes that in order for HIW and (CSSIW) to become a strong and independent regulator able to regulate effectively there needs to be: • A comprehensive regulatory framework that ensures there are no regulatory gaps and allows for adequate proactive inspection and investigation (of incidents, including individual cases) by the specialist

regulator, adequate regulatory powers to secure improvement and hold organisations and individuals to account
- Clarity about roles and responsibilities
- A duty to report incidents so that there is early identification of issues and relevant regulators can take appropriate, prompt action to address them before e they develop into significant problems.

HSE has provided a similar response to earlier Welsh Government consultations
Namely:
- The Regulation and Inspection of Social Care (Wales) Bill. April 2015
- The Future of Regulation and Inspection of Care and Support in Wales January 2014

National Assembly for Wales Health and Social Care Committee Inquiry into the work of the Healthcare Inspectorate Wales (HIW) December 2013

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
Full statutory independence would remove any potential conflict of interest between HIW and Welsh Government, who are both regulator and provider/commissioner of health services in Wales. This would also allow for clear water between the role and decision making of the regulator and any political decisions taken by WG. For consistency, the same arrangements should exist for both HIW and CSSIW

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
Clarity between the roles and responsibilities of the two regulators. Memorandums of Understanding and Joint Working Agreements can also assist. The establishment of clear incident selection criteria.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
Advantages – consistency in regulation of social care and healthcare providers. Identical investigation and enforcement policies. Greater clarity in the roles and remit of the organisations. Deal with one body across health and social care. Seamless approach to regulation of issues and better accountability and transparency. Disadvantages – Potential for under-resourcing of single unified body and increased workload. Potential for reduced independence from Welsh Government.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
HSE believes that strong leadership and good governance are essential elements in securing quality in health and social care provision. We are aware of and support work currently underway to develop framework standard for health and safety management within Wales NHS.

WGGP061 – Zac Mader – Police Federation
Tref / Town – N/A

General comments

1. The Police Federation
1.1. The Police Federation of England & Wales ('The Federation') was formed in 1919 by an Act of Parliament and, in Wales, it represents 6,780 police officers, of all uniformed and CID ranks from Constable to Chief Inspector. The Federation's membership comes from each of Wales' four police forces.

1.2. The Federation was established to protect and promote the 'welfare & efficiency' of police officers and in its discharge of functions as laid down by statute.

1.3. The Police have a duty of care to the public. The sworn and attested duties are discharging their duty 'to protect life' and to 'enforce the law'. The Police Federation's principal representatives, are all serving police officers who are elected to their respective roles.

1.4. The Federation welcomes the opportunity to submit evidence to the Welsh Government we are happy for this paper to be published not only in the public domain, but we also make ourselves fully available to discuss it further if required.

2. Evidence
2.1 The Federation periodically submit evidence to the Welsh Government (and indeed committees at The National Assembly for Wales). Those past documents have helped form and shape polices and legislation, and as difficult as it is, have played their part in defining the police service (non-devolved) within a operational public services theatre that is devolved. The Welsh Government will acutely know the difficulties that the police service experience daily in this regard and it is with a view towards this particular backdrop that this evidence is submitted to aid and assist the Welsh Government in their Green Paper to develop a model of health which promotes physical, mental and social well-being.

2.2 We note that the Green Paper is to examine the following:
Quality – providing the right care, in the right place, at the right time and in the right way.

Governance – the management, monitoring, decision making process and accountability of organisations.

Functions – the activities and services of organisations.
2.3 Taking the above three elements as a whole, on a daily basis, police officers, both uniformed and CID – who it must be remembered are not health workers – face significant challenges in dealing with the public who

themselves are being administered, known to, or cared for within the health service.

2.4 This may or may not be associated with criminal activity, but can also cover mental health issues, vulnerable adults and children, refugees, social services, missing-persons, suicide attempts, civil contingencies, engagement with the (already devolved) two other emergency services and indeed, how we interact with varied bodies within Welsh and Local Government structures, including NHS Trusts, Community Health Councils, Health Inspectorate Wales (HIW), Care & Social Services Inspectorate Wales CSSIW), the third sector etc.

2.5 We have found that collaboration and legislative changes can work provided that each and every partner in the 'link' of the NHS understands the position of where policing fits into such services. Operationally we are often the call of last resort, but in creating 'new structures' we must be integral – or at the very least fully understood - in that decision making process.

2.6 Albeit the Department of Health does not exists in Wales, we note consistently that they do forget that devolution exists and make policy decisions that are 'England only', but by default, impact greatly upon how we – as police - operate with the Welsh (devolved) NHS.

2.7 Therefore, where the future changes being explored by this consultation exist, there has to be consistency and the deepest understanding of any impacts such changes may make upon operational policing - irrespective of the police service being devolved or not. In short such changes being proposed by the Welsh Government need to be *'police-proofed'* at every stage.

2.8 During the Summer of 2015, the Welsh media reported broadly on the changes being proposed in this Green Paper and indeed their main headline was (and remains) that *'NHS decisions could be removed from political control'.* Such a move is not unknown to the police service as we are – or at least we should be – outside of 'political control' holding a unique position in public services and society of what is termed *'The Independence of Office of Constable'.*

2.9 However this consultation is not about policing, but about health services, but for the four police forces in Wales their interaction with NHS Wales is different in this regard and context - vastly different - and wherever this Green Paper may be taken we need to highlight that *'political ownership'* – howsoever defined in the future – has to have a place, backed firmly by a Welsh Minister, to serve policing needs within the Welsh NHS.

2.10 Passing control of the NHS decisions onto say HIW or CSSIW or any other body is not an issue that we can comment upon other than our deepest concerns lay that where any decision is taken, whether 'police-proofed' or not, that Welsh Ministerial responsibilities and functions should be in place to ensure that the needs of the police in Wales are not undermined; this could

form the roles of current of future Welsh Ministers, but that executive and political weight is important to how policing operates.

2.11 Our operational roles could be negatively compounded if there is fragmentation of responsibility, or indeed if differing decisions are made across Wales, or that such a pan-Wales consistency (to our integrated roles) alongside the Welsh NHS are not developed or understood, or as is often seen, impacted upon by UK Ministers making decisions that negatively affect Wales. This need is fundamental not only to serve the Welsh public, but also in our roles operating across-borders and with other police forces not only in Scotland, but also in Northern Ireland and indeed England.

2.12 The Federation hold regular meetings with Welsh Ministers and indeed our briefings to them highlight concerns not only in Wales but often across borders, and for us to have that 'non-political contact' via a Minister in Wales is vitally important to ensure that we, as a police service, can operate across the UK and at the same time give our best service to the Welsh Government and the Welsh public.

3. Proposals:
We therefore propose that any changes via legislation to structures in Wales should:
a. Be *'police-proofed'*.
b. That ultimate responsibilities for issues impacting upon the Welsh NHS that involve the police service have functions and responsibilities remaining with Welsh Ministers.

Response to specific questions

No response to specific consultation questions.

WGGP062 – Mike George – Welsh Optometric Committee
Tref / Town – N/A

General comments

This is the response of the Welsh Optometric Committee, a statutory advisory committee to Welsh Government representing all optometrists and dispensing opticians in Wales.

We have expressed no view in response to questions that do not relate to our field of expertise.

Response to specific questions

Chapter 1: The changing shape of health care

Continuously engaging with citizens

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Yes. We support the idea of a national expert panel convened in-line with the regulatory framework for public appointments processes.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
We support the notion that common standards should apply across all health services, including primary medical care, dentistry, optometry and pharmacy and independent healthcare settings. Sufficient consideration must be given in the development of the any standards to the consequences of their application in these varied settings, particularly to the scale of the organisation to which they apply and their cost versus benefit. NHS optometry has been shown to be a low-risk health care environment. (Risks in the Optical Profession, Europe Economics on behalf of the General Optical Council, March 2010.) Over-zealous application of standards applicable to other high-risk settings may drive optometry contractors out of business if there are high costs for compliance or for compliance-reporting

arrangements. This would be of detriment to the availability of services and to eye health care.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
We caution against the use of mechanisms such as accreditation and peer review in addition to those imposed on healthcare providers by the UK professional regulatory bodies (the General Optical Council in our case) without adequate consideration of duplication of effort, cost and the potential of developing career pathways in Wales that are incompatible with free movement of healthcare professionals across the UK.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Optometrists currently have peer supervision of revalidation through the General Optical Council's Continuing Education and Training Scheme that is mandatory for on-going professional registration: Similar models could be considered by other healthcare regulators. As per our answer to 15 above, we caution against the use of mechanisms different from or in addition to those already developed for the whole of the UK.

17. What arrangements should be put in place for self-employed health professional registrants?
The GOC's arrangements (see 16 above) support both employed and self-employed registrants.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Many professional regulators, including the General Optical Council in our case, already impose a duty of candour on registrants as a condition of on-going registration.

A statutory duty of candour within the NHS in Wales should only be introduced alongside a statutory limitation of liability: In true co-production, a patient and healthcare professionals in NHS Wales would be part of the same 'team' in selecting and implementing care and treatments. This implies shared risks and shared liability in the event of an adverse outcome. A duty of candour must not impose a statutory requirement to admit civil liability for negligence; this would make it impossible for healthcare professionals to purchase medical malpractice insurance.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
There is a presumption that 'better than online banking' levels of safety should be in place before any information is shared – this often means that patient information is not shared at all. We believe that the public expects relevant information to be shared between their care providers in a timely manner and in their best interests. The safety of the care of the patient should be paramount, not the safety of the information.

22. How can we consider breaking down any barriers?
The introduction of a statutory presumption of consent in the sharing of relevant information between care providers would help to break down barriers.

Chapter 8: Leadership, Governance and Partnerships

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
No. The current statutory status of the national and local advisory committees ensures that Welsh Ministers and NHS leaders receive advice in a formalised and fairly uniform manner across the various professional specialities. It also ensures an element of intra-professional democracy and consensus in the formulation of the advice. If the advisory committee structure is removed, any appointment of advisors should be subject to the regulatory framework for public appointments processes.

WGGP063 – Sali Davis– Optometry Wales
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
We do not believe that further changes in the law are necessary. Within Optometry we believe that we are able to adequately plan and meet people's health needs with the co-operation of government officials and via the Together for Health – an eye care plan for Wales.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
We do not foresee any need to change the legislation.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
We do not believe that further changes in the law are necessary.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
In our experience within Optometry and our attendance at the eye care groups (meetings held in every health board to take forward the Welsh Government; Together for Health – an eye care plan for Wales it has been very difficult to secure patient representation. Most Health Boards rely on the Community Health Council's but within Optometry, and for the effective delivery of the eye care plan what is needed are patients who do not have specific sight loss as such but who represent the wider public who may not wear glasses/contact lenses or have an refractive error but merely access their high street optometrist regularly as part of their general health check ups. We would query whether enough patients could be recruited at that statutory level and that this would have implications on the resources of the health board in terms of recruitment, ongoing support in delivering this level of engagement

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
We support the idea of a national expert panel convened in line with the regulatory framework for public appointments.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section? 9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations? 10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales? 11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
We don't believe that a change in the legislation is required.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
See above. As a regulated profession we believe that quality is at the core of the standards and guidance that regulate us.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
We do not believe that there is a need for a change in the legislation. We support the notion that common standards should apply across all health services, including primary medical care, dentistry, optometry and pharmacy and independent healthcare settings. Sufficient consideration must be given in the development of the any standards to the consequences of their application in these varied settings, particularly to the scale of the organisation to which they apply and their cost versus benefit. NHS optometry has been shown to be a low-risk health care environment.

(*Risks in the Optical Profession*, Europe Economics on behalf of the General Optical Council, March 2010.) Over-zealous application of standards applicable to other high-risk settings may drive optometry contractors out of business if there are high costs for compliance or for compliance-reporting arrangements. This would be of detriment to the availability of services and to eye health care.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Within Wales, 97% of the optometric profession are accredited via the Welsh Optometry Postgraduate Education Center (WOPEC) to deliver the Wales Eye Care Service (the national enhanced service for delivery of eye care in primary care). The accreditation system is a valued and respected mechanism through which (in the absence of a contract – we currently work to a 1948 Terms of Service; General Ophthalmic Services - GOS) governance and audit ensure that those accredited to provide the service deliver the highest quality of patient care outside of the narrow GOS. We would seek to preserve this function of WOPEC as we believe that accreditation and re-accreditation every 3 years allows the profession to keep up to date with their core competencies.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
We do not believe that this is appropriate – in optometry our regulator (the General Optical Council) compels practitioners to demonstrate that they have regular peer review sessions with colleagues as part of their continued professional development As per our answer in 15, we caution against use of mechanisms different from or in addition to those already developed for the whole of the UK.

17. What arrangements should be put in place for self-employed health professional registrants?
See above. The GOCs arrangements support both employed and self employed registrants.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
See above – the GOC as our regulator already imposes a duty of candour which we believe is sufficient. A statutory duty of candour should only be introduced alongside a statutory limitation of liability: In true co-production, a patient and healthcare professional would be part of the same 'team' in selecting and implementing care and treatments. This implies shared risks and shared liability in the event of an adverse outcome. A duty of candour must not impose a statutory requirement to admit civil liability for negligence; this would make it impossible for healthcare professionals to purchase medical malpractice insurance.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Within Optometry, although 84% of the workforce have now confirmed their connections to be able to access the NHS Wales infrastructure (and in time will hopefully be able to refer their patients electronically) there is still a gross lack of feedback from secondary care to primary care with secondary care Hospital Eye Services routinely and consistently failing to feedback care/treatment and management plans to the referring optometrist. Many consultants in Wales are of the view that optometrists do not need to be copied in to the patient's care plans and we would strongly oppose this culture. As an independent contractor profession to the NHS in Wales we cannot properly address the needs of the patient if we do not have access to what their journey post primary care referral has been. As long as security is assured we would strongly advocate the sharing of patient information. As a profession we are regulated by the General Optical Council and are obliged to adhere to their standards on information governance.

22. How can we consider breaking down any barriers?
We believe that acknowledgement from within Welsh Government of the vital role that healthcare bodies play in delivery of care will help educate and raise awareness of the need for transparency in this area. We believe that government in Wales have already made great progress within eye care with the funding provided to primary care optometric practices for connectivity in doing this.

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
We believe that the CHCs have a vital function – to represent the patient choice but we do not believe that legislation needs to be deployed to strengthen this.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
We believe that the current CHC model is fit for purpose.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
We believe that the law should be changed to allow Health Boards borrowing powers. We believe that this would mitigate some of the controversial commissioning decisions that health boards have been faced with in previous Assembly terms.

Chapter 8: Leadership, Governance and Partnerships

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
We do not believe that the current statutory status of the advisory committees should be changed. Within eyecare the Welsh Optometric Committee (WOC) plays a vital role in providing ministerial advice to the delivery of eye care in Wales. We would query the way in which these bodies are funded and whether it is truly impartial (WOC members are currently reimbursed for their time from Welsh Government and yet their appointment to WOC is typically from within the Regional Optical Committees (ROCs) which have a statutory duty to represent their profession and not provide advice to Welsh Government. The role of the statutory ROCs is likewise of immense value to the health boards in terms of accessing support, advice and delivery of local eye care.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
We would agree that an amendment to the legislation may be necessary to reflect the prudent healthcare approach in Wales and indeed the current government agenda policies.

WGGP064 – Anonymous
Tref / Town – Unknown
Sefydliad / Organisation – N/A

General comments

Response to specific questions

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
I am unsure of the implications of this question. the CHC already represent the people through its present structure and four core functions. To reduce either of these functions to concentrate on more specific representation would surely impact on the others and ultimately weaken the service rather than strengthen it. The only way, in my opinion, the CHC role can be strengthened would be for Government legislation to be more focused on issuing directives to Health Boards to responding/working more closely with the CHC's.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
We don't live in an integrated system at the moment in respect of services such as Health and Social Care even and it is difficult to predict how one can change without the other. The way we recruit members needs to be re-considered to ensure the views of all the people are considered and that all corners of our country are represented. Who would be best placed to do this - I suggest it should be subject to more local input as each region of Wales needs a different type of representation due its diversity and variance in geography. Younger people should be encouraged to join.

WGGP065 – Nesta Lloyd-Jones – The Welsh NHS Confederation
Tref / Town – N/A
Sefydliad / Organisation

General comments

The Welsh NHS Confederation, on behalf of its members, welcomes the opportunity to respond to 'Our Health, Our Health Service' (the Green Paper). It is widely acknowledged that the governance of the NHS in Wales is complex and therefore any changes resulting from the consultation should seek to clarify and not further complicate the wider understanding of accountability, citizen engagement and quality.

By representing the seven Health Boards and three NHS Trusts in Wales, the Welsh NHS Confederation brings together the full range of organisations that make up the modern NHS in Wales. Our aim is to reflect the different perspectives as well as the common views of the organisations we represent.

The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work. Members' involvement underpins all our various activities and we are pleased to have all Health Boards and NHS Trusts in Wales as our members.

The Welsh NHS Confederation and its members are committed to working with the Welsh Government and its partners to ensure there is a strong NHS which delivers high quality services to the people of Wales.

As part of the process to respond to this Green Paper the Welsh NHS Confederation has received written responses from a number of Health Boards and Trusts, Chairs and Chief Executives and also facilitated a workshop to gather the views of Chairs and Chief Executives. Our response summarises the key areas and issues highlighted by Health Boards and Trusts and discusses the opportunities available as a result of the progress of the Green Paper.

Summary
The Welsh NHS Confederation believes that the Green Paper has been an opportunity to stimulate debate around whether legislation is required to help further improve the quality of healthcare services in Wales and whether legislation is needed in order to bring the current NHS governance structures up to date and ensure its functions are fit for purpose. From the discussions that we have had our members do not necessarily support the introduction of new legislation in a number of areas. It is considered that there are a number of existing provisions that could be more effectively used. There are a number

of systems and mechanisms that are currently in place and we recommend that the NHS in Wales should be strengthened through those mechanisms rather than placing further statutory duties on organisations.

As well as the discussions around whether further legislation is required, the following are the main points raised by our members:

- It is helpful that any legislation being considered as a result of the Green Paper will not be developed in isolation and will be drawn up to compliment and be consistent with emerging legal frameworks (for example the Social Services and Well-being (Wales) Act 2014, The Well-being of Future Generations Act (Wales) 2015). Any new legislation drafted should positively encourage the delivery of an integrated health and social care system across Wales. If health and social care services are increasingly working together with agreed joint aims and goals through Local Service Boards and the future statutory Public Service Boards, the current governance and management models operated by the NHS and local government in Wales could be changed fundamentally and this would impact on many of the areas covered in the Green Paper.
- How speedily changes proposed by the Green Paper could be achieved and whether or not such changes really require legislative support merits detailed consideration. Current planning cycles across public service, and notably across health and local government, are not fully aligned. The potential for this should be explored further in the implementation of any new legislation.
- The culture, values and behaviours that we are looking to develop and mature need to be explored further. Evidence clearly indicates that it is culture that may have a more profound and positive impact on the way services are provided than legislative change alone.
- The continuous engagement of patients and the wider public in the planning and provision of health services is increasingly important. As the Green Paper states, Health Boards are already under a duty to involve and consult local people and their representatives in the planning and delivery of health services. While we agree there is a need to ensure consistency and best practice across Wales, we believe that this can be done through the mechanisms that are already in place rather than through additional legislation.
- In relation to a national panel for referrals, it is felt a permanent panel would not have the local knowledge required to take full accountability and responsibility for the powers which it would hold.
- There already exists clear lines of professional accountability through professional codes. This could be strengthened further by aligning standards used across health and social care to support integration and co-operation.
- A more robust and consistent system of inspection would be welcomed so the public could be better assured about the quality and safety of services. There is support for Health Inspectorate Wales (HIW) to have a strong independent presence and be integrated with Care and Social Services Inspectorate Wales (CSSIW).

- While there is a lot of case law around the duty of candour, and it is supported by employment law, the proposal overall is supported. If a duty of candour is introduced it must be recognised that there will be training and culture implications that would need to be addressed and the relevant professional bodies would also have to recognise such a duty in their own standards.
- It would be beneficial for Health Boards to be allowed to borrow, although we understand the risks involved and this would require clear policies to operate across NHS Wales. The benefits would be much greater local flexibility, the ability to invest in accelerating capital investments, a discipline of longer term planning and assessing business cases on a more commercial footing and securing an even greater focus on due diligence, even in areas where borrowing is not required.
- There is a general view that the current size and configuration of Health Board membership inhibits the quality of the Board's deliberations and decision making. While a large diverse membership which includes a broad range of perspectives can be helpful, a narrower membership would provide a more streamlined focus so that the Board could adapt to more strategic decision making. However, with a more streamlined Board, the demand placed on Independent Members must be reconsidered because the significant time commitments placed on Independent Members presently. With the expectations on scrutiny, and the ever growing number of "Champion" roles, if there are a reduced number of Independent Members then the training, experience and time-commitment they need to give would have to be seriously reconsidered. Presently, there is huge demand placed on Independent Members' time through requirements in regulations which have built over time.
- An improved referral mechanism is needed for when Community Health Councils (CHC) wish to challenge service change. Our members believe that the Minister's role should be reconsidered during resolution if the NHS Chief Executive is unable to reconcile the positions.

<u>The key areas raised by Local Health Boards and Trusts</u>

<u>The current arrangements</u>
Health Boards were established in 2009 following a large scale restructuring of the NHS in Wales. Over recent years Health Boards have begun to realise the potential of the benefits expected when they were established. Across Wales there are positive examples of joint working/partnership arrangements which are benefiting local populations. Given this, it is not the time to consider wholesale structural change in the NHS in Wales.

<u>The need for legislation</u>
Firstly the key question to be posed is - is this legislation aimed at 'tidying up' the existing legislative and governance framework or looking at a more extensive and comprehensive reform of the governance system?

The Green Paper should be welcomed in terms of the proposals to review, simplify and streamline the complex and complicated governance and reporting arrangements within NHS Wales, which have built up over time. Therefore, proposals such as these, if they can streamline arrangements, make accountability clearer and ensure clear delegation without the need for micromanagement by Welsh Government would be helpful. This will enable empowerment, responsibility and accountability at organisational level. However, it is not proposed that additional legislation is required to make this happen.

The Green Paper is helpful in supporting the current integration agenda both within the NHS and with partner organisations, particularly with social care. The proposals seek to ensure that the whole of the NHS is working to the same standards and expectations and have clear and transparent systems. The Green Paper could, however, be seen as a mechanism through which the current legislative and regulatory landscape in health and social care in Wales can be tidied up and clarified. Therefore, if this document can be the prompt for further action on revising and harmonising the governance, performance, reporting and inspection and regulation regimes across the public sector in Wales in the interests of improving and ensuring quality and maintaining high standards, it should be welcomed. However, it is not clear that we require further legislation to do much of what is contained within the Green Paper. In many areas the NHS already has the provisions, regulations, codes of practice and statutory instruments, which could be adjusted or implemented fully to provide the framework and changes that are being sought within the Green Paper.

An underpinning issue which is not addressed in the Green Paper is the type of culture, values and behaviours that we are looking to develop and encourage within the NHS in Wales. Evidence clearly indicates that it is culture that may have a more profound and positive impact on the way services are provided than legislative change alone. While legislation in some cases can modify and change behaviour, it is extremely important to firstly consider what change we are trying to achieve and what behaviour we are trying to encourage. Legislation alone will not necessarily lead people to modify and change behaviour to achieve the desired outcomes. There is a significant dimension which is not fully explored in the Green Paper; that is the culture, values and behaviours that we are looking to develop and mature.

A vision for NHS Wales

While the Green Paper stimulates debates and seeks people's views on a range of areas it is difficult to see what the long term vision for the NHS in Wales is and how this Green Paper and future legislation will ensure that this vision is achieved. As it stands it is difficult to make changes to legislation, or introduce new legislation or policy, unless the Government is clear what the NHS, or health and social care, should look like.

In our recent briefing for the National Assembly Election, 'The 2016 Challenge: A vision for NHS Wales', the Welsh NHS Confederation called for all political parties to commit to publishing a 10 year vision for the health

service in Wales in their manifestos. We need a positive shared vision for the future which encapsulate the needs, assets and wishes of the people using the health and care system, and the values of the people working in it. We believe a health and care system fit for the future should:

- Invest in prevention and early intervention to support and maintain health, well-being and independence in communities;
- Provide person-centred care that is integrated, compassionate and joined-up across sectors;
- Empower and inform people to take responsibility for their health and shape their own care around their individual needs, ensuring they are involved in decision-making;
- Listen to and learn from the experiences of patients, their carers and staff and be accountable to the public;
- Continually improve quality and safety, engage and equip staff to work in new ways and embrace innovation and technology to achieve this;
- Reduce inequalities in outcomes, eliminate discrimination and value mental and physical health equally; and
- Use finite resources responsibly, efficiently and fairly, making tough choices which ensure sustainable services.

While the vision may require further legislation, or amendments to present legislation, as it stands it is difficult to see what steps are required before there is consensus around what the vision is and who is responsible for drafting this vision, whether it is the Minister or the Director General, Health and Social Services/Chief Executive of NHS Wales. With the Director General's accountabilities and the accountabilities of the Chief Executive of NHS Wales held within the same role this has the potential to create a conflict of interest. It would be beneficial to have the role and accountabilities of the Director General and the Chief Executive of NHS Wales to be separated to ensure that there is professional leadership and support on behalf of the NHS and professional leadership providing direction from the Welsh Government.

Links with other legislation/reports

In addition to considering whether legislation is required, it is important that this Green Paper is considered within the context of the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015, as both pieces of legislation will be fully effective from 2016. It is also important to be cognisant of the recommendations made within the Commission on Public Service Governance and Delivery report (the Williams Review).

While the totality of the implications of the Social Services and Well-Being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 are not yet fully understood, their introduction will transform the way the health and social care system operates. This, in turn, will be further impacted by the development of GP clusters/community networks. It is helpful that any legislation being considered as a result of the Green Paper will not be developed in isolation and will be drawn up to complement and be consistent

with these emerging legal frameworks. Stability within the NHS is extremely important.

If it is accepted that the Social Services and Well-being (Wales) Act 2014, the Well-being of Future Generations (Wales) Act 2015 and the Williams Review have the potential to impact on the way health and social care operates then further change may be necessary to the current system. How speedily such change could be achieved and whether or not such changes really require legislative support merits detailed consideration.

Governance and management models

It is widely acknowledged that the governance of the NHS in Wales is complex and therefore any changes resulting from the Green Paper should seek to clarify and not further complicate the wider understanding of accountability, citizen engagement and quality.

Firstly as health and social care services increasingly work together to define and deliver against agreed aims and objectives through Local Service Boards and Public Service Boards, the current governance and management models operated by the NHS and local government in Wales may require further change. The role of Welsh Government (in its broadest sense) in leading and managing this transformational change is pivotal and clarifying this as part of any legislative change would be helpful. Any new legislation drafted should positively encourage the delivery of an integrated health and social care system across Wales.

One scenario could be that respective Public Service Boards would develop joint plans, based on shared aims and objectives and this could either supplement or replace the existing Integrated Medium Term Plan (IMTP) arrangements within the NHS in Wales. In such a scenario Public Service Boards would develop arrangements to hold each other to account and the Welsh Government would need to consider whether its current performance, management and accountability arrangements should change to reflect this. Furthermore it is important to consider and be clear about how NHS Trusts in Wales link in and report to Public Service Boards. This has clear implications for IMTPs and the current, direct accountability of NHS organisations to Welsh Government.

In this scenario the issue of how engagement with the public, patients and partners needs to be considered and how service quality is assessed would need to be reviewed. This would need to include how to facilitate engagement which will help to shape and build the joint plans which are likely to be built up from GP cluster/community network level through Local Service Boards to the Public Service Boards. In the context of quality it will become increasingly important to consider how we ensure consistent quality and safety standards are in place across the health and social care system. If these were agreed then this would clearly impact on the role and function of the regulators, e.g. HIW/ CCSIW.

A second issue relates to the role of Welsh Government in leading and managing the system going forward. In governance terms the current system is prescriptive and allows little freedom for health bodies to flex arrangements locally, e.g. in the composition of Boards. Health organisations are increasingly moving to systems that 'empower the front line' by increasing autonomy and accountability at a local level and the current arrangements at an all-Wales level are inconsistent with such a model. This, in turn, leads to the question of what are the underpinning principles on which the health (and social care) system should be developed and judged, e.g.

- be citizen-centred and easily understood;
- be based on Prudent Healthcare and co-production and allow decisions to be made at the nearest point to the citizen as possible;
- encourage service integration; and
- encourage consistent standards.

It is possible to review arrangements based on these principles without the need to consider further legislation. Perhaps the critical factor is that legislation alone will not necessarily lead people to modify and change behaviour to achieve the desired outcomes.

Finally, there is no specific legislation in relation to 'hosting', despite a number of health organisations, including Velindre NHS Trust and Cwm Taf University Health Board, successfully 'hosting' services through varying governance models. Clarity on the status and governance relating to hosting organisations, and all Wales governance arrangements, is welcomed.
Improving the current arrangements nationally

From a wider perspective it is important to recognise that the current overall governance arrangements in NHS Wales have not been designed but have grown and developed. This development has led to the establishment of a number of Groups/ Joint Committees at an all-Wales level which are very complex and can lead to uncertainty. These all have differing governance, accountability and reporting arrangements. Examples include:

- Welsh Health Specialised Services Committee (WHSSC);
- Emergency Ambulance Services Committee (EASC);
- NHS Wales Shared Services Partnership (NWSSP);
- NHS Wales Informatics Service (NWIS).

In addition, there are a number of 'hosted' organisations, again with different hosting arrangements. Examples include:

- Delivery Unit;
- 111 Service.

In addition it is important to consider the governance arrangements when service change is increasingly being considered on a pan-Wales basis e.g. the Wales Collaborative. However the statutory obligations of Boards are to their resident populations and not the overall population of Wales. This has led to governance issues within the South Wales Programme.

There are potential opportunities to standardise and rationalise these arrangements e.g. through the establishment of a single all-Wales body to manage or host these arrangements. If an all-Wales body is established then it could be led by the Chief Executive for NHS Wales.

Service redesign and integration, collaborative working

We would recommend that the requirements to consult are consistent across health and social care. At a time when partnership working is increasing, and the health impact of changes made by all Public Service Boards needs to be understood, it would be beneficial if a similar process could be adopted across health and social care. At present the requirements to consult are different in health than local government.

Furthermore, while there is integration between Health Boards and Local Authorities, it is important that measures are put in place to ensure that Health Boards work together. As previously highlighted, Health Boards are accountable to their Boards and their local population and this can sometimes prevent Health Boards working collaboratively across boundaries. It would be useful to have someone independent who can provide the direction that Health Boards may require. There needs to be a vehicle that enables an all-Wales planning and decision making process when it is necessary. For example if Health Boards cannot agree, or if Health Boards and Local Authorities cannot agree in relation to planning services, what process or person is there to support them to make the decision? There is already a significant amount of planning occurring on a Local Authority and Health Board level but there needs to be other vehicles to support this on an all-Wales level if a decision cannot be made.

Public engagement

It is vital that any legislation that is developed as a result of this Green Paper is understood by the public and they are engaged in any changes. While Health Boards are continuously engaging with the public through the future Public Service Boards, engagement boards and other means, it is vital to recognise that there will need to be a major change in culture and approach in order for the public sector to truly to embrace the very different ways of working required in the future.

A key aspect of the Green Paper will be further shaping arrangements and plans going forward to ensure that citizens, patients and services users are at the heart of any redesign and service delivery. It is patients and service users who get caught up in the differences between public services and the gaps between organisations and if these proposals could help with this and make decision making and taking in the interests of citizens more streamlined, this should be welcomed.

Although co-design and co-production are beginning to happen in some parts of the public sector, the prevailing mind-set in many areas is still one in which citizens and service users are passive recipients of services. In order to move towards the kind of engagement needed there will be a significant task in

terms of skilling public sector staff to work with people and communities in a way which recognises assets to build on, rather than problems to be solved. Similarly, there is a major cultural shift required to move away from the view of public services as delivery agents to passive populations, to a greater focus on localities in which everyone does their bit to maintain and improve services.

The future success of the NHS relies on us all taking a proactive approach to health and ensuring that we create the right conditions to enable people in Wales to live active and healthy lifestyles. Within the Welsh NHS Confederation paper 'Rhetoric to Reality – NHS Wales in 10 years' time'i we highlighted the importance of working with the public to co-produce services and reduce demand, releasing capacity in the system. To enable this we need to make it easier for the public to understand the challenges that the NHS in Wales faces and ensure that they are involved in deciding the local priorities for them. If they do not agree with the local decisions that have been made, we must also ensure that they are fully aware of why those decisions have been made.

Health Board names

With the many proposals highlighted and discussed in the Green Paper, is it now the time to reconsider the names of the Health Boards to ensure consistency and raise awareness of the geographical areas that Health Boards cover. At the moment some of the Health Boards are named after people and others are named after geographical areas which does cause confusion, especially in relation to recruiting people to come and work in the NHS in Wales from other parts of the UK or outside of the UK. If we are working more collaboratively across organisations, and with issues around recruitment, it would be beneficial to consider the names given to the Health Boards in Wales.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
We would not support any further changes to the law to strengthen local collaboration in planning and meeting people's health and well-being needs closer to home. While new legislation is not supported, governance arrangements are becoming more complicated, with more and more legislation introduced that sometimes repeal recent legislation, so more does need to be done to streamline rather than 'add to'. We recognise the significance of, and welcome, the new legislation recently introduced, including the Public Health (Wales) Bill, the Social Services and

Well-being (Wales) Act 2014 and in particular the Well-being of Future Generations (Wales) Act 2015, in relation to the requirements for closer collaborative working between health and other public services. The totality of the implications of these Acts are not fully understood at present but their introduction could transform the way both the health and social care system, and the wider public service, operates in partnership. The new legislation will introduce a statutory duty to plan together, have a single needs assessment and for all organisations to share local population level data to undertake that joint needs assessment, which are all welcomed. We would recommend that the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 are implemented and embedded before consideration is given to further legislation. It will be important to assess the effectiveness of joint planning arrangements and clarify the governance arrangements of the revised arrangements following the implementation of these two pieces of legislation.

For Trusts, as all-Wales service providers, local collaboration and planning poses different and unique challenges. The health and care delivered to a wider population, cross-cutting boundaries, is reliant on wider collaborative working across geographical boundaries. We do not believe the current legislative framework prevents Trusts from achieving collaborative working. We are mindful that to fully support this, leadership and demonstration of true collaborative behaviours at the most senior level across health and social care is key to the success of realising benefits. Statutory obligations of Health Boards to their resident population needs to be balanced with pan-Wales collaboration for the greater good.

2. If so, what changes should be given priority?
As previously highlighted we do not support any further changes to the law however some improvements could be made to strengthen collaboration. With the introduction of the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014 it is important that clear guidance is available to Health Boards, and other public services, to facilitate a clear and common understanding of the opportunities and requirements created by the new legislation. This will enable the Health Board and partners to maximize the opportunities around local collaboration. We would recommend that consideration is given to single plans for key population outcomes relating to population groups and/ or priorities which should then be reflected into organisational operational plans. However to enable this there should be consideration for single public sector service budgets to measure such outcomes and collective responsibility for a single needs assessment with all parties bringing their data and expertise. At present, although we are closer to shared outcomes and strategic plans, these are not consistently reflected into each organisation. We would also recommend the potential to impose sanctions, such as escalated measures, for the planning function if planning is still taking place in

silos. If a partner is not collaborating, the Welsh Government should have the power to direct partners to collaborate with the potential for mediation and arbitration.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?

If the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 fulfil their desired potential then further change may not be necessary to the current systems.

Integration of services is important for patients and service users, but again these arrangements have brought challenges of their own regarding governance, accountability, financing and staffing. If this Green Paper can again look at this to clarify these arrangements, especially community based accountabilities, we believe it could be powerful, especially if this focused on clear alignment with the new Social Services and Well-being (Wales) Act 2014 and also the Well-being of Future Generation Act 2015. Otherwise, we will seek to clarify the health and social care position through this Green Paper.

While there is a risk that the introduction of further legislation may only serve to make the position more complicated and complex, the Green Paper provides the opportunity to review, remodel and, where applicable, rationalise existing models and structures. This should take place before any further legislation is considered and other avenues and options discussed. Any legislation to be considered as a result of the Green Paper should not be developed in isolation and will need to be drawn up to complement and be consistent with the emerging legal frameworks.

As health, local government and other public service partners increasingly work together to define and deliver against agreed aims and objectives through Public Service Boards, the current governance and management models notably operated by the NHS and local government in Wales may require further change. This would have a direct link with many of the areas under discussion within this Green Paper. The Welsh Government would need to consider whether its current performance management and accountability arrangements would need to change to reflect this.

Ongoing engagement with the public, patients and partners is critical and determining how this is best managed would require detailed consideration and planning. This would need to include how to facilitate engagement which will help to shape and build the joint plans which are likely to be built up from GP cluster/ community network level through organisations to the Public Service Boards.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
We do not believe that legislation is required because Health Boards already have a duty under the NHS (Wales) Act 2006 to ensure that local populations are consulted on service changes and there is already significant case law in relation to the requirement to consult. We feel that legislation would not lead to further strengthening engagement. The effectiveness of the existing arrangement in Health Boards or Advisory Groups is variable, and a review should inform consideration of any further changes in relation to their wider use rather than introducing legislation. It would be helpful to define the level of service change that requires engagement and/or consultation. The continuous engagement of patients and the wider public in the planning and provision of health services is increasingly important. It is important that the public are engaged in shaping service change. With the development of GP clusters and new models of care in line with the principles of Prudent Healthcare the level of service change is likely to increase. Related to this is the increasing way that change is being considered on a pan-Wales basis e.g. the Wales Collaborative. However the statutory obligations of Boards are to their resident populations and not the population of Wales. This did lead to governance issues within the South Wales Programme. One of the main issues at the moment in relation to shaping service change often lies in the interpretation of Welsh Government Guidance on Engagement and Consultation – and particularly in relation to the definition of "substantial". It is not therefore felt that further legislation is required but that the guidance needs to be revisited and made more explicit. We would recommend that the requirements to consult are consistent across health and social care. At a time when partnership working is increasing, it would be beneficial if a similar process could be adopted across health and social care because at present the requirements to consult vary between agencies. Much more could be done to maximise use of co-operative service mechanisms and solutions (e.g. co-ops, social enterprise, community asset transfer etc). More will also need to be done to enable information sharing in order to facilitate innovative service change involving non NHS solutions. More focus is needed on the outcomes achieved by service change. Robust mechanisms need to be in place to facilitate ongoing engagement, and the Community Health Councils' role should be clarified to focus on the robustness of that process, and not necessarily the final recommendation itself. Finally, drawing on examples in social care, the document highlights openness, transparency and good access to accurate and timely information. This is key to taking this area of work forward if the NHS wants to be trusted and be seen as candid with regard to services and organisations. The building

of trust needs to be achieved and demonstrated through our actions as public servants, and organisations, every day through continuous engagement and good communication. It is about how every member of staff demonstrates these qualities. Therefore, it is not proposed that any additional legislation is required to make this happen consistently. The provisions are already in place, it requires further cultural change at organisational level to make this a consistent reality.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?

As the Green Paper states, Health Boards are already under a duty to involve and consult local people and their representatives in the planning and delivery of health services. While we agree there is a need to ensure consistency and best practice across Wales, we believe that this can be done through the existing mechanisms that are already in place rather than through legislation. It should be noted that Health Boards already have Advisory Groups, although their role and effectiveness is variable. This may be an opportunity for a review, with the proposal for one Stakeholder Reference Group for Public Service Boards and utilising this for integrated planning.

The NHS needs to ensure that we engage with citizens, patients and service users and therefore the principle of co-production is crucial here. Many communities and interest groups will need support and their actions will need to be supported to sustain them. The NHS is always considering new initiatives to ensure that arrangements are in place to continuously engage and make sure that the citizen's voice is part of everything that the NHS proposes, plans and delivers. Many of our required consultative approaches can be traditional and episodic rather than having a continuous dialogue with communities, but the NHS is increasingly looking to harness new technologies to facilitate improved engagement with some groups and communities.

The option of patient panels has been in operation elsewhere in the UK for some time and raises issues of credibility and legitimacy that need to be considered. Based on existing practice in England, the success of introducing patient panels or participation groups would be dependent upon the groups having:
- Clear objectives of what the group was set up to do;
- Continuous support from the Health Board/ Trust.

Other issues to consider would be:
- Would the "executive core" of the group be granted an annual audience with the Health Board/ Trust Chief Executive?
- Would the group require standing orders, code of conduct – if yes who would undertake the secretariat?
- Would there be a requirement to affiliate with the National Association for Patient Participation (NAPP). Membership is popular in England, but not popular in Scotland.

Within the modern environment, accessing people's time to become members

of panels or participation groups can limit membership and create bias within the group. Health Boards are already under a duty to involve and possibly this should be given a technological support rather than a statutory basis to improve engagement.

The role and authority of such groups would need to be clearly defined – particularly in terms of whether they are advisory or whether their views must be acted upon (the latter then raising questions in terms of the Board's accountability within existing legislation). Constitution of such groups can result in "vested interests" coming to the fore in discussions on engagement and consultation. Similar issues could arise with another group being introduced with a similar remit. The other issue relates to the role of the CHC – which later in the Green Paper is put forward as the voice of the public. That premise could seem to be at odds with introducing another statutory group.

Formal consultation is needed for substantial service change, but the NHS is moving away from tokenistic engagement towards continuous engagement, and a review of the role of Community Health Councils will facilitate this. It is considered that their focus should be to support and advise the population on how they can raise issues and take matters forward rather than as an inspectorate. There could be an obligation for Health Boards and Trusts to formally engage the Community Health Councils with internal organisational mechanisms and vice versa. This does not require legislation. If Community Health Councils were organised differently, with a pan-Wales remit and seen as neutral, they could have some formal obligation to lead on continuous engagement.

There are a range of tools to facilitate continuous engagement and it should be for each organisation to determine the most appropriate local mechanisms. Health Boards and Trusts are continuously engaging with the public and are being innovative in this process. The conclusion therefore is that Health Boards and Trusts are committed to engage with the public and further legislation is not needed, especially if it could potentially tie the hands of the NHS in the use of innovative engagement methods.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
The proposal to establish an Expert Panel is not supported. The establishment of such a panel would add an unnecessary step in the process and referrals to the Minister should be a last resort. It is important for NHS Wales to consider previous arrangements, including the National Clinical Forum, which have involved a panel approach and which have not assisted the NHS with service change / reconfiguration. Therefore this is not supported as it could be construed as an additional tier of bureaucracy and overburden governance arrangements.

The National Clinical Forum undertook some elements of this work previously and the perception was that this group did not always reflect local circumstances, and on occasions put forward views which reflected a pure standards driven model without taking account of other factors (e.g. rurality). It is felt a permanent panel would not have the local knowledge and accountability. Responsibility and scope of powers would be a cause for concern. The question would be whether Boards in NHS organisations would become redundant in terms of decision-making relating to service change. Other issues that need to be taken into account are:

- Would such a panel understand local issues? The panel could be seen as second guessing Board decisions, where the expertise already exists;
- The term 'expert panel' implies that the views of the expert will outweigh those of local people;
- What constitutes an 'expert' would need to be defined;
- Issues such as what level of authority would it have, who would the panel be accountable to, would need to be considered, especially with regard to the risk of judicial review;
- The implications on the role of CHCs would need to be assessed.

The local government model is based on locally elected members forming a "Cabinet". Would the NHS expert panel be formally elected by the public? Would there be a Health Commissioner similar to the Police Commissioner? If the expert panel dictated a pan-Wales approach to providing a specific element of health care, how would the delivery be monitored? Would it be adopted consistently across the different boundaries? For example, the NHS Wales Shared Services Partnership (NWSSP) Committee makes decisions on behalf of NHS Wales, however what is agreed is not always adopted across the different Health Boards due to local views amongst executives and clinicians.

Our preference, instead of a national Expert Panel, would be for each service change under consideration to have a separate panel appointed. However, it is felt important that the Minister should appoint such a panel when required rather than having a permanent panel. It is felt that a process of referral to the Minister should remain in place, since this ensures that referrals are not made lightly and that referrals to the Minister are made in exceptional circumstances only.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Ensuring quality will rely on the organisational structures, their accountabilities and the performance regime and not legislation alone. If these are clarified through this Green Paper and expectations are clear, organisational and individual behaviours and cultures will be framed in different ways. We need

to allow people to focus on the key roles of caring and providing high quality services and ensure that organisationally the NHS provides the environment and support to enable that to happen. It is therefore, not proposed that additional legislation is required to make this happen. Improving quality is far more organic than legislation and needs to be woven into the values and culture of the organisation and measured against a robust performance and audit regime. Furthermore there already exists clear lines of professional accountability through Professional Codes. This could be strengthened further by aligning standards used across health and social care to support integration and co-operation.

Legislative measures merely outline the process and therefore to ensure continuous improvement in quality, a shared performance management framework would need to be introduced across health and social care to monitor performance across different geographical boundaries. The framework would need to encompass specific measures to enable monitoring and evaluation of "real time" performance indicators through a dashboard. This would be heavily dependent on sophisticated IT structures which were interoperable across NHS and social services. To meaningfully monitor the delivery of quality in NHS Wales it will require investment in data capturing facilities to gain timely performance information across all health (and social care) organisations. Currently, only Health Boards have a mandated performance dashboard, giving limited intelligence on performance.

In relation to quality it is vital that there is a culture of continuous improvement across the NHS and more emphasis needs to be placed on this. While 1000 Lives Improvement is an important example where improvements across the NHS are being driven forward, all staff working within the NHS need to understand that this applies to them. While legislation could provide a sharper focus on quality, all regulated health care professions already have a Code of Conduct and this would just add another layer of legislation and regulation. Revalidation and continuous professional development (including appraisals) should support quality improvement and we could perhaps strengthen the quality and improvement of training in all under graduate, post graduate and other staff training programmes. There needs to be consistency across the integrated system about how quality is measured, with the same principles and standards applied to directly provided services, those commissioned (either from primary care or the third and independent sectors) and all professional groups that may not be regulated, for example healthcare support workers.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
We need to continue to build on the existing systems and apply the tools which already exist which evidence quality and safety of care. In light of the Mid Staffs review and the Andrews review, there needs to be a focus both on quality and safety. We need to be clear what we mean by quality, especially in an integrated

health and social care environment. In relation to integration, this should not just be an NHS priority but should be a health and social care priority. The gap that needs addressing is for health and social care to be working towards the same quality standards and targets, with the standards and targets to be agreed with the Welsh public. There needs to be a public debate around Welsh NHS priorities. The Social Services and Well-being (Wales) Act 2014 provides legislation on a citizen centred approach and how this can be achieved through partnership and integration. Before further legislation is required a review of the impact of this Act should be undertaken to ensure that it has facilitated a citizen focused integrated delivery of care.

In considering service change there is currently no requirement to complete a quality impact assessment, whereas there is for other areas, such as finance and equality.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
With the other range of regulations, codes of practice and professional regulations in place it is not proposed that additional legislative measures are required. As highlighted, quality of care is dependent upon attitude, behaviours and cultures of individuals and organisations. It may be more appropriate to consider how we could establish safe standards that could ensure consistency across the system and would have the same monitoring and audit arrangements that apply to the financial systems and the Annual Quality Statements. Introducing and mandating Quality Impact Assessments for all agencies providing health and social care would support consistency.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
It is difficult to see how any one individual could be held wholly responsible or accountable over and above the existing arrangements. Given the issues regarding quality, as highlighted above, it is difficult to see how such an individual could be responsible or accountable. It is clear that organisations need to have good leadership to ensure that it meets its responsibilities. These individuals need to have the right skills and competencies to fulfil their roles. Accountability lines within the NHS Wales at Health Board/Trust level are already clear. NHS organisations already have accountable officers and the Board is collectively accountable for the work of the organisation. The duty of quality is detailed within the Chief Executive’s accountability letter, the Chair’s appointment letter and is detailed within professional accountabilities of the Executive Directors. The collective effectiveness and individual effectiveness of organisations already have a range of external and internal tests. Individual roles have annual assessments of their effectiveness through Personal Appraisal

Development Reviews (PADR). However, the adequacy of these collective and individual mechanisms might need to be reviewed.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
It is difficult to judge the merits of this without further information but the principle of the introduction of a “fit and proper persons” test is generally supported. However, this should not distract from the primary responsibility of the employer to check that its Board members are competent in discharging their roles and responsibilities effectively and that they behave in a fit and proper manner and continue to do so for the tenure of their employment. Some questions that need to be considered before it is introduced includes: 1. How will the test apply to those Directors who occupy a professional as well as corporate role (concern regarding dual regulation)? 2. How will the test differentiate between those who are clearly the decision makers versus the responsibility of a Board? 3. If a Chief Executive has standards that they have to meet then leaders would then need to get protected like a professionals are with regulation.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Current legislation and specifically the NHS planning framework makes this clear and provides adequate provision to promote quality. At a local level we need to ensure that we provide support to local GP clusters to focus on, and address, quality of care in primary and community settings, in addition to working to improve quality and outcomes within hospital care settings. While quality assurance through the NHS planning framework is adequate, further consideration is required to promote quality in the broader service integration agenda. With the shift to integration between health and social care, it would be helpful if quality was set in the context of an overarching health and social care plan for Wales. Many of the quality targets set down by Welsh Government are related to accessing services and it is the core Tier 1 targets on which health organisations are held to account. If quality is to be promoted this needs to be the core requirement within the planning framework and guidance for integration.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
This should be viewed in light of the section on quality. As previously

highlighted standards already apply to the NHS and it would be helpful to have an integrated set of standards across health and social care, plus joined up regulatory and monitoring arrangements. This is particularly important given the changes in legislation, such as the Social Services and Well-being Act 2014.

Furthermore, the Health and Care Standards have just been refreshed and these need time to be embedded and to be reviewed. The new Health and Care Standards seek to provide certainty for both staff and citizens and provide a key frame through which judgements can be made about the quality of services. They allow citizens to know what they should expect and promote consistency of approach.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
We support the creation of consistent healthcare standards across the NHS and the independent sector to be set in legislation. However, this should not be just for health and the independent sector, it should seek to provide consistent standards for health, social care, third sector provision and the independent sector. A common set of standards across the NHS and independent sectors may improve patient outcomes and experience. A common standards framework will provide certainty and clarity for patients and service users. The introduction of a common standards framework would have implications for the function and role of the regulators which need to be considered.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
We support peer review if it is well planned and executed with commitment from all concerned and implemented consistently to an agreed standard. Peer review and accreditation systems are important aspects of providing external assurance to the public around promoting better service quality. While peer review is supported it is important that other mechanisms are considered. Each peer review should have an agreed set of measures which organisations should provide a self-assessment against and then be audited. While peer review can be a powerful approach to change and could enhance quality, experience from England tells us that it can be time consuming (and therefore expensive), so some real thought would need to be given to the practicalities. In relation to accreditation, there are already a number of national bodies that provide accreditation and these need to be utilised fully to avoid the risk of duplication. Accreditation should be seen as a mechanism to promote service quality and mandatory accreditation across the sector would require the appropriate resource to support the cost of the process.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
While we support the principles that clinical peer supervision should be implemented as an integral part of health professional practice, we do not support legislation as this could create more of a burden on organisations and individuals and become a tick box exercise. Good clinical supervision does improve services but legislation would not ensure the quality of the supervision, just that supervision activities have taken place. With the introduction of revalidation for nurses and doctors, and other professions to follow, it could be more constructive to make some financial support available to Health Boards/ Trusts to support the process of clinical supervision, rather than mandating legislatively. All practitioners should have dedicated time for supervision and Health Boards/ Trusts should expect all practitioners to have dedicated time for quality improvement in the form of sessions for audit. Consistency is needed around the terms 'supervision' and 'peer review', and particularly around processes that promote better practice, and processes that assure on-going safe practice (with associated processes to manage registrants if unsafe or ineffective practice is detected).

17. What arrangements should be put in place for self-employed health professional registrants?
The NHS could offer mutual supervision cover with private practitioners (i.e. cross sector supervision or peer review arrangements). There are a number of regulatory gaps which could be addressed through the requirements for clinical supervision, mandatory training and revalidation.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
We are broadly supportive of the introduction of a statutory duty of candour in the aftermath of the failings at Mid Staffordshire NHS Foundation Trust. However this is more than considering a legislative approach but considering the values, principles and culture of organisations and the way individual members of NHS staff seek to provide the best service for citizens every day. The definition of candour used will need to be clearly defined and considered. Candour is defined in the Francis report as: "the volunteering of all relevant information to persons who have or may have been harmed by the provision

of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made. Prompt apologies and explanations, with a reassurance they will not reoccur, may prevent a claim being brought at all."ii Francis Report recommendation 181 provides that there should be a statutory obligation of candour on healthcare providers, registered medical practitioners, nurses and other registered health professionals where there is a belief or suspicion that any treatment or care provided to a patient by or on behalf of their employing healthcare provider has caused death or serious injury. It is difficult to dispute the definition or the recommendations within the Francis report around candour (and around openness and transparency).

While professional groups already hold a duty of candour, it would be powerful if this is extended across the NHS. The NHS in Wales needs to be clear about our duty of candour for patients and their families. Promptly identifying negligence, actively responding to complaints in a timely and open way and also providing redress for the patient and their family should also be encouraged. However, these principles of openness and candour need to apply from the design and agreement of plans and care plans for patients and not come as part of redress or part of investigations. If we apply these principles in our design and delivery of services and behaviours of our staff, the expectations of patients, their families and their carers, should be more clearly understood and as a result they should receive the quality services they expect. Key to this will be how we measure quality and how citizens play a key role in that measurement.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
We need to be clear about what elements of performance are being referred to and where it is felt transparency could be improved. We need to have much more easily accessible real time information about the performance of services to enable patients to make choices about their care and also how and when they access services. Transparency will be greatly enhanced by the provision of real time information as many of the systems in healthcare take an extended period of time to produce meaningful data currently e.g. mortality data and other information can take three months or more to produce. To ensure transparency is the norm, performance and data systems need to be supported, however it is unclear how legislation in isolation would improve transparency as this would need to be underpinned by cultural change. The performance management framework for Wales could be used to drive improvement in terms of transparency and openness. Performance is regularly monitored by Boards at public meetings and information is readily available on websites and this should be developed to be outcome focussed rather than process focused. National IT systems should be available to allow NHS organisations to make their performance information publicly available and reportable.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
There are already well established good practices in place for the joint investigation of complaints. With the principles that there should be greater integration across health and social care, the complaints process should be an integrated process which ensures that the same principles and processes are followed. Health Boards work across health boundaries and the current NHS re-dress system allows for organisations to agree the lead organisation and respond to individual complainants. There is an opportunity as part of the review of NHS re-dress that this also includes primary and social care. It is also important to consider whether the NHS re-dress process should apply to all public bodies and healthcare providers. This could be strengthened either by legislation, guidance or requirement for a formal agreement to be in place. Statutory guidance could be issued which sets out clear expectations for a joint complaints process for people who are in receipt of a package of care which includes health and social care and are making a complaint about both aspects of their care. It should be a requirement that the Local Authorities and Health Boards are open and transparent and publicly set out what the joint complaints process is. Cross border issues should also be considered when looking at complaints. When a patient makes a complaint about a cross-border provider service, there can be a lack of transparency and information sharing between Trusts in England and Health Boards in Wales. Welsh GPs who refer English residents to English providers are not generally informed of any complaints or issues of concerns raised by the patient. This issue was recently highlighted within the Silk II Commission report: “It has been suggested to us that there is a need to ensure that complaints are swiftly and effectively dealt with…We agree and believe that a sub-committee should be established under the new Welsh Intergovernmental Committee…to consider and resolve cross-border issues when they are not resolved through normal channels.”iii It is important that national regulators and inspectors in England ensure information around any concerns or complaints raised by Welsh residents is communicated with the Health Board. As it stands, health and care regulators in England do not inform Welsh commissioners (Health Boards) of any complaints or concerns. This is important to ensure that Health Boards are commissioning safe and quality assured services.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
It is not felt that further legislation is required but that a different culture needs to be adopted by organisations in an integrated service environment. Organisations need to adopt a culture of sharing information where the benefit is to improve care for an individual rather than using consent and other issues as a barrier. There are many perceived barriers to sharing patient information across the health and social care system. The Data Protection Act 1998 provides a legal framework for allowing organisations to share information appropriately, taking into consideration the privacy and confidentiality of individuals. However, it is often through a lack of understanding by an organisation or staff, or through a lack of training, that the legislation is used to prevent the sharing. There is no doubt that the misunderstanding of the Act does act as a barrier as it is likely to prevent legitimate sharing when staff err on the side of caution. As a result of the Information Commissioner's powers in extending fines for breaches in the Data Protection Act 1998, we now find ourselves in the position where the sharing of clinical data is restricted. Clinical information that is critical for prudent treatment and quality care for patients is sent in password protected formats that cannot be opened without considerable delays. We have defaulted to a system where now data protection risk trumps risk to the patient. The NHS in Wales needs to look closely at the way in which we transfer data and the limitations of our systems, rather than the law itself. If we want a joined up health and social care system, we need the infrastructure and the finances in place. An integrated IT infrastructure would make this possible but investment is needed as a priority. Due to a lack of published national information governance standards in Wales, there is often a lack of trust between organisations to ensure that once their information has been shared, similar systems, processes and security measures will be applied to that information to help prevent damage to the organisation's reputation or application of a financial penalty. This is an area where the Welsh Government can take action to ensure that all policies requiring partnership working are supported by current or new legislative provisions enabling data sharing. The recent Social Services and Well-being (Wales) Act 2014 and related regulations set a good example of ensuring that organisations have the necessary legal basis for sharing information across the new partnerships. Such legal gateways can obviate the need for the individual's consent when sharing their information.

22. How can we consider breaking down any barriers?
Organisations already have the ability to interpret Data Protection legislation from a position of wanting to share information rather than withholding information, but often they take a negative approach at the outset. The main issue relates to consent and the reluctance to share personal information without explicit consent. However, many serious incident reviews highlight the lack of communications between organisations as a root cause. Continued use of Wales Accord on the Sharing of Personal Information (WASPI) and the central arrangements would support the breakdown of perceived barriers. The introduction of published national standards around information governance, security and compliance with WASPI would lead to increased confidence between organisations and encourage more effective sharing, ultimately benefiting the patient and the care they receive. Fundamental review and upgrading of IT systems and security is crucial. Investing in good quality and compatible IT systems that can 'speak to each other' across organisations would break down many barriers. Also, IT equipment and software systems that are of the highest standard can facilitate such sharing of information right across the patient/client pathway rather than acting as barriers. The Welsh Government has recently moved to a position of presumed consent and an opt-out system for organ donations, following consultation and the adoption of a similar approach for personal information This would create a positive shift in behaviours and approach. We consider that if patients feel their care will benefit they would be happy to have organisations share information. This will also avoid patients having to give the same information on numerous occasions to different professionals/ organisations. It would be beneficial if we follow the opt-out model being adopted by the Human Transplantation (Wales) Act 2013 because many citizens assume that their information is shared in order to plan and co-ordinate their care and would want the clinicians and professionals to have best access to the information about them.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
We support the collection and sharing of patient identifiable information for research when it complies with the legislation and supports the improvement of patient care. It is vital that our patients have confidence in our ability to protect their privacy, comply with the law and safeguard their personal health data. Data holders within the health service must ensure that they obtain information about their patients properly and keep it secure in accordance with the well-established rules of medical confidentiality and the provisions of the Data Protection Act 1998 and the Caldicott principles. Researchers should always be able to justify and provide risk assessments for requiring identifiable information. However, where possible anonymised information should always be a preferred option.

Research which makes use of existing patient identifiable data (and stored samples) must comply with NHS Caldicott Guidelines and have the permission of the Health Board/Trust Caldicott Guardian and be approved by the Information Governance Committee. However it is recommended that a "national research governance framework" is adopted to ensure consistent safeguards are in place to protect patient information, ensure the quality of information and appropriate consent models are followed. This could be in the form of local Research Ethics Committees.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
The themes about regulation and inspection should be welcomed especially if they can clarify the complicated framework of inspection and regulation, which has built up over time. The role of HIW needs to be reviewed in the light of the move towards integrated health and social care provision. The opportunity to develop a single regulator or inspection body/framework for health and social care in Wales should be explored. This will also reflect some of the increasing integration of services, where the responsibility for inspection and regulation has become blurred, where integrated services have been developed. The possibility of a joint or integrated inspectorate should be considered and this would better reflect the integration of services that is underway. Therefore, more joint working would be welcomed as a first stage with a gradual build-up to the potential of a genuinely joint health and social care inspectorate which is independent of the Welsh Government. Furthermore, as highlighted, once a 10 year vision for the NHS has been agreed then we need to consider what regulatory framework and regulator is required. For health services, HIW effectiveness here is key. Presently the effectiveness of HIW is more related to the resourcing and operating procedures within which they operate rather than legislative issues. There needs to be more public awareness of what HIW does so that their reports become valued by citizens. Finally given the independent review of the work of HIW 'The Way Ahead: To Become an Inspection and Improvement Body' and the findings of other reviews that have found failings in multi-agency investigations, there needs to be clear investigatory leads and full co-operation across sectors.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
The NHS needs a strong and effective regulator and it is likely that the public would have more confidence in the regulator if it was independent (not arm's

length) from Welsh Government. HIW independence has not been compromised but it is the perception by the public. If HIW receive statutory independence it is likely that they are too small at the moment and need to be resourced through possibly merging with another organisation. There is support for HIW to have a strong independent presence and be integrated with CSSIW.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
We need one integrated regulatory body working within one framework. It's more than joint working, it requires legislative change with common standards and common framework. Merging the inspectorate bodies seems necessary if we are really working towards integral health and social care. This would create a stronger, less complex system for patients, public and the service to understand and prevent issues falling between organisations. However joint working between the two regulators (HIW and CSSIW) should be encouraged with or without a merger. If change is not going to happen, we would still need to look closely at the effectiveness of the ways in which HIW and CSSIW work together, their engagement with services and their profile for the public and patients. It is also suggested that there might be an argument for closer cross-referencing with Community Health Councils as their work provides very rich and insightful information about the quality and safety of services and importantly patient experience. One question that has been raised by our members that has not been considered is the role of the Auditor General as part of the inspectorate discussion, especially in light of the tripartite escalation discussions.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
A single inspectorate would create a stronger, less complex system for patients, public and the service to understand and prevent issues falling between organisations. It would lead to consistency in standards and the regulation framework. The main advantage to citizens would depend on the methods of working and the way people can be engaged in the monitoring processes with citizens knowing how to raise concerns. The disadvantage is that it may dilute the focus on each area if there is a drive for generic standards and inspection, particularly given the highly complex nature of health care provision. Such a move must be properly resourced and introduced in a careful, incremental fashion.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The role of the CHC is an important one and the role they play is supported by Health Boards across Wales. Health Boards have a very positive relationship with CHCs and CHCs provide a constructive source of advice, provide challenges when appropriate and also support. It is important that the CHCs are maintained but we would recommend that their role is refocused to represent the patient voice and improving advocacy services. If they are given such a remit, consideration needs to be given to the appropriate "weighting" of the feedback received from CHCs and how this is played in any formal consultation mechanism the NHS is required to undertake. For the CHCs to represent the patient voice their membership will need to be reviewed and be representative of the population served rather than through the current arrangements. CHCs could never be the only voice of the patient. Expert patient groups, patient's panels, direct patient feedback, joint engagement with local authorities using their citizen's panels, all provide useful and valid ways of hearing the views of those who use health and social care services. In relation to service change, consideration should be given to the duty placed on CHCs to identify alternatives to service change as the question should be raised whether the membership is clinically qualified to do this. CHCs should be able to listen to the public and look at whether the Health Board has followed the correct process and whether the engagement process was robust. It is unfair to ask CHCs, made up of lay members, to comment on proposals themselves, but more appropriate questions to ask would include: • was the rationale for change clearly laid out with supporting evidence? • is it clear what outcomes will be achieved by the changes – and how will these be measured? • have appropriate steps been taken to engage relevant patient groups/communities and stakeholders? etc. Furthermore the referral mechanism from CHCs to the Minister should change. There should be an independent CHC panel which considers the questions around service change before referring to the Minister.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
The current CHC model is not fit for purpose in a more integrated system. There are two potential options to ensure changes are made. The first is to amend the current model slightly and retain local CHCs as statutory organisations or to create a CHC for Wales that deploys teams to local areas but with the statutory powers being vested in a single organisation. In taking the suggestions forward, stronger links between Town and Community Councils and the Local Authority Scrutiny Committees could be considered,

thereby ensuring to a certain degree, some democratically elected input. Such a move would address some of the current issues and criticisms in terms of lack of integration between health and social care at a grass roots level. In any restructuring, given the economic backdrop, care needs to be taken not to add further complexity and duplication to the system, but to use this as an opportunity to streamline.

As highlighted previously, the membership of CHCs is drawn largely from lay people with little direct experience or knowledge of healthcare practice and modern medicine. This places them in an invidious position when considering whether service change is for the benefit of their population. We would recommend that their membership profile is more reflective of the communities that they represent, for example more young people are part of their membership.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
It would be beneficial for Health Boards to be allowed to borrow, although we understand the risks involved and this would require clear policies to operate across NHS Wales. Giving Health Boards borrowing powers would lead to the following benefits: • Borrowing will give much greater local flexibility of resource across revenue and capital; • NHS providers could modernise and improve estate at a greater pace than is currently achievable; • Health Boards could invest in accelerating capital investments, where these demonstrate a clear revenue saving and payback; • It will instil a discipline of longer term planning and assessing business cases on a more commercial footing, securing an even greater focus on due diligence even in areas where borrowing is not required; • It will clarify current arrangements surrounding finance leases and PFI arrangements where Health Boards do, in effect, borrow to fund future developments. This needs to be balanced over revenue to pay back any borrowing and requires some form of underwriting to facilitate competitive borrowing rates. Prudential Borrowing codes, as used by Monitor and other public sector organisations, won't apply to Health Boards, and careful consideration will need to be given to the NHS Wales policy framework in this area to ensure that Health Boards do not become exposed to over borrowing. System changes may also be required. For instance, there may be a need to review the process of capital charges and cash allocations to Health Boards.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
We would agree with the findings of the Green Paper that producing separate NHS Wales, Trust and Health Board summarised accounts provide very little value, and do not reflect the current state of the NHS landscape. There is an opportunity to review the entire reporting arrangements and processes within NHS Wales and simplify these. Within Health Boards, providing summarised accounts are important in terms of demonstrating transparency and accountability to the general public, although the timing of publication (September) detract from this value. We do not believe the same benefits are obtained from summarised Trusts accounts. There may be an argument that the timetable for Annual Reports and Annual General Meetings should be shortened to create timelier reporting. Crucially, any change in reporting should encourage more meaningful and understandable analysis. There should also be consideration given to the Annual Report as a whole, to ensure that it can become a document which is understandable and accessible by the general public. Furthermore accounts should be prepared in such a way to disclose as much information to the reader. Health Boards (with guidelines for minimum disclosure) should have the autonomy to publish results in the most meaningful way to their public, subject to Wales Audit Office approval.

32. 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?
As previously highlighted, there is an opportunity to review the entire reporting arrangements and processes within NHS Wales and simplify these.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
We would support the statutory planning duty, currently in place for Health Boards, to apply equally to Trusts. Health Boards are accountable for the planning of services for their resident population. The role of Trusts is different but there should be a similar duty which expects Trusts to have approved plans and strategies to deliver commissioned services. This would ensure the seamless planning of activities to improve health and for meeting patients' needs across the pathways of care.

34. 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?
Overall we support the principles of a one system planning approach across health and social services. There is a real opportunity to remove duplication and confusion and to have some unique Welsh legislation that is public service focused to give freedom for organisations to integrate, plan together and reward innovation where it delivers better services. These discussions in terms of alignment and joint planning are beginning to happen at a local level in the contexts of the above Acts. While we do support the principle of aligning planning duties, we do not support the review of the Act because it could create even more complex governance structures than what already exist. Furthermore Public Service Boards will provide leadership and alignment of planning duties to meet the shared aims between the NHS and their partners as part of the Well-being of Future Generations Act once it is implemented.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
The Green Paper suggests a full review, which would be welcomed. Since the 2009 restructuring of the NHS, a range of complex adjustments and fixes has emerged, with the establishments of joint committees, shared and hosted services, network arrangements and collaborative arrangements. These range of approaches need to be reviewed, clarified and where possible streamlined. However, we need to be clear about what problems and issues we are seeking to resolve, which is not clear in the Green Paper. Therefore it is difficult to answer such a broad question succinctly so each category has been separated. **Leadership:** To answer this fully it needs to be clear which leadership community is covered here and the expectations of this group as the term leadership is very broad. If it refers to Boards then it needs to be responded to in terms of Question 36. In relation to Boards, the NHS Wales Act 2006 permits the Welsh Ministers to set in regulations the number of Executive and Non-Executive Directors for NHS Trusts (Schedule 3, Part 1, para 4(1)(c)). There is therefore no requirement for primary legislation to address the size of Boards to ensure they are fit for purpose. **Governance:** As indicated earlier the governance arrangements in NHS Wales are complex, as highlighted by the WAO recently. The governance arrangements could be simplified greatly if an all-Wales body was created to manage all-Wales service matters.

Partnerships:
Legislatively the Well-being of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014 will place a duty to integrate on Local Authorities and Health Boards and this is welcome – but does it go far enough? It should ensure that it is mandatory to have strong partnership governance in place via Section 33 Agreements and also a shared approach to risk management, performance managements, information sharing and work to align processes and procedures.

In order to strengthen leadership, governance and partnerships, clear accountabilities are required, with a route of escalation if concerns arise built on sound principles with clear expectations and outcomes. There is already in place an escalation and intervention process for NHS Wales that clearly outlines how Health Boards or Trusts are moved into a position of escalation, and this is applied systematically and consistently. Furthermore, clear principles of behaviours over and above the Nolan principles need to be further developed so that they truly reflect the principles of NHS Wales together with what is expected of all public servants. There also needs to be a greater focus on career development and succession planning.

If co-production is truly the way forward then working in partnership with the population is paramount, recognising that sometimes this may cut across the views of clinical experts. Health Boards and Trusts would need the latitude to design and co-produce services that truly did meet the populations health needs and improve population outcomes.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
The current Health Boards have been in place since 2009 and have faced considerable quality and safety issues, as well as financial and professional challenges. There is an overall view that the current size and configuration of Health Board membership inhibits the quality of the Board's deliberations and decision making. While a large diverse membership which includes a broad range of perspectives can be helpful, a narrower membership would provide a more streamlined focus so that the Board could adapt to more strategic decision making. When considering the Board membership it is necessary to consider the breadth of portfolios required by health organisations to deliver against the current policy drivers. Board membership needs to give adequate Board level resource to allow robust fulfilment of each portfolio item and ensure Board members can fulfil their obligations and accountabilities. This includes ensuring appropriate skills base on Boards, particularly to cover complex professional issues across the entirety of health professions, and to ensure there is a strong, clinically focused cohort of Board members. The Board

should be able to vary the regulations and to decide the executive structure that is needed rather than being prescribed by regulations. There should also be more flexibility in relation to Independent Members rather than being prescribed by regulations.

The Williams Review commented that Health Boards must be accountable and responsive, accessible to their local populations and provide excellent leadership and direction to their senior executives (and by extension the rest of the workforce) and hold them to account. The need to separate clearly those who make decisions and those who scrutinise them means that the role of a Health Board's Independent Members is a particularly challenging one.

Consideration also needs to be given to how a trade union and staff perspective is brought to the Board if the current board composition changes. There is a value in having a trade union member from the employing organisation at the board, providing a different internal perspective to that of the executives. The advantage of having a full board member is that the individual will have been through the full public appointments process and should therefore have the necessary skills and abilities to undertake the role; however there are inevitable tensions when the trade union view may differ from that of the Board.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
The set number of executive directors should be clarified and scope provided as to roles within minimum and maximum numbers. While there is some benefit in there being the same executive roles on each Health Board (facilitates all-Wales working through all-Wales groups), there is room for some discretion to give Boards greater flexibility. Public Health Wales NHS Trust has discretion over three of five executive directors and they find this allows them to flex and change the executive team structure to suit their changing and evolving priorities. However the business of Public Health Wales is quite different to the service delivery for Health Boards. If such an arrangement were put in place for Health Boards, there is a risk that one Health Board could end up with a completely different structure than the neighbouring Health Board. This would make it difficult to enact or discuss all-Wales issues across Health Boards and could introduce variation across Wales. If there is variation it must be clear why that variation will enable stronger leadership, governance and partnership working. If we are going to remain with the prescribed number of executive directors, one missing is the Chief Operational Officer.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
When considering views on the suggestions made by the Williams Review on the election of community representation it is difficult to see how this would work in practice within the current governance structures of NHS Wales.

Given the diverse communities served by the Boards it is difficult to envisage how one or two individuals could in reality respond to, and be held accountable, to local communities. The recent experience of electing Police and Crime Commissioners saw a low turnout from the electorate and it raises the question of how representative the elected individual would be. Furthermore the cost of such elections could be significant. For example under Act of Parliament the Malvern Hills Conservators hold elections in the six parishes around Malvern for 11 directly elected Conservators every four years. The turnout for the wards is around 2.5% and the cost of this election is in the region of £35,000.

While there are benefits of accountability to local communities, concerns remain regarding the capability of local elected members to deal with the magnitude and complexity of the agenda. Perhaps it would be better for Health Boards to have stronger mechanisms for continuous engagement with the communities they serve. Furthermore, careful consideration needs to be undertaken as locally elected members could lead to politically elected appointments influencing health care provision.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
There would be a benefit in further exploring this proposal. In general joint appointments, for example Directors of Public Health, could be an area for real innovation. The Public Service Boards should have the local Director of Public Health as part of its membership. This role is not the only one that should be considered as there is an opportunity to look at greater joint/dual roles.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
As highlighted, there needs to be a long term vision for the NHS in Wales and once that vision has been established we then need to consider what changes are required to Health Board membership to ensure they are fit for the future. At present health organisations should be given more freedom to appoint Independent Members with the skills the Board feels it needs rather than the current model, which is prescriptive. It would also be useful that consideration for staggering Independent Members appointments to avoid instability when terms of office end.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
Overall the current size and configuration of NHS Trust Board membership best promotes an effective focus on decisions, priorities and service provision. For Public Health Wales NHS Trust their current regulations require Independent Members with Local Authority; university; and third sector background. This leaves four Independent Members with no specified background, including the Chair. This gives flexibility and adaptability to revisit the composition of the Board when making new appointments and to specify specific skills and knowledge depending on the priorities at the time of the appointment. The configuration of Velindre NHS Trust Board has worked well for 21 years. However, given the increase in focus and the role of the Board during this time, the size of the Board has proved challenging. It is widely acknowledged that the current 21 members on Health Boards is too large, but the 12 strong membership of Trusts is too few. Velindre Trust would welcome an increase in the number of Executives on the Trust Board to a minimum of six Executives, with the Trust Board retaining the privilege to determine the strategic areas to award Executive Director status. The Trust would also welcome an increase in the number of Independent Members from seven to nine, one of which to be recognised formally as a Vice Chair for the Board, a role that currently does not exist in a Statutory Instrument for the Trust.

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
As highlighted above, the ability to appoint a Vice Chair should be incorporated within the membership arrangements for NHS Trusts and the size and configuration of the NHS Trust Boards be expanded.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
There is support for greater clarity for the role of Board Secretary. The original role of the Board Secretary for NHS organisations was introduced in 2009 when the role was ill understood. Since that time the variance of the role, including responsibilities, has varied to a greater or lesser extent across NHS Wales organisations. The proposal to provide greater clarity is welcomed, ensuring the role is perceived at an appropriately senior level and to effectively challenge and advise Directors (Executive and Independent) at Board level as necessary. While the role of Board Secretaries is stipulated in Standing Orders, and a model Job Description has been produced by the Welsh Government, we would recommend that there is no deviation from the model to ensure the

protection of the independence of the Board Secretary role and eliminate opportunity for conflicts of interest. It is essential that operational management is not allowed to encroach on the stipulated accountabilities of the Board Secretary to ensure potential conflicts are avoided as identified recently by the Public Accounts Committee in the review of the Board Secretary role and accountabilities at Betsi Cadwaladr University Health Board.

The importance and status of the role may be strengthened if it were renamed (e.g. Director of Governance) and a professional head assigned from Welsh Government. The current NHS job evaluation and grading system makes it difficult to fully recognise the role of the Board Secretary, although the role requires the Board Secretary to challenge and to be seen as Director level in the organisations. Currently within Health Boards the grading is equivalent to Agenda for Change Band 9.

The role could be set out within the Regulations. Similar roles exist in other public bodies upon which it could be modelled. For example, the role of the Monitoring Officer within Local Authorities which in accordance with the provisions of the Local Government & Housing Act 1989 and 2000 Act which makes the role a statutory requirement for all Local Authorities and gives them a legal duty to report on legal issues and maladministration, manage the code of conduct and complaints associated with conduct of Principal officers and elected members, manage the standing order's etc. The Local Government (Wales) Measure also provided a statutory resource to support the Monitoring Officer in undertaking his/her duties, specifically the appointment of a "Head of Democratic Services" role to fulfil the corporate requirements of the role. The only caveat here would be that in an NHS environment the role would not need to have a legal qualification, and would require tacit experience of NHS operations and governance instead.

44. If so, what aspects of the role should be additionally set out in law?
Linked to the response to the previous question, additional aspects could include the Board Secretary role as a statutory role with a specific job description that would be included in Standing Orders so as to avoid deviation of duties across different Health Boards/Trusts. The role would be directly accountable to the Chair of the Board and indirectly to the Chief Executive.

45. How could potential conflicts of interest for the board secretary be managed?
There would not be conflicts of interest if the role is clear, professionally discrete, with no broader operational management responsibilities. The importance and status of the role may also be strengthened if there was a professional head within Welsh Government. Making the role accountable to the Board and providing the role with powers to challenge the Board and Chief Executive team if required, as currently available for monitoring officers in Local Government. To reduce the potential for conflicts of interest to arise, it is important to

ensure a clear, corporate portfolio of responsibilities is adhered to, with the notable absence of operational aspects. No additional responsibilities should be taken on which could compromise the independence of the role.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
It is still unclear of the status of the previous Clinical Networks for Wales review that has been undertaken. The Clinical Networks have been reviewed and it is important that the work led by the service is integrated into any proposal to change the way in which the Ministers obtain clinical advice. There is often a disconnect between some of the national groups/committees and local decision making. This includes the lack of focus for health professional forums as advisory committees of Health Boards which have limited value and impact currently. We need to think about the governance models and the wider engagement arrangements for Health Boards, as to whether the Stakeholder Reference Group and Healthcare Professionals' Forum are now the right models going forward. Also, the national advisory structures require further clarity with regard to how local mechanisms link to the national arrangements.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
Legislation could ensure appropriate consultation with advisory structures/networks, however a question could be raised that this is at odds with current and proposed arrangements to engage the public and other stakeholders in service change. Advice from speciality bodies in Wales could be accessed through a reformed clinical network system given that networks engage multi-professional groups service users and members of the third sector. However, this has to relate to the nature and speed of the advice required and the membership should be widened to include professional working outside Wales.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
It is important that we fully explore the implications of the Social Services and Well-being Act 2014 and the Well-being of Future Generations Act 2015 before considering whether we need to amend the law further.

The architecture of workforce partnership needs to reflect the policy framework set by Welsh Government.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
The increasing popularity of hosted, joint and shared services has led to a complex system that is often difficult to navigate, leaving individual accountabilities unclear. We would therefore welcome consistent models of hosting and shared services, focused on a clear and well understood governance framework. However, it is not necessary to legislate as this would reduce the current flexibility and collaborative working. Integration of all-Wales services provided for, on behalf of and by NHS Wales, would result in clearer lines of accountability and performance management, focusing on whole systems benefits. There needs to be a common definition with hosted, joint and shared services and clarity of the associated governance arrangements. At present each of the current hosted organisations has separate governance arrangements, Standing Orders etc. It is not clear why these are necessary as the hosted organisations are required to comply with the host body governance arrangements. A review of the current arrangements will enable simpler governance arrangements, more consistency across Wales and also integration where feasible.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Before considering this, the current working arrangements within the NHS need to be formally evaluated and the accountability and reporting arrangements would need to be considered if such an approach was adopted. It is still relatively early days for the operation of NWSSP and the potential for it to expand is significant. Overall we are supportive of NWSSP to take on sector-wide shared services role, building on the expertise already in place and making it more widely available to other public services, benefitting Wales further. However there are significant risks that a wider expansion will make the service less responsive to the needs of the health service, which would need to be carefully managed. Currently it is a significant agenda for NWSSP within the NHS Wales context and the service hasn't yet matured sufficiently, or demonstrated enough resilience, to meet its existing customer demands to be able to extend its reach further to the wider public sector.

WGGP066 – Tessa Wildermoth – Llandudno Town Council
Tref / Town – Llandudno

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The Statutory Guidance for the Well being of Future Generations (Wales) Act 2015 places a requirement on key public bodies to work together. This should be enforced and existing legislation should be extended to apply to Local Authorities and Health Boards.

2. If so, what changes should be given priority?
There should be: i. Less reliance on the Welsh Deaneries and more links with the adjacent English Deaneries. ii. Integrated and effective amalgamation of Health and Social Services under one budget. iii. Greater investment in Primary Care.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Welsh Government should ensure that legislation and regulation reinforces joint working.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
There should be laws in place to allow for local collaboration in planning and decision making.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
The CHC's should be strengthened and made more accountable.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
No. The Ministers have access to experts. There is no need for another tier.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
No.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Only that it should be understandable.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
There should be one Governing body covering Health and Social Care.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
The existing arrangements should be strengthened.

17. What arrangements should be put in place for self-employed health professional registrants?
The arrangements should be the same regardless of employment status.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
We support this proposal, it should also include a duty to report breaches of legislation and regulations.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Strengthen the FOI Act and make NHS Wales performance figures more accessible and understandable by the public and Health staff.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
The complaints procedure should be more readily accessible and understandable.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
There should be a mechanism by-passing patient confidentiality in order to share clinical and medical information when a particular situation may have an effect on other patients, staff and future procedures.

22. How can we consider breaking down any barriers?
Computer/electronic formats are the norm in holding and sharing information. Note should be taken of the different but comparable industries share information, sometimes using different systems/formats.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Sharing of information should be for non-commercial purposes and that will be of benefit to the patient and NHS. A common standard of confidentiality across Health and Social Care would be helpful. Any scheme should comply with Data Protection Principles and be fully monitored by the Information Commissioner.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
HIW are not independent of Welsh Government. The CE of HIW stated, in her evidence in the Public Accounts Committee on 10th November 2015, that she considered the organisation to be inadequately resourced. She informed the Public Accounts Committee that HIW have only 15 investigators and, in consequence, carried out fewer investigations than she would wish. HIW requires material approval in order to raise the escalation profile (e.g. close supervision) of NHS organisation, to place a Health Board under 'Special Measures' or to close a facility as a result of adverse inspections. Members believe that HW should be able to take these actions independently.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
HIW should be fully independent and have access to sources/resources outside Wales.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
HIW and CSSIW should be amalgamated with retraining and restructuring at management level.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
CHC's are not representative of the public. Welsh Government appointments should be reduced to 25% and the third sector appointments increased to 50%.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
CHC's should retain their independence and their right to inspection. CHC's in Wales should be given responsibility to recruit directly as is the case in England with Health Watch, which has a strong set of criteria for ensuring appointments are diverse and representative. This would be appropriate for

Wales.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
No.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
Given the poor performance in managing budgets in most Health Boards/Trusts, the legislation should be tightened and improved so that financial trends can be reversed. The public want more transparency in financial/accounting matters.

32. 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?
As above.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes.

34. 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?
Where relevant the Acts should be reviewed to integrate the parts of the Acts which duplicated or overstated.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
See Q. 34.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
The socio/geo-demography of the Health Boards in North Wales renders the membership too large and unwieldy. They would benefit from some pruning of some members who have little to do.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Yes.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
Good idea.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
There should be only one strategic line of command.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
It is necessary to appoint people who have the appropriate knowledge and expertise for the position. Expertise in a different field does not necessarily transfer.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed? 42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
The membership numbers should be reduced commensurate with the demography of the board area.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?

Yes.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
There is no need for amends to legislation. The current laws should be enforced.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
The drive to share services should be incentivised rather than be subject to legislation.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
More direct workforce and less administrative bodies.

WGGP067 – Dr Richard Greville – Association of the British Pharmaceutical Industry
Tref / Town – N/A

General comments

Response to specific questions

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
There are a number of issues preventing healthcare bodies from sharing patient information including; ○ Protecting patient confidentiality when patient information is shared with other healthcare bodies ○ Making patients aware of what information is shared with whom and to what purpose e.g. ▪ the sharing of patient identifiable information amongst healthcare providers from primary, secondary and social care, or even from different care specialities, the use of anonymised information to improve healthcare services, ▪ the use of pseudonymised information with researchers for the purposes of medical research ○ Establishing appropriate information governance measures that provide confidence and trust of the sharing of data ○ Highlighting data security measures in place to protect patient information from security breaches or hacking ○ The lack of interoperability of systems (or other technical barriers) that are barriers to the sharing of information from different care settings ○ Raising the awareness amongst staff of the importance of sharing patient information and the benefits that it can provide ○ The need to address any organisational or cultural reasons that patient information is not shared

22. How can we consider breaking down any barriers?
The two key themes seem to be • improving communication, and • overcoming technical or governance barriers <u>Better communication</u> is needed, that addresses the concerns or issues for all stakeholders including members of the public, patients, family or carers, healthcare professionals and relevant healthcare provider staff. For the public, patients and family or carers it is important to highlight;

- what information is shared,
- with whom it is shared, and
- how it is shared

in order to instil confidence and trust. The importance of examples cannot be underestimated to help communicate this, and demonstrating the value achieved from sharing patient information, whether that is to improve patient outcomes, services, or the lives of patients.
The communication with healthcare professionals and healthcare staff is important to raise awareness of the objectives of sharing patient information, embed best practices in the sharing and use of patient information and ultimately to improve the maturity of using patient information in the most appropriate way.

In overcoming the technical barriers a coordinated approach is needed which is open and flexible, that facilitates the interoperability of systems, perhaps by setting some overarching principles that would maintain cohesion of the healthcare systems and avoid the development of local systems that cannot be integrated into a holistic solution.

Although healthcare systems do not always have a good reputation for implementing large scale IT solutions, this approach may allow the organic growth and integration of healthcare systems. Indeed there are examples across Europe (e.g. Estonia), where electronic healthcare systems have been implemented across care services, and these examples should be looked at for breaking down barriers.

In England, the governance of sharing information with researchers is presently being addressed through the Health Data Programme of work under the Ministerial Industry Strategy Group being led by the Department of Health and Office of Life Sciences, which should begin to come into effect in January 2016. Notably, Dame Fiona Caldicott in her role as National Data Guardian is conducting a review of data security standards and consent, which again will be communicated back to the Health Secretary in early 2016. A review and assessment of how these initiatives are relevant and appropriate for Wales should be considered.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
The purpose and use of patient identifiable information needs to be clearly articulated, particularly where it is not related to non-direct patient care outlining why patient identifiable information is needed, whether that is for research or to improve services. The pharmaceutical industry use aggregated patient information to understand population health issues and achieve a better understanding of the use of medicines on a population basis. Pseudonymised patient-level information can be used to understand the patient journey and help improve service redesign, particularly where, for example, it can be demonstrated that using a medicine early in the care pathway can lead to better patient outcomes through observational research.

The pharmaceutical industry are not interested in patient identifiable information per se but the experience of the patient through the healthcare system, and where there is a need to identify patients that, for example, would benefit from early treatment of a medicine, that the identification and follow-up takes place within the healthcare system.

The sharing of patient identifiable information for the purposes of research is likely to occur under the guise of patient consent, particularly for clinical trials or real world data studies. A key consideration for the NHS in Wales may be how it can attract and facilitate investment in the NHS to support clinical trials and real world data studies through the collection and sharing of patient identifiable information where the conditions of consent are met.

WGGP068 – Jonathan Bidmead
Tref / Town – Unknown
Sefydliad / Organisation – N/A

General comments

I attend an excellent GP surgery but they are overworked and occasionally overbooked. I was recently misdiagnosed by one of the doctors and ended up in hospital. I believe that something like a patients council should be set up within each practice, funded by the surgery. As patients are unlikely to have medical experience other than in there own complaints/conditions I believe it should be advisory only. However no-one wants a talking shop with no teeth so I suggest using the committee as a sounding board for any new ideas/procedures. Similarly patients could act as a 'complaints body' if there were any problems. I think that there should be posters up in the surgery encouraging any one who is interested to apply. I know there are CHCs but these seem to be more concerned withe hospitals.

Response to specific questions

No response to specific consultation questions.

WGGP069 – Andrea Matthews – Board of Community Health Councils
Tref / Town – N/A

General comments

INTRODUCTION

This response to the Welsh Government Green Paper "Our Health, Our Health Service" is submitted on behalf of the Board of Community Health Councils. It represents the collaborative contribution of all of the Community Health Councils (CHCs) in Wales and accommodates the views of CHCs members from all areas of the country.

CONFIDENTIALITY

In line with its own philosophy and principles, the Board entirely supports the Welsh Government's commitment to undertake its Consultations in a transparent manner and the information herein may be published in full or in part by the Welsh Government, on the understanding that such publication will not be made out of context or with the intention of misrepresenting the Board of CHCs in Wales or any of the individual CHCs across Wales.

PREAMBLE

CHCs have featured in the life of the National Health Service in Wales for longer than any other entity or institution, serving the citizens of Wales and contributing to the health service improvement agenda.

During that time CHCs have been subject to continuous change in the way they operate and how they work together to ensure that their collaborative efforts best serve the people of Wales.

THE BOARD AND THE CHCs.

This response will be in the public domain and, therefore, for the benefit of non-Welsh Government readers, there may be value in summarising in more detail the function of CHCs and their Board.

Supported by the Board, CHCs across Wales represent the interests of and act as the independent voice of the citizens of Wales regarding their NHS services. The CHCs fulfil these functions by:

(a) continuously engaging with the populations they represent and the health service providers serving those populations;
(b) systematically monitoring and scrutinising local health services, through service inspections and visits;
(c) supporting the public to engage in consultations about major NHS service changes that have an impact on them and

(d) Enable users of the NHS to raise concerns about the services they receive through an Independent Advocacy Service.

There are seven CHCs in Wales, serving the populations residing within the catchment areas of the Local Health Boards. The majority of the human resource available to the CHC movement in the Principality is provided by volunteers, not paid professionals, who champion the voice of the citizens of Wales regarding their NHS from a "lay perspective". Notwithstanding the fact that the work of CHCs is underpinned by volunteers, we stress that with the structured support of the CHC staff, our volunteer members fulfil their lay roles to the highest "professional" standards.

Amended CHC Regulations[2] came into force in April 2015. The key emphasis is to enable better consistency and effectiveness across Wales, with the CHC Board ensuring that the organisation operates to consistent standards, enhancing national as well as maintaining local capability. Work is on-going apace to develop improved ways of working to ensure the CHC strengthens its role as the 'Independent Patients Champion' for Wales. This will be accompanied by a strategy to ensure better awareness of our organisation, including a more appropriate name that better describes our function.

METHODOLOGY.

This response is informed by deliberations at local CHC level and at the CHC Board and takes into account the view of the Board of CHCs Senior Management Team comprising of the Chief Executive of the Board and CHC Chief Officers. The views of CHC staff have also been sought, including contributions made at a Staff Forum.

The process has been underpinned by contributions from each CHC. The views of individual CHCs and their members have been sought in numerous ways, including discussions at CHC Board meetings, CHC member workshops, CHC Executive Meetings and CHC Full Council meetings.

In addition to answering the specific questions posed, we have also offered comments on some general themes that emerge within each of the sections. In our opinion some important discussion points within the sections are not appropriately covered by the specific questions themselves.

CONTEXT OF THE GREEN PAPER

The Board of Community Health Councils in Wales (BCHCW) and CHCs wholeheartedly welcome this Green Paper, regarding it as a vital and timely opportunity to ensure that the health service in Wales is adequately structured to provide the right level of appropriate care for its' citizens into the future. It also provides important opportunity to ensure that the lessons identified within a number of independent investigations and reviews[3] are embedded within

[2] Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2015
[3] To include Francis, Andrews, Evans, Williams, Lloyd, Marks

healthcare delivery, scrutiny and regulation structures, truly placing the patient at the centre of all that we do.

It also comes at a time when CHCs, as the independent patient champion, are working hard to improve the way we carry out our statutory remit, driving hard towards more consistency across Wales, increasing public awareness of who we are and expanding our visiting reach (even into social care), but with the prime aim of improving the patient experience and providing support if things go wrong. We believe there is a good opportunity here to enhance the agility of the CHC, working with other organisations, to scrutinise the whole patient pathway. The drive to integrate services demands this, with the prize being a seamless healthcare pathway across health and social care, with the right framework in place to ensure robust and effective scrutiny and monitoring.

GENERAL COMMENTARY.

Integration. The report emphasises the importance of delivering a 'properly integrated service' but does not wholly succeed in clarifying what this actually means in practice. Within the NHS the drive towards integration is generally the result of concern about service fragmentation for patients and in particular the lack of coordination between community/primary, secondary and tertiary care[4]. Additionally, the CHC believe that to ensure a more seamless 'cradle to grave' healthcare pathway for the citizens in Wales, there must be a more coherent and formalised bridge between health and social care. We would also wish to see, and play a core part in, more effective, agile, consistent and coherent independent scrutiny and patient support across what is currently a break in the healthcare pathway.

Prudent Healthcare. Cognisant of over-bearing financial and staff resource limitations, it makes undeniable sense to ensure that any health interventions are absolutely necessary, are not duplicated and, importantly, cause no harm. The alternative results in unnecessary waiting lists, acute bed occupancy and wasted money. However, for prudent healthcare to gain traction, along with the subsets of co-production and Choosing Wisely, this concept must be thoroughly understood and accepted by public and patient. The CHC, employing local and national reach, can embed this within its' continuous engagement strategy. The CHC, as patient champion, also has lay representation on the Choosing Wisely project for Wales and will be ensuring the appropriate public/patient representation is achieved. The project is being led by the Academy of Medical of Royal Colleges Wales (AMRCW) and the CHC also has lay membership of this important group.

The 'three lines of defence'. The report does well to highlight and identify what these lines are, in the drive to reduce quality failures in healthcare. The CHCs sit with other statutory inspection bodies, such as HIW, within the third line of defence. Our core lay functions of gathering patient experience; continuous public engagement, advocacy and a formal inspection framework contribute to the quality of healthcare, but do not actually deliver it. A unique

[4] Nuffield Trust – What is Integrated Care June 2011

CHC strength is dedicated local knowledge and awareness, because it has a permanent footprint within each LHB area. CHC can react quickly and positively when issues are identified because it has the right mix of indigenous functions to do so. Additionally, through an operational protocol, CHC can routinely share timely intelligence with HIW, as well as with other organisations through, inter alia, the Healthcare Summit process and Concordat delegates.

Leadership and Governance. No matter how effective and how well coordinated the 'third line' is, if the first ('the ward') and second lines ('the Health Board') are ineffective, then sub-optimal care and poor patient experience will inevitably be the consequence. 'Ineffective' invariably finds root in poor top down leadership and management/supervisory functions across the organisation, resulting in poor staff motivation and, ultimately, poor patient care that may well go unnoticed.

The CHC continuously interacts at both ward and Board levels and, along with other 'third line' agencies, can identify the tell-tale patient care shortcomings that have gained root through failures at lines one and two. The issues that recently placed BC UHB in special measures are a prime example that 'line three' alone will never provide the best assurance that patient care is optimally delivered. The Green Paper does question whether the CHCs should retain an inspection function. We would argue that the findings in the Andrews Report and events in BC UHB, for example, strongly reinforce the importance of this being maintained – even strengthened, given that CHC continues to develop strong operational relationships with HIW.

NHS and Social Care. The report refers to the 2009 reform of the NHS in Wales into a more simplified structure, a prime aim being for an integrated healthcare system to work closely with local government and the third sector. That close working has developed inconsistently across Wales – the troughs and ever recurring peaks of Delayed Transfers of Care (DtOC) being one indicator that the social care 'bridge' is still not working as it should.

The Williams report [5] recommended that the CHC should extend its' Independent Advocacy Service (IAS) into social care, although it is recognised that this move would require primary legislation change. The CHC has a remit to scrutinise standards of NHS care wherever that care is delivered, including care/nursing homes and is exploring how this latter role complements the work of the Older Peoples Commissioner (OPCW) and the Care and Social Services Inspectorate (CSSIW). In addition, the Hywel Dda CHC has developed a joint initiative with the Carmarthenshire Health and Social Care Scrutiny Committee, working on such areas as Dementia and DtOC. All of these initiatives must be embedded in the necessary legislation, with appropriate resourcing, to therefore better support the patient along a seamless, fully integrated patient pathway.

[5] Commission on Public Service Governance and Delivery paragraph 2.59

NHS (Wales) 2006) Act. The CHC firmly believes that the changes required to create a fully integrated health service will require a full review of the 2006 Act. It does not provide the agility that is now required to keep people healthy, living longer with often complex health conditions and routinely receiving their care, hitherto delivered within the acute environment, within the community setting. If CHC are to deliver their IAS function into social care then the Act will need to change, as it will to support any aspirations to extend our other functions beyond the NHS boundary.

CHAPTER 1
CHANGING SHAPE - Comments and Observations.

(Paragraphs 17, 18)
Continuous Engagement**.** A core statutory function for CHC is continuous engagement with the public. Whilst we collect information from our communities we also inform them of health service changes and assist them in understanding the often complex language that surrounds them. It is too often the case that changes to healthcare delivery and underpinning culture are treated with suspicion, often exacerbated by political footballing and unrepresentative action groups. That role for the CHC has never been more important, to reach out to the broadest public/patient spectrum, and will continue to be so.

(Paragraph 20)
Languages. It is particularly important that patients can access services in the medium of Welsh. Whilst also emphasising the linguistic needs of the increasing multi-cultural community in Wales, it is vital not to forget the important needs of those with sensory loss, embracing, for example, British Sign Language for the hearing impaired or braille for the blind.[6] There is more work to be done here: for example, a recent CHC survey of Hearing Loop provision across NHS Wales identified real shortcomings within some NHS establishments.

(*Paragraphs 21, 22. See also comment in "Context" above)*
Prudent Healthcare. Prudent healthcare, along with the bedfellows of co-production and Choosing Wisely, are fundamental to NHS success going forward. This was underpinned at the Prudent Healthcare International Summit held in Cardiff on 9 July 2015. It is vital that patients see this as beneficial and not a threat and fully understand their role in this key partnership with the clinician. The CHCs are well-placed to contribute to this understanding and will champion this framework, in plain language, within its' continuous engagement strategy.

PROMOTING HEALTH AND WELL BEING- Comments and Observations

(*Paragraph 23)*

[6] All Wales Standards for Accessible Communication and Information for People with Sensory Loss, Jul 2013)

The Wellbeing of Future Generations (Wales) Act 2015 requires public bodies to "do things in pursuit of the economic, social, environmental and cultural well-being of Wales". Within this legislation there is a role for the CHC as part of the new Public Service Boards being developed in each local authority area. CHC will contribute to the development of local wellbeing plans and are well placed to provide both health service related intelligence and promote the local well-being plan at engagement events.

(Paragraph 24)
Working together to stop problems. The vital CHC relationship with their respective Local Health Boards is one of "critical friend", with eyes and ears at grass roots level gathering intelligence and views, where necessary reacting quickly by visiting NHS facilities where issues have been identified. In many instances such timely action resolves problems and prevents the situation escalating. As part of this process the CHC will routinely share relevant intelligence data with HIW. Additionally, on-going CHC patient and public engagement activity provides the opportunity to engage with the public to better understand the patient experience.

CONTINUOUSLY ENGAGING WITH CITIZENS.
(Paragraph 32)
CHC in Wales have in place a continuous engagement strategy, where we work collaboratively with the NHS, public bodies and third sector organisations to provide opportunities for patients and the public to influence NHS service improvements, development and delivery. This embraces Together for Health, requiring a working partnership with the public and full and continuous engagement with local communities. It is also designed to ensure that the 'NHS Guidance for Engagement and Consultation on Changes to Health Services (2011)', currently being updated by the WG, is adhered to by all CHC. CHCs envisage that this process will also be effective in responding to the new responsibilities placed on them under the Well-being of Future Generations (Wales) Act 2015 and their participation in Public Service Boards.

Maintenance of public trust and confidence throughout any service change programme is vital. Failure to achieve that can result in considerable concern amongst the local communities, as evidenced by the difficulties experienced in, for example, the Hywel Dda and Betsi Cadwaladr UHB areas. CHC have the capability to work closely with local communities and good collaboration with the LHB and third sector is vital in this regard. CHC recognise the importance of embracing and understanding the views of hard to reach groups, whose interests may not be adequately represented by non-inclusive action groups, who capture the media but do not represent the community as a whole.

ABM CHC comment that continuous engagement with citizens is a particularly important given that LHB/Trusts can now plan services over a 3 year period. They consider that consultation with respect to (1) "service change" poses different challenges to engaging in relation to (2) "planning priorities" and to

(3) “service user evaluation of services”. Continuous engagement should encompass all three phases.

(Paragraph 33)
CHC have successfully introduced Patient Participation Groups (PPG) in some areas of Wales, serving to capture the views and concerns of patients relating to care received from their local GP practice. They also act as a mechanism to inform the community about any service changes and are able to allay unfounded fears.

The CHCs routinely work with LHBs in developing regional Citizen Panels or taking part in joint engagement initiatives, such as those currently on-going within the Hywel Dda UHB area. ABM CHC highlight the importance of developing third sector engagement activities to ensure they are truly representative of communities, in particular the less often heard groups that would not traditionally join PPG. They point out that effective continuous engagement is resource heavy, easily outstripping current CHC resources. It is an activity that must be coordinated across CHC, LHB and the 3rd sector groups in a coordinated way, tailored to be easily understood by lay people.

ABM CHC argue that whilst LHBs are obliged to involve and consult local people in planning and delivery of services, the role of the CHC as an independent body to advise on the adequacy of that process is vital, if people are to have a meaningful dialogue and have the potential to influence services. The Andrews’ review of ABMU HB engagement efforts over the last year noted shortcomings in achieving open and realistic discussions that empower patients to properly influence the NHS they want now and in the future.

(*Paragraph 35)*
The CHCs’ statutory right to refer a matter relating to a service change to the Health Minister for decision is not taken lightly. The Green Paper is not entirely correct in saying that the referral can be made if the CHC is not content with the way the change has been consulted on. This was clarified in a Judicial Review judgement following service changes proposed by HD CHC in 2013, where CHC were reminded that they can make a Ministerial referral if the CHC has not been properly consulted, but NOT regarding the LHBs engagement processes with the public.

It is inevitable that proposed service changes are subject to divergences of opinion, with ‘political footballing’ and the activities of some action groups serving to confuse and raise unnecessary public concern. The proposed ‘independent Expert Panel’, properly constituted and empowered, might remove the need for Ministerial intervention in the case of disagreement between the CHC and LHB, with the CHC possibly being the catalyst to set up an independent Expert Panel. Properly constituted with relevant clinical expertise, with the appropriate level of independence and statutory ‘clout’, proposals could be scrutinised and potentially resolved regionally, obviating the need for direct Ministerial intervention. However, ABM CHC members echo a general view that CHCs ought to retain the right of Ministerial referral

as he/she is the elected accountable lead for NHS in Wales. The CHC Board is drawing up appropriate Standards to ensure that any decision to refer is subjected to strict criteria and scrutiny by the CHC Board.

CHAPTER 5 – BETTER INFORMATION SAFELY SHARED.

General Comments
CHC have long argued that effective, secure sharing of patient information is critical, particularly to support integration within the NHS as well as integration with social services. Given the availability and agility of modern technology, it is disappointing that patient care may be prejudiced because of poor inter-operability of IT systems – with patients with long-standing diagnoses experience delay in receiving appropriate care when moving between health-care centres. The clear benefits of Prudent Healthcare and co-production will be hampered unless patient-centric intelligence data is quickly and appropriately shared between those who need to see it.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
A fully working preventative primary care model, based upon the principles of Prudent healthcare and with the population taking responsibility for avoiding those factors which lead to unnecessary ill health, is absolutely essential in developing an equitable healthcare service. However, in spite of the Social Services and Wellbeing (Wales) Act 2014, effective partnership working between LHBs and coterminous local authorities and the Third Sector is inconsistent across Wales. On-going and often high levels of Delayed Transfers of Care (DToC), being wasteful in resources and often dangerous to patients, can act as one simple litmus test to identify breaks in the patient pathway and sub-optimal collaboration. The CHC would recommend that the Health and Social Care Act (Wales) Act 2014, along with the outdated NHS (Wales) Act 2006, be revisited together, the aim being to better harmonise the activities of the NHS and Social Care – especially at the primary care/community level. Uniformity is the goal and if integration is to work effectively then legislation must ensure the necessary baseline of approach – not leave it to the vagaries of different local arrangements. With respect to the Abertawe Bro Morgannwg University Health Board (ABM UHB) context, Abertawe Bro Morgannwg CHC (ABM CHC) report good evidence that partnerships and collaboration are being developed under the current legislative framework. Amongst other good initiatives, the Health Board IMTP shows strong commitment to this via the ARCH project, the South Wales Acute Care Alliance and GP Clusters.

Sharing best practice and learning across all Welsh Health Boards and Trusts is key to national consistency and ultimately effectiveness.

Strengthening legislation to ensure that agencies plan together to meet people's health and well-being needs is therefore key. ABM CHC cites the progress of the Bridgend Local Service Board (LSB). The Future Generation (Wales) Act 2015 makes it mandatory for named public bodies to be members of the new Public Services Board. It also creates a new office; Future Generations Commissioner for Wales, who has been given various powers including recommendations to a public body about the steps it must take to set and meet its wellbeing objectives. Whilst the Commissioner will be supported by an Advisory Panel, there is no mandatory role for CHC. In the Bridgend context, a panel has been reconfigured to scrutinise the partnership work programmes being carried out by the LSB.

The Well-being of Future Generations (Wales) Act 2015 requires public bodies listed in the Act to work collaboratively in planning services that will deliver against seven key goals. The Act places a well-being duty upon the public bodies concerned. Whilst there is every indication that partnership working is on the ascendancy, how integrated services are to be collaboratively scrutinised has not been clarified either via primary legislation or regulation. ABM CHC recommends that Policy Leads should consider whether the Well-being of Future Generation Wales Act presents an opportunity to clarify/formalise scrutiny arrangements for partnership work programmes.

Cardiff and Vale (CAVOG) CHC members have expressed concern about the costs associated with new legislation, but agree a formal mechanism is required in this case.

Hywel Dda CHC (HD CHC) are concerned that legislation may be a heavy-handed way of achieving better local collaboration and planning. Examples were offered where strong and committed leadership led to better collaboration, such as Torbay in England, where health and social care integration for older people has shown improved service user outcomes.

2. If so, what changes should be given priority?
If health services are to be increasingly delivered within the community setting, then priority must be given to identifying the mechanisms for scrutinising, monitoring and regulating those services. Without that oversight being embedded in legislation, the spectre of a Mid-Staffordshire NHS abuse scandal going unnoticed, amongst the spread of patients being cared for at home could become a tragic reality. HIW, CSSIW and CHC, working optimally together, need the statutory agility to have oversight of the whole patient pathway, along with the resources to match that task. CAVOG CHC members agree that mechanisms must be in place to monitor care in the community, in particular the standards of domestic care provided by third party organisations. This service is considered key to promoting and

retaining independence. They are also very concerned that the Health Board focus is still hospital care, resulting in insufficient investment in Primary and Community Care and primary care providers having to do more with fewer resources as funding streams are not being released. As a result primary care is suffering with the introduction of the requirement to establish sustainability panels for General Practice. Investment into primary care should be a priority.

HD CHC comment that as challenges to rural district general hospitals increase, there must be a focus on strengthening community provision. Further, a process of joint needs assessment is required as this could help NHS and Local Authorities understand their populations, providing more context in the planning process.

Powys CHC comment that as CHC members are recruited and operate locally, they are uniquely placed to capture patients needs in their area, with the CHC Board working with CHCs to develop a comprehensive national picture. Unlike HIW and CSSIW, CHCs across Wales are in a unique position being able to capture patient experience across the patient journey on a local basis, if appropriately resourced to do so.

NW CHC identify the following matters as requiring priority;

- The recruitment of more GPs and Nurse Practitioners.
- Less reliance on the Welsh Deanery and better links with the Liverpool Deanery in order to address shortages of doctors in all specialities in North Wales.
- Integrated and effective joint working between health and social services.
- Prioritising primary services.
- Greater investment in Primary Care.
- Wellbeing duties to apply equally to Local Authorities and Health Boards.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Extant legislation is based upon poor health prevention, community care and healthcare itself being delivered by Social Care and NHS care as separate organisations, but identifying where collaboration is required to achieve more effective integration. It is not enough. As outlined above, there are too many differences across Wales, where it all depends on the level of collaboration between LHBs and however many local authorities are co-terminous with them. Legislation now needs to take the 'chance' out of this vital relationship. In addition, scrutiny, regulation and monitoring of NHS care and social services lack consistency and do not seamlessly follow the patients' healthcare pathway. The Williams' report recommended, for example, that the WG should 'extend the remit of CHCs advice and advocacy roles to provide seamless support to those who use both health and residential social care services'. If the proposal to merge the roles of HIW and CSSIW is taken forward, then accompanying legislation must place responsibility on the new

organisation to ensure compliance by NHS and social care in areas of collaboration and effective joint service planning and delivery. CAVOG CHC members consider it time to fully integrate health and social care through the use of combined budgets etc., they believe that only then will a model which places the patients' well-being at the centre of public services be achieved.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
The current procedures relating to the implementation of any service changes by NHS organisations are laid down in WG Guidance . LHBs have a statutory duty to share service change intent with CHCs at the earliest stages of planning, less those urgent, operational changes the LHB must make in the interest of patient safety. Events in both Hywel Dda and Betsi Cadwaladr UHBs, for example, have raised questions as to whether this process is working effectively. Of particular concern has been the variable standard and quality of NHS public engagement surrounding service change, seriously and deeply damaging public trust and confidence should this process be sub-optimal. It may be that legislation is required to ensure that the NHS complies with the requisite continuous engagement standards, in line with the Standards for Public Engagement in Wales . CAVOG CHC would wish to see the CHC role strengthened in legislation to place CHCs as the lead citizen engagement organisation. They placed priority on developing effective continuous engagement methods relating to service changes, in order for public and patient input to fully inform decision making.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
The unprecedented pace of service change within the NHS, as well as the necessity of establishing a more meaningful relationship with social care, has indicated that legacy practices of engagement are not fit for purpose. Getting sensitive public engagement right first time is essential: not doing so can mean a loss of hard-won trust and confidence that is difficult to recover. Whilst each LHB region is different, in terms of demography, geography and health provision, there are consistent, permanent engagement mechanisms that must be adhered to. Patient Panels and PPG are some specific ways to discharge this remit, but this general function should be a statutory, consistent requirement, embedded in the routine that the public are familiar with. Any statutory mechanisms put in place should clearly outline the CHCs independent engagement role, but with LHBs/Trusts working closely with the CHC in such activities. This joint working does not compromise CHC independence: the aim is to ensure the public receive a clear understanding

of the changes proposed and can influence the process and outcome.

CAVOG CHC believes patient participation groups/panels risk becoming insular, focusing on the treatment of conditions rather than service planning. There is also the risk of individuals with the "loudest voice" being heard, rather than the whole community. Previously, LHBs and NHS Trusts had established such groups, however the agenda was set by the NHS and they became talking shops. There are a number of organisations who have responsibility for patients/service user and public engagement. This can often be confusing to the public, especially when the NHS, CHC and 3rd Sector attempt to engage sometimes with slightly different agenda and terminology. Coordination is required – we would suggest that this is a valid role for the CHCs.

CAVOG CHC members suggest that if the CHCs are to be THE voice of the public and patient, they should have a statutory lead to do this, approving all engagement activity in partnership with clinical leads.

CAVOG CHC also raise concerns about the effectiveness of Stakeholder Reference Groups (SRG), established by Health Boards since 2009, and whether they are in a position to effectively challenge Health Boards on service change – given their composition. It is recommended that SRG be subject to a full formal review. CAVOG members suggest that in this process consideration is given to passing some SRG functionality to the CHC, thereby empowering organisations to feed views to the Health Board via an independent organisation.

CAVOG CHC suggests that LHBs and NHS Trusts include engagement within their Integrated Medium Term Plans (IMTP), for approval/endorsement by the CHC as is currently the case with the Annual Quality Statement.

HD CHC comments that engagement should be an integral Health Board/Trust function, but without a means of independent facilitation it may not be meaningful. CHCs should be placed centrally within public engagement and with a strengthened role and responsibility. CHC experience is that many people are uncomfortable about openly discussing issues with a body that provides their care – leading to reluctance to discuss these candidly in a forum run by Health Boards/Trusts. An example is where NHS staff, who have also been patients, want to share experiences but not identify themselves.

NW CHC is of the view that there is need for a truly independent organisation to undertake engagement and consultation. CHCs have that independence and are trusted by those who have had experience of their work.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
This proposal is supported in principle, but it is really important that CHCs do

not lose their right of referral should statutory discussions with the LHB/Trust fail to achieve agreement. It is acknowledged that this right is an action of last resort and should be used wisely. However, the current methodology is for CHC to refer direct to the Health Minister, and for the CHC to have suggested an alternative clinical service model to that proposed by the LHB. The CHC is a lay organisation so the latter is intrinsically difficult to achieve.

There is some merit in replacing the Ministerial referral option to a referral directed to a national expert panel, independent of the LHB in question and outside political influence. The panel must be constituted with the appropriate expertise to consider the grounds for referral and take an informed decision. CHC Regulations would need to be changed accordingly, and the statutory role of the CHC in relation to the panel given careful thought. It is important that this method in no way devalues the process, but essentially achieves a better opportunity to resolve a matter effectively, probably using the same expert grouping the Minister would apply, post referral to him/her.

It is suggested that WG give some thought as to whether the Academy of Medical Royal Colleges in Wales (AMRCW) might form the basis for this panel. Given the proliferation of 'advisory panels' within Wales, it is further suggested that reform here might consider the creation of an Expert Panel.

CAVOG CHC members note that the only power that CHC have in relation to service change is the referral to the Minister. They consider that this in itself is enough of encouragement for the NHS to enter into dialogue where there has been disagreement, if this was lost then the CHCs role in representing the public and patients would be significantly weakened.

HD CHC comments that referral does provide the opportunity for greater expert scrutiny on proposed changes when key issues remain unresolved locally. In their opinion this strengthens the emerging service model with regard to Women and Children's services in HD UHB.

HD CHC acknowledges that proper application of any future referrals is vital but every effort must be made to ensure that catalysts to preventable/inappropriate referral are removed. As an example, current rules can force a CHC decision (whether to refer or not) too early in the post consultation process. Given the experiences within HD, the LHB consulted on principles relating to its' strategic direction as it felt it could not develop more detailed implementation plans until agreement in principle had been reached. However, the CHC felt it could not agree principles without the necessary detail in order to understand more fully the impact on patients. This limits the window for adequate CHC decision making.

NW CHC members believe that a national expert panel would be seen by a sceptical public as an instrument of the Minister, appointed by Welsh Government, and in consequence, would lack credibility and accountability. NW CHC members strongly dispute the Minister's suggestion that a referral is always a failure and consider that in certain circumstances, it is the only option available to CHCs. The CHC is also of the view that CHCs should not

be expected to produce their own costed plans and consider this requirement impracticable and unworkable. CHCs are made up of lay people and are not resourced nor have sufficient expertise to develop alternative plans.

The Board of CHCs has established a framework of national standards relating to Service Changes, within which the CHC Board has a key role in supporting and advising CHCs should a referral be considered necessary.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
If organisations are increasingly working with partners beyond their own statutory boundaries, it clearly follows that those boundaries MUST be bridged with the appropriate legislation. Failure to do so could result in unacceptable variation, at the expense of good quality and consistent patient care. Effective integration of health and social care is the prize: that integration can only be achieved through statutory obligation, not leaving it to chance. It may well be that on-going deliberations around the redrawing of local authority boundaries may reduce the obstacles preventing, for example, coherent LHB – local authority relationships. No matter how comprehensive legislation is, quality of care and co-operation in doing that relies on having the right staff in place – achieved through effective and rigorous recruitment and selection. Effective leadership is key, starting with the Chief Executive, Board Executive Directors down to the senior member of staff at ward level. Good leaders do not learn their craft entirely from books: it is a quality in itself and requires headroom for personal development. As evidenced by recent events in Betsi Cadwaladr UHB, failure to lead by example, failure to motivate and ensure effective management throughout every level down to the front-line, inevitably impacts on high quality front-line care. The casualty is invariably the vulnerable patient.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
The existing “duty of quality” dates from 2003 (Section 45 of the Health & Social Care (Community Health and Standards) Act 2003). It is based on acute services and does not embrace integrated care. It is therefore strongly recommended that it be subject to urgent review, incorporating the differences within an integrated healthcare system that has developed at a different pace and to inconsistent standards across Wales. It also follows that clear standards and consistency follow the patient into the complexity of a developing social care/community care framework. Powys CHC wish to see clarity in relation to the CHCs potential lay role of keeping pace with the patient experience across health and social care

services pathway.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Whilst there must be legislation in place to ensure that standards for quality of care are complied with, that legislation counts for little when staff actually delivering patient care fail to achieve those standards. The issue is compounded when poor levels of leadership, management and supervision fail to either notice or address sub-optimal care quality within that organisation. 'Care comes from the heart – you can't learn it from a book'. Staff Nurse We would suggest that an effective leadership behavioural framework be firmly established within each NHS organisation, against which rigorous performance management takes place to ensure quality is paramount. We are unsure that legislation is required to ensure this, just the minimum standards of effective leadership and supervision through sensitive staff recruitment, from top to bottom in the organisation. Powys CHC commented that quality must be put at the forefront of all decisions and joint decision making. The CHCs main 'driver' is about the quality of service, rather than the budget, and CHCs endeavour to ensure that this focus is maintained.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
We would caveat that whilst effective legislation is required, there must be adequate provision to ensure that effective local leadership and governance (1st and 2nd line) is in place to ensure compliance – the 3rd line of defence, no matter how good, often comes into play after a healthcare incident has occurred. The principles within the Regulation and Inspection of Social Care (Wales) Bill equally apply to NHS provided healthcare: if the two are to integrate effectively they must be contained in the same legislation. The drivers for the Bill include Mid Staffs and Winterbourne. The role of the 'responsible individual' must be clearly defined and designated as such in all posts where the delivery or supervision of healthcare is a core function. This is particularly important when a patient at home receives care from a multi-agency/discipline team: someone must be responsible and accountable.

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
The fit and proper persons requirements (FPPR) focus on assessing an individual's honesty, integrity, suitability and fitness and are able to discharge the roles and responsibilities of the job. The new FPPR standards were introduced in England in November 2014. Whilst legislation can be applied to ensure that the qualities required of a particular post are met, there is no

substitute for ensuring effective and regular supervision/validation within existing governance measures. This is a matter of good leadership and culture: failure to achieve that standard could mean that lapses are only identified after evidence of poor care is found (such as Tawel Fan in Betsi Cadwaladr UHB). The FPPR concept and test should be applied to all those who have responsibility for patient care.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
There is a sense that Integrated Medium Term Planning (IMTP) is more driven by targets and planning to ensure that functions remain within funding parameters than actually the quality of the healthcare provided. We believe that existing legislation should be reviewed to ensure that the principle of prudent healthcare – applied across the whole integrated NHS landscape – has pre-eminence at all stages of decision making. Prudent healthcare, along with the subsets of Choosing Wisely and 'co-production', should not be fashionable buzzwords, but a culture that has a close relationship with the citizen/patient at its very centre. If we are to promote quality through the IMTP process, then it needs to demonstrate that learning through effective Concerns handling, for example, is properly resourced and managed. Legislation may well be required to ensure that the IMTP has a 'people-centred' focus and that quality of care IS at the core. It might also be worth considering how the IMTP might act as the 'planning bridge' for extending the patient pathway into social care. CAVOG CHC members suggest that an integrated plan should include all aspects of Health and Social Services and that this seems to be missing in the current planning landscape. CAVOG believe that to develop a well-rounded plan the planning cycle should include all three elements namely the NHS, Social Services and the Citizens.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
We would support the proposal made in the Marks' Review of HIW that common standards should apply across all health services. It also follows, particularly as integrated healthcare gains traction and to reflect the complexity of healthcare provision in the community setting, that there is a requirement for all providers to have a legal obligation to comply with common standards. As mentioned elsewhere in this response, common standards

should apply to a common pathway that embraces all health care from cradle to grave. If this were achieved then it would also lend some credence to the proposal of merging the function of CSSIW and HIW, where coherent and consistent scrutiny of common standards along the pathway might be better achieved.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
CHCs support the view that a common standards framework covering both the NHS and independent sector, closely aligned to those developed for social care, is essential. This framework surely underpins improved outcomes for citizens and, in turn their experience of the care received. Prevention of ill health and effective delivery of healthcare intervention and rehabilitation is obviously dependent on more than just the NHS. Reducing hospital admission at one end and maintaining DToC at a consistent zero at the other is the prize. Community care requires several staff working for different organisations in a coordinated way: the same patient expects the same standard. CAVOG CHC are concerned that if there are common standards, then there should be underpinning legislation so ensure compliance by healthcare providers other than NHS. The common standards should be understandable and well publicised so citizens know what to expect. ABM CHC comment that the governance framework underpinning collaborative initiatives should make clear what information the public and patients are entitled to have, how such information will be shared, how quality assurance will be derived. Currently, where a collaborative service fails, a service user is able to receive NHS Advocacy support in respect of NHS delivery, but not that of partner organisations. The better practice would be for services to be structured to provide an integrated experience to include accountability in the event of service failure.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
There is a danger that accreditation can sometimes be little more than a 'tick-box' exercise. Where accreditation is applied it should be done using external mechanisms. The same would apply to peer review – too often such appraisals of those responsible for delivering high standards of care fall victim to time constraints and sometimes a laissez faire attitude to the requisite standards required. There should be a robust and auditable system of validation to ensure that these processes are carried out. For example, the Health and Care Professions Council (HCPC) has in place ten standards for the healthcare professions within its remit. The HCPC sits in London and relies upon effective governance structures within distant employing organisations to monitor compliance. Using the recent issues within Betsi Cadwaladr UHB, these effective structures might be missing and therefore

require clear, enforceable and regular validation.

Further downstream and should legislation allow, it might be worth considering a patient satisfaction standard or charter-mark produced by the CHC for private care homes.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
It is imperative that the citizen has confidence in any mechanism for clinical and peer supervision. This should be a transparent process and applied to all clinical staff across all sectors. From the patient's perspective we would expect that all health professionals are appropriately supervised via mechanisms that work effectively. Whilst regulatory bodies such as the HCPC have recently introduced 10 new standards for the 16 healthcare professions under their jurisdiction, they expect the employer (the LHB, GP Practice, Trust) to ensure compliance locally and regularly. Healthcare professionals are expected to 'reflect' when things do not go as they should. The reality of endemic understaffing leads to lack of time to learn from the experience – with the excess paper work impacting on the time available to provide safe care. Care can only be improved by recognising mistakes and issues and to discuss care quality at certain points in the career of a clinician. Time to do this is at a premium and if legislation is required, to galvanise this requirement, then the CHC would support it. It is understood that the GMC are currently working, via the Law Commissioners Bill, to rationalise and improve the way all clinical staff are regulated, using common standards.

17. What arrangements should be put in place for self-employed health professional registrants?
The same criteria should apply (see question 16) for self-employed professionals, although a clear framework of peer supervision should be available, possibly through the LHB within whose area the individual practices. GMC, NMC and the HCPC produce Standards of conduct, performance and ethics. They set out in broad terms the behaviours expected from registrants. They need to reflect both public expectations of professionals and the high standards that professionals expect of each other.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
The CHCs wholeheartedly support the introduction of a statutory Duty of Candour. '…the introduction of the new Duty of Candour is potentially the biggest advance in patient safety and patients' rights in the history of the NHS'. Peter Walsh, CEO of AvMA and former Director of CHCs in England and Wales The report of the Francis Inquiry proposed that health and care professionals should have a 'duty of candour', meaning that they should be open and honest with service users and their carers when something has gone wrong with their care, treatment or other services provided. The 2014 Evans Review 'Using the Gift of Complaints' found that the NHS in Wales appeared to be in a state of 'lock down' when it came to openness and transparency. In terms of effective complaints handling, along with the fear of litigation should the word 'apology' be used at an early stage, this situation was the cause of immense service user frustration. Too many resolvable complaints find their way unnecessarily to the Public Services Ombudsman, the inherent costs and delay serve no one and, above all, result on poor learning within the NHS body concerned. ABM CHC Advocacy Service raises the issue of candour in relation to NHS primary care. Where frank disclosure might raise issues of qualifying liability, GP practices often have their responses reviewed by their medical defence union before releasing them to complainants. The complainant is therefore left uncertain that the response has disclosed all pertinent issues including those that might be detrimental in tort. A duty of candour for the NHS might go some way in addressing this. Whilst the duty of candour might be enshrined within legislation, it can never really work effectively within a NHS organisation that is poorly led from top to bottom, the staff are poorly motivated and feel they are 'at risk' if mistakes are admitted (that 'blame culture' was identified in the Evans Review). The CHCs Advocacy Service has often struggled to achieve timely resolution for clients because 'candour' is missing from the primary behavioural fabric of an LHB. The CHC would suggest that the strapline 'being open when things go wrong' accompanies the term 'candour': when the HCPC reviewed their standards recently they found that 'candour' was not always well understood by clinical staff, service users and carers. The CHC would also recommend that this 'duty' is embedded within training for ALL NHS staff, and forms a key part of regular staff briefings.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
The CHCs have too often found that LHB Board meetings tend to reflect largely on corporate successes rather than place primacy on dealing with shortcomings/complaints/concerns and ensuring they are being rectified. To do so would only increase public confidence in the service, confidence that has been severely damaged in areas such as the Betsi Cadwaladr UHB. The CHC has also found a remarkable 'distance' between the 'Board and the Ward', where front-line issues, well known to the service-user and often reported by the CHC, never seem to reach top-level management. Legislation could be used to ensure that all LHB consistently, regularly and routinely make clear, jargon-free and understandable performance figures available for public consumption: and that their continuous public engagement mechanisms work effectively. The requirement should be enshrined within Model NHS Standing Orders for health boards. But, once again, legislation should not override the need for effective leadership and corporate governance – there is a tendency to over-legislate when all that is required is the encouragement of an open and honest NHS culture where transparency is the normal way of behaviour. CAVOG CHC considers that the current reporting mechanisms they have seen are complex and not public friendly and have persuaded some NHS organisation to make their reports more user friendly. NW CHC suggests that the Welsh NHS adopts identical and directly comparable measure to NHS England; that the information should be made available to the public so that they can compare performance and make informed decisions about their healthcare. They also call for the strengthening of the Freedom of Information Act and that NHS Wales performance figures should be made more accessible and easier to understand.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
As the integration of care between health and social care providers further develops, with more patients being looked after at home within a community setting, the more it is likely that a care-related concern or complaint will inextricably combine both NHS and social services factors. To extricate one from the other might be inappropriate and serve only to delay a resolution, as well as failing to contribute to the process of 'learning' – so vital if integration is to learn from mistakes. It is suggested that the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 be reviewed to see how they might be further amended to better bridge the gap between NHS and Social Care. In the Commission of Public Service Governance and Delivery Report, Sir

Paul Williams recommended 'extending the remit of CHCs advice and advocacy roles to provide seamless support to those who use both health and residential social care services'. The CHC would generally support that as being in the best interests of the patient travelling along the continuous care pathway, but to do so would require major changes to primary legislation as well as having major resource considerations. CAVOG CHC members hold a strong view that the current complaints system needs to be streamlined with both NHS and Social Services using the same process "Putting things Right". The CHC further suggest that the powers of the Public Services Ombudsman are extended to allow for independent investigation of issues arising when services have been provided through a combination of public and private services. ABM CHC comment that whilst the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, provide for joint investigations between NHS organisations, the user experience is that investigations are laboured and take an inordinate length of time to reach an outcome, even where the issues are fairly simple. More work needs to be undertaken to streamline processes perhaps by setting deadlines around information sharing between providers and encouraging organisations to arrange joint meetings with a view to early resolution. With respect to joint investigation of social service and NHS complaints, when things go wrong the user experience of the complaint process ought to be seamless. Legislation that allows for joint investigations and the sharing of information in response to concerns would be welcome. Currently, patient confidentiality is cited as a reason why separate NHS and Social Service investigations are undertaken. NW CHC members and staff believe that legislation in itself is not the answer to improving the performance of the NHS complaints system. Staff development will provide a more effective answer. Furthermore, they believe that there should be a contractual obligation on all NHS staff to engage with the complaints process and comment that many senior clinicians are able to avoid co-operating in the concerns process.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
One main cause is that the seven LHBs in Wales essentially operate independently of each other, with inconsistent approaches to handling patient-related information/intelligence. Add to that the different systems used by other providers such as GP Practices. For example, the DATIX risk management system could be the medium for collating all

concerns/complaints and clinical errors across Wales, establishing trends, the provision of actionable intelligence and informing learning. Instead, LHBs use the system differently and, in fact, are currently using different versions of the same system.

The Data Protection Act 1998 is often used as an excuse as to why information sharing does not take place. The Act is, in fact, a proper safeguard not an obstacle, as long as the proper provisions, supported by the patient, are in place. This was very much the spirit of the seventh principle within the 2012 Caldicott Review.

Patient Confidence. Recent headlines of cyber-attacks on personal records dent public confidence in the security of public-information systems. Patients worry not only about systems but also about who legitimately shares potentially embarrassing personal information.

22. How can we consider breaking down any barriers?
The whole Prudent Healthcare framework relies on effective sharing of patient-related intelligence. ABM CHC comment that patient centric data is not currently shared effectively across organisations and used as it should be because of system inconsistencies. The development of Prudent Healthcare, along with the subsets of co-production and Choosing Wisely, will be a good opportunity to break down barriers and gain the confidence and understanding of the patient as to why their information must be shared. It is also recommended that the term 'Prudent' might be better clarified in the same context as 'Candour', so it is seen as a route to better healthcare rather than cheaper healthcare. The CHC believe it is important that the patient and public have a strong voice in the development of national IT systems for the NHS. Whilst ensuring that these views are used to shape the IT system itself, this involvement would go a long way to dispel some of the public concerns about the confidentiality and utility of such systems. As well as introducing a uniform IT sharing system for all NHS organisations, this must come with a safe bridge into social services and all those who provide care for an individual in the community setting. Given the multiplicity of providers in this area, great care will be needed to ensure confidentiality of information. It is not just the healthcare providers who must share information effectively; it is those who scrutinise delivery services. The CHC has in place a working Operational Protocol with HIW. This allows for the regular and routine sharing of intelligence derived from their respective activities. The CHC shares anonymised patient information derived from its' Advocacy service with HIW, helping to identify trends and to focus inspection activities. Ruth Marks' recommendation to embed this function as a two-way duty is supported, as it is for all NHS providers.

23. What are your views on the collection and sharing of patient identifiable

information for non direct patient care, such as research? What are the issues to be considered?
The CHC generally supports this activity as being in the best interest of the patient, for example, in cancer research. Obviously this information must be safeguarded, with patients confident that is will be used to benefit and not misused. CAVOG CHC stress that citizens must be fully informed from the outset, ensuring they know who would have access to their data and give the opportunity to opt out. Processes for sharing and safeguarding information must be fully and transparently audited, with any breaches and relevant corrective actions placed in the public domain. Once more, a clear and transparent engagement programme is required, to reassure the public that information is not directly being used for the financial benefit of drug companies and the like. This type of question should be embedded within the co-production framework, a relationship where patient trust can either be instilled or diminished

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
As outlined in the Green Paper, HIW currently require ministerial approval in order to raise the escalation profile of an NHS organisation. A recent, high profile case was where Betsi Cadwaladr UHB was placed into Special Measures. Given that all of the evidenced indicators necessary to take that step were available, HIW should have been able to take that step without recourse to political intervention. It is the CHC view that HIW should be given full statutory independence to make such decisions, subject to close discussion with colleague inspectors/regulators and the CHC. A forum to enable this would be the Healthcare Summit process, within which patient/public related intelligence provided by the CHCs can be aggregated with other information. It is recommended that the basis for Healthcare Summits, which enable all-Wales, multi-agency intelligence sharing, are also embedded in related legislation.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
The CHCs are of the view that HIW does enjoy effective operational independence, but that legislation is required to provide the strategic autonomy necessary so that decisions to the benefit of the patient and public are transparently free from political intervention. The changes necessary to do

this should be made within the supporting legislative documentation. This would enhance public confidence overall that NHS scrutiny is independent in every sense.

However, if legislation is to be changed to allow such changes for HIW, before doing so it is timely to examine the future role and function of HIW, where health and social care should be subject to coherent scrutiny across the patient pathway. This naturally calls into question the current separate role of the CSSIW.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
There currently exists a Memorandum of Understanding which sets out the relationship between the WG and both HIW and CSSIW, who are component parts of the WGs' Directorate for Local Government and Communities. HIW and CSSIW do work closely together and there are strategic agreements and operational protocols to allow for this to happen. In their Operational Plan for 2015-16 HIW also intend to carry out joint work with CSSIW. This level of agreement does not require legislative change and, subject to both parties agreeing and resources are available, it works relatively well. However, given the ever increasing, over-arching requirement to provide seamless scrutiny along the entire patient pathway, we consider that legislation to improve joint working may not provide the strategic agility and focus that a single, combined organisation would offer.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
It is recommended that the role and function of the Care Quality Commission (CQC) in England is examined in this regard. They cover both health and social care services in England and their current, improved structure has been built upon the lessons identified in the Francis Inquiry report. The general public in Wales is generally confused over who does what in health and social care: one organisation covering both, discharging a clear remit with the ordinary person at its heart, would inject a better understanding and a greater level of confidence across the population. One disadvantage might be that a single organisation would be too large and bureaucratic, although this was a lesson incorporated within the CQC's current mandate. The CHCs believe that the Green Paper should be putting frameworks in place that stand the test of time, and that 'half-way house' legislation should be avoided. Thus we recommend that a single inspectorate be examined in some detail, rather than tying two separate organisations with numerous Operational Protocols and MOU umbilicles connecting them. CAVOG CHC identified the advantages of having two organisations able to

focus on their current remits, but also identified the need for greater collaboration in the sharing of information. CAVOG CHC suggests one inspectorate with two definitive arms supported by a central secretariat. The CHC acknowledges that cost implications may prevent the abolition of the two organisations into one and believe that HIW and CSSIW should decide on the best way forward.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?

The strength of the CHC lies in its' statutory remit to discharge four key functions, all of which are inter-related and provide the optimum framework to represent the patient voice in the most comprehensive way:

- An independent advocacy service;
- A right to inspect NHS premises;
- Public and Patient Engagement activities and
- Measured responses to NHS service change proposals.

These functions are strengthened because individual CHCs have a permanent local presence within each LHB area and are familiar with local health service and local population and nurture a trusting, honest relationship with the NHS organisations in their area.

Recent discussions with senior, former Association of CHCs in England Wales (ACHCEW) staff highlight their real concerns that what replaced CHCs in England, Health Watch, simply does NOT achieve what Welsh CHCs currently do – even bearing in mind the shortcomings identified in the Longley report and others. Hywel Dda CHC emphasise the general CHC concern related to the adequacy of any system/organisation that sought to replace the main existing CHC functions here in Wales. Both the evaluation of Local Health Watch by the Kings Fund and the Francis Inquiry did not consider that this new organisation in England is working effectively.

Aneurin Bevan CHC puts emphasis on the fact that CHC Members are appointed to represent the interests of patients and the public in the NHS. This is achieved through "systematic deliberative engagement" whereby members of the CHC have the opportunity to consider "multiple information streams" to inform their decision making, including that of patient experiences of services, health policy and strategy and through independent monitoring of the quality of services from a patient perspective.

With that in mind, there is widespread concern that the really positive contribution made by CHC now, plus the tangible steps in train to strengthen that capability, should not be swept away as they have been in England. HD CHC highlight the improving role of the statutory Services Planning Committee, as well as the mutually supportive role CHCs have with the Public Health Wales agenda, in raising the profile of the 'wellbeing' programme.

All of this draws into sharp focus the importance of the CHC volunteer membership. The Board of CHCs must we feel, have greater, or indeed full self-determination over the appointment of its' members, rather than relying on the three outside agencies to do this. This would be a positive step towards ensuring we have the right people to discharge a demanding function, and to seize opportunities to widen the diversity of this group. CAVOG CHC reinforces this view, describing the current system as cumbersome and difficult to navigate. For example, some high quality co-opted members who wish to become full members are discouraged from doing so because of the cumbersome WG interview process. They also feel that CHC membership should be based on the population and geography of the CHC, rather than 'one size fits all'. Additionally, the cumbersome recruitment process results in most CHCs experiencing serious shortfalls in their membership cadre.

With all this in mind, CHC members and staff emphatically disagree that CHCs should, in future, 'step back' from activities such as inspections or service change proposals for the following reasons:

Inspections
It should be noted that currently CHC volunteer members are the main workforce to undertake statutory "inspections". These volunteers are "lay" people approaching the work from a "lay" perspective. However CHC members are vetted, trained in the CHC inspection process and work to a strict Code of Conduct, able to be mobilised at short notice to undertake targeted unannounced visits. Current maximum membership across all seven CHCs is 276, as well having the ability to co-opt additional members as and when required.

CHC Regulations clearly state that the CHC has an inspection and scrutiny function. There has been some debate about changing terminology, to use the term 'visits' rather than 'inspections', the latter term being the source of much discussion between the CHC's purely lay and HIW's both peer and lay inspection functions. The 'visits' would still be regular, often unannounced and formal in nature, embracing the two key elements of patient engagement and observing the environment in which the care is taking place, the latter being an invaluable element of the now defunct Hospital Patient Environment (HPE) programme. Our intention is to include the core HPE elements into our future visiting regime. Hywel Dda CHC point out that CHC visiting achieves the aims of targeted patient engagement, or the testing of specific questions relating to patient experiences in certain services where concerns may have arisen.

Given that HIW and CHC both have 'inspection' functions, the fast developing Operational Protocol between the two organisations ensures that inspection activity is complementary, driven by shared intelligence and field activities coordinated wherever possible. The Protocol allows for joint inspection activity to cover off both peer and lay functions with the organisations working together. It is clear that peer and lay members working together offer the most comprehensive and complementary overview of patient care. The contents of a recent HIW Dignity and Essential Care Inspection Report (DECI)

reflect approximately 2/3 of the content is lay-derived and the remainder peer. CHC members are currently taking part in a HIW-lead GP inspection programme across Wales and developing ways of working effectively together.

Powys CHC would like to further develop joint inspection activity with HIW beyond what they are currently doing with GP practices. They further comment that current legislation enables CHCs to undertake inspections visits cross border in England, where many patients from Wales access services. HIW does not appear to have this function.

Aneurin Bevan CHC considers that the right of entry and inspection and offering the patient perspective of services (through a lay membership) is crucial to maintaining public confidence in the NHS. People generally do not want to make a complaint, but they do want to know that someone independent of the NHS will pursue their concerns. Through the triangulation of the intelligence received from enquiries, complaints, surveys, inspections and performance monitoring, CHCs are able to spot areas of concern, to prioritise CHC activities and inform the NHS where action is required to drive standards back to the optimum level. This enables CHC to influence the NHS quality agenda by ensuring that the patient perspective is at the centre of that agenda.

CHC conduct inspections on a very regular basis, where each week across Wales CHCs are observing and reporting on the quality of care provided, and are in direct contact with patients, families and carers. The loss of our rights to enter and inspect NHS premises would restrict the CHCs ability to utilise our information streams to effectively support the quality agenda. CHCs are the only organisations that can triangulate and provide such a broad range of lay intelligence. They can also act with immediacy when they receive reports of patient concerns about the quality of care provided and we maintain the view that the people best placed to identify the quality of the service are those that receive it.

To remove inspection/visiting from the CHCs' statutory remit would seriously erode our ability to function as the 'patient champion'.

Service Change Proposals
The drive to place patients at the centre of health policy, strategy and service planning is to be commended. It will however require a paradigm shift in NHS culture to achieve the goals of "Prudent Healthcare". The challenges of the complexity in which participatory practices are suited to the modernisation of Healthcare services, a focus on clinical and managerial imperatives, and the cost of meaningful engagement may hinder the progress of the Prudent Healthcare agenda, without full consideration of the opportunities CHCs current core functions can provide. It would be inaccurate to assume that CHC duplicate the role of the Regulators of the NHS. CHCs enhance the role by providing crucial intelligence on the day to day delivery of services and the patient experience.

The copious literature on participation expounds the virtue of "deliberative participation" which offers people the opportunity to consider all available information, provide learning opportunities, and the reconsideration of their hitherto positions on effective and efficient delivery of healthcare. This model of participation is employed by CHCs in Wales to great effect in reducing special interest bias and taking a whole systems approach to decision making. The strength of CHCs is the ability to offer a set of principles, underpinned by a commitment to diversity and equality, within a coherent structure, with common purpose and goals for the benefit of patients.

A key CHC statutory requirement is to establish a Planning Committee, where the LHB and CHC discuss any changes to the service delivery framework. The NHS is statutorily obliged to consult with the CHC at the earliest stages of any proposed service change. This process informs the basis for a continuous engagement strategy with the public, by both the CHC and LHB working jointly, obviating wherever possible the need for formal consultation. (See also response to Questions 4, 5 and 6).

Where formal consultation is deemed necessary, the CHC will work closely with the LHB to ensure widest possible engagement and input from the public into the process.

The general public are invariably suspicious of any change to services and can be fiercely protective of them, even when faced with compelling clinical reasons that change must take place. As events in both Hywel Dda UHB and Betsi Cadwaladr UHB have shown, the erosion of public trust in the NHS adds a layer of suspicion and robust opposition from the public, exacerbated further by action groups and inevitable political footballing. The CHC has a key role to play in ensuring a full understanding of the service proposals by the public and to represent the widest capture of public opinion to the LHB while at the same time demonstrating independence from the service providers.

Given that public engagement and consultation is a key aspect of service change proposals, it is illogical that the CHC should 'step back' from this key representative function. The issue surrounds the current CHC right to make a Ministerial Referral related to service change. This is an action of last resort when all other avenues have been exhausted. It essentially projects the failure to agree, at the local level, into the national political arena.

If the right of Ministerial Referral is removed, the CHC should have the option of elevating service change concerns elsewhere. It may be that an appropriately constituted, independent Expert Panel could provide that alternative, to carefully consider the alternatives and have decision-making powers. Failure to agree at panel level could require Ministerial involvement or involvement of the Chief Executive of the NHS in Wales at that point

Aneurin Bevan CHC identifies that CHCs are the crucial local link between those who plan and deliver the National Health Service, those who regulate it, and those who use it. CHCs Independent Scrutiny and Monitoring of the NHS are essential components of the quality agenda for the NHS in Wales, and as

such affords each CHC the opportunity to focus their activities based on the priorities that emerge within their geographic areas of responsibility.

Legislation
The 'light touch' changes to CHC Regulations, effective from April 2015, primarily focussed on the role of the CHC Board to ensure the organisation operates in a consistent manner across Wales and adheres to uniform standards set by the Board. Work is currently underway to refocus CHC activity, supported by an organisation based upon a matrix management model, combining geographical management with functional management. To weaken any of the CHC main functions would weaken opportunities for intelligence gathering and subsequently the quality of intelligence and information CHC are currently able to share with other organisations. A key benefit and feature that the CHC has over other organisations such as HIW, is one of local reach but also national impact.

The Green Paper makes reference to the National Social Services Citizen Panel and CAVOG CHC questions the legitimacy of this group which has no visible public presence and are of the view that such a Panel will only serve to weaken the voice of the citizen.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?

CHCs were reorganised in 2010 to be coterminous with the newly formed Health Boards. CHCs are Independent organisations that have independence of decision on the scrutiny and monitoring of local health services and the outcomes of their deliberations on service planning, performance and service change. However, it must be noted that CHCs are not autonomous organisations and are accountable to the WG through the Board of CHCs in Wales for their performance and delivery of National Standards in conducting their activities.

If integration of healthcare is to succeed, then the means by which it is inspected, monitored and regulated (cognisant, still, of the line 3 of defence) as a whole will need to change. In this scenario we consider it essential that the public and patient retain a strong, statutory and independent voice that represents their concerns – and they trust it to do so. The current CHC model has the mechanisms in place that could extrapolate from the NHS into social care, but the supporting legislation currently does not allow us to do that. As we have found with our right to enter Care Homes, we can only focus on NHS care, not other environmental factors that have a mighty impact on the residents' dignity and quality of life.

Following the amendments to CHC Regulations from April 2015, the CHC is actively exploring more effective ways to discharge our function, particularly embracing the recommendations within the Longley report (June 2012). One of our key, unique strengths is that we are permanently based within the LHB area, enjoying strong local reach with the communities there and have a good understanding of their healthcare needs. We are improving our national

impact and strength by establishing consistent standards across Wales, and a review of how we organise ourselves to discharge that is currently underway.

For the future, CHCs must have the agility to carry out their functions beyond the remit of health and into social care – following the patient pathway from primary care, through secondary cares and onto whatever location the correct level of health care is being delivered in the community. These functions would be directed nationally and delivered locally to established standards. Similarly, the CHC advocacy service should also be able to follow the patient's experience via the patient pathway as recommended in the Williams review.

It is recognised that meaningful expansion of the CHC remit into social care will require primary legislative change and necessary resourcing to achieve that, with careful consideration given to the scrutiny functions currently discharged by local authorities. HD CHC discussed the Northern Irish model of 'Patient and Client Councils (PCCs) as a good model that covers both health and social care services. HD CHC also notes that there appears to be public demand for CHC to help them when care issues span both NHS and social care arenas. As integration gains traction, with health and social care increasingly inter-dependent, it seems inevitable that this trend will only increase.

CHCs fiercely (and rightly) protect their independence to act for people and to represent their interests within the NHS. CHC rights of Independent Scrutiny and Monitoring of the NHS, is not a luxury but an essential component of the quality agenda for the NHS in Wales. Recent reports on the scandals in the NHS in England have highlighted the need to sustain a lay scrutiny and monitoring of the NHS in England, we have seen many attempts to reinvent CHCs since they were abolished in 2003. It would be incongruous to change the current model of CHCs until the current model of Health Boards and Local Authorities are reorganised to deliver "in a more integrated system".

Comments received from Aneurin Bevan CHC clearly demonstrate recognition of the emerging integration of some services, and the different patient pathways across Health Board areas. They are mindful that each Health Board and Local Authority will retain the right and responsibility to plan and deliver services for their respective populations which is funded and focussed on local needs.

CAVOG CHC believes the current CHC model is fit for purpose. For more integrated services then a partnership CHC approach should be considered. This approach is already taking place in relation to the All Wales Collaborative and the Acute Healthcare Alliances where CHCs have formed federations to consider cross boundary issues.

As already outlined, the CHC enjoys a constructive and growing relationship with HIW, via an Operational Protocol that allows for intelligence sharing, coordination of inspection activities and opportunities for joint working. Work is in hand to see how similar relationships can be developed between CHC and

CSSIW. Inter alia, HIW also works closely with CSSIW and other inspectorates. It is recommended that the operational and strategic relationships be more fully developed between CHC, HIW and CSSIW, before considering mergers or transferring functions (such as 'inspection) from one to another. Working effectively, the CHC lay 'patient/public voice' can mutually support the other two organisations, but legislation would be required for CHC to extend into social and independent care sectors.

NW CHC considers that some form of organised independent public scrutiny of NHS Wales is necessary. In the light of the Andrews Report, the Lessons Learned Report, Tawel Fan, the Evans Report, the HIW/WAO Report on Governance at Betsi Cadwaladr UHB and the subsequent Special Measures and the recent report to the Minister on the operation of BUHB by Ann Lloyd, it is not credible to claim that Independent Members of Local Health Boards can fulfil the function of holding the NHS to account. The key formal check and balance is currently the CHC movement and the experience of the abolition of CHCs in England in 2003 and subsequent "replacement" organisations suggests that it would be better to strengthen CHCs than to radically transform them.

On a related note, the name of Community Health Council has only served to confuse and does not in itself accurately describe the role and responsibilities of CHCs. The CHC is currently considering a new name which would provide a clearer definition of the role of CHCs.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
On the face of it CHCs would generally support this proposal, as long as the appropriate funding safeguards are in place. It would allow NHS organisations to responsibly plan their future spending and seize opportunities as they present to the benefit of the public and patients they support. ABM CHC capture the situation within ABM UHB, where the IMTP describes a current over-spend of £17m with a projected over spend of £35m. Whilst CHC members are concerned about mandating for unfettered borrowing powers, a concern shared by HD CHC, it is appreciated that financial forecasts for ABMUHB might require new and innovative solutions. Any Health Board borrowing powers must be tightly framed, and should be based upon actuarial evidence that supports each Health Board's case for eventually paying back of the debt. Borrowing should also be subject to consultation. North Wales CHC expressed similar concerns that: a) Given that LHBs have limited means to generate income (nor should this be their focus) it is difficult to see how repayments (especially over periods longer than 3 years) could be achieved without potential risk to patient care.

b) NHS organisations will be using taxpayer's money to service any private borrowing. Ultimately, WG would be responsible for the debt if a LHB got into financial difficulties. It might also mean that the WG would have no control over LHB borrowing decisions and be open to huge potential future liabilities. In practice WG would have to underwrite any such borrowing. If LHBs are able to raise money on private markets this might undermine the current Business Case process and result in unplanned and uncontrolled development of NHS services which are not part of a planned health economy. There is much to be learnt from the English system where Foundation Trusts have been able to borrow money for over 10 years and they can borrow only up to a limit agreed by an independent regulator. This limit is set based on the ability of each individual hospital to service the debt.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
CHC believe this is still relevant. This facilitates openness and transparency with public money. Patients and the public in Wales have a right to know how money is being spent on health services nationally and locally. Furthermore, the language and format used should, as far as practicable, be free from impenetrable accounting jargon so that the public can understand how public money is being spent. NW CHC believe that given the poor financial performance of all Welsh Health Boards it is difficult to see why existing rules should be relaxed at this time. From a patient perspective, the current requirement to produce two sets of summarised accounts may not add anything to the information produced by individual organisations and the rationale for how and why summarised accounts are produced as they are is unlikely to be understood by many.

32. 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?
Recent changes in legislation as contained in the NHS Finance (Wales) Act 2014 relates to the financial duties of Local Health Boards and to NHS Trusts. The Act changed the statutory financial duties of Local Health Boards from one single duty to two financial duties, i.e. (S175) (1) to ensure that expenditure does not exceed the aggregate of the funding allocated to it over a period of 3 financial years, and (S175) (2A) to prepare a plan and for that plan to be submitted to and approved by the Welsh Ministers. Further direction is covered in Welsh Health Circular 2015 (014). It is considered that these recent changes provide sufficient legislation so long as that the correct level of governance is applied to ensure compliance. Furthermore, such plans should be included in LHB/Trust public and patient engagement strategies and activities articulated in a clear concise manner to

inform the public, aid understanding and facilitate discussion. Transparency remains the key driver for any changes in reporting. NWCHC comments that until there is better LHB financial performance, increased flexibility needs to be earned on the basis of consistently good financial stewardship.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
The National Health Service Finance (Wales) Act 2014 gives effect to the WG proposals in 'Together for Health' to introduce a more flexible finance regime. It provides a new legal financial duty for LHBs to break even over a rolling 3 financial years rather than each and every year allowing flexibility to manage resources and expenditure. It is the view of CHCs that this statutory planning duty is extended to NHS Trusts i.e. Public Health Wales, Velindre NHS Trust and Welsh Ambulance Service NHS Trust. The Well-being of Future Generations (Wales) Act 2015 aims to simplify and streamline strategic planning for public bodies in Wales to ensure the needs of the present are met without compromising the ability of future generations to meet their own needs. Public Services Boards (PSB) are a key to the planning system at local level. PSBs will be in place for each local authority area in Wales and members of the Board will include the local authority, local health board, Welsh fire and rescue, the Natural Resources Body for Wales, with invitations to participate being extended to Welsh Ministers, Chief Constables, Police Commissioners, local County Voluntary Sector along with "other partners" under which Public Health Wales NHS Trust features as well as the CHC. Other than Public Health Wales NHS Trust, the remaining NHS Trusts i.e. Velindre NHS Trust and Welsh Ambulance Services NHS Trust do not feature. To meet the objectives of the Bill i.e. promoting the well-being of future generations, representatives of these Trusts should be included and play an active part in the planning process. To achieve this end, CHCs consider that the statutory planning duty be extended to NHS Trusts and that NHS Trusts as well as Health Boards are included in the activity of Public Services Boards. Powys CHC proposes that CHCs across Wales should be part of their Local PSBs.

34. 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?
We refer to our response to Question 1 where we identified that in spite of the Social Services and Wellbeing (Wales) Act 2015, effective partnership

working between LHBs and coterminous local authorities appears to be inconsistent across Wales The CHC recommends that the Health and Social Care Act (Wales) Act 2014, along with the outdated NHS (Wales) Act 2006, be revisited together, the aim being to better harmonise the activities of the NHS and social care – especially at the primary care/community level. These would then facilitate the delivery of the well-being objectives contained in the Well-being of Future Generations (Wales) Act 2015.

We stress the need for clarity in regard to the requirement to consult and engage the public in planning and design of services. Current planning arrangements involving multiple agencies can result in a lack of clear accountability in relation to these requirements and affect the ability of patients, public and their representatives to influence at an early stage.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?

We have already highlighted earlier in this response the careful balance required between setting legislation, directions and formal Standing Orders on the one hand and the existence of sound leadership and governance within NHS organisations on the other. The two are essential partners. It naturally follows that a properly led and constituted Board, an effective Chair-Chief Executive relationship, with independent members properly exercising their own core functions, are pre-requisite. CHCs believe that appropriate leadership is a fundamental part of the future success of the NHS. Responsibility and accountability sits with the Chief Executive: greater focus on appropriate leadership rather than expertise in health matters is essential.

The CHC would highlight again the ‘distance’ between Ward and Board that is sometimes apparent to us. When staff on the front-line tell us that they have no idea who the Director of Nursing is, that ‘Free to Lead, Free to Care’ is unworkable because they neither have the time to care nor the headroom to manage even the simplest thing on their ward area. When we observe and report on shortcomings at the line 1 level – be it high levels of DToC, under-staffing or trends derived from what patients tell us - but not picked up through LHB governance systems - the CHC will always work closely with the NHS to the mutual benefit of the patient. The CHC reinforces and complements good LHB governance; it is not a substitute for it.

Partnership working, especially as we develop an integrated healthcare system embracing health and social care, often means sensibly breaking new ground. Whilst legislation and standing orders can accommodate the broad parameters within which this should take place, it is down to good leadership, direction and initiative to seize the opportunities.

Against this background, the CHC would certainly recommend that the Local Health Boards (Constitution, Membership and Procedures) (Wales)

Regulations 2009 are now thoroughly reviewed. This should be done in light of the salutary lessons identified in the Francis Review and, more locally, recent events in Betsi Cadwaladr UHB, the Andrews Review and the Evans Review, as examples where poor governance, leadership and supervision had a direct effect on patient care.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
The Green Paper usefully stresses the importance of effective leadership throughout the organisation, ensuring good governance from top to bottom and serving to motivate and therefore optimise LHB output. Insofar as the Board is concerned, if the Chief Executive does not possess the necessary leadership qualities, no matter how good the membership is and how it is constituted, it is unlikely to succeed. Recent events in BCUHB are a case in point. There should be minimal ideological distance between ward and board and back again. There have been cases where CHC representatives at Health Board meetings have identified a clear disconnect between Board discussions and the reality of what is happening on the ward frontline and, on occasion, only superficial relevance paid to placing 'public and patient' at the centre of things. The CHC fully supports the comments made within the 'Andrews One Year On' report , where it states that strong Board leadership is fundamental, with the WG recognising the need for effective board level leadership which is 'transparent and inclusive'. It goes on to state. 'It is important that boards take ownership so that staff have the confidence and belief that when issues are raised with senior management they will be taken seriously and will be dealt with competently….all board members must play a full and active part in the leadership of the health board'. Adequate training MUST be provided for ALL board members, to ensure they understand exactly what their remit is and can discharge it effectively. Powys CHC believes that Health Boards should be more democratic with a more strengthened role for independent members to challenge the work of the executive directors. In that vein, the chief executives and executive directors should not be able to vote in health board and board sub-committee meetings on papers and proposals that they themselves are promoting. HD CHC feel that CHCs could work more closely with Board Independent members through engagement and visiting activities in order to equip them better to provide real challenge at Board meetings. An example of this was a recent step to undertake Emergency Department joint visits between HD CHC members and independent Board members. Taking all this into account, the CHC would strongly recommend that WG take

stock of the several leadership and governance failures that have been a feature in some health boards recently, identify the causes and take the necessary actions to reform boards accordingly.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
CAVOG CHC comments that if the CHC is accepted as the independent, statutory voice of the citizen/local community then this role could be discharged by the respective CHC Chair.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Generally, HD CHC feels that joint appointments can strengthen those roles where integrated working is a core activity. More specifically within public health the English model of universal joint appointments is relatively recent and the nature of public health influence means that evidence of effectiveness of such a move takes some time. Accepting this, the theory behind joint appointments is sound and the social determinants approach to health and wellbeing is the natural territory of local government. A formal evidence review exploring such a change would be welcome. HD CHC hope that any move toward joint appointments would strengthen the ability of public health departments to provide needs assessment and analysis to inform NHS decision making, as within Hywel Dda service development plans have not always demonstrated an understanding of local need. This can increase the sense of medical logistics being the primary driver of service change rather than local needs.

NHS Trust size and membership

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
CAVOG CHC believes that a CHC representative should attend NHS Trust Boards as is the case with Health Boards.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
The role of the Board Secretary acts as the guardian of good governance within the LHB. The requirement for this role was introduced as part of the restructure of the NHS in Wales in 2009, although it is not established in regulation (albeit reference is made to the role within the model Standing Orders for LHBs and Trusts). The role is crucial to the ongoing development

and maintenance of a strong governance framework within LHBs and Trusts. Independent of the Board, the Board Secretary should report directly to the Chair, and in doing so acts as the guardian of good governance within the LHB.

Significant failures in governance result in poor healthcare for patients and the public. Earlier reviews, such as the governance review of Betsi Cadwaladr UHB have identified the importance of the role of the Board Secretary and demonstrated the effect if that role is compromised.

The role remains under-developed across NHS Wales, and many NHS organisations appear to have continued to limit its effectiveness by adding other responsibilities to the post. In some cases, this has resulted in a span of responsibility that is too wide for one individual to carry out effectively or has created an inherent conflict between the 'independent advisor' function and an operational delivery responsibility.

Defining the role more clearly within statute would help more firmly establish and protect the integrity of this important role.

44. If so, what aspects of the role should be additionally set out in law?
Powys CHC suggest that the post of Board Secretary should be a designated statutory post, and that legislation should be framed to enable the post holder to give advice, and to be protected if the Board decides to ignore the advice given.

45. How could potential conflicts of interest for the board secretary be managed?
As set out above, to protect the integrity of the role: • the responsibilities placed on the Board Secretary should not include any executive or operational delivery function • the Board Secretary should report directly to the Chair of the Health Board or Trust

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees? 47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
We would refer to the WG Advisory Structure Review aimed at developing a "more effective and effective advisory structure for both the NHS in Wales and the Welsh Government" and support the recommendation that a single Joint Professional Council replace the 32 committees and groups acting separately. We believe that any clinical advice provided to WG should be independent and impartial and that no change to statutory status of committees is required. From a patient perspective, policy and service delivery should be informed by

expert advice and patient views. It is important that structures have the flexibility to ensure that the right people are involved at the right times in the right decisions. Recognising that some expert groups are better organised and exert greater power and influence than others, any structures should seek to encourage balanced participation. We would note that the Board of CHCs is the lay member of the Academy of Medical Royal Colleges in Wales, a non-statutory advisory committee to WG which offers independent advice on a wide range of healthcare issues.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Workforce partnership arrangements are unlikely to have an immediate impact on patients and the public. However consideration should be given to possible future impact of any proposed changes, both in relation to time spent away from patients in any 'Wales specific' negotiations and on staff recruitment and retention in the case of increased divergence in terms and conditions between UK countries. Powys CHC is anxious that any Wales solutions do not adversely affect patients resident in Wales, for who access to and treatment at hospitals in NHS England is the most convenient and appropriate.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
Any measures to improve transparency in terms of accountability could be of benefit to patients and public.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Any change should only be considered if it is not to the detriment of NHS service, and that it will ultimately lead to improvement for patients and the public. CAVOG CHC expressed concern that the organisation might become too difficult to manage and as this is a hosted organisation should this become an entity in its own right and if so who would it be accountable to?

WGGP070 – Peter Martin – Hafal
Tref / Town – Neath Port Talbot

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Yes. We think that there should be an increased emphasis on the health and wellbeing needs of people with a serious mental illness. Many of these illnesses, such as schizophrenia, are not preventable (although we know that some actions can help minimise risk), but the consequences, e.g. greater poverty, poorer accommodation, fewer job, training and educational opportunities, etc. can be prevented. We think that health and social services should be fully integrated and have fully integrated budgets to meet the needs of people with a serious mental illness.

2. If so, what changes should be given priority?
Making it mandatory for health and social care services to have integrated budgets, integrated performance management systems, integrated IT systems, integrated management arrangements, integrated policies and protocols and integrated services.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Although we think it is sensible to have a focus promoting health and wellbeing and preventative primary care, there are still people who, through no fault of their own, become ill. We agree that care and treatment should be a priority for those with the greatest health need, in line with prudent healthcare principles, and that a higher priority should be given to the health and wellbeing needs of people with serious mental illness.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Yes. We believe that the starting point for service change within health services must be based on the needs of people who use, and will use, those services. The new Social Services and Wellbeing Act already sets out the duties on Health Boards to undertake local population assessments, but we

think the duties on Health Boards need to be far more robust, detailed and prescriptive.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Yes. But we believe that there should not be a one size fits all approach to engagement and involvement. We think that establishing patient panels and/or participation groups is one part of the process of engagement and involvement, and that it is important to ensure a wide and diverse range of views, ideas, proposals, etc. are sought, including from people who may not always be content or comfortable being part of a formal panel/group.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Yes. The King's Fund's *Lines of Defence* model, which outlines what it sees as three 'lines of defence' against quality failures in healthcare, and is described in the Green Paper, crucially misses out the point that it is patients/service users themselves and/or their families/carers that firstly need to be easily and freely able to voice their concerns, be listened to and taken seriously about the quality of care they are receiving – without the fear of receiving lesser treatment. Quality assurance is discussed as if it is merely a process/system with some vague connection to patients/service users, rather than about a system that foremost must be about and centred on the needs of the people who use services. We think that individuals, carers and families must themselves have the major say over whether or not they are receiving a high quality service, and be able to state their views freely and without fear. Our view is that quality assurance begins and ends with the experiences of the people receiving a service. We strongly support what paragraph 39 says, *'NHS in Wales is clearly committed to putting quality at the heart of the services it provides'*, and goes on to say how a change in mind-set and behaviour is what is required, and that Boards should create *'the right cultural conditions for quality healthcare'*. However, we think this is easier said than done! We agree that quality needs to be at the heart of everything the NHS in Wales provides, and that to help enable this every Health Board and Trust must have: • A clear vision • Clear and focused direction

- Strong leadership that does not tolerate a mind-set that accepts poor quality
- A clear focus on establishing what the top priorities are, and sticking to them
- A culture that celebrates successes and learns from mistakes
- A robust performance appraisal system that recognises high quality practices, and identifies and rectifies poor performance (including where quality falls below the high standards expected)
- A clear and transparent process for healthcare professionals to raise concerns about quality without the fear of retribution, and for each Health Board and Trust to state and make this clear to all of its staff

We believe that these important principles should be enshrined in legislation, and be open to judicial challenge when they are not being applied.

WGGP071 – David G Matthew – Immune Deficiency Patients' Group, Wales
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority?
There should be less emphasis on law changes and more on managing the process; legislation may be necessary to shift the emphasis to the individual to take responsibility for their health.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Legislation should really only be used to direct agencies to work together with appropriate policing to ensure this is done.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
We do not believe that legislation should be applied to patient groups as in general, a more informal approach is more effective.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
The Patients' Group approach, if this permits us to engage the NHS hierarchy directly with their customers/patients is believed to be more effective voluntarily than through a complex process of legislation.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
It is considered that a national expert panel would be beneficial, provided that the quality of such a panel was of a high calibre and that it would promote and

carry out necessary action. If these pointers are in place there should not be a need to involve Ministers in this process.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section? 8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
Delivery of quality services is all about management and personal commitment from staff at all levels and is not seen as a matter for a legislative approach per se. Perhaps a Total Quality approach as has occurred in manufacturing industry should be initiated as a Journey involving staff at all levels.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
We do not believe that quality decision making should be subject to legislation; this should be at the heart of what is done daily. There is concern that the process of empowerment, when taken down to non qualified staff levels, dilutes the work of professionals in Nursing and Clinical areas. This can compromise the core activity of patient care.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
Provided that any proposed legislation in this regard can bring clarity to the role of the “Responsible Individual”, this could be supported.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
A Fit and Proper persons test should be governed by and embodied within a clear hierarchical management structure, rather than legislation per se. Such a structure must however be fully effective at all levels

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
We repeat the potential for a TQ approach to be initiated in the planning process as well as that of service delivery, on the basis of Communicate, Agree and Implement.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Healthcare standards should be enshrined in the ethos of the NHS and where this is inconsistent, then the basis of setting standards should incur change.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
There is merit in a common standards framework where this covers both medical and alternative therapies to benefit the customer[patient] in both public and private sectors.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
There is a need if anything to simplify the work of clinicians and nursing staff and whilst accreditation and peer reviews are desirable, it must not be allowed to sub optimise the valuable time of professional staff.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Again, this should not need legislation if the management process is effective and it has to be if the service is to restore and build confidence in both staff and patients. Health care registrants should indeed have the opportunity for peer supervision but it has to have the backing of strong management and not detract from service delivery.

17. What arrangements should be put in place for self-employed health professional registrants?
There should be clear guidelines established and adherence to these would need a clear and effective monitoring process.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within

the NHS in Wales?
In this case, there is probably a need to have a legislative framework to ensure the duty of candour is carried out; confrontation is not an easy process for many and thus such guidelines would be helpful.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
There is a danger that over reliance on statutory powers could require more cost in the form of creation of non added value jobs and thus diversion of limited cash resources away from patient care. Focus should be on management and peer pressure to perform, day in day out.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Joint investigation into service failure could be strengthened by ensuring that a robust procedure is followed through limited legislation along these lines. Each job description should, in any event, be very clear on personal accountability.

WGGP072 – Richard Bevan – Aneurin Bevan University Health Board
Tref / Town – N/A
Sefydliad / Organisation

General comments

Thank you for the opportunity to contribute to the consultation on the above Green Paper. This response to the consultation is made on behalf of Aneurin Bevan University Health Board. The response has been developed following engagement with the members of the Health Board and also the Health Board's Stakeholder Reference Group and our Healthcare Professionals' Forum.

We would like to thank colleagues form Welsh Government who presented to our Board in joint session with the above groups, and facilitated a discussion on the key issues. This was very helpful in framing this response.

Therefore, this response reflects a range of views from across Aneurin Bevan University Health Board on the key consultation questions, but it also offers, where appropriate, suggestions for issues and areas of further consideration by Welsh Government and the NHS in Wales.
As you will be aware, Health Boards were established in 2009, following the restructuring of the NHS in Wales, which resulted in the establishment of seven integrated Health Boards along with three NHS Trusts. Since that time, Health Boards have begun to realise the potential of the benefits of integrated organisations, which were expected when they were established. Aneurin Bevan University Health Board has a range of positive examples of innovative internal and external joint working and partnership working, which are benefitting local populations in our area.

Therefore, given that Health Boards are continuing to develop and are beginning to realise some of the originally intended outcomes of integrated organisations, it is considered that this is not the time to use this Green Paper to prompt further fundamental structural change in the NHS in Wales. However, it is considered that the Green Paper offers the opportunity to resolve and 'tidy-up' some of the governance architecture, reporting and accountability issues that have become apparent since the NHS reorganisation in 2009. It is considered that these changes could facilitate clarity for the NHS in Wales and also resolve some of the uncertainties that currently exist in the operation of current structures and systems of governance and reporting.

Stability within the NHS is extremely important at a time when the full implications of the Social Services and Well-being (Wales) Act 2014 and the Well-Being of Future Generations (Wales) Act 2015, which will be fully effective from 2017 are beginning to be understood. It is also important that the NHS takes into consideration the recommendations made within the

Williams Review 2014 (The report of the Commission on Public Service Governance and Delivery), given that fundamental to the success of NHS delivery is its relationships and co-ordinated delivery with Local Government and particularly social services.

Whilst the full implications of the Social Services and Well-Being (Wales) Act and the Well-Being of Future Generations (Wales) Act are not yet fully understood, their introduction will potentially transform the way health and social care systems operate. Health Boards, themselves, however, are also further changing their approaches and the ways in which they work through the development of GP clusters/Neighbourhood Care Networks (NCNs) in the Gwent area. It will be helpful that any changes to or clarification of existing legislation being considered as a result of the NHS Green paper is developed in such a way as to take into consideration and respond to these existing changes in order to compliment and be consistent with these new emerging partnership arrangements and changing governance structures and processes.

As health and social care services increasingly work together to define and deliver against agreed aims and objectives through Local Service Boards and Public Service Boards, the current governance and management models operated by the NHS and local government in Wales may require further change and refinement. The role of Welsh Government (in its broadest sense) in leading and managing this transformational change is pivotal and clarifying this as part of any legislative change would be helpful. Therefore, it is suggested that any new legislation that might be drafted should positively encourage the delivery of an integrated health and social care system across Wales, which better meet the needs of the population of Wales.

A theme of the Green Paper is also with regard to ongoing engagement with the public, patients and partners. This will be critical for the success of the NHS in Wales and how this is best managed will require detailed consideration and planning, particularly with the new legislation as outlined above, and local developments such as NCNs. However, there is already a network of existing partnership governance arrangements and the ongoing role of these structures such as Local Service Boards and the Public Service Boards will also need to be clarified going forward.

However, it is suggested that much of this clarity and required review and clarification is possible without the need to consider further legislation. Certainty and clarity is required about arrangements in partnership, but this is also true with regard to existing arrangements within Health Boards and Trusts. However, the current statutory instruments for Health Boards are often too prescriptive in respect of issues such as, Board membership, Board Committees and Advisory Groups and appointments of associate members. It would be helpful to review the current frameworks for Health Boards and make adjustments, where required, or use to better effect the current framework we have in place. However, this will need to be undertaken between Welsh Government and NHS Wales to be clear about what

relationship and holding to account arrangement Welsh Government wishes to have with Health Boards/Trusts going forward.

Therefore, it is important to recognise that the current overall governance and structural arrangements in NHS Wales have not been designed per se, but have grown and developed over time, sometimes to plug gaps in the original arrangements put in place at the time of reorganisation or to respond to new issues as they have arisen. However, it is suggested that this has not always been thought through in terms of their potential implications and new arrangements have been established, which were expedient for the issues at hand, but the governance implications of these approaches were not always fully appreciated. Therefore, this has led to the establishment of a number of Groups/Joint Committees at an All Wales level. These have all got differing governance and accountability and reporting arrangements and can be causes of tension and uncertainty.

Examples include:

- Welsh Health Specialised Committee
- Emergency Ambulance Services Committee
- NHS Shared Services Partnership
- NHS Wales Informatics Service

In addition there are a number of “hosted” organisations, again with different hosting arrangements. Examples include:

- NHS Wales Delivery unit
- 111 Service
- Emergency Medical Retrieval and Transfer Service Cymru (EMRTS Cymru)

There are potential opportunities through this Green Paper to standardise and rationalise these arrangements e.g. through the establishment of a single All Wales body to manage/host these arrangements and the functions that are currently managed via joint committee arrangements.

However, there is perhaps a further dimension which is not fully explored in the Green Paper, which is the culture, values and behaviours of the NHS in Wales and those we are looking to instil, develop and mature over time. Evidence clearly indicates that it is culture that may have a more profound and positive impact on the way services are provided than legislative change alone. There is some evidence that legislative change can have the opposite impact leading to unintended consequences encouraging adversarial behaviours and leading to potentially poor decision making and disenchantment with systems. Therefore, perhaps the critical factor is that legislation alone will not necessarily lead people to modify and change behaviour to achieve the desired outcomes for citizens. Therefore, this would suggest that legislative change should be seen as the course of last resort and not the first tool to be used to change the approach and success in delivery of the NHS in Wales.

The remaining elements of this response provide perspectives from the Health Board on the key questions asked within the consultation document.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The Green Paper is helpful in support of the current integration agenda both within the NHS and with partner organisations, particularly with social care. The proposals seek to ensure that we are all working to the same standards and expectations and have clear and transparent systems. The Green Paper therefore could be used as a mechanism through which the current legislative and regulatory landscape in health and social care in Wales can be tidied up and clarified. Therefore, if this document can be the prompt for further action on revising and harmonising the governance, performance, reporting, inspection and regulation regimes across the public sector in Wales in the interests of improving and ensuring quality and maintaining high standards, it should be welcomed. However, it is not clear that we require further legislation to do much of what is contained within the Green Paper. In many areas we already have the provisions, regulations, codes of practice and statutory instruments, which could be adjusted or implemented fully to provide the framework and changes that are being sought within the Green Paper. Key to the Green Paper will be further shaping arrangements and plans going forward to ensure that citizens, patients and service users are at the heart of any redesign and service delivery. It is patients and service users who get caught up in the differences between public services and the gaps between organisations and if these proposals could help with this and make decision making and taking in the interests of citizens more streamlined, this should be welcomed.

2. If so, what changes should be given priority?
Preventative primary care services is an important area in support of the wider health and well-being agenda. However, if we want primary care to further step up in this way, we will need to give a clear leadership role NCNs (clusters) with clear accountabilities, responsibilities and deliverables. They will need to be adequately staffed, financed and supported, but what we want to avoid is this approach developing new complex bureaucracies for new organisations, as this would run counter to what the Green Paper is seeking

to achieve. However, clearly governance frameworks will need to be established to enable this to happen. Therefore, this is an area where further consideration should be given to the ways that this could be enabled through a clear framework of governance in Health Boards and between statutory and third sector bodies, if we are to genuinely to extend the role of NCNs to cover health and social care for our citizens in local communities.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Integration of services is important for patients and service users, but again these arrangements have brought challenges of their own regarding governance, accountability, financing and staffing. If this Green Paper can again look at this to clarify these arrangements, especially community based accountabilities, we believe it could be really powerful, especially if there is a focus on clear alignment with the new Social Services and Well Being Act and also the Future Generation Act. Otherwise, we will be seeking to streamline and clarify the health and social care position through this Green Paper, whilst more complexity is added through additional legislation elsewhere within the Government's programme.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
The document highlights as crucially important openness, transparency and good access to accurate and timely information. This is key to taking this area of work forward if we want to be trusted and been seen as candid with regard to our services and the work of our organisations. Also, the building of trust needs to be achieved and demonstrated through our actions every day as public servants and organisations, but also through positive continuous engagement and good communication. It is about how every member of staff demonstrates these qualities and approach and are supported to understand and further develop these values and behaviours, which then reinforces our organisational communications. The Health Board in the last year has agreed a new Engagement Strategy alongside our existing Communication Strategies and in recent months a new Engagement Team has been established, which is already actively working within local communities and with interest groups. Therefore, it is not proposed that any additional legislation is required to make this happen consistently. The provisions are already in place, it requires further cultural change at organisational levels to make this a consistent reality.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement

mechanisms, such as patient panels or participation groups?
The NHS and partners need to ensure that we engage with citizens, patients and service users to ensure they have the opportunities to be clear on their needs and 'wants' from community to community and not assume we know the answers. Therefore, the principles of continuous engagement and co-production are crucial here. We also need to think about community based approaches, such as community mobilisation where responses and solutions are grown from within communities with our support rather than saying it is just the responsibility of individuals to improve their own health and well-being. Many communities and interest groups will need support and their actions will need to be enabled in order to sustain them. However, it is already a requirement of organisations to continuously engage with its citizens – therefore, it is not considered that this needs to be made a legal requirement, in addition to the range of mechanisms that are already in place. The NHS needs to ensure that arrangements are in place to continuously engage and make sure that the citizen's voice is a fundamental part of everything that the NHS proposes, plans and delivers. Additionally, there could also be a focus on young people and using 'new' media to facilitate their engagement. Many of our required consultative approaches are quite traditional and episodic rather than having a continuous dialogue with communities and we should be harnessing new technologies to facilitate this for some of our groups and communities.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
The concept of the Expert Panel is an interesting one, however, the Health Board is not sure that this is true engagement and consultation, if decisions are then referred to an appointed panel. If the concept is to be taken forward the Expert Panel would need to be independent, be accountable, credible and have clear legitimacy in the eyes of communities. However, to tick these boxes will be a challenge. The role of the CHC in our area to make judgements and advise and provide constructive challenge on these matters currently works well.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Ensuring quality will rely on clear organisational structures, clarity of accountabilities and a well understood and reported performance regime. If these are clarified through this Green Paper and expectations are made clear both organisationally and individually then this could have a positive effect on

behaviours and cultures to ensure safe and high quality care. We need to allow people to focus on the key roles of caring and providing high quality services and that organisationally the NHS provides the environment and support to enable that to happen. It is therefore, not proposed that additional legislation is required to make this happen.

This is far more organic than that and needs to be part of the values and culture of the organisations, the attitude of its staff, its focus on standards and the performance and audit regime that is in place to test against these standards to ensure organisations can be satisfied that their services and care are safe and of a high quality. We also need to ensure that patients and their families and carers are at the heart of assessing whether experience and quality of services are good.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
The Green Paper should be welcomed in terms of the proposals to review, simplify and streamline the complex and complicated governance and reporting arrangements within NHS Wales, which have built up over time. Therefore, proposals such as these, if they can streamline arrangements, make accountability clearer and ensure clear delegation without the need for close management by Welsh Government would be helpful. This will enable empowerment, responsibility and accountability at organisational level. However, it is not proposed that additional legislation is required to make this happen.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
We have recently introduced the new Health and Care Standards in Wales and it will be important that that this common framework is clearly embedded and the intentions of the standards are delivered for patients. Therefore, with the other range of regulations, codes of practice and professional regulations in place it is not proposed that additional legislative measures are required. The NHS in Wales needs to be clear about our duty of candour to patients and their families. Promptly identifying negligence, actively responding to complaints in a timely and open way and also providing redress for the patient and their family should also be encouraged, as it has worked well in our area. However, these principles of openness and candour need to apply from the design and agreement of plans and care plans for patients and not come as part of redress or part of investigations. If we apply these principles in our design and delivery of services and the approach and behaviours of our staff, the expectations and experience of patients, their families and their carers should be more clearly understood. As a result they should receive the quality service we intend and they require. Key to this will be how we measure quality and how citizens play a key role in that measurement.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
It is clear that organisations need to have good leadership to ensure that it meets its responsibilities. These individuals need to have the right skills and competencies to fulfil their roles. NHS organisations already have accountable officers and the Board is collectively accountable for the work of the organisation. The collective effectiveness and individual effectiveness of organisations already have a range of external and internal tests and individual roles have annual assessments of their effectiveness (PADR). However, the adequacy of these collective and individual mechanisms might therefore, need to be reviewed. However, it is difficult to comment further on the concept of a 'responsible individual' without more definition of the concept and also the role profile. This role vis-à-vis collective responsibility and accountability will also have to be understood. However, it is not proposed at this stage that there should be any change to the current accountable officer status.

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
Please see above. It is difficult to judge the merits of this without further information.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
We have a range legislation that is already focusing on these areas, such as the Future Generations Act and the Social Services and Well Being Act. What we need to do is ensure clarity and connectedness between all these areas including the proposals within this Green Paper. Otherwise, even with the best intentions of these strategies and approaches they will run in parallel and will not effectively connect and will continue to promote silo approaches rather than connected planning and delivery. Therefore, is it proposed that clarity and alignment of the NHS and partnership Planning Frameworks is required rather than additional legislation.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
The new Health and Care Standards have only recently been launched and seek to provide certainty for both staff and citizens and provide a key frame through which judgements can be made about the quality of services that are required to be delivered by organisations and also a lens through which citizens can make a judgement if a quality service is being provided and also

identify when things have not gone so well. They allows citizens to know what they should expect and avoids inconsistencies and patchiness of approaches, which have been criticisms of existing approaches. Therefore, it is not proposed that further change is required at this stage.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes, better connectedness between different aspects of the care system will benefit from a common framework for all. It will also provide certainty and clarity for patients and service users. However, this should not be just for health and the independent sector, it should seek to provide consistent standards for health, social care, third sector provision and the independent sector. Work has been undertaken in terms of the commissioning frameworks for CAMHS/Mental Health which has set out an agreed set of standards of care, this work needs to be reflected in all contracting arrangements with the Independent Sector.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
We need as organisations to share more. We also need to test more regularly against our best peers nationally and internationally, not just in Wales. Testing national and international standards and performance against outcomes will help NHS Wales improve and focus on quality services. However, testing by peers only can be a flawed approach, as this will rely on experience and adequacy of those undertaking the reviews. If others peer review, their existing approach or service would need to be identified as an exemplar from which others could learn. Better arrangements for shared-learning would be beneficial in NHS Wales. Peer Review is an important process and whilst there have been examples of how this has been used across the service, it is time consuming and important that it is seen as an integral part of a role(s) and not as an add on. There would be a need to consistency of approach which would be agreed by the Health Board. Whilst this would have much benefit across the whole system, this is a decision that could be taken at a local level and does not require any changes to the legislation framework

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?

Clarity here will be the important role of standards and clinicians signing up to these and regular revalidation. Also, the NHS needs to be regularly asking ourselves how we know if individuals are doing a good job and providing a safe service. Continual testing is key and ensuring people are keeping up with their education and knowledge as services move at pace. Also, however, we need to ensure health professionals are focusing on patients and not business or organisational interests, which reflects some of the earlier comments. Aneurin Bevan UHB has been leading national work, particularly on nurse revalidation and this has had a positive impact.

17. What arrangements should be put in place for self-employed health professional registrants?
Further consideration is required with regard to independent contractors in the NHS system and also the contractual arrangements and regular revalidation and competency based assessments are equally important. The performance regime in primary care for primary care practitioners who are independent contractors is any area that could be explored further, as currently the system does not appear to be adequate to test the quality, accessibility and safety of services.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Please see earlier comments. However, we also have to move away from a culture of blame – as this drives perverse and protectionist behaviours. If fear rules, people become frightened of failure and also frightened to innovate and therefore can act not in the best interest of patients, but in the interests of themselves and organisations. We need to open up at all levels of the NHS – from Welsh Government to day to day patient interactions. By being more open and providing good quality and timely information (in real time) we will do a lot more to build trust in the system. We also need to speak the language of the citizens and not a pseudo-professional language. However, it is not clear that introducing a statutory duty of candour would achieve the desired outcomes. This needs to be about the values, principles and culture of organisations and the way individual members of NHS staff seek to provide the best service for citizens every day. It is suggested that this should be a cultural and standards approach and not a further legislative approach.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
We need to have much more easily accessible real time information about the performance of services to enable patients to make choices about their care and also how and when they access services. However, it will also help patients to keep aware of the standards of services and what they should be expecting of services and therefore, to allow them to ask legitimate questions, especially about the timeliness of their care. More information about

clinicians, their records and current performance would also help patients have confidence in the system.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
We must see complaints as a gift – private business does, and uses that to improve their services, otherwise they lose customers and business. Joint standards, joint training and integrated teams will help with this work between health and social care. However, it is not clear at this stage if further legislation is required to make this happen. Current agreements and joint working protocols could be used to facilitate this.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
It is suggested that we need to better use the legal and governance framework that we already have for the sharing of information and that no new legislation is required. The current arrangements need to be used as enablers and not as excuses or barriers not to do things. Key to making sure that these arrangements work well, is a sensible approach to training within organisations and also in partnership and also joint training. We also have to ensure that staff identified as requiring training also comply with this requirement. There are key safeguarding issues here also and the importance of sharing protocols and training and learning together are important.

22. How can we consider breaking down any barriers?
It is considered that the key to unlocking this area is investing in good quality and compatible IT systems that can 'speak to each other' across organisations. Also, IT equipment and software systems that are of the highest standard and facilitate such sharing of information right across the patient/client pathway are required. Currently we have systems therefore that act as barriers and also result in requirements to duplicate actions and activities to gather and share information.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Also, the permissions with regard to information sharing with regard to research are also in place. Information governance issues in research are

also well rehearsed. As long as there are clear safeguards in place, the NHS should be supporting this approach as long as patients have given their consent to allow their information to be used in these ways. However, the definition of research is important. This relates to research that has undergone ethical approval and not simply sharing information for the purposes of commerciality say in the pharmaceutical industry. We consider that if patients feel their care will benefit they will be happy to have organisations share what they have about them. This will also avoid patients having to give the same information on numerous occasions. There is also a suggestion that we could follow the model being adopted for Organ Donation, where presumed consent for the sharing of patient/client information is presumed within clear parameters, unless permission is withdrawn by the citizen. It is considered that many citizens had already assumed that this happens in order to plan and co-ordinate their care and would want the clinicians and professionals to have best access to the information about them.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
The themes about regulation and inspection should be welcomed especially if they can clarify the complicated framework of inspection and regulation, which has built up over time. The opportunity to develop a single regulator or inspection body/framework for health and social care in Wales should be explored. This will also reflect some of the increasing integration of services, where the responsibility for inspection and regulation have become blurred, where integrated services have been developed. The possibility of a joint or integrated inspectorate should be considered and this would better reflect the integration of services that is underway and therefore more joint working would be welcomed as a first stage with a gradual build-up to the potential of a genuinely joint Health and Social Care inspectorate in due course. For health services, HIW effectiveness here is key. There needs to be more public awareness of what HIW does and that their role and reports will then become more valued and understood by citizens.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
Consideration should also be given to their independence and whether there should be a separation from Welsh Government and for HIW to be set up as an independent inspectorate. Separation would give further confidence about its independence.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change? 27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
If change is not going to happen with regard to an integrated inspectorate, we would still need to look closely at the effectiveness of the ways in which HIW and CSSIW work together, their engagement with services and their profile for the public and patients, which has been perceived to be low historically. However, it has improved over recent times. It is considered that legislative change is not required to make this happen. However, it is also suggested that there might me an argument for closer cross-referencing with Community Health Councils as their work provides very rich and insightful information about the quality and safety of services and importantly patient experience.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The Health Board has established a very productive, but still constructively challenging relationship with the CHC through our Joint Planning Committee and regular joint meetings. The joint committee discusses a range of proposed service developments and changes. The CHC's early view and advice and continuing involvement in discussions is important to the Health Board to enable the organisation to continue to test the anticipated impact on patients of proposed service changes and reconfiguration and obtain advice about consultation and engagements with local communities. The CHC is an important mechanism working on behalf of patients and their interests. We have an open relationship with the CHC and they come to each of our Board Meetings and 'tell us as it is' about key issues and the adequacy of services and responsiveness to patients. This is very valued by the Health Board.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
The Health Board has a very constructive and positive working relationship with Aneurin Bevan Community Health Council. Locally the CHC's members and officers are a very valued source of advice, guidance and constructive challenge for the Health Board and also provide important insights into the views of patients, their families and carers about Health Board services and the quality of our care. Therefore, the model works well in our opinion. The Health Board recognises that setting consistent standards for CHCs is important, especially with regard to the delivery of CHC functions and consistency of their engagement with patients, carers and NHS organisations

in Wales. This will also support the continued empowerment of CHCs and their clear accountabilities. Therefore, effective performance management and monitoring based on a clear and standardised performance framework will be important. However, it will also need to be clear that the standards applied by the CHC Board to CHCs in Wales are consistent with other existing standards in Wales against which NHS organisations and services are judged and assessed. This would to enable the NHS and CHCs to be working within a common framework, as far as possible.

However, consideration should be given to names changes or CHC as currently the alignment of their name to the Health Board area, appears to undermine their independence and is confusing for patients and citizens.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
This will require further exploration to obtain a clearer understanding of what is proposed. However, this would appear sensible in the context of the flexibility now also offered by the delivery framework for the Integrated Medium Term Plan. However, we would need to be clear about Health organisations' ability to pay back from a finite resource, which is an allocation from Welsh Government and whether that would be acceptable. Also, the ability to pay back would only be a reasonable suggestion if organisations had the ability to generate additional income through genuine outsourcing to enable payments to be made. Also, organisations already can take out loans as they can borrow from the Invest to Save Fund. Therefore, it would be beneficial for Health Boards to be allowed to borrow, although we understand the risks involved and this would require clear policies to operate across NHS Wales. Giving Health Boards borrowing powers would lead to the following benefits: • Borrowing will give much greater local flexibility of resource across revenue and capital; • Enable NHS providers to modernise and improve estate at a greater pace than is currently achievable; • Health Boards could invest in accelerating capital investments, where these demonstrate a clear revenue saving and payback; • It will instil a discipline of longer term planning and assessing business cases on a more commercial footing, securing an even greater focus on due diligence even in areas where borrowing is not required; • It will clarify current arrangements surrounding finance leases and PFI arrangements where Health Boards do, in effect, borrow to fund future developments. This needs to be balanced over revenue to pay back any borrowing and

requires some form of underwriting to facilitate competitive borrowing rates.

Prudential Borrowing codes as used by Monitor and other public sector organisations won't apply to Health Boards, and careful consideration will need to be given to the NHS Wales policy framework in this area to ensure that Health Boards do not become exposed to over borrowing. System changes may also be required. For instance, there may be a need to review the process of capital charges and cash allocations to Health Boards.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
32. 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?

This will require further exploration to obtain a clearer understanding of what is proposed. The reporting regime is required through HM Treasury, but clarification will be required as to the purpose and relevance of the current requirement and also the purpose for which summarised accounts are produced and whether that is still relevant to local communities and those that read the Health Board's accounts and Annual Report.

However, we would agree with the findings of the Green Paper that producing separate NHS Wales, Trust and Health Board summarised accounts provide very little value, and do not reflect the current state of the NHS landscape. There is an opportunity to review the entire reporting arrangements and processes within NHS Wales and simplify these.
Within the Health Board, providing summarised accounts are important in terms of demonstrating transparency and accountability to the general public, although the timing of publication (September) detract from this value. We do not believe the same benefits are obtained from summarised Trusts accounts. There may be an argument that the timetable for Annual Reports and Annual General Meetings should be shortened to create timelier reporting. Crucially, any change in reporting should encourage more meaningful and understandable analysis.
There should also be consideration given to the Annual Report as a whole, to ensure that it can become a document which is understandable and accessible by the general public. Furthermore accounts should be prepared in such a way to disclose as much information to the reader. Health Boards (with guidelines for minimum disclosure) should have the autonomy to publish results in the most meaningful way to their public, subject to Wales Audit Office approval.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as

we have for health boards?
There should be a clear position with regard to their responsibility to plan with other NHS bodies and wider partners and where required to produce approved financially balanced plans. The Health Boards should be accountable for the planning of services for their resident population the role of Trusts is different. However, there should be a similar duty which expects Trusts to have approved plans and strategies to deliver commissioned services. This would ensure the seamless planning of activities to improve health and for meeting patients' needs across the pathways of care.

34. 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, these discussions in terms of alignment and joint planning are beginning to happen at a local level in the contexts of the above Acts. Therefore, a Wales level review should be undertaken to ensure that legislation is aligned, consistent and coherent. We support the principles of a one system approach across Health and Social Services and the impact of this new legislation needs to be fully understood. However, we would not support the review of the act creating even more complex governance structures than what already exist.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
The Green Paper suggests a full review, which would be welcomed. As the Health Service in Wales since the 2009 has become quite complex as the service with Welsh Government seek to resolve some of the shortcomings of the original establishment arrangements and also because the original arrangements do not allow for real flexibility. Therefore, we have a range of complex adjustments and fixes, with the establishments of joint committees, shared and hosted services, network arrangements and collaborative arrangements. These range of approaches need to be reviewed, clarified and where possible streamlined. However, we need to be clear about what problems and issues we are seeking to resolve, which is not clear in the Green Paper. Also, therefore, it is not proposed that major structural change is required per se and also that no new legislation is required, but better use must be made of the existing legislative framework. Nonetheless, consideration still needs to be given to one Strategic Health Body for Wales. However, we also have to also guard against major structural change – so evolution rather than disjuncture. We should look for opportunities to explore more joint governance

arrangements with key partners, such as the work underway through the Social Care and Well Being and again explore arrangements for genuine joint scrutiny. This might help with reduction in the size of Boards, if we have effective partnership scrutiny models. Also, in terms of Standing Orders, some of the provisions are hugely restrictive and run counter to the new models put in place for three year plans for instance. The financial limits for example, limit the autonomy and decision making of Health organisations. The prescribed committee guidance in Standing Orders could also benefit from a review. The model is very much based on a local authority style member/officer model, but governance in the NHS is different and accountabilities are much more complex. Therefore, we also need to look at how we harness the expertise that Independent Members bring to support development as well as providing effective scrutiny.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
The current size of Health Boards is not really an issue as long as they are run effectively and led well. However, there is also an argument for more flexibility in terms of the regulations regarding the requirements for specific independent member roles and that more generic roles should be considered, which could be flexed over time depending on the key priorities and areas of strategy development for Boards.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
We need to think about the current specified Executive roles, as many organisations have already changed with the Chief Operating Officer role for instance, which does not meet current regulations. We also have the tension between operational roles and professional roles – and these are a legacy of having used a blended model between LHB and Trust establishment orders at the time of reorganisation.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
Democratic accountability is important, but does this always provide the range of expertise and professional knowledge that is required to run a complex Health organisation. These models then rely more so on the expertise of officers and advisers. Therefore the benefit of the democratisation can be lost, however, the connectedness to local communities and interests might be a benefit. Careful thought needs to be given to this – as democratic processes are not always the answer – there might be a case however, for

any joint scrutiny model and democratic appointment to this or better use of the existing local authority scrutiny arrangements for health services and not just partnership areas.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
There would be a benefit in further exploring this proposal. However, if there is a joint appointment of a Director of Public Health role for a given geographical area, it is suggested that it will be important that the role stays within the NHS. Joint roles have been used in the past, however, this might beg a further questions that if joint roles are required – are joint health and social care organisations the logical next step. However, with joint roles accountability and responsibilities are often blurred or confused, which can get in the way of the desired outcomes and achievements expected from a joint approach.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
It is suggested that health organisations should be given more freedom to appoint Independent members with the skills the Board feels it needs rather than the current model, which is prescriptive. It would also be useful that consideration for staggering Independent Members appointments to avoid instability when terms of when tenures end, which we are currently experiencing due to having a relatively stable Board but members having been appointed together at the time of reorganisation are now leaving together having exhausted their allowable eight year terms.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
The Board Secretary role would not necessarily need the benefit of protected status to allow them to be able to act and advise without impunity. The Board Secretary can genuinely now act as the 'conscience' of the organisation and provide independent advice to the Chair, Chief Executive and the Board. However, it is important to ensure that they have a lead role for governance and governance structures and processes; the role therefore, should be one not confused by other executive portfolios and especially not operational responsibilities, which might affect independence. It is also suggested that the role title might need to altered to make the role more clearly understood and more reflective of its level of seniority within organisations. It is important that the Board Secretary is an independent, well informed and

trusted voice/adviser – therefore, further work would be necessary to fully understand what is proposed. However, the role could be set out within the Regulations. Similar roles exist in other public bodies upon which it could be modelled for example, the role of the Monitoring Officer within Local Authorities which in accordance with the provisions of the Local Government and Housing Act 1989 and 2000 Act which makes the role a statutory requirement for all local authorities and given them a legal duty to report on legal issues and maladministration, manage the code of conduct and complaints associated with conduct of Principal officers and elected members, manage the standing order's etc. The Local Government (Wales) Measure also provided a statutory resource to support the Monitoring Officer is undertaking his/her duties, specifically the appointment of a "Head of Democratic Services" role to fulfil the corporate requirements of the role.

44. If so, what aspects of the role should be additionally set out in law?
It is not proposed that further legislation is required.

45. How could potential conflicts of interest for the board secretary be managed?
The potential conflicts, as outlined above come from the position of the role being conflicted because of a portfolio of other operational or corporate responsibilities, which can undermine the independence of the role. Any personal conflicts would need to be managed through the usual Declaration of Interests arrangements.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
We need to think about the governance models and the wider engagement arrangements for Health Boards, as to whether the Stakeholder Reference Group and Healthcare Professionals' Forum are now the right models going forward. They have worked well in this Health Board, but have not got off the ground in other areas as well. They were somewhat of a proxy for engagement when put into the Standing Orders originally, but we need to think about new engagement models. Also, the national advisory structures require further clarity with regard to how local mechanisms link to the national arrangements.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
As Health Boards we already have professional expertise at the Board level through Independent Members and also the professionally qualified Executive

Directors. It would be helpful to have an understanding of the proposed further requirements over and above this.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
The Health Board's current Trade Union Partnership Forum and wider arrangements are well established and are working well. The Trade Union Independent Member also plays an important role at Board and Committee level.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
We have a range of different models for hosted services, joint committees and shared services. These have been built up over time and expedient solutions have been found to make them happen in required timescales. It would be helpful if these could be reviewed as the governance, decision-making and accountability arrangements are not as clear as they could be. There is also no clear mention of the Emergency Ambulance Services Joint Committee and also its funding and governance regimes within the Green Paper. This should be considered and clarified further, especially with regard to its role vis-à-vis the Wales Ambulance Services NHS Trust.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
It is not anticipated that further flexibility is required as shared services should be an extension of NHS organisations and provide the services and support required by organisations to help them deliver. The services provided should only be those where it realises a benefit and add value to NHS services and avoids duplication and ultimately saves money. However, the interface between organisations and shared services can already be complicated and unclear – so any approach that can clarify this client – customer relationship would be helpful.

WGGP073 – Phillipa Ford MBE – Chartered Society of Physiotherapy
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The Chartered Society of Physiotherapy (CSP) would welcome changes to law to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home if it is needed. Welsh Government is currently consulting on the regulations for the Social Services and Wellbeing (Wales) Act 2014 which has included guidance in relation to Part 9 of the Act on co-operation and partnership. These regulations will provide the Regional Partnership Boards which will oversee planning and meeting people's health and wellbeing needs closer to home. Until these are in place and operational it is difficult to know if additional legislation is required to ensure Health Boards and NHS Trusts do more around local collaboration in planning to meet people's health and wellbeing needs closer to home. The profession would welcome improved working across health and social care in the areas of planning, delivery, inspection regulation and workforce education.

2. If so, what changes should be given priority?
The CSP supports the strong focus and emphasis on prevention and early intervention. If legislation is required then this focus across health and social care must continue to be strengthened. How this links with regulations under the Wellbeing of Future Generations (Wales) Act 2015 must also be clear. This will be of particular importance when defining the role and remit of the Local Service Boards in regard to promoting health and wellbeing. Clarity on the roles and remit of all these various boards is required for the public.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The CSP considers there may be an argument for strengthening the tools already available within existing legislation. The importance of pooled budgets, joint performance management and joint planning will be essential to successful integration of health and social care service provision. Provision is made within social care legislation but future legislation may be needed to effect desired change in relation to health services.

The profession considers that co-terminosity will need to be a key consideration in order to ensure agencies work together. This means considering the needs of the health service alongside the decisions around Local Government reform. Co-terminosity will also make it far easier to develop and progress joint appointments across health and social care.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
The CSP does not consider there is a clear case for legislation change or creation to shape service change at this time.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Under current legislation, Health Boards already have a stakeholder forum and health professions forum. The CSP considers Welsh Government will need to evaluate these before moving to new statutory groups. NHS Trusts may need to be looked at to ensure their citizen engagement processes are transparent and robust. It may be that legislation can be used to bring the Trusts in line with the Health Boards. However, an evaluation of the efficiency of the stakeholder forum (across all Health Boards) is required to inform any decision on change.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
The CSP questions the need for an expert panel as separate from the Minister and considers that when arriving at decisions Ministers may decide an expert panel might provide support to the decision making process. The CSP sees a range of dilemmas in appointing to an expert panel as a stand-alone body enshrined in law. The profession would prefer to see the Minister appoint an expert panel to provide assistance on a case by case basis. Legislation would not be required for this.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
The CSP is not convinced, as yet, that legislation is required to address the

issues raised in the section on quality and co-operation although, as has been previously said, it will be important to look at the requirements on social care services through the regulations underpinning the Social Services and Wellbeing (Wales) Act and assess whether complementary legislation on health would be useful to facilitate standardisation and promote co-operation and partnership working.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
The profession is supportive of a more integrated approach in this area to include quality across health and social care. It is not clear if further legislation would be needed to achieve this.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
The CSP is not sure if a legislation measure is required to ensure quality is put at the forefront of all decisions and joint decisions of health organisations. The profession considers that decisions around this will need to link with the wider Wellbeing of Future Generations (Wales) Act decision making by Local Service Boards in respect of their health, social care and wellbeing responsibilities. Decisions will also need to link with requirements on social care to provide quality preventative and care and support services.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
The CSP would need to see more detail on concepts such as the ‘responsible individual’ and tests around the “fitness” of senior leaders and others to carry out the roles. However, if this is introduced successfully in social care then in the interests of progressing integration, and to provide further assurance to the public, this is something to be considered within health.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
The advantages of setting out in legislation the role of the ‘responsible individual’ • Clarity for the public • Clarity for executive board members • Similar concepts used across health and social care Disadvantages • Cost of enacting legislation It must be noted that regulatory frameworks are already in place for those executive board members from clinical backgrounds (NMC, HCPC, GMC). These will have standards and codes of conduct.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
The CSP would support any developments which strengthen quality and learning as being integral to health service plans. The profession is unsure if legislation is necessary at this stage.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
The CSP considers there is a case for changing the basis under which the healthcare standards for use in the NHS are set.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
The CSP supports a common standards framework which would cover health, social care and the independent sector focussing on outcomes for people and experiences of citizens.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
The profession considers that the best way to build in accreditation and peer review is to make it a commissioning requirement (where services are commissioned) or a planning/provider requirement as part of organisations demonstrating that they are delivering quality in practice.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
The CSP notes progress being made by regulators to ensure that clinical supervision is a key aspect of revalidation. The profession considers the responsibility of the employer is to support the clinicians to meet the requirements of the regulators. The CSP is not sure, at this stage, if legislation is required to support this process but it could be brought forward if Health Boards and NHS Trusts were deemed not to be supporting their staff.

17. What arrangements should be put in place for self-employed health professional registrants?
For self-employed staff, the responsibility of the individual is to maintain their

registration with their regulatory body.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
The CSP supports the introduction of a statutory duty of candour within NHS Wales. The profession would like to see this duty across health and social care.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
The profession is not convinced that legislation is required to improve transparency on performance in the NHS in Wales.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
The CSP considers joint investigation of complaints across the NHS and social services in Wales will be complex but made easier where there is co-terminosity between NHS bodies and local authorities. The profession would support changes to regulations (The NHS (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations) but is mindful of the difference is managing complaints in social care and the lack of a formal complaints process to certain aspects such as eligibility for care and support services as opposed to the full process included within 'Putting Things Right'. Work would be needed to harmonise complaints processes across health and social care. The CSP supports extending the powers of the Public Services Ombudsman for Wales.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Data protection and different governance arrangements continue to be cited as reasons preventing health and social care organisations from sharing information.

22. How can we consider breaking down any barriers?
Breaking down the barriers requires continued joint working and viable IT

solutions that provide ability to share with security. The new community service information system (CSIS) should help this process.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
The CSP supports the collection and sharing of patient identifiable information but under strict requirements. Data for research may be appropriate with full consent and ethical approval etc. ... as part of the criteria. The issues of concern will include clarity and transparency about the use of the data in the public domain, who will use the data and how that data will be presented.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
The CSP supports any developments which will strengthen HIW. Legislation is required that allows the inspectorate to include any new clinical and non-clinical activities that are developed as within their sphere for inspection.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
The CSP supports a strengthened HIW and would support full statutory independence. The CSP would also support full statutory independence for CSSIW.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
The CSP supports full integration of HIW and CSSIW. Whilst this would be a big step it would provide one inspectorate across health and social care.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
The CSP considers the main advantages for citizens of a single inspectorate are experiencing a streamlined, single investigation and inspection body operating to common standards and processes across health and social care. Disadvantages to the citizen should be none but to the organisation may be its size.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The CSP remains very supportive of the Community Health Councils and supports the stance taken by the Welsh Government to retain the CHCs. However, the profession does recognise over-lap with regard to inspection between HIW and the CHC. The CSP supports the role of the CHC in service change proposals. CHCs have shown themselves to be a vital part of ensuring local public engagement. The CSP supports the CHC maintaining one of each health board which, should the health boards change in number, would need to keep co-terminosity so CHC numbers would also need to change. The CSP notes the development of the National Social Services Citizen Panel but is not convinced of the need to create something similar for health services. An argument is made to make best use of what is currently available and not look to introduce yet another body or statutory committee. The CSP suggests that the CHC are best place to make developments/changes that brings them in line with arrangements that are currently in place for social care.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
The CSP considers there will be an argument for CHCs to change to meet the new integration agenda. Closer working with the National Social Services Citizen Panel is required to ensure there is no duplication. The CSP considers the CHC are best placed to offer up the most appropriate developments which will meet the new requirements. They will be able to develop, for example, patient panels to link directly with primary care clusters and appropriate panels to link directly with Local Health Boards.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
The CSP has concerns about LHBs having borrowing powers. The profession understands the new flexibilities these powers would provide to Health Boards but there are concerns around loans to pay off debts leading to

further serious debt and the checks and balances that must be in place before this development should be allowed to proceed. It will need very careful scrutiny by Welsh Government.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
The CSP considers that health boards and NHS Trusts need to provide reports that reflect both the commissioning/planning aspects of their work and separate provision aspects of their work to demonstrate they are meeting both requirements.

32. 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?
The profession does consider that legislation may be useful to provide greater flexibility regarding summarised accounts. The key outcome from this is that the public should be able to clearly see the planning and commissioning undertaken by health boards and NHS Trusts and separately the provision in response to planning and commissioning.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
The CSP considers NHS Trusts should have a statutory planning duty where they are planning and commissioning services.

34. 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?
The CSP considers it is essential to review the NHS (Wales) Act 2006 with regard to planning duties to improve alignment with the Social Services and Wellbeing (Wales) Act 2014 and the Wellbeing of Future Generations (Wales) Act. The profession points out that definitions should read across all pieces of legislation so, for example, the definition of wellbeing should be the same for all pieces of Welsh Government legislation that make reference to wellbeing which is not the case currently.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
The CSP suggests that more needs to be done to support those in leadership positions, involved in governance and responsible for partnership relationships. This does not necessarily require legislation but requires a properly financed programme to not only support those currently in leadership positions but to grow the leaders of the future. Despite the presence of Academi Wales, the CSP sees no evidence of a clear drive to support and develop leadership teams.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
The CSP understands that the size and configuration of Health Boards and NHS Trusts needs to ensure the ability to promote an effective focus on decision, priorities and scrutiny. It is essential, therefore to ensure a full range of professional leadership across health and social care. The expertise from the three professionally regulated executive directors (GMC, NMC and HCPC) are crucial to delivering for citizens across health and social care.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
The profession considers there may be potential for discretion about some of the roles with developments such as joint appointments but the CSP is clear that Health Boards must retain professionally regulated executive directors covering the majority of registered practitioners. It is important to note that HCPC equates to 25-30% of the NHS workforce and the Directors of Therapies and Health Scientists (DoTHS) executive role spans professionals working in both health and social care. The DoTHS role is well positioned to lead in co-operational and partnership responsibilities in relationship to Regional Partnership Boards under the guidance in relation to Part 9 of the Social Services and Wellbeing (Wales) Act on co-operation and partnership. DoTHS roles are also essential for leadership on the development to community service provision and progression of workforce modernisation in primary care.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
The CSP notes the recommendations of the Commission on Public Service Governance and Delivery (Williams Commission) around election of community representatives. The profession is unsure how this would work in practice.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
The profession supports the idea of joint appointments but there would need to be clear accountability arrangements with local appointment to ensure an appropriate understanding of the needs of local populations rather than appointments centrally within Public Health Wales.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
The CSP has no other suggestions to add on the make-up of the boards and NHS Trusts other than to highlight that the profession would not want to see a 'tiered' arrangement with a small executive and a wider board which meant that some current board members were excluded from high level decision making processes. The danger is a return to a restricted 'medical model' traditional structure which loses the strength and depth that has been brought to the current boards and which has been much admired internationally.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
The CSP would like to see a DoTHS role for the NHS Trust boards. Velindre NHS Trust in particular would benefit from the addition of this role and bring it in line with the Health Board executive roles. The CSP suggests that the NHS Trusts should also create a DoTHS role on the Executive Board so that all NHS organisations have leadership at executive level for professions other than medicine and nursing. These roles help to provide a collaborative leadership style to the Board, promote strategic decision making and support the change in culture needed to drive the prudent healthcare agenda.

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
The CSP has no other specific points to make on changes to NHS Trust board membership.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
The CSP considers there would be benefit in greater statutory clarity for the

role of the board secretary.

44. If so, what aspects of the role should be additionally set out in law?
The CSP notes and supports the recommendations made by the Assembly Public Accounts Committee in relation to clarity for the role of the board scrutiny.

45. How could potential conflicts of interest for the board secretary be managed?
Appropriate changes to standing orders, changes to accountability arrangements and clarity of role, remit and separation of key aspects of the role are required to manage potential conflicts of interest A review of current arrangements and past experience where conflicts of interest have arisen should provide an opportunity to improve arrangements.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
The CSP continues to hold the view that statutory advisory committees provide a clear opportunity to Welsh Government to gain independent advice. The profession is keen to maintain a statutory duty to consult. The CSP does not favour the continued use of the National Statutory Advisory Groups but does consider Welsh Government should retain statutory professional advisory committees for all professions. Better use of these committees should be made in requiring advisory papers and professional advice to inform forward planning. The CSP considers WTAC and WSAC both provide valuable advice and support Welsh Government and their advice differs to that which they receive from DoTHS. Advisory machinery assures independence from LHBs.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
The CSP considers a statutory requirement to consult is essential. If this is lost Welsh Government will lose a wealth of clinical engagement. The statutory nature of requirements means that clinicians are afforded time by employers to be involved in providing responses to Government and being involved in development of strategy and policy direction.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do

they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Pay, terms and conditions under Agenda for Change continue to be UK-wide and the workforce continues to be mobile across the UK. The CSP would not favour amendments to the law in relation to partnership working in this area at the current time.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
The CSP is unsure if legislative measures are required to put in place better clarity for hosted, joint and shared services.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
It would appear that NWSSP could operate for the whole public sector in Wales. This, however, would be a huge development and the service itself will need to advise the Ministers on such a development with a full cost/benefit analysis. It is likely that an NHS body will not be able to host NWSSP should this option be pursued.

WGGP074 – Abigail Fitzgibbon – British Pregnancy Advisory Service (BPAS)
Tref / Town – N/A

General comments

British Pregnancy Advisory Service (BPAS) is a reproductive health charity that provides care to 70,000 women a year on behalf of the NHS across Britain. In Wales we provide care to NHS patients and women who feel they must pay privately because of NHS waiting times. Our clinics in Cardiff and Powys provide support to women who have unplanned pregnancies and those considering ending a wanted pregnancy for other reasons. This submission is based on our experience caring for these patients.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
BPAS believes that the Welsh Assembly Government (WAG) has existing powers it can use to improve the standard of care for pregnant women needing early abortion care in Wales. Using this power will be cost and time effective as well as improving the experience of women undergoing early medical abortion (EMA). 8,333 women in Wales had an abortion in 2014.

2. If so, what changes should be given priority?
BPAS' understands that the devolution of health powers to the WAG gave the Minister for Health and Social Services authority on some matters that the Secretary of State for Health at Westminster previously held for Wales.[7] Included is the ability to approve a 'class of place' for women having abortions. This means that the Minister is able to approve a change in the

[7] Halsbury Vol 12(1) (2011 reissue), title Criminal Law.: "The functions of a Minister of the Crown under this Act, so far as exercisable in relation to Wales, were transferred to the National Assembly for Wales constituted under the Government of Wales Act 1998, by the National Assembly for Wales (Transfer of Functions) Order 1999, SI 1999/672, art 2(a), Sch 1 (which now takes effect under the Government of Wales Act 2006, s 58). Functions exercisable by the Assembly constituted by the 1998 Act are transferred to the Welsh Ministers by the Government of Wales Act 2006, s 162(1), Sch 11, para 30, subject to any Order in Council made under para 31 of that Schedule. As to the consequential construction of references to the Assembly, see Sch 11, para 32 to that Act."

regulation, which would significantly improve access to EMA for Welsh women. Making use of this power has no cost implications and will reduce clinically unnecessary appointments in NHS hospitals and charitable abortion clinics.

The 'abortion pill' is a medicine that ends a pregnancy. The medical name for the abortion pill is mifepristone. It works by blocking the hormone progesterone. Without progesterone, the lining of the uterus breaks down and the pregnancy cannot continue. The abortion pill is followed by another medicine called misoprostol, which makes the womb contract, causing cramping and bleeding similar to a miscarriage. At BPAS women are able to take both pills at the same time though this is less effective than if there is a gap in time between taking the medications. Best practice would be for a woman to take the mifepristone at the clinic then take the misoprostol in her home, at a time that is best for her, where she can miscarry in private.

The Abortion Act 1967 (amended 1990) stipulates that "any treatment for the termination of pregnancy" must be carried out in a hospital or clinic. The original intention was to stop unlicensed providers or 'backstreet abortionists' carrying out procedures that were unsafe. Currently this is interpreted by the Department of Health in Whitehall as meaning that all EMA medication must be both prescribed **and** administered on licensed abortion premises. In other countries, including the US, France and Sweden, the second medication is issued to women on their first visit with instructions for use at home. The 2007 report by the House of Commons Science and Technology Committee on developments relating to the Abortion Act noted that there was "no evidence relating to safety, effectiveness or patient acceptability" that should stop legislation allowing the second medication to be taken at home.[[8]] Indeed women who have suffered an early "missed" miscarriage are given the same medication to take at home in recognition of the fact that at such a sensitive time it is preferable for a woman to be in the comfort and privacy of her own surroundings. It is inherently discriminatory that one group of women are allowed to take this medication at home while another are not.

BPAS believes that the WAG should use its powers to extend the place an abortion can be carried out in order that misoprostol that has been *prescribed and issued* in a clinic can be *administered* by a woman at home. This is provided she has received careful instructions, has appropriate support, and chooses to do this. This simple change would prevent the risk of a woman miscarrying while travelling home, which is a significant concern for women in some parts of rural Wales. BPAS in Wales alone sees over 300 women a year for an EMA. Our experience shows us that NHS abortion services in Wales have serious capacity issues. The reduction in number of appointments required by each woman would go some way to easing the pressure on NHS services while also improving the experience of their patients and widening the choices available to them. Making this change would be hugely positive for the women of Wales, the NHS in Wales and reduce pressure on public funds.

[8] House of Commons Science and Technology Committee on developments relating to the Abortion Act, 2007, http://www.publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Abortion legislation in Britain is outdated and needs reform. While the Abortion Act represented progress in 1967 it now hinders women accessing the best possible care and denies them autonomy as patients. It is no longer acceptable to women that they should require the legal permission of two doctors to have an abortion. Women are competent individuals capable of making decisions. In no other area of healthcare do we require legal authority from doctors, in addition to the standard process of obtaining informed consent for a patient to access treatment. As is demonstrated by the limitations placed on the provision of EMA, the legal framework stops healthcare providers giving women the best care possible. The WAG may not have the powers necessary to reform abortion legislation in its entirety but BPAS hopes that in the event of such a discussion in Westminster the WAG would advocate on behalf of Welsh women.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
In the case of abortion provision there are improvements that can be made via commissioning arrangements to address waiting times in NHS settings. However, the use of existing powers to improve the quality of care for Welsh women is a necessary and simple way to enhance services in Wales.

WGGP075 – Jo Wilson – Hywel Dda University Health Board
Tref / Town – N/A

General comments

Developing the University Health Board's Response
As part of the consultation process, Welsh Government has been holding a number of stakeholder events which members of the Health Board have attended. The Health Board arranged for NHS confederation to give a presentation to the Board. Local events have also been held with the statutory advisory groups (Stakeholder Reference Group and the Local Partnership Forum) in September. Individual Executive Directors have also developed responses as part of their professional networks at an All Wales level. This has generated a range of comments and feedback which have been summarised within this response.

The current arrangements
Health Boards were established in 2009, following a large scale restructuring of the NHS in Wales. Over recent years Health Boards have begun to realise the potential of the benefits expected when they were established and across Wales there are positive examples of joint working/partnership arrangements which are benefitting local populations. Given this, it is not the time to consider wholesale structural change in the NHS in Wales.

Planned Legislative changes
Stability within the NHS is extremely important at a time when the full implications of the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 which will be fully effective from 2017. It is also important to be cognisant of the recommendations made within the Williams Review 2014 - The Report of the Commission on Public Service Governance and Delivery.

Whilst the totality of the implications of the Social Services and Well-Being (Wales) Act and the Well-Being of Future Generations (Wales) Act are not yet fully understood, their introduction will transform the way the health and social care system operates. This, in turn, will be further impacted by the development of GP clusters/community networks. It is helpful that any legislation being considered as a result of the NHS Green paper will not be developed in isolation and will be drawn up to compliment and be consistent with these emerging legal frameworks.

As health and social care services increasingly work together to define and deliver against agreed aims and objectives through Local Service Boards and Public Service Boards, the current governance and management models operated by the NHS and local government in Wales may require further change. The role of Welsh Government (in its broadest sense) in leading and managing this transformational change is pivotal and clarifying this as part of any legislative change would be helpful. Any new legislation drafted should positively encourage the delivery of an integrated health and social care system across Wales.

Ongoing engagement with the public, patients and partners is critical and determining how this is best managed would require detailed consideration and planning. This would need to include how to facilitate engagement which will help to shape and build the joint plans which are likely to be built up from GP cluster/community network level through Local Service Boards to the Public Service Boards.

Suggested principles

In this context it is important to consider what are the underpinning principles on which the health (and social care) system should be developed and judged, for example:

- be citizen-centred and easily understood;
- be based on Prudent Healthcare and co-production and allow decisions to be made at the nearest point to the citizen as possible;
- encourages service integration;
- encourages consistent standards.

It is possible to review arrangements based on these principles without the need to consider further legislation.

Improving the current arrangements locally

Within the existing arrangements within Health Boards and Trusts the current statutory instruments are prescriptive in respect of issues such as

- Board membership;
- Board Committees/Advisory Groups;
- Appointments of associate members.

It would be helpful to review these arrangements in light of the overarching principles suggested above and the relationship the Welsh Government wishes to have with Health Boards/Trusts going forward.

Improving the current arrangements nationally

From a wider perspective it is important to recognise that the current overall governance arrangements in NHS Wales have not been designed but have grown and developed. This has led to the establishment of a number of Groups/Joint Committees at an All Wales level. These have all got differing governance/accountability and reporting arrangements for these, including joint committees, and hosted bodies.

There are potential opportunities to standardise and rationalise these arrangements, for example through the establishment of a single All Wales body to manage/host these arrangements.

Culture

There is perhaps a further dimension which is not fully explored in the Green Paper that is the culture, values and behaviours that we are looking to develop and mature. Evidence clearly indicates that it is culture that may have a more profound and positive impacts on the way services are provided than legislative change alone. There is some evidence that legislative change

can have the opposite impact leading to unintended consequences encouraging adversarial behaviours leading to poor decision making.

Perhaps the critical factor is that legislation alone will not necessarily lead people to modify and change behaviour to achieve the desired outcomes. This would suggest legislative change should be seen as the last resort and not the first.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The Health Board recognises the significance of and welcomes the new legislation including the Public Health (Wales) Bill, the Social Services and Wellbeing (Wales) Act 2014 and in particular the Wellbeing of Future Generations (Wales) Act 2015 in relation to the requirements for closer collaborative working between health and other public services. The totality of the implications of the Social Services and Well-Being (Wales) Act and the Well-being of Future Generations (Wales) Act are not fully understood at present but their introduction will transform the way both the health and social care system and the wider public service operates in partnership. As such we do not currently think that additional legislation is needed specifically to strengthen local collaboration for planning. What will be important is for clear guidance to be available to Health Boards and other public services to facilitate a clear and common understanding of the opportunities and requirements created by the new legislation, notably the Wellbeing of Future Generations Act. This will enable the Health Board and partners to maximise the opportunities around local collaboration. Collaborative planning requires not only the recognition of and adoption of common priorities and outcomes, but a framework and timetable that facilitates joint commitment and resource. Current planning cycles across public service and notably across health and local government are not fully aligned. The potential for this should be explored further in the implementation of the new legislation. A statutory duty to plan together, have a single needs assessment and for all organisations to share local population level data to undertake that joint needs assessment. Any legislation to be considered as a result of the NHS Green Paper should therefore not be developed in isolation and will need to be drawn up to comply

and be consistent with the emerging legal frameworks. The governance arrangements are becoming more complicated with more and more legislation and this needs to be streamlined rather than added to.

2. If so, what changes should be given priority?
Please see previous comment. Scrutiny of integrated services with one set of shared outcomes. The potential to impose sanctions for escalating measures - if a partner chooses not to collaborate and for Welsh Government to direct partners to collaborate with the opportunity for direct dialogue with Welsh Government to mediate and arbitrate. Collective responsibility for a single needs assessment with all parties bringing their data and expertise. The University Health Board also needs more informatics and analysis capacity as a public sector -sharing this would reduce waste and would provide powerful data. Clear definition of what is a health responsibility and what health inputs are considered to be part of maintaining well-being and can be undertaken as normal activities of life. Within this definition there should also be a clear statement over the individual citizens' choice, personal control and risk enablement.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The existing governance structures within NHS Wales are complicated and not easily understood. However, the goodwill of individuals will often circumvent these complexities. Whilst changes in legislation will outline the process for undertaking local collaboration, a paradigm shift to achieving consistent local collaboration will not automatically occur and progress and development will be dependent on leadership behaviours, local agendas and financial priorities. There is a risk that the introduction of further legislation may only serve to make the position more complicated and complex. The Green Paper provides the opportunity to review, remodel and, where applicable, rationalise existing models and structures. This should take place before any further legislation is considered.

<u>Continuously engaging with citizens</u>

4. Are there ways in which the law could be reformed to shape service change?
This would be difficult to legislate - a DUTY to involve patients in every service

change is already there but not operationalised at every level. This has to be done service by service, specialty by specialty and locality by locality. The University Health Board would welcome some duty to involve at this level - whether through clusters, localities or pathways (i. e. Together for Health plans) but at a strategic corporate level it is less valuable. People are very interested in their condition or their locality and will happily engage and shape but struggle to know how to contribute at a strategic level.

With the development of GP clusters and new models of care in line with the principles of Prudent Healthcare the level of service change is likely to increase. It would be helpful to define the level of service change that requires engagement and/or consultation.

At a time when partnership working is increasing and the health impact of changes made by all PSBs needs to be understood, it would be beneficial if a similar process could be adopted across health and social care as at present the requirements to consult are much different in health than local government.

Related to this is the increasing way that change is being considered on a pan Wales basis e.g. the Wales Collaborative. However the statutory obligations of Boards are to their resident populations and not the population of Wales. This led to governance issues within the South Wales Programme.

The role of the advisory bodies could be amended with a suggestion that these support the PSBs.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
As the Green Paper states, Health Boards are already under a duty to involve and consult local people and their representatives in the planning and delivery of health services. Whilst we agree there is a need to ensure consistency and best practice across Wales, we believe that this can be done through the existing mechanisms that are already in place rather than through legislation. The main issue often lies in the interpretation of Welsh Government Guidance on Engagement and Consultation - and particularly in relation to the definition of “substantial”. It is not therefore felt as mentioned that further legislation is required but that the guidance needs to be revisited and made more explicit. The option of patient panels has been in operation elsewhere in the UK for some time and raises issues of credibility and legitimacy that need to be considered. Based on existing practice in England, the success of introducing patient panels or participation groups would be dependent upon the groups having: o Clear objectives of what the group was set up to do; o Continuous support from the Health Board.

Other issues to consider would be:

- Would the "executive core" of the group be granted an annual audience with the Health Board/Trust Chief Executive?
- Would the group require standing orders, code of conduct - if yes who would undertake the secretariat?
- Would there be a requirement to affiliate with the National Association for Patient Participation (NAPP). Membership is popular in England, but not popular in Scotland.

It should be noted that Health Boards already have Advisory Groups, although their role and effectiveness remains questionable and this may be an opportunity to review with the proposal for one SRG for PSB and utilising this for integrated planning. This would ultimately lead to a refresh of membership within the Advisory Forums.

Within the modern environment accessing people's time to become members of panels or participation groups can limit membership and create bias within the group. Health Boards are already under a duty to involve and possibly this should be given a technological support rather than a statutory basis to improve engagement. This would need a national solution to enable this but local feedback and engagement and opinion polling.

The other issue relates to the role of the CHC - which later in the Green Paper is put forward as the voice of the public. That premise could seem to be at odds with introducing another statutory group.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?

There are a number of considerations in relation to a permanent national panel including local knowledge, authority and accountability (particularly in relation to the outcomes of a formal consultative process), the role of the CHC and the scope of its work.

Issues that need to be taken account of are:

- Would such a panel understand local issues? - it could be seen as second guessing Board decisions, where the expertise already exists.
- The term expert panel implies that the views of the expert will outweigh those of local people.
- What constitutes an expert would need to be defined.
- Issues such as what level of authority would it have, who would the panel be accountable to would need to be considered, especially with regard to the risk of judicial review.
- The implications on the role of CHCs would need to be assessed.

The Local Government model is based on locally elected members forming a "Cabinet". Would the NHS expert panel be formally elected by the public?

Would there be a Health Commissioner similar to the Police Commissioners? If the expert panel dictated a pan Wales approach to providing a specific element of health care, how would the delivery be monitored? Would it be adopted consistently across the different boundaries? For example, the NHS Wales Shared Services Partnership (NWSSP) Committee makes decisions on behalf of NHS Wales, however what is agreed is not always adopted across the different Health Boards due to local views amongst executives and clinicians.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
There already exists clear lines of professional accountability through Professional Codes. This could be strengthened further by aligning standards used across health and social care to support integration and co-operation. If legislation is introduced, it should make quality the focus for the integrated systems rather than, as is now, other measures such as finance. Legislative measures merely outline the process and therefore to ensure continuous improvement in quality a shared performance management framework would need to be introduced to monitor specific key performance indicators across different geographical boundaries. The framework would need to encompass specific measures to enable monitoring and evaluation of "real time" performance indicators through a dashboard. This approach would provide valuable business intelligence. This would be heavily dependent on sophisticated IT structures which were interoperable across NHS and social services. We recognise that in the NHS quality is paramount and there is an escalation and intervention framework now in place across NHS Wales. However, there is an imbalance between the financial and quality duty, with the former more easily defined and measured that need to be addressed in any changed approach.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
In considering service change there is currently no requirement to complete a quality impact assessment, whereas there is for finance; equality; health needs, privacy etc assessments are required. In the existing economic climate, the reality of the situation is that there is a balancing act to be achieved in considering financial pressures with maintaining quality of service provision. Therefore the gap that needs addressing is making "quality" count and matter. The Health and Care

Standards were introduced to focus on quality and improving patient care, however there are no tangible repercussions if you do not meet all of the standards, but there are significant consequences if financial targets are not met.

Dichotomy between “quality” and “safety”, too much focus on quality in isolation. Need to factor in the safety element especially in light of the Mid Staffs review and the Andrews report.

Not just NHS priorities but this should be joint H&SC priorities.
The Social Services and Well-being (Wales) Act 2014 provides legislation on a citizen centred approach and how this can be achieved through partnership and integration. Before further legislation is required a review of the impact of this Act should be undertaken to ensure that it has facilitated a citizen focused integrated delivery of care and that the citizen’s are satisfied with this within the coproduction agreements and maintaining prudent health and care. ‘The Prudent Citizen’.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
We need to be clear what we mean by quality, especially in an integrated health and social care environment. In considering service change there is currently no requirement to complete a quality impact assessment, whereas there is for finance; equality; health needs etc. The views of the experts and the public are much different on this and the need to engage with people on this was stressed in Trusted to Care. Quality of care is dependent upon attitude, behaviours and cultures of individuals and organisations - rather than on legislation. Quality is a time and culture sensitive measure, would legislation be able to keep pace with quality development and would it be prudent within the time and context of the developing future? It may be more appropriate to consider how we could establish safe standards that could ensure consistency across the system and would have the same monitoring and audit arrangements that apply to the financial systems and the Annual Quality Statements would then have primacy and would be resourced accordingly.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
Given the issues above regarding quality it is difficult to see how such an individual could be responsible or accountable. Accountability lines within the NHS Wales at Health Board/Trust level are already clear. There is already an accountable officer in the Chief Executive and the Nurse Director is not only accountable as part of the Board but is also accountable to the Regulator.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
Following the aftermath of recent failings in managing quality and care standards within the NHS the principle of the introduction of a “fit and proper persons” test is supported. However, this should not distract from the primary responsibility of the employer to check that their Board members are competent in discharging their roles and responsibilities effectively and that they behave in a fit and proper manner and continue to do so for the tenure of their employment. Some questions to consider: 1. How will the test apply to those Directors who occupy a professional as well as corporate role (concern regarding dual regulation)? 2. How will the test differentiate between those who are clearly the decision makers versus the responsibility of a Board? Checks are already in place including professional regulation, DBS and financial matters such as bankruptcy.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
The term integrated planning refers to the integration of the systems within the NHS, whereas the Social Services and Well-Being (Wales) Act and the Well-Well Being of Future Generations Act are aimed at broader service integration and quality (however defined) needs to be seen in this context. It is not felt that we need to strengthen existing legislation further to promote quality through the NHS planning framework as this already makes adequate provision to promote quality. Perhaps what is more important is how this is embedded in practice at a local level. The development and integration of services has to be progressed through co-production between service users, service providers and the wider population so that they are configured to meet local need. It would be helpful if this was set in the context of an over arching health and social care plan for Wales. Many of the quality targets set down by Welsh Government are related to accessing services and it is the core Tier 1 targets on which health organisations are held to account. If quality is to be promoted as indicated this needs to be the core requirement within the planning framework and guidance. This will then lead to a full focus on quality throughout the system. As Health Boards improve the quality of their plans, the promotion of quality will develop and be much stronger. The danger of trying to legislate for this would be to impose further complexity onto an already complex process and the subsequent risk of reducing the quality of the plans. Rather the main

requirement in a cultural change in mindset and legislation is not the answer. Therefore we do not believe that legislation is needed to further strengthen the NHS Planning framework.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
This should be viewed in light of the section on quality. As indicated there may be merit in setting safety standards that can be easily monitored. Again the standards apply to the NHS and it would be helpful to have an integrated set of standards across Health and Social Care. This is particularly important given the changes in legislation mentioned above. The standards are mainly provider led and as integrated organisations it is important that these reflect all the accountabilities of Health Boards/Trusts. The Health and Care Standards have just been refreshed and these need time to be embedded and to be reviewed. Royal Colleges and Professional Bodies have specific roles in improving quality and setting standards. These standards need to be appropriately utilised to eliminate confusion within professions and organisations. A more robust and consistent system of inspection would be welcomed so the public could be better assured about the quality and safety of services.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
A common standards framework would be supported across Health and Social Care including the Independent Sector. This has implications for the function and role of regulators. Common goals and standards that complement each other and remove perverse incentives and enhance the overall journey and experience for the citizen would be welcome. Work has been undertaken in terms of the commissioning frameworks for CAMHS/Mental Health which has set out an agreed set of standards of care, this works needs to be reflected in all contracting arrangements with the Independent Sector.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
It is important to ensure development of such systems provide assurance to the public. Peer Review is an important process and whilst there have been examples of how this has been used across the service, it is time consuming and important that it is seen as an integral part of a role/s and not an add on. There are already a number of national bodies that provide accreditation and these need to be utilised fully to avoid the risk of duplication. There would be a need for consistency of approach which would be agreed by the Health Board. Whilst this would have much benefit across the whole system, this is a decision that could be taken at a local level and does not require any changes to the legislation framework. Mandatory accreditation across the sector would require the appropriate resource to support the cost of the accreditation process. Thought needs to be given as to the escalation of services that are unable to meet accreditation such as endoscopy across Wales as the current infrastructure is not to the accreditation standards. Would patients have to travel outside of Wales to access an accredited service until infrastructure is up to accreditation?

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Support the principles that this should be implemented as an integral part of health professional practice. Do not support the suggestion that this should require legislative changes as this would create more of a burden on organisations and individuals and this needs to be linked to the introduction of revalidation for nurses, and other professions to follow. There would be significant resource impact if this were to be legislated and this would require additional funding to Health Boards to ensure appropriate resources are allocated to undertake the role of clinical supervision. Good clinical supervision does improve services but legislation would not ensure the quality of the supervision just that supervision activities have taken place.

17. What arrangements should be put in place for self-employed health professional registrants?
The NHS could offer mutual supervision cover with private practitioners for example cross sector supervision or peer review arrangements.

There are a number of regulatory gaps which could be addressed through the requirements for clinical supervision, mandatory training and revalidation. The NMC are introducing a new Revalidation process - this requires all nurses and midwives to have a professional discussion to support the process.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
We are broadly supportive of the introduction of a statutory duty of candour in the aftermath of the failing at Mid Staffordshire NHS Foundation Trust. The Francis Inquiry Report made 290 recommendations including: o Openness, transparency and candour throughout the healthcare system (including a statutory duty of candour), fundamental standards for healthcare providers; o Improved support for compassionate caring and committed care and stronger healthcare leadership. Candour is defined in Robert Francis' report as: 'the volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made'. 'Prompt apologies and explanations, with a reassurance they will not reoccur, may prevent a claim being brought at all'. Mr Francis' recommendation 181 provides that there should be a statutory obligation of candour on healthcare providers, registered medical practitioners, nurses and other registered health professionals where there is a belief or suspicion that any treatment or care provided to a patient by or on behalf of their employing healthcare provider has caused death or serious injury. Provision of information should not itself be evidence or an admission of civil or criminal liability, but not disclosing the information should entitle the patient to a remedy. Candour (and its close allies openness and transparency) permeates throughout Mr Francis' report. Out of his 290 recommendations, several are drafted with those themes in mind. It is difficult to dispute that these are laudable recommendations. Promptly identifying negligence and providing redress for the patient and their family should be encouraged. Doing so quickly and efficiently will reduce expenditure on legal costs and should provide a better experience for the patient and their family.

It is likely that Health Boards/Trusts will be required to draft candour and disclosure policies to ensure all staff are clear about what their obligations should be in order for them to avoid liabilities arising.

While criminal sanctions may arise for senior individuals, Health Boards may also be held vicariously liable for the actions of their employees. However, there are other forms of redress and remedies that already exist for potential claimants and which may be more easily proved in a civil claim. Training on such policies may also be required.

Professional groups already hold this duty. If Boards could be held accountable for its emphasis and delivery this is more powerful. Legislation implies NHS Bodies do not want to be open and transparent. Putting Things Right and redress already require this and needs to be implemented fully.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
We need to be clear about what elements of performance are being referred to and where it is felt transparency could be improved. As indicated previously transparency will be greatly enhanced by the provision of real time information. Many of the systems in health do not provide this and mortality data and other information can take three months or more to produce. To ensure transparency is the norm the system needs to support this when media and other sources use information provided in ways that can be seen to damage the reputation of NHS Wales. Unclear how legislation could improve transparency, as this needs to be cultural/behavioural change. The performance framework for NHS Wales should ensure that NHS organisations are measured in terms of their transparency and openness. Performance is regularly monitored by Boards at public meetings and information is readily available on websites and this should be developed to be outcome focused rather than process focused. National IT systems should be available to allow NHS organisations to make their performance information publicly available and reportable. We need to look at the current legislation (e.g. professional regulatory duties of candour, Freedom of Information, published performance reports, annual reports etc). Information is available and could be made more transparent.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of

complaints across the NHS and social services in Wales?
There are already well established good practices in place for the joint investigation of complaints, although variable in development. The principles that there should be integration across Health and Social Services is supported. The complaints process should be an integrated process which ensures that the same principles and processes are followed. Health Boards work across health boundaries and the current system NHS Re-dress allows for organisations to agree the lead organisation and respond to individual complainants. There is an opportunity as part of the review of NHS Re-dress that this also includes primary and social care.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
There are many perceived barriers to sharing patient information across the health and social care system. These are set out in the ICO response however issues may increase as joint information systems are developed. The Data Protection Act does not prevent the sharing of personal data, rather its purpose is to ensure that when sharing takes place, it is carried out properly, ie. with due regard to the privacy of the individual. It sets out criteria that must be met in order for the sharing to be legitimate. The Data Protection Act is not considered to be a barrier to the appropriate sharing of information. There is no doubt that the *misunderstanding* of the Act does act as a barrier as it is likely to prevent legitimate sharing when staff err on the side of caution. Due to a lack of published national Information Governance Standards in Wales, there is often a lack of trust between organisations to ensure that once their information has been shared, similar systems, processes and security measures will be applied to that information to help prevent damage to the organisations reputation or application of a financial penalty. Organisations need to adopt a culture of sharing information where the benefit is improved care for an individual rather than using consent and other issues as a barrier. An increase in the use of mediation is also helpful in enabling patients to obtain closure. This is however an area where the Welsh Government can take action to ensure that all policies requiring partnership working are supported by current or new legislative provisions enabling data sharing. The recent Social Services and Well-being (Wales) Act 2014 and related regulations set a good example of ensuring that organisations have the necessary legal basis for

sharing information across the new partnerships. Such legal gateways can obviate the need for the individual's consent when sharing their information.

22. How can we consider breaking down any barriers?
The main issue here relates to consent and the reluctance to share personal information without explicit consent. Continued use of WASPI and the central arrangements would support the breakdown of perceived barriers. The Welsh Government has recently moved to a position of presumed consent for organ donations, following consultation and the adoption of a similar approach for personal information would create a paradigm shift in behaviours and approach.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
It is vital that our patients have confidence in our ability to protect their privacy, comply with the law and safeguard their personal health data. Data users within the health service must ensure that they obtain information about their patients properly keep it secure and handle it in accordance with the well established rules of medical confidentiality and the provisions of the Data Protection Act 1998. In addition, the Caldicott 'Report on the Review of Patient-Identifiable Information' identified weaknesses in the way parts of the NHS handled confidential patient-identifiable data and a result all Health Boards and Trusts were required to appoint "Caldicott Guardians" with a specific responsibility to ensure patient-identifable data was kept secure and used in accordance with the Caldicott principles. All patient-identifiable information, relating to living or deceased patients is confidential and must be treated in accordance with the Caldicott Principles. Research which makes use of existing patient identifiable data (and stored samples) must comply with NHS Caldicott Guidelines and have the permission of the Health Boards/Trusts Caldicott Guardian and be approved by the Information Governance Committee. It is also suggested that a "research governance framework" is adopted to safeguard public information and ensure consistency in quality of information. NHS Wales could also consider adoption of the IG toolkit which provides a framework to assess the systems, processes and attitude to information governance of an organisation and would provide assurance in respect to the question raised.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
The role of HIW needs to be reviewed in the light of the move towards integrated health and social care provision. In the meantime the effectiveness of HIW is more related to the resourcing and operating procedures within which they operate rather than legislative issues. The role of the regulator in the English NHS is seen to be much more powerful than in Wales due to both the way inspections are carried out (based on the Keogh reviews) and the sanctions that are applied. This raises the issue of the ethos of working of Inspectorates e.g. supportive/ punitive. Given what is stated above and given the Marks review and the findings of the independent reviews that have found investigatory failings in multi agency investigations, there need to be clear investigatory leads and full co-operation.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
The NHS needs a strong and effective Regulator and it is likely that the public would have more confidence in the Regulator if it was independent (not arms length) from Welsh Government.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
As indicated previously clarity is required about what is being inspected and whether this relates to core minimum safety standards. If these are joint standards between health and social care then a single inspectorate would be advantageous. An integrated provider should only have one regulatory framework to work within and not have both regulators asking sometimes contradicting requests of the provider. Should a provider need dual regulation a lead regulator should be independently nominated to regulate the provider. Learn how to do things better rather than just applying punitive sanctions. A question is raised why the role of Auditor General has not been considered as part of the inspectorate discussion especially in light of the tripartite

escalation discussions.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
With clear minimum standards and a single inspectorate it would mean the arrangements are easy to understand. The main advantage to citizens would depend on the methods of working and the way people can be engaged in the monitoring processes with citizens knowing how to raise concerns. Citizens would know where to go. A single inspectorate would enable the inspection and regulation of services that support citizen focused independence and well-being and not just health or social care provision. This would create a stronger less complex system for patients, public and the service to understand and prevent issues falling between organisations. However, this may dilute the focus on each area if there is a drive for generic standards and inspection, particularly given the highly complex nature of health care provision. Such a move must be properly resourced and introduced in a careful, incremental fashion.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The role of the CHC is an important one which should be maintained. Refocusing their role on representing the patient voice and improving advocacy services seems an appropriate way forward, providing that clear mechanisms and structures are established. If they are given such a remit, consideration needs to be given to the appropriate 'weighting' of the feedback received and how this is played in to any formal consultation mechanism the NHS is required to undertake. In order to do this effectively their membership will need to be reviewed and be representative of the population served rather than through the current arrangements. Consideration for remuneration of Chair role due to the important nature and stature of this role. Consideration should also be given to the duty placed on CHC to identify alternatives to service change as the question should be raised whether the membership is clinically qualified to do this.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
In taking the above suggestions forward, stronger links between Town and Community Councils and the Local Authority Scrutiny Committees could be considered, thereby ensuring to a certain degree, some democratically elected input. The CHC role in terms of scrutiny of healthcare and their links to HIW needs to be addressed. Currently, both organisations work largely independently and revising legislation to make the CHC an agent of HIW merits consideration. Such a move would address some of the current issues and criticisms in terms of lack of integration between Health and Social Care at a grass roots level. In any restructuring, given the economic backdrop, care needs to be taken not to add further complexity and duplication to the system, but to use this as an opportunity to streamline.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Giving Health Boards borrowing powers would increase the flexibility of resource across revenue and capital and enable NHS providers to modernise and improve estate at a greater pace than is currently achievable. This needs to be balanced over revenue to pay back any borrowing and requires some form of underwriting to facilitate competitive borrowing rates. Limited opportunities with strict guidelines and limits could be made available. Reflection and lessons learnt from the English Foundation Trust model.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
There is an opportunity to review the entire reporting arrangements and processes within NHS Wales and simplify these. This does however enable the public to see the All Wales NHS accounts. Accounts should be prepared in such a way to disclose as much information to the reader. Health Boards (with guidelines for minimum disclosure) should have the autonomy to publish results in the most meaningful way to their

public; all subject to WAO approval of course. Within the Health Board, providing summarised accounts are important in terms of demonstrating transparency and accountability to the general public, although the timing of publication (September) detract from this value.

32. 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?
There is an opportunity to review the entire reporting arrangements and processes within NHS Wales and simplify these. Please see above.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
The Health Boards should be accountable for the planning of services for their resident population however the role of Trusts is different. There should be a similar duty which expects Trusts to have approved plans and strategies to deliver commissioned services.

34. 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?
Support the principles of a one system approach across Health and Social Services and the impact of this new legislation should ensure alignment. Do not support the review of the act to create even more complex governance structures than what already exist. It is not felt necessary to review the 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. Public Service Boards will provide leadership and alignment of planning duties to meet our shared aims with our partners.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
It is difficult to answer such a broad question succinctly so each category has been separated. Leadership:

To answer this fully it needs to be clear which leadership community is covered here and the expectations of this group as the term leadership is very broad. If it refers to Boards then it needs to be responded to in terms of Question 36.
Potential to review the role of Director General to consider separate of role to facilitate All Wales decision making.

Governance:
As indicated earlier the governance arrangements in NHS Wales are complex, as highlighted by the WAO recently. The governance arrangements could be simplified greatly if an All Wales body was created to manage All Wales service matters. A more radical model would be to create a Strategic Health and Social Care Body for Wales.

Partnerships:
Legislatively the new Act will place a duty to integrate on LA and Health Boards and this is welcome - but does it go far enough? It should ensure that it is mandatory to have strong partnership governance in place via Section 33 Agreements and also a shared approach to risk management, performance managements, information sharing and work to align processes and procedures. Shared Services across NHS Wales are currently hampering this as they are not working well and also prevent local integration and improved local performance.

Reinforce arms length for Inspectorates.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
When considering the Board membership it is necessary to consider the breadth of portfolios required by health organisations to deliver against the current policy drivers. Board membership needs to give adequate Board level resource to allow robust fulfilment of each portfolio item and ensure Board members can fulfil their obligations and accountabilities. This includes ensuring appropriate skills base on Boards, particularly to cover complex professional issues across the entirety of Health Professions, and to ensure there is a strong, clinically focused cohort of Board members. The Board should be able to decide the Executive structure (Officer Members) that is needed rather than being prescribed. There should also be more flexibility in relation to Independent Members rather than being prescribed the background which is needed. The current Health Board membership is based on a stakeholder model. This has advantages but does not mean there is an effective focus on decisions. The current Board configuration of 20 members is considered too large. The current SI should be replaced by one that provides Boards with more

autonomy to determine the size of Boards and the skills required on Boards, within prescribed upper limits. Consideration also needs to be taken of the recommendations within the Williams Review.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
The set number of Executive Directors should be clarified and scope provided as to roles within minimum/maximum numbers e.g. it would be required there is a Chief Executive, Medical Director, Nurse Director, Public Health Director and Finance Director and Boards can appoint up to 3 further Executive Directors.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
It is difficult to see how this will work in reality with current governance structures in NHS Wales. The benefit of accountability to local communities can be seen however concerns remain regarding the capability of local elected members to deal with the magnitude and complexity of the agenda. Careful consideration needs to be undertaken as locally elected members could lead to politically elected appointments influencing health care provision. This would partly depend if the aim is to move more towards stakeholder Boards. Consideration of the Rowntree Foundation Research needs to be undertaken.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Alignment of local organisations will need to be determined with implementation of the new legislation. Legislating for this at this time may be more restrictive than empowering. This could be an area for real innovation and also the PSB could have the local Director of Public Health as part of its membership - unique role. This role is not the only executive role that should be considered as there is an opportunity to look at greater joint/dual roles. Consideration should be given to: dissolve Public Health Wales to local Health Boards and; for Public Health to have a joint role with Local Authorities.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Health organisations should be given more freedom to appoint Independent members (Non Officer Members) with the skills the Board feels it needs rather than the current model, which is prescriptive. The current arrangements for Associate Board members and Board advisory forums e.g. SRG and HPF are variable across NHS Wales and there remains a lack of clarity and purpose of these which warrants consideration. Consideration of the staggering of Independent Members appointments to avoid instability when terms of office end. The Trade Union Board member should be selected by workforce and become an associate role.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
Nothing to add.

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
Ability to appoint a Vice Chair should be incorporated within the membership arrangements.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
The role could be set out within the SI. The role could be strengthened by taking cognisance of the role of the Monitoring Officer within Local Authorities which in accordance with the provisions of the Local Government & Housing Act 1989 and 2000 Act makes the role a statutory requirement for all LA's. This provides them with a legal duty to report on legal issues and maladministration, manage the code of conduct and complaints associated with conduct of Principal Officers and elected member and manage the standing order's etc. The Local Government (Wales) Measure also provides a statutory resource to support the Monitoring Officer undertaking his/her duties, specifically the appointment of a "Head of Democratic Services" role to fulfil the corporate requirements of the role. The only caveat here would be that in an NHS environment the role would not need to have a qualification, and would require tacit experience of NHS operations and governance instead.

A professional governance operational lead within Welsh Government with whom the Board Secretaries on transforming the governance agenda would be welcomed.

44. If so, what aspects of the role should be additionally set out in law?
Linked to the above response additional aspects could include the Board Secretary role as a statutory role with a specific job description that would be included in Standing Orders so as to avoid deviation of duties across different Health Boards/Trusts. The role would be directly accountable to the Chair of the Board.

45. How could potential conflicts of interest for the board secretary be managed?
There would not be conflicts of interest if the role is clear, professionally discrete, with no broader operational management responsibilities. The importance and status of the role may also be strengthened if there was a professional head within Welsh Government. Making the role accountable to the Chairman of the Board and providing the role with powers to challenge the Board and CEO team if required, as currently available for Monitoring officers in Local Government.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Unclear on the status of the previous review that had been undertaken. There is often a disconnect between some of the national groups/committees and local decision making. The Clinical Networks have been reviewed and it is important that the work led by the service is integrated into any proposal to change the way in which the Ministers obtain clinical advice. There is a disconnect between national groups/committees and local decision making. This includes the lack of focus for health professional forums as advisory committees of Health Boards which have limited value and impact currently.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
A question could be raised that this is at odds with current and proposed arrangements to engage the public and other stakeholders in service change.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Suggest we explore fully the implications of the Social Services and Well-being (Wales) Act 2014 and the Well-Being and Future Generations (Wales) Act 2015.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
There needs to be a common definition with hosted, joint and shared services and clarity of the associated governance arrangements. The current framework does not allow for Health Boards to host organisations unless set by Direction. All NHS Wales organisations should be given this power. The increasing number of hosted bodies, committees etc has created complex governance arrangements which are difficult often to operationalise. Each of the current hosted organisations has separate governance arrangements, Standing Orders etc. It is not clear why these are necessary as the hosted organisations are required to comply with the host body governance arrangements. The collaborative arrangement for some committees is difficult with Providers and Commissioners as part of the decision making process with IMs drawn from the Health Boards. A review of the current arrangements will enable simpler governance arrangements, more consistency across Wales and also integration where feasible. Describe the role of a hosted body including lines of accountability to the host and Welsh Government where appropriate. Any such governance should be strengthened through service level agreements with Health Boards to ensure that the entity is fully responsive to the needs of the service and individual clients and can demonstrate it provides value for money for all customers.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?

Shared Services need to step up further and procure (and negotiate prices) for the coordinated purchasing of goods and services. The services of the Shared Services need to be properly developed, or bought back in house, before any consideration is given to providing services to the wider public sector.

There are significant risks that a wider expansion will make the service even less responsive to the needs of the Health Service, which would need to be carefully managed.

WGGP076 – Andrew Davies – Abertawe Bro Morgannwg Health Board
Tref / Town – N/A

General comments

Response to Green Paper - Governance overview

The current arrangements
Health boards were established in 2009, following a large scale restructuring of the NHS in Wales. Over recent years health boards have begun to realise the potential of the benefits of a vertically integrated system expected when they were established and across Wales there are positive examples of joint working/partnership arrangements which are benefitting local populations. Given this, we believe strongly it is not the time to consider wholesale structural change in the NHS in Wales.

Planned Legislative changes
Stability within the NHS is extremely important at a time when the full implications of the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 which will be fully effective from 2017. It is also important to be cognizant of the recommendations made within the Williams Review 2014. (The report of the Commission on Public Service Governance and Delivery).

Whilst the totality of the implications of the Social Services and Well-Being (Wales) Act and the Well-being of Future Generations (Wales) Act are not yet fully understood, their introduction will transform the way the health and social care system operates. This, in turn, will be further impacted by the development of GP clusters/community networks. It is helpful that any legislation being considered as a result of the NHS Green paper will not be developed in isolation and will be drawn up to complement and be consistent with these emerging legal frameworks.

As health and social care services increasingly work together to define and deliver against agreed aims and objectives through the existing Local Service Boards and proposed Public Service Boards, the current governance and management models operated by the NHS and local government in Wales may require further change.The role of Welsh Government (in its broadest sense) in leading and managing this transformational change is pivotal and clarifying this as part of any legislative change would be helpful. Any new legislation drafted should positively encourage the delivery of an integrated health and social care system across Wales.

Ongoing engagement with the public, patients and partners is critical and determining how this is best managed would require detailed consideration and planning. This would need to include how to facilitate engagement which will help to shape and build the joint plans which likely to be built up from GP cluster/community network level through Local Service Boards to the Public Service Boards.

Suggested principles

In this context it is important to consider what are the underpinning principles on which the health (and social care) system should be developed and judged, e.g.

- be citizen-centred and easily understood
- be based on Prudent Healthcare and co-production and allow decisions to be made at the nearest point to the citizen as possible
- encourages service integration
- encourages consistent standards.

It is possible to review arrangements based on these principles without the need to consider further legislation.

Improving the current arrangements locally

Within the existing arrangements within Health Boards and Trusts the current statutory instruments are prescriptive in respect of issues such as

- Board membership
- Board Committees/Advisory Groups
- appointments of associate members

These arrangements were developed from previous models and are based on a stakeholder rather than a decision making model for Board working.

It would be helpful to review these arrangements in light of the overarching principles suggested above and the relationship the Welsh Government wishes to have with Health Boards/Trusts going forward.

If a review of the existing Statutory Instruments were to take place it would be an opportune time to review the names of Health Boards so that there was consistency in names, e.g. geographically based. This could also significantly assist with recruitment.

Improving the current arrangements nationally

From a wider perspective it is important to recognise that the current overall governance arrangements in NHS Wales have not been designed but have evolved over time. This has led to the establishment of a number of Groups/Joint Committees at an all-Wales level. These all have differing governance/accountability and reporting arrangements. Examples include:

- WHSSC
- EASC
- Shared Services
- NWIS

In addition there are a number of "hosted" organisations, again with different hosting arrangements. Examples include:

- Delivery Unit
- 111 Service
- EMERTS

There are potential opportunities to standardise and rationalise these arrangements, e.g. through the establishment of a single all-Wales body to manage/host these arrangements. Such a body could also provide strategic direction for the NHS in Wales. The creation of such a body could have implications for the current role of the Director General and Chief Executive of NHS Wales and there may be merit in consideration being given to separating these roles to reduce the risk of a potential conflict of interest.

The Board Secretary role

This is a pivotal role in ensuring effective governance arrangements are in place. It is important that the role is given proper status and this status could be strengthened by including the need for this role within the Statutory Instrument on membership regulations. This should specify the need for the role to be separated from any operational management requirements.

This status could be further enhanced by changing the role title may assist in ensuring the role is perceived at a senior level, e.g. Director of Governance or Director of Corporate Services. It will be important to see this in the context of the current NHS job evaluation and grading system. The evaluation criteria makes it difficult to fully recognise the role of the Board Secretary, although the role requires the Board Secretary to challenge and to be seen as Director level in the organisation.

A possible model could be based on the role of the Monitoring Officer within Local Authorities which is in accordance with the provisions of the Local Government & Housing Act 1989 and 2000 Act.

Culture

There is perhaps a further dimension which is not fully explored in the Green Paper, which is the culture, values and behaviours that we are looking to develop and mature. Evidence clearly indicates that culture is more likely to have a more profound and positive impact on the way services are provided than legislative change alone. There is some evidence that legislative change can have unintended consequences encouraging adversarial behaviours, leading to poor decision making.

Perhaps the critical factor is that legislation alone will not necessarily lead people to modify and change behaviour to achieve the desired outcomes. This would suggest legislative change should be seen as the last resort and not the first.

Response to specific questions

No response to specific consultation questions.

WGGP077 – Paula Martyn – Hywel Dda University Health Board Stakeholder Reference Group
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority?
Legislation may not always be the answer, good leadership, good clinical and corporate governance, and good financial management is also required. More needs to be done to strengthen local collaboration, and need to encourage good partnerships not competition between sectors (as legislation may impact only on one organisation and set organisations against each other).

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The current regulatory bodies - HIW, CSSIW and CHC - may need statutory agility to have oversight of the whole patient pathway. Legislation may actually need to be relaxed as it can bring with it funding issues, etc., which makes it very complicated. The Future Generations Bill should be the vehicle for this - nothing else should be needed. Inconsistency in terms of quality and efficiency is an issue across Health and Social Services across Wales.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
There should be no need to legislate, indeed this could be seen as negative (i. e. forcing people to do it), and legislating for this is less likely to result in change, and therefore counter-intuitive. No one size fits all in regard to consultation, but needs to be tailored. There needs to be shared ownership of decision-making and a more positive united approach to change with all facts shared.

5. Should we consider establishing, on a statutory basis, the requirement for

health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
One size does not fit all, and needs to be allowed to evolve; it can become institutionalised if it's too prescribed. There is no one way of doing it so until that time the answer to this question is no. Supposed to tailor engagement mechanisms to fit target audiences - again, this could encourage only the minimum standard to be met (which is the problem with a target approach).

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Taking referrals away from Ministers would take the politics out of this. Could support this if the Expert Panel is made up of the right people with the right clinical mix and no politics involved (acknowledging the difficulties involved as the composition of the Expert Panel is likely to need to be constituted differently according to each issue). All will need to be comfortable with the constitution of the Expert Panel.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Legislation perhaps to make Health and Social Care work together (i. e. reduce the number of Local Authorities from 22)s. Potentially legislation does play a part, but there needs to be a streamlining of what is currently in place.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
Whilst there are no major repercussions for not meeting quality targets, there are for not meeting financial targets, and this needs to change.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Rather than legislative measures, it would be better to focus on strong management, clinical leadership, etc. - quality is everyone's concern and joint ownership is key.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
Would not agree, A "responsible individual" could be seen as a scapegoat. Needs a more corporate culture.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
There are some very welcome elements in the planning guidance and it is frustrating when plans are turned down due to finances - often it feels like an impossible task. Perhaps the principle of prudent healthcare need to be looked at in terms of patient healthcare. The IMTP is a very useful focus for the SRG but any changes do need to be able to be financed.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
There needs to be an integrated set of standards across Health and Social Care - and standards that can be easily monitored. Need to allow for innovation without compromising quality.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Would support a common standards framework.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Need to question how independent such a peer review would be.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Lesson learned from the Francis Inquiry - to admit fault immediately. Learning organisations learn from their mistakes. There is therefore a strong case for this. Mistakes do happen but it is how these are addressed when they happen that is important. This may not require a change in statute but a culture change

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Need to question whether the performance being measured make sense to the public - it is more about what is being done in response to poor

performance.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Need to introduce consistency rather than separate guidance for each.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Bureaucracy, data protection without understanding it, IT systems that do not relate to each other.

22. How can we consider breaking down any barriers?
It is about educating patients that we need this information recognising this is patient's information. Also need IT systems that communicate with each other.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Would support this provided the sharing of information is consented to.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
HIW is not independent and it needs to link in with CSSIW and the CHC. Also a role for the CHC linking in with HIW, and HIW with CSSIW to be more integrated. There are areas that HIW do not cover as mentioned in the Green Paper. If everything was currently effective we would not be seeing the present major issues.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
No.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
More integration to support innovation.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
Can cover the whole patient journey.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Would support a more wholesale review as the public have to understand the role of the CHC. Would want to optimise not minimise the CHCs role and link it with HIW and CSSIW. The CHC needs to be closer to patients and there needs to be local regional presence.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
Has to focus on Social Services and link in with Local Authority's scrutiny process. Not aware of National Social Services Citizens Panels. Representing patient voices should mirror GP clusters.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
No.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant? 32. 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?
Need to have clear accounting systems in place.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes for consistency purposes.

34. 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.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
This is more about culture than introducing legislation.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Need Independent members to be more engaged externally to be able to better represent the issues involved. Beneath the Board there may need to be groups to represent patients and carers. Could introduce shadowing as a concept.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Yes for local flexibility.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
Yes this could be considered.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Would agree.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
Yes - around ethical leadership, accountability, openness, honesty i.e. a much stronger role than currently.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Need amending as current partnership working arrangements can serve to block some of the good work being undertaken across Health and Social Care.

WGGP078 – Emily Bacon
Tref / Town – Caernarfon
Sefydliad / Organisation – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Patient panels and participation groups are undoubtedly examples of good practice. However, I'm unsure whether legislating for this would really be practicable. When it comes to consultations regarding service change, members of the public absolutely must be given the opportunity and should be actively encouraged to engage. However, they can't be forced to engage. If legislation dictates the need for patient panels and participation groups, what happens if there are no patients who are willing to take part? How would the Health Board fulfil their obligations? Would the legislation specify which areas of healthcare would have panels or participation groups or would it be for the individual Health Boards to decide based on the local needs?

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
It is vital that the independent watchdog (i.e. the CHC) has the necessary powers to act effectively where systems fail. I can agree that a referral to the minister is the result of a system failure but it is an inescapable fact that systems do sometimes fail. It is the role of the independent watchdog to act and address system failures and, without the power to refer, the CHC becomes what it has often been accused of being – a watchdog with no teeth. CHC recommendations and comments just become a nagging voice in the background unless CHCs have the opportunity to refer the matter to the relevant authority i.e. the Minister. Whether an independent panel would be a suitable alternative really depends on the makeup and the role of the panel. Would the panel have the power to enforce change or would they be just another advisory body? It may actually be advantageous to have a panel of independent experts who can scrutinise a Health Board's proposals from a position of specialised knowledge and experience. However, it is essential that the legislation empowers the recipients of any referral to overrule the

Health Board's decisions – particularly when the proposals fail to comply with existing legislation with regards to public engagement/consultation.

Chapter 3: Quality in Practice

Meeting common standards

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
It would seem to make sense for all healthcare providers (both NHS and independent) to have to adhere to the same minimum standards. This is, of course, providing that the guidelines/standards are evidence-based and regularly reviewed.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes. I can see no way in which a statutory duty of candour would be a negative thing. One of the most common concerns around complaint responses is that things may be covered up. Openness and honesty is better for everyone – it promotes service improvement and engenders an attitude of mutual respect between the service and the public. Ironically, covering things up to try and "save face" actually damages the organisation's reputation and leaves the public feeling unable to trust those delivering the service.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
The regulations currently allow for complaints about primary care services to be investigated jointly. Although the redress element doesn't apply here, it allows for a joint response to be provided in order to streamline the process from the patient/complainant's point of view. Based on the assumption that the Social Services complaints process follows WG's "Model Complaints and Concerns Policy and Guidance" the differences between PTR and the Social Services complaints process are presumably minimal. As such, it would make sense to allow for cooperation between Health Boards and Social Services to produce a joint response. I do think that, in an ideal world, there should be a complaints advocacy service for Social Services complaints, equivalent to that provided by the CHCs for NHS complaints. Ideally this would be one, integrated service to

keep the process as simple as possible for the complainant. However, in practice, this would require a major injection of resources to expand the service as well as a fundamental change in the legislation governing the overall function of the Community Health Councils. It would be of huge benefit in terms of the patient/complainant's experience of the process to have a skilled advocate support them in coordinating the complaint across the different organisations. However, it could not be done without additional resources and so no change in legislation should even be considered without the commitment to resource the implementation. Were the CHC regulations amended to include advocacy for Social Services complaints, careful consideration would need to be given to whether this could or should include expanding the other functions of the CHC to include scrutiny/engagement in respect of Social Services. It would be a major shift and expansion in the CHC's role. My initial instinct is that this would not be appropriate or practicable.

Undoubtedly, in my mind, revisions to the PTR regulations are needed. I am unclear as to what the current process is for revisions to be made and who has powers to do this. I therefore feel inadequately informed to comment on whether primary legislation changes should be made to afford such powers to Welsh Ministers. Any revisions should be carefully considered in consultation with those involved such as NHS complaints/concerns teams as well as CHC Complaints Advocates.

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
"Refocusing" the CHC's role to exclude inspection/monitoring would require a fundamental change, not only to the legislation, but to the whole make-up of the CHC. The vast majority of member activity involves inspection visits and monitoring activities. Without this, would the members be necessary at all? Without the members, the CHC is no longer a "council" and would become a completely different type of service – if it survived at all. There are a number of advantages to keeping the core functions of the CHC together, in the current model. The shared intelligence of the different functions helps to inform the work of each and creates a strong base of specific local knowledge. The advocacy service and engagement activities help to inform the inspections and highlight areas of particular concern. It is also an advantage that the council is made up of local people, representative of the local communities they serve. They are lay people who may well be patients of the same NHS services themselves. As such there is a greater understanding of the local picture as well as an increased level of personal investment in the particular services they inspect. CHC members

have more than just a professional interest in the services being of a high standard – they could well find themselves or their family members accessing the very same services.

There may also be an increased willingness among patients and the public to engage with and speak openly to CHC members because they are local people with a lay perspective, particularly focussing on the patient's experience of the service, rather than clinical guidelines and policies.

Because of the number of voluntary hours provided, the CHCs are also able to inspect far more regularly and consistently than a national organisation such as HIW and this creates a culture of continuous monitoring to ensure standards are raised and are kept up in the long-term.

Perhaps, above all, the effectiveness of CHC inspections speaks for itself. There are numerous examples of Health Boards making excellent use of the intelligence provided to them through CHC inspection reports in order to improve services. The frequency and regularity of CHC inspections mean that problems can be identified quickly and rectified quickly. One, over-arching, national body simply cannot provide this level of ongoing intelligence at a local level. In other words, if the Health Board had to wait for the HIW inspection to highlight any areas for improvement, they could be waiting years and it could be years again before any follow-up visits are made to ensure that the recommendations have been implemented. CHCs have the advantage of volunteer hours to do the leg-work in order to keep on top of things at a local level.

One way in which the CHC's role as the patients' representative could be strengthened is to consider how members are recruited – are they a truly representative cross-section of the population that they serve? I am not familiar with all the details of member recruitment processes but this is something that could perhaps be considered and there may well be room for improvement to ensure representative diversity according to the local population. However, how this is interpreted through legislation needs careful consideration. Each local area will have a different demographic to represent and specified diversity "quotas" should be avoided to prevent positive discrimination. Recruitment should be undertaken intelligently and selectively but not prescriptively.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
In a word, yes. The current model of one CHC for each Health Board area presents very few, if any, complications when it comes to the increasingly integrated system of healthcare provision. CHCs represent the interests of the patients living in their area. It is of little consequence whether those patients are accessing services from within that same area or whether they are being treated across the border. CHCs work closely together and share best practice to ensure that the national picture can be pulled together as well as the local. It is also advantageous for CHCs to be situated according to Health

Board areas as this enables close working with the respective Health Board which further promotes local knowledge and effective partnership working.

See comments for Question 20 in relation to the impact of CHCs of the integration between Health and Social Services.

WGGP079 – Mark Elliot – Wales Heads of Environmental Health Group
Tref / Town – N/A

General comments

We write in response to the above consultation and would wish to make comments regarding para 123 and the question of joint appointments in particular in relation to Directors of Public Health. The Wales Heads of Environmental Health Group represent the professional heads of Environmental Health services of all local authorities in Wales. It aims to protect and promote public health and help address inequalities in health through the effective, efficient and consistent delivery of environmental health services.

We believe that there is significant merit in considering the establishment of joint appointments between local authorities and the NHS for Directors of Public Health.

We subscribe to the basic public health principle that local people should have a say in matters that impact upon their health and well-being and acknowledge that the concept of LHB Directors having joint accountabilities to local authorities may be one step towards addressing the issue of democratic deficit within the NHS.

Additionally and importantly we feel that such a move can help strengthen the public health perspective of local authorities. Local government has a key role in public health and protection. Indeed Local Government was originally founded to address public health issues. Environmental Health Practitioners have long been seen as the primary public health professionals within local authorities, founded over a century ago. However, as the Wales Audit Office's 2014 Report [1] "Delivering with Less" highlighted, Environmental Health Departments across Wales have experienced savage cuts. There has been significant loss of senior posts and the public health voice in local authorities has been depleted significantly, especially around the "top tables".

In the climate of austerity local authorities are having to make challenging decisions and it is vital that the public health impact of those decisions is adequately assessed and properly considered. We are concerned that such decisions are taken with insufficient regard to public health impact nor sufficient regard to other delivery options. In particular an evaluation of effectiveness of interventions, with the robustness that Public Health Specialist input can bring, may bring significant value. Such an approach is vital if Welsh Government is to deliver its ambitions set out in the Wellbeing of Future Generations Act.

We acknowledge the work of Durham University [2] in assessing the potential for joint appointment of Directors of Public Health in England. Given the implementation in England, we would wish to review the experience some 2

years on. We note also the Local Government Association's publication "Public Health Transformation twenty months on". We reflect the views of many who believe that Local Government is the right place for Public Health BUT only if its resources are adequately protected. However, it is important to acknowledge the importance of the three traditional spheres of specialist public health work – health protection, health improvement and health service quality. We believe that any proposals need to be cognisant of that.

We would suggest that an approach of (merely) joint appointments of DPH's is unlikely to deliver real value within the current structure of local authorities and LHBs in Wales because one LHB could currently have up to 6 local authorities and clearly one DPH could not effectively give time to all 6 plus their LHB! Other models are possible - including appointing consultants to each LA under a jointly appointed DPH.

To conclude. We hold the view that there is real merit in considering this proposal further but work is needed to ensure that potential benefits are realised and unintended consequences are minimised. Consideration of wider issues is also needed to ensure that public health resource (and importantly we do not mean "social care" resource) and public health considerations within local government are protected and strengthened.
We would be very pleased to contribute to further discussions on this matter.

References:
1. Delivering with Less – the Impact on Environmental Health Services and Citizens. Wales Audit Office Cardiff, 2014.
2. Perspectives on Joint Director of Public Health Appointments. Durham University. IDEA, London, 2008.
3. Public Health Transformation twenty months on: adding value to tackle local health needs. Local Government Association, London, 2015.

Response to specific questions

No response to specific consultation questions.

WGGP080 – Andrew Fletcher – Wales Information Governance Board

Tref / Town – N/A

General comments

Response to specific questions

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
The Board is of the view that there is in general a culture of risk aversion amongst NHS professionals that needs to be addressed. The Board are aware that the law is very complex with multiple layers that must be considered; however it is the Boards view that it is a lack of understanding that is the biggest barrier to information sharing. The Board feel the area that would have the most impact on improving information sharing is not changes to legislation but rather the provision of clear, accessible guidance for health and care professionals that explains what can and can't be done in a simple step by step format. In relation to identifying the issues preventing healthcare bodies from sharing patient information, the Board draw attention to the detailed analysis and recommendations contained in the 2013 report Information: To share or not to share? The Information Governance Review led by Dame Fiona Caldicott and in particular a new 'seventh Caldicott principle': 'The duty to share information can be as important as the duty to protect patient confidentiality' (as noted in Welsh Health Circular (2015) 013). The Board suggest that the content of the 'Caldicott 2' report should be reflected in any guidance that is developed. The Board also strongly agree with the underlying ethos of the 'seventh Caldicott principle', namely that health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by the Caldicott principles and most significantly they should be supported by the policies of their employers, regulators and professional bodies. To this end the Board supports development of all Wales policies that set out consistent standards to support the safe and lawful sharing of patient information, for example disciplinary procedures that ensure inappropriate access to patient information is dealt with in the same way in all organisations, irrespective of a position or role.

22. How can we consider breaking down any barriers?
The Board note that any guidance produced should be cognisant of the need to share information with health and care organisations outside of Wales; this is highlighted as a particular requirement for organisations that border England. The Board are of the view that guidance produced should be consistent with guidance available in England. **Patient Informing** The Board are aware that there is evidence to support the premise that patients expect their information to be shared for their 'direct care' and most sharing would meet the 'no surprises' test – i.e. that the patient should not be surprised that the information had been shared and that contact should only be made via a provider that the patient would expect to contact them. However the Board highlight that even where there is a legal gateway to sharing the requirement that the patient must be informed must be met. Although challenging it is vitally important that best efforts are made to inform patients and the public about how their health and care information is used and shared. The Board are of the view that this is an area where a more co-ordinated and sustained effort is required, to meet not only the compliance aspect but also in order to maintain the confidence of the public, and the professionals who need to share information in order to provide care. **Staff training** The Board note that associated with the need to produce clear guidance for health and care professionals is the need to ensure adequate training is provided. The Board recently received the Information Commissioners report on Information Governance Training in NHS Wales and fully back the position that all staff should have appropriate and up to date training in data protection, supported by clear policies and procedures. As noted previously the Board are of the view that such policies should be 'national' policies, ensuring consistency across all organisations. **Information Governance assurance standards and scrutiny** In order for organisations to have the confidence to share with one another there must be an appropriate mechanism for them to assess their information governance compliance and to demonstrate this to organisations with whom they share. Currently health boards and trusts are required to undertake an annual self-assessment against the NHS Wales Caldicott Principles into Practice (C-PIP), with general practice and community pharmacies assessing against a 'scaled down' version known as the Information Security Management System (ISMS). The Board agrees with the recommendation of the Information Commissioner that the C-PIP process should be reviewed, revised and strengthened. The Board will, in due course make recommendations to Welsh Government in this regard. The Board is aware that a closer alignment to Information Governance Assurance with England would ease difficulties that have arisen when sharing information outside Wales for research and for direct care. It is recognised that the divergence on how Information provisions were set

within the Health and Social Care Act 2012 do not translate in the same way within the statutory responsibilities of NHS Wales organisations.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
There is already extensive guidance available to health and care staff about the use of information for direct care but less so for research purposes. Studies show that the majority of people are happy with their information being used for audit and running of the NHS, which are taken to be part of direct care. The majority are also happy with use for research but the key message is that they do want to be told about it and asked in some circumstances. There is more of a problem with requests for use of data when the research has a more commercial focus. It is known that there is a perception and discomfort felt by the public and less support for this use. Approving requests from these groups is more problematic and difficult to make consistent decisions on. The Board is of the view that there is a significant amount of work that needs to be done in respect of informing the public and organisations about use of information for research and other secondary uses; for example it is known that there is often a lack of understanding with GP practices.

WGGP081 – Rhion Jones – The Consultation Institute Centre of Excellence
Tref / Town – N/A

General comments

This response is from The Consultation Institute, a not-for-profit, best practice body he whose mission Is to promote the highest standards of public, stakeholder and employee consultation by initiating research, publications and specialist events in order to disseminate best practice and improve subsequent decision-making.

Whilst the Green paper raises many issues of interest to the Institute and its members, we have chosen to confine our answers to specific questions which we deem to be of greatest relevance, and where our knowledge and experience may be of greatest value.

We have comments to make in response to questions 4,5 and 6 in Chapter 1 and questions 28 and 29 in Chapter 6.

Chapter One: Continuously engaging with citizens

A brief commentary

This Section in the Green paper is a broadly fair reflection of the issues, but suggests that continuous public engagement can eliminate controversy, and we believe this is a somewhat optimistic assumption. We specifically disagree with the statement that *"Referral of plans is a failure of the process"*. Were this to be true, the 'process' would be seen by the public as deliberately designed to discourage disagreement and place undue pressure on participants to suppress dissent. A referral process is seen by local communities as a last resort mechanism of appeal whereby opposing views can be considered by those previously uninvolved in the issue before a final, politically accountable decision has to be taken.

If undertaken properly, continuous public engagement should serve as an effective filter to prevent issues from being escalated beyond local levels unnecessarily.

It should include provision for routine service changes to be considered without the cost and organisational burdens of an extensive formal consultation procedure. We therefore agree that 'formal set piece consultations' should be relatively infrequent, but disagree with the Anne Lloyd recommendation that they should be confined to 'fundamental' changes to the service. Such a formulation would, in our view add further to the confusion over when a consultation is necessary, would encourage further litigation and be operationally unworkable.

To stimulate better continuous engagement, we suggest

- Significant improvements in the IMTP process to support a dialogue with interested stakeholders and to set the agenda for change in a timely way
- The development and encouragement of more local forums based on the 64 Primary care clusters in Wales, building on the PPG concept which we believe to be underdeveloped.
- Greater clarity for the role of CHCs (see below) in respect of their remit to act as the pubic and patient voice, but with resources and skills to reflect the views of the cluster-based forums.
- Health Boards accountable for enabling meaningful engagement and consultation in their areas, and subject to standards that set realistic expectations jointly-agreed with the local CHC

Chapter Six: Representing patients and the public

A brief commentary

This short section of the Green paper does scant justice to the plethora of discussions and reports that have successively considered change to CHCs but, in reality amounted to very little. On balance we believe the attractions of stability override the urge to make changes, but we agree that CHCs should play a more constructive role in facilitating change and in helping local communities feel more comfortable about such changes.

In this respect we find it surprising that the Green paper does not refer specifically to the prudent healthcare agenda when discussing the role of CHCs. Elsewhere in the document, it points out that

"*Prudent healthcare requires a change in mind-set and behaviours across Wales - from the public in taking control of their health; to staff in the NHS in meeting patients' needs, learning from mistakes and striving to improve; to Boards creating the right cultural conditions for quality healthcare*" (Par 40)

In our view, this culture change and all the policies and behaviour changes being sought under this programme cannot succeed without public and patient support. This is more than silent acquiescence, and if CHCs are to play a part in expressing and shaping local understanding of issues and changes, their remit has to include participating in dialogues about how these changes should be managed. In that context it is hard to see a case for CHCs 'stepping back form activities which may be better carried out by others, such as inspections and *service change proposals*. (our italics)' (Par 92).

We believe that any attempt to curb the right of CHCs to engage with their local HBs about changes to NHS services would be controversial and interpreted as an attempt to suppress comment on matters of concern to local people.

Response to specific questions

Chapter 1: The changing shape of health care

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
The current wording is not ideal and, contrary to a widespread misapprehension, does not constitute a 'duty to consult'. In reality it is a 'duty to involve' (which may be by consultation or providing information. In reality, however, making changes to this provision would be difficult, and politically hazardous, for virtually any change could be portrayed as the Government withdrawing from the commitment to engage and consult, and this would certainly be seized upon by opponents or campaigners! On balance we do not think that changes are particularly necessary, and are not worth the political pain of revision.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Legislation is not really required to oblige these bodies to do sensible things, and the difficulty of specifying Panels and PPGs is that it would be a mistake to highlight some engagement methods at the expense of others; this field is noted for requiring a 'horses for courses' approach. Also it might stifle a number of promising initiatives related to the 'prudent healthcare' theme, by placing emphasis too firmly on more traditional methods of involvement. A better approach might be to place a statutory requirement on HBs to produce an engagement plan each year and to subject their performance to an annual independent audit so that the public have a form of accountability for the adequate performance of public engagement in their territory.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
The comparable provision in England via the Independent Reconfiguration Panel has, generally speaking worked well, and we support the establishment of a comparable unit for Wales. It is important however that the Panel has the remit and skills to review both the technical/clinical issues under reference as well as the engagement/process matters that are raised.

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The abolition of CHCs in England has totally destabilised the machinery for public engagement with a succession of successor bodies (PPI Forums, LINKS and latterly, Healthwatch) failing to capture public support and demoralising those involved as volunteers. The legacy role in inspection may by now be anachronistic, given the tougher regulatory regime instituted post-mid-Staffs, but we would urge caution as there is a significant body of public and popular support for continuing this activity.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
The Institute believes that the integration of health and social care continues to be slowed down by the legacy machinery that was created before this became the agenda. Although CHC membership includes local authority representation, current practice remains focused on the relationship with the NHS and not with a truly integrated multi-agency service. It would be more in keeping with modern realities to re-christen these bodies Community Health & Social Care Councils, and ensure that local government reorganisation takes full account of the need for integrated machinery able to represent public views on the full spectrum of relevant public services. Note however that there is tension between the principle of an informed 'key stakeholder' (the role the CHCs play in respect of the NHS) and the more democratic traditions of local government. Doing the right thing here may involve the squaring of a rather difficult circle.

WGGP082 – Anonymous
Tref / Town – N/A
Sefydliad / Organisation – Anonymous

General comments

Wishes for response to be kept anonymous.

WGGP083 – Brian Stapley
Tref / Town – Unknown
Sefydliad / Organisation – N/A

General comments

After being treated at Wrexham hospitals Gladstone centre… I had the best treatment possible from each and every one at the centre are outstanding.

One thing that should be done is that all managers and bosses must go to the wards and see first-hand if there are any problems and talk to the staff, this is the only way to improve the way that hospitals work.

Response to specific questions

No response to specific consultation questions.

WGGP084 – Doreen Jones, David Jones, Helen Jones
Tref / Town – Holywell
Sefydliad / Organisation – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
If the reduction in services is continuing to take place across Wales, what forward planning should be conducted to ensure that services are not compromised and risks are mitigated when altering service provision?

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Yes. Encourage enforcement of current legislation / regulations. There are already numerous standards / strategies / plans supposedly in place. What reassurance do citizens have that further legislation will bring about change if not enforced? What penalties are in place or will be in place to address non-compliance?

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
This depends how the patient panels or participation groups are selected and on what basis. Are there going to be guarantees that they will be impartial and not formed by the "revolving doors crowd", those with vested interests or those comfortable with the delivery of poor care quality standards?

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Legislative measures are only effective when there is a commitment and the desire to enforce them. Our experience is that current legislative measures

are not being enforced. Other appropriate measures are effective leadership, and a unifying purpose. Our experience is that there are leaders within the BCUHB with a distinct lack of moral fibre that fall well below the standards expected when in public service and are breeding a culture that does not support a unifying purpose focussed on quality of care.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes. However, if the "Putting Things Right" process was implemented, monitored and enforced properly then this might not be necessary? The Keith Evans review highlighted variations of its implementation across Wales.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Ensure that legislation is enforced, by ensuring appropriate action is taken against health boards who refuse to respond to requests for information and/or communicate with patient representatives. That health boards should be just as accountable when things go wrong as in any other organisation.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Is this not already meant to be in place as laid out in "The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011"?

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
After all the money which has been spent on procuring IT systems there are too many varying IT systems operating / implemented within the health service already which are not compatible / transferrable.

22. How can we consider breaking down any barriers?
Reassure the public that records are safely stored and data protection is not breached as in the recent cases of: • Aug 2015 Anxiety UK - Personal data on website was publically

available for 12 months

- June 2015 SW Yorkshire NHS – Series of incidents where patient data sent to wrong address
- March 2015 North Tees NHS – Sensitive patient data found at a bus stop – one of a number of incidents resulting in data being lost or disclosed

WGGP085 – Ruth Crowder – College of Occupational Therapists
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority?
The current array of services and providers provide opportunity for inefficient use of resources, poor delivery, quality and lack of outcomes unless collaboration and strategic planning are improved. The Social Services and Wellbeing (Wales) Act 2014 regulations under part 9 are relevant, as is the Wellbeing of Future Generations Act 2015, which establishes Public Service Boards on a statutory basis. The College of Occupational Therapists (the College) would suggest that a single, robust legislative requirement is more likely to deliver impact than several pieces placing separate duties of separate partners. So further legislation should only be added if the two existing requirements are insufficient and consideration should be given to repealing previous duties to ensure clarity. For example, the title of this green paper implies this only relates to the NHS; if it seeks to improve collaboration, the title could indicate the intent more overtly The recent legislation needs to be implemented with processes, regulations, financial structures which allow change and performance targets which deliver the existing legislative opportunities before adding more legislation. There is a risk that legislation framed around "meeting people's health and well-being needs" could, if incorrectly framed, work against the intended direction of travel, by reinforcing the public perception of passive and ongoing entitlement to "services", rather than a co-productive and collaborative approach to achieve shared goals. In this respect there is learning to be gained from the Mental Health (Wales) Measure, which legislates for the provision of care and treatment plans, thereby defining the service user as the passive recipient of care and treatment, rather than an enabled co-producer of valued outcomes (which is the purpose of occupational therapy). This is very well expressed in Para 75 of the Green Paper, which would perhaps be better sited here in the section on Promoting Health & Wellbeing rather than in the section on Sharing Information. Collaboration needs to explicitly include housing, third sector and other providers if it is to maximise effect and deliver prudently.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Legislation cannot stand in isolation from, or in conflict with, policy, guidance or performance targets. If Wales is to drive greater collaboration in health services and with partners in promoting health and wellbeing then the same purposes, requirements and outcomes need to be placed on each partner in the same way. This requires targets, budgets, workforce terms and conditions, organisational directives to drive the same message and agenda at all levels. The College believes that commitment at all levels is what will transform service delivery. Culture and service aims will always be stronger than processes, however the right format of organisations with common and co-terminous boundaries, alongside processes facilitating cross boundary/ border working will help. The complexity of collaborating with different partners for parts of one organisation's services will prevent even the best intentioned from succeeding.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
There is no clear case for legislation at the moment. The two new Acts above should provide all the legal drive needed. It is other drivers, including organisational targets, budget parameter and culture change which are most likely to deliver engagement with citizens.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
The College does not consider there is a clear case for this. There does not appear to have been much evaluation of the outcomes from existing statutory and voluntary engagement mechanisms. The College expect the recent legislative changes to empower citizens to influence their own service provision (through co-production). Structural groups need to consist of people who have the skills and confidence to participate in large meetings and yet who are sufficiently independent to not become 'professional' engagers. Getting a culture where engagement, co-production and equally valued participation exist is likely to deliver more effective and transparent services than a statutory requirement which is not underpinned by belief and respect. That goes for citizens who are patients or service users, stakeholders such as third sector or independent providers as well as staff voices. Tokenistic processes should be avoided. This will require a clear definition of the relevant community or constituency to be represented. The population of current or former service users (whose historical experience

of services will have conditioned their future expectations of healthcare) have a very personal experience to draw on. Their own expertise of living with conditions and of using one service is likely to be a different experience to other citizens and may not represent a population-wide perspective. Even in areas where the involvement of users of services might be regarded as well-developed (such as Mental Health) there are still problems with tokenism, due to small pools of representatives, inadequate understanding of and training in representation skills, and narrow interest groups. This will need investment and appropriate support to make it effective.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
No, The College would expect that in arriving at a decision a Minister would seek appropriate expert advice from all relevant stakeholders. The College is not convinced that legislation is needed but a requirement for a Minister to widely consult and seek appropriate advice is more useful than a requirement to seek views from a single specific group.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
The College agrees that improved collaboration, joint working and integration of health, social care and housing services will improve quality and outcomes. Many of the issues of care quality require a far greater contribution from good professional governance, management leadership, staff supervision, development and training and clear accountability than exists at present. Access to training, supervision, the opportunity to reaffirm and debate the purpose and values of a caring service are not always available to our members. Sharing of good practice, a sense of ethical practice and respect for colleagues and clients relies on good governance and culture as much as it does on legislation. There is a need for improved working across health and social care infrastructure. That includes inspection, regulation, workforce education and training and planning all of which are currently not integrated or working in partnership.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
The College is not yet convinced that legislation is the best tool. The College would wish to see consideration of many of the backroom infrastructure processes being integrated. This would include workforce planning,

education, training and career development as well as inspection. There needs to be equal and equitable approaches and opportunities for all staff groups. For example, as joint teams and services grow, the existing career development frameworks of all NHS staff and social workers in social care need to be expanded and integrated to enable the workforce to move around the sector for the best delivery of integrated care: for all parties equally to be able to make a career pathway in the sector and to ensure that public money used in pre and post registration education and training is used to best effect. That includes recognition of qualifications in integrated services, or even over the whole sector without prejudice of which employer first supported them. A practical example here is where management qualifications and experience in leading health services is not accepted for leading social care or integrated services.

The College is aware of the current separation of workforce planning and commissioning between the Workforce Education Development Service, WEDS, (for the NHS) and Care Council for Wales (to become Social Care Wales) for social workers and some other social care staff. The current separation of service improvement and quality inspection services for health and social care will become obsolete. These need to be integrated now in order to assure the quality of future service models and to protect the public. The College is not clear whether that needs legislation to achieve, but the objective is essential.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Please see above answer. The clear objective and outcome to be achieved needs to be articulated and at that stage the decision about whether it can only be achieved through legislation needs to be determined. It may be that the provisions of the Wellbeing of Future Generations Act can deliver this through the actions of the service boards or secondary legislation under that act.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
The College would not wish to see a ‘responsible individual’ for public bodies in Wales if that reduced the corporate responsibility for the Board as a whole. The Board or CEO should be corporately accountable. In independent and private sectors this may needs strengthening. It is also important to note the requirement for all registered staff to be accountable for their actions to regulators.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
The College notes that registration and regulation is already in place for clinical professionals through the HCPC, NMC, GMC and others.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
The College supports the intention to promote quality. It is not clear whether this requires legislation.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Yes, it will be essential to develop common standards to ensure effective quality assurance and accountability for NHS, and integrated services across agencies and organisations.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes, the College believes a common framework for NHS, independent, contractor will improve outcomes and citizen experience. However, it will be essential that this also includes local government services, especially if greater integration is to come. There is an opportunity here to think about quality in practice by integrating service improvement functions which government currently undertakes in separate routes for health and social care. Specifically, there is a need to think about joining up improvement for the NHS, currently via 1000lives+ in Public Health Wales and for social services, currently the Social Services Improvement Agency. There would seem to be great benefit in considering the benefits of as single integrated health and social care improvement agency given the growing number and range of integrated or joint services. Otherwise, whose responsibility is quality in integrated services? The role of Social Care Wales is also unclear in this at present. This raises particular issues about quality and standards needing to focus on the experience and outcomes for the person, rather than for a bed-based service which is no longer the norm.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
This should be included in commissioning arrangements, quality standards and service specifications. It needs to be an overt element in all inspections of services. These are already required of many registered practitioners. A requirement for this could be extended to non-registered staff, who currently

struggle to gain access to support and supervision, and to those managers who are not also professionally registered.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Access to clinical supervision and good management will have a significant impact on service quality and improvement and should be a requirement of quality standards for all services, whether directly provided or commissioned. This would need to be an obligation placed on employers to enable staff to meet their regulatory requirements. That may not need legislation, but could be a service specification, common standards framework or commissioning requirement and should be a part of all inspection regimes. Individual registrants are already regulated in this regard. Therefore the only valid place for legislation is to oblige employers to make time and resources available to staff. It should be noted that “revalidation” as referred to in the text is specific to the doctors’ (GMC) and nurses’ (NMC) regulatory bodies – however, revalidation is not the only framework for Continuing Professional Development, with HCPC setting its own standards for which its registrants also require time and resources. Nor is peer supervision the only viable model, unless Welsh government is using it in this context to mean from a member of the same profession. It should be noted that while professional (clinical) supervision and governance from a senior member of the profession is essential, there are other equally valuable sources of supervision, for example, managerial supervision is equally common in services, particularly in multi-professional teams and where line management is not from a member of the same profession. These forms of supervision can co-exist and are the bedrock of effective multi-agency integrated teams.

17. What arrangements should be put in place for self-employed health professional registrants?
These professionals have their own responsibility to meet their regulatory requirements. However, it should be a requirement of any commissioning or employment standards where they deliver on behalf of public services that staff are registered where they can be. Again, this would most effectively be included in any service inspection requirements as well as any inspections and quality assurance of commissioning standards and processes.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within

the NHS in Wales?
The College supports this proposal. The legal duty of candour should apply to organisations rather than individuals, to avoid duplication and/or possible conflict with the requirements of the regulatory bodies for registered practitioners. This needs to be introduced across all public care and support services in order to capture integrated and other future models of services.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
The College is not convinced that legislation is required to improve transparency. Culture and values drive this and this should be achievable in standing orders and directives from the Department of Health and Social Services. Please also note our answer above (Q14) in respect of service improvement and the need for those processes to be joined up. Service improvement agencies also have a role in transparency and learning from practice.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
There are a range of options to achieve this, including a single integrated quality body, joint working of currently separate bodies and common standards. There is also an opportunity to join up service improvement activities across health and social care. If legislation is needed to achieve these than the College would support this. The College notes that this section only refers to NHS and social services. We are unclear why this would not be a corporate issue for local government. For example, the joint investigation of complaints including housing services, such as adaptations, and of wider bodies for example, complaints across social services and a housing provider such as an Registered Social Landlord, or in relation to continuing health care. The College notes the lack of a complaints process under the Social Services and Wellbeing (Wales) Act. What is the route for a citizen to complain about an integrated service?

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Data protection and different governance systems continue to be claimed as reasons for this. Secure electronic sharing would be useful. It is unclear how

widely understood the Wales Accord for Sharing Personal Information (WASPI) is by frontline practitioners in different organisations. Many members of staff are still unclear about what they are or are not allowed to share. Supervision and good management can assist with this as will closer collaboration, a focus on quality and citizen experience and trusting relationships with colleagues from different agencies.

22. How can we consider breaking down any barriers?
Organisations need to articulate a shared policy at a high level and then ensure that is implemented and understood throughout their systems. Senior leaders need to give staff confidence to share and to ensure that good governance systems protect staff and individuals. The new Public Service Boards, Regional Partnership Boards and the Community Care Information Systems will assist.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
This also requires clear and effective governance and control. However, if those processes are in place, this is a valuable tool.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they? 25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
Both organisations should be fully independent with clear governance processes. The College supports integration of the two inspectorates. It is vital that inspection can follow the natural relationships and interaction of service provision.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
The College supports full integration of both inspectorates as a sensible and enabling approach to the future models of more integrated and complex service provision. Short of that both inspectorates would require common governance processes, of which independence is the first step. Common standards and a legal duty to work together wherever possible and appropriate. It will be essential to require joint or co-inspection or even to

allow delegation of inspection from one to the other if that better 'fits' the service being inspected.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
The College supports full integration of both inspectorates as a sensible and enabling approach to the future models of more integrated and complex service provision. The new single organisation should be fully independent. The advantages include: - More coherent, thorough investigations from a citizen pathway perspective. - Clear accountability as separation cannot be used to fudge learning and behaviour. - Issues identified in one organisation cannot be avoided or excluded from action and improvement because of a false separation in inspectorate jurisdictions. The possible disadvantage is that it would be a large organisation. Although this will allow for possible economies of scale in resources. A single given inspection event will need to be undertaken by inspectors with expertise in that area of service or practice. The College suggests that even with a single body there will need to be a duty to work in an integrated way even with other, remaining separate inspectorates. Such as police, public services ombudsman and education inspectorates. It will be most valuable to include community health councils (CHCs) in as integrated a way as possible.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice? 29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
The CHC's provide a valuable route for maximising the voice of citizens in respect of health services. The overlap in inspection roles with HIW may need to be considered. It is also noticeable that these are only for NHS services. What happens for a citizen voice in integrated (joint services) or indeed social care services? Is there a potential co-relation between the roles of CHC's and the National Social Services Citizen Panel?

Chapter 7: Finance, functions and planning

Borrowing powers

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

The College is not convinced there are benefits for health boards to have borrowing powers. We recognise the consultation document comments about flexibilities but the ability to pay back any borrowing has to be paramount and this would potentially create more problems than it might solve where health boards experience high service demand.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
Both health boards and trusts should be required to provide reports that include the planning and/or commissioning as well as the delivery and provision of services element of their duties.

32. 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?
The College sees benefit in greater flexibility for reporting. Any new system needs to be created in a way that allows future change more easily in order to allow a true reflection of future service models. This may mean legislation which lowers the level at which decisions about future changes can be made.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes

34. 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?
It will be vital to review the NHS (Wales) Act 2006 with regard to planning duties to improve alignment with the Social Services and Wellbeing (Wales) Act 2014 and the Wellbeing of Future Generations (Wales) Act as well as any future legislation. It is also vital that where definitions of common concepts appear in legislation these need to be the same in all legislation, or if updated, earlier versions should be repealed. The desired integration will not be possible if different organisations are working to different definitions, for example, of wellbeing.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
A coherent programme to develop new leaders is essential, including new roles and when new professional groups have access to new roles. The creation of the Executive Director in Therapies and Health Science was not preceded by sufficient leadership development opportunities for members of those professions. This must change and leadership development needs to be open to all aspiring leaders, irrespective of their professional background and whether a 'specific relevant' existing post can be identified if public services in Wales are to make best use of the prospective leadership pool. Governance and accountability need initial training and learning, as well as continuous reinforcement and in-role support to ensure these principles are not lost in busy organisations. If integrated services are to be delivered more widely in the future then leadership development opportunities must be available to staff groups across both health and social care. This will ensure that leaders are created from both 'sides' and bring experience and expertise from all areas and that the learning is wider than just a knowledge of one agency. Future leaders will need to be able to work across complex boundaries and in a range of management matrices.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
The starting point for this has to be what is the task to be achieved and who needs to be part of that decision making process? The College recognises the need for health board size to enable good decision making and scrutiny. However, the board must retain access to expertise from the three professionally regulated executive directors (GMC, NMC and HCPC) to ensure robust decision-making. The creation of the Executive Directors of Therapies and Health Science is unique in bringing expertise and experience of working in community, therapeutic and complex cross boundary working. These are skills which are not routinely available from other board member roles. If NHS Wales and local government social care services are to move service delivery closer to people's homes and to meet the more complex needs requiring new ways of working, the boards must include directors with experience of new ways of thinking, working and delivering in order to drive the transformation required.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
There may be potential for joint appointments for some of the roles but health boards must retain the professionally regulated executive directors covering

the majority of registered practitioners as full board members. It is important to note that HCPC equates to 25-30% of the NHS workforce and the Executive Directors of Therapies and Health Science spans professionals working in both health and social care. The Executive Director for Therapies and Health Science brings a different perspective to others on the board and is well positioned to lead in co-operational and partnership responsibilities in relationship to Regional Partnership Boards under the guidance in relation to Part 9 of the Social Services and Wellbeing (Wales) Act on co-operation and partnership. These executives are also essential for leadership on the development of primary and community service provision and progression of workforce modernisation in primary care. The Independent Member for Trade Unions is also an indispensable role, to ensure the voice of all staff groups is heard by the board.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
It is not clear how this would work. The non-executive directors should already be representative from the community and are citizens. What would be the role of a community 'representative' given the need for full board members to be taking, and held to account for, corporate decisions? There is potential that a 'community representative' in fact confuses the separation for the community to hold the board to account. How do the CHCs fit into this as representatives of patients? The voice of carers is currently missing from this process as well, but first and foremost clarity is needed on what is the role expected of a Board member and how a representative person holds the Board to account on behalf of the people they represent if they are also a corporate director?

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
It is difficult to be specific about this given the current lack of clarity on what 'local government reform' will result in. As a general principle, the College would wish to see co-terminous health and social care bodies. In the absence of that, there needs to be consideration about why and how joint appointments would work if there are several local authorities to one health board footprint. Is this joint appointment across every local authority and board in a health footprint? Who is that person accountable to? What elements of public health are the responsibility of health and what of local government? Where do Public Service Boards fit here? Will the Wellbeing of Future Generations Act have any impact on these roles?

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
The College does not think that it will help health boards deliver effective

decisions about complex matters if those decisions are taken by a small executive without vital expertise and knowledge as part of that process. It is also unclear why only health board membership is considered here. There is opportunity in this green paper to bring the three trust boards into line with the health board system. For example, the health boards have a statutory Executive Director of Therapies and Health Science. Therapists and health scientists are also employed in significant numbers in the three trusts and director level roles would be valuable in holding to account and improving governance in these bodies in the same way as currently occurs for health boards. There is a different challenge for these roles as the Directors of Nursing and Medicine are responsible only for their own profession, whereas the Director of Therapies and Health Science could come from any one of the 13 AHP professions. The role therefore has a much broader remit which has added challenges to the roles as they have developed. An effective infrastructure behind them is essential to support the delivery of the objectives of the board whilst ensuring that the valued contribution of AHPs is kept central to their role. The Executive Director of Therapies and Health Science also bring expertise about working with social care and this expertise would seem equally important for the three trusts as it is for the 7 health boards.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed? 42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
There is opportunity in this green paper to bring the three trust boards into line with the health boards. For example, the health boards' statutory Executive Director of Therapies and Health Science. Therapists and health scientists are also employed in significant numbers in the three trusts and clear director level leadership would be equally as valuable in holding to account and improving governance in the trusts as it is in health boards.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
The College does not think so. Their role has to be to provide advice. The board corporately then decides to what extent they accept and follow that advice. It is the board corporately who must be accountable for the decisions they make.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the

statutory status of the advisory committees?
No, The College believes that it should be a statutory requirement for Welsh Ministers to access professional and clinical advice. The decision whether to accept and follow that advice is the Ministers' own and s/he will be held to account for that decision. That is appropriate. Professional advice, often technical or based on specific knowledge and expertise is very different to the advice from a range of other stakeholders. A Minister is free to listen to and ignore or follow advice from as many other sources as s/he wishes. But it is right that professional expertise is provided via statutory processes which lay a responsibility as well as an opportunity on the providers of advice. The systems underpinning the Statutory Advisory Committees ensure a robust, independent advice route to Welsh Ministers. The College is commenting from the perspective of the close links it has with the Welsh Therapies Advisory Committee (WTAC). WTAC has two members from each profession; one is a service representative and one a professional body representative. The committee includes 13 professions and underpinning the individuals on the committee are a network of profession and speciality specific subgroups and experts able to provide robust independent advice quickly and effectively. The statutory nature of the committees ensures participation and structured advice. Removing these committees will mean a looser network of advice based on who someone knows to approach rather than a coherent representative network of experts. In addition the committee has space to decide responses and ensure a considered response is given. This is a strong model and it would be a loss to government to remove it. Further, the College does not support the proposal to create a single multi-professional statutory advisory committee. This would contain too many different ranges of expertise and risks losing the specific technical and professional basis which brings the current strength to the system. The College is less clear about how advice is provided from other groupings for example the National Statutory Advisory Groups and health boards' internal 'Health Professions Forum'. Unions and Regulators are different from Professional Bodies. Paragraph 133 should be amended to read as follows: "The Welsh Government obtains professional advice from a large number of sources, including [....] Professional Bodies Trade Unions Health Professional Regulators [....]" The advisory role should remain on a statutory basis.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
The College recommends that the statutory requirement to consult advisory committees is retained. This ensures staff are released to participate and that a range of professional advice is made available giving a wealth of evidence from which Ministers can make decisions. The real strength is that this is independent professional advice which is from both professionals employed in the service and the professional body. This is independent of the advice that comes to government from the health boards. The College notes these are all health advisory structures. Given the increase of integration it would seem necessary to develop a social work or wider social care advisory structure or indeed even an integrated advice mechanism. Again, this needs to cross the health social care divide. Occupational therapy advice from WTAC includes social care expertise, but there is no overt established process to deliver this professional advice to the social services side of the department. This seems to miss an opportunity for effective advice provision.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
The current partnership working arrangements are fit for purpose, enabling NHS Wales to create its own distinct identity within a UK-wide framework that preserves and promotes a truly National Health Service. Legislation, or at least strong policy drivers, will however be necessary to ensure that Prudent Healthcare principles – the only pragmatic response to the current and predicted pressures on health and social care in Wales – do not lose impetus and “fizzle out”. In particular, staff who act in good faith to take positive risks for the best interests of services and service users, require protection under law, otherwise risk-averse practices will continue to become the norm.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
The College is not clear that legislative measures are needed. The first question needs to be what extra clarity is needed? The answer to that question should identify whether legislation is the best way to achieve it. This appears to mean only joint and hosted services within NHS Wales. If this is intended to mean joint services across health and social care then this should be covered by the Social Services and Wellbeing Wales and the Wellbeing of Future Generations Acts. What happens with contractor services as more services are moved to primary care?

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
This would seem logical given the intended direction for public services in Wales. The College would tend to the view that that should then sit outside the NHS. This question highlights to the College that this green paper appears to continue the existing separation of legislation for services which are being asked to integrate. Given the duties on health boards in the Social Services and Wellbeing Wales Act and the potential for this green paper to place duties on local authorities it may be worth considering a title which more overtly reflects the intent to drive integration.

WGGP086 – Sarah Capstick – Cardiff Health and Social Care Network, Cardiff Third Sector Council
Tref / Town – Cardiff

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
There is already a lot of legislation that is yet to be fully implemented. These include the Social Services and Wellbeing (Wales) Act 2014, Wellbeing of Future Generations (Wales) Act 2015 as well as the Public Health (Wales) Bill. Some of the issues that you may want to resolve may already be solved once these are implemented. The Health Boards and Local Authorities already have a number of duties placed upon them for collaboration. Sometimes the flexibility to reach across boundaries and work with additional areas is blocked by legislation and regulation that puts these boundaries in place. We would encourage more co-production of services, involving service users and Third Sector organisations as well as the statutory bodies. However these are much more difficult to legislate for as they often depend on the needs of the local population. The Social Services and Wellbeing (Wales) Act 2014 already requires Local Authorities and Health Boards to jointly undertake an assessment of the local population's care and support needs which you already say (30) will also be used to inform new local wellbeing plans required by the Wellbeing of Future Generations (Wales) Act 2015. Therefore, reviewing the situation in a few years time may be more appropriate. There is also the possibility of the reconfiguration of Local Authorities which will have an impact on the make up of the statutory sector to take into consideration.

2. If so, what changes should be given priority?
There are lots of requirements for statutory sector organisations to work collaboratively. This excludes third sector organisations and those who require services. There should be a wider focus on co-production and involvement and less on timely collaborations.

3. Is there anything else we should do to strengthen legislation to ensure

agencies work together to plan to meet people's health and wellbeing needs?
Review the success of the Social Services and Wellbeing (Wales) Act 2014, Wellbeing of Future Generations (Wales) Act 2015 and the Public Health (Wales) Bill once they have been implemented for two years. Then identify if there are any gaps that require legislation. This will also enable changes made to the number of Local Authorities to have progressed.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
The Social Services and Wellbeing (Wales) Act 2014 requires national and regional citizen panels to be set up (33). Rather than have health recreate these, could they be extended for use by all statutory services as a consultation mechanism? This would require citizens to be part of one panel only rather than a potential 3 or 4 in order to have their say on how the statutory services in their area should be planned. This would also enable sharing of plans between statutory services, potentially reducing duplication and increasing collaboration.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
No, (34) states "the need for better continuous engagement with local communities and not just when specific change options are being presented." Whilst this relates to reconfiguration of services, the same would apply to any general service planning. Therefore there is a need to continue to gather patient feedback. However, if we are looking at the wider preventative agenda, this is likely to be better served through engagement with citizen panels as mentioned above.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
It could be a good idea; however, what would the costs be? Where would the money come from? And if this would take money from health services at a time of austerity this could be seen as a waste of monies. Could the role of the HIW be strengthened to assess and advice the Minister whilst keeping additional costs down?

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Quality should be driven by the IMTPs and by the needs of the local population. Addressing quality issues should be part of the contract between the Health Boards and Welsh Government and therefore should not require additional legislation.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
As there is an existing duty of quality this should be adequate and where quality is not met then the Welsh Government should be able to take action. This has already been demonstrated in North Wales and did not require any additional legislation.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
The only reason quality is overlooked is when cost comes into consideration. Given that there is already a duty of quality, the Welsh Government should look at financial options to enable them to invest in better quality services whether they are provided by health, local authorities, private sector or the third sector. Currently tenders are scored on cost as well as on quality; ensuring cost effectiveness is important, but if too high a percentage is based on the cost then the quality is more likely to be overlooked. A cost to quality ratio should be agreed nationally for all services, with no more than 30% being based on cost.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
There was insufficient information to fully understand what the ‘responsible individual’ role. Is this the same as a ‘responsible individual’ used in England as part of the CQC requirements for services? Within the Health Boards their Board’s already hold the overall responsibility for the Health Board along with the Senior Management Team; to replace this one named person would appear to weaken this structure and limit the reach and capacity of this function. The Board of the Health Boards should be answerable to its citizens, the regulators and Welsh Government. This limits any confusion in roles which could be caused by having a separate responsible person.

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
The Health Boards should already have job descriptions and application processes in place for appointments to their Boards. If they do not then these should be dealt with through the usual channels and not require additional legislation. This seems an extra burden for no real benefit.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
This is already covered in the IMTPs - (49) "IMTPs provide the vehicle for ensuring that quality and learning are integral to health service plans…" Asking as part of the IMTP for evidence of what has been learnt since the last one and how the quality of services has been improved would fulfil this requirement. It would not require additional legislation but may require the guidance on what should be included in an IMTP to be slightly amended.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
The Cardiff and Vale UHB already treat the Health Care Standards as if they are a statutory duty, so legislation to make them a statutory duty would be obsolete from a local perspective. If they are not treated as such by the other Health Boards or parts of the Health service then this should be picked up through governance arrangements and should not require more legislation.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
A clear definition of what is meant by the independent sector would have been useful in the Green Paper. In the UK it refers to the Private Sector whilst in the USA it refers to private and large scale third sector organisations. For the purposes of this response we have assumed that it refers only to the Private Sector. If however, you are using the USA definition, this would include some of the Third Sector but exclude many of the smaller and local Third Sector organisations who are meeting very local needs as required in prudent healthcare and wellbeing services. Given the above assumption the question only takes into account the NHS and the independent sector (private) and appears to ignore the Third Sector as partners in providing Health services and often leading the way in preventative services. We are concerned that the Third Sector are being

side-lined nationally whilst at a local level we are seen increasingly as partners with the flexibility to develop and deliver the innovative solutions required.

There needs to be a more joined up approach to outcome frameworks across Welsh Government. There are currently many outcome frameworks. These include the poverty agenda programmes national outcomes framework; the Supporting People programme framework; the new frameworks which are being developed for the Social Services and Wellbeing (Wales) Act 2015; those expected to be linked to the Wellbeing and Future Generations (Wales) Act 2015 and the Regulation and Inspection of Social Care (Wales) Bill; and the outcomes framework which Public Health Wales are looking to develop for their own use. Given that the Third Sector often work across the silos of the statutory sector this is putting a large reporting burden on organisations. It would be much better if there was one or two outcome frameworks which pulled together all of these, enabling organisations to focus on services without the burden of having to report in multiple formats and templates.

The recent report '*Management charges within Supporting People service provision*' suggested that there should be a cap on the percentage that can be charged in management charges. As many services have multiple funding sources, one element which keeps this management fee high is the multitude of reporting systems; if there was one reporting system to cover Health (including Public Health), Wellbeing and Social Care this could reduce the burden and allow management charges to be reduced. (http://gov.wales/statistics-and-research/management-charges-within-supporting-people-service-provision/?lang=en)

Reducing the number of systems would enable the standardisation of ICT systems used for reporting and potentially provide economies of scale resulting in more savings from any management charges. This may mean breaking down the silos between the different departments of the Welsh Government in order to develop such a framework.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Peer review is important. Where a peer review identifies a high quality service those providing the service could be involved in supporting services that are not yet as high quality to meet the same standards. The school system in England does this with Head Teachers and Heads of Departments acting as peer support to less successful schools identified by OFSTED.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?

This appears to already be covered or in the planning. "Clinical supervision is an important facet…currently in place for doctors and is being introduced for nurses and midwives in 2016, with other professional groups to follow. Revalidation is being introduced to give confidence to the public and employers that professionals are up to date with their practice." (57).

17. What arrangements should be put in place for self-employed health professional registrants?
This should be managed by the professional bodies that they must be members of and whose registration should be able to be quickly and easily checked.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
This could be included in the *Putting Things Right* guidance as part of its review. Progress is being made with initiatives such as the '*Safety Valve'* which has been introduced at the Cardiff and Vale UHB to enable issues to be raised directly with the Chair of the UHB. Candour and protection of the person is built into the culture of the NHS and is embedded in all of the training, so the need to legislate may be obsolete in this instance.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
A large range of statistics are already collected on NHS services; communication of these stats in a clear, easy to read manner would improve transparency. In addition, combining the statistics could give a more complete image of what is happening within the NHS. For example, Ambulance delays, A&E waiting times, hospital bed spaces, and delays in discharge all provide information on different parts of a pathway. This together with candour (described above) should mean that additional legislation is not required.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
In none of the paragraphs covering this part (68,69,70) is there any mention of the Third Sector, only public and private services. Again this suggests that the Third Sector are not partners in service provision. A single ombudsman to carry out investigations across Health and Social Care, whoever carries out the service to citizens from public funds, would

prevent duplication and could be a more cost effective solution. We do not have any thoughts on which of the regulators in Wales should be given this responsibility or whether combining the regulators (PSOW, CSSIW, HIW) would be a better way forward.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Data Protection, and the threat of individual as well as organisational fines encourages a culture of fear about sharing patient information. Having clear systems, policy and procedures for how and when information can be shared across Wales could remove these issues. This should be policy or guidance and would not require new legislation. Carers have told Third Sector organisations that health professionals often do not share important details with them under patient confidentiality. This has on occasion resulted in emergency admissions when, had the carer been given key information, they could have managed the situation and prevented the admission. Details on what can and cannot be shared with carers should be produced nationally. Whilst each instance will be different, having some basic principles would be helpful.

22. How can we consider breaking down any barriers?
As mentioned above, providing clear systems and procedures for how and when information can be shared. Re-writing the Wales Accord on the Sharing of Personal Information in a plain English/Welsh format. It is full of jargon and means very little to the people who actually deliver services at an operational level. Having one ICT system across Health and Social Care with different levels of access so that information can be easily shared between the hospitals, GP surgeries, Out of Hours services, Social Services, Social Care etc. There was a specific request from patients as part of the IWA report '*Let's Talk Cancer*' to avoid having to repeat the same things to different people. (http://www.clickonwales.org/wp-content/uploads/IWA_CancerReport.pdf) Legislation for information sharing and IT improvements may actually delay activities that are already being undertaken locally. There are some ICT solutions being developed around sharing information such as the Citizen Driven Health Care which is being developed in Cardiff.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Why does patient identifiable information need to be shared? SAIL is a database which has been developed in Swansea which can collect data but is done in a secure way which maintains patient confidentiality. Could this be explored to be used more widely and to be made use of by the research facilities. The Office of National Statistics has procedures in place to allow the publication of statistical data whilst removing the ability to identify an individual. These systems should be looked at and utilised by research facilities.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
Create a single inspectorate should result in savings on back office functions.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
The advantage is having just one place to go to complain without needing to know whether the service you have received is health or social care. This will also mean only one complaint where the complaint relates to services provided by health and social care. Another advantage would be improved investigations which cover the whole range of provision and can identify areas for improvement without each part being able to blame the other.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The CHC has a lot of overlap with some of the Third Sector advocacy services. There is a risk if this area is developed and legislated for that the opportunity of choice is taken away from the patient or their family. A patient with an issue regarding a specific cancer service in the hospital may feel more comfortable using a Macmillan advocacy service as they already know the organisation and trust them. The CHC is known very little outside of the Hospital settings. A member of

the Cardiff Health and Social Care Network commented that until recently they had not heard of the CHC despite working in health and social care for over 12 years.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
The CHC appears to have more flexibility to carry out ward/service inspections which the HIW does not have. To remove this role of the CHC would mean that HIW may need additional resources to carry out all of the inspections required and to review services from perspectives which go beyond a purely clinical approach. The CHC are often used to advise on service planning in place of the Third Sector and service users. Whilst the independence of the CHC may be seen as an advantage in this, a focus on collaboration and co-production may render this historical role of the CHC less relevant and may reduce a barrier to co-production of services.

Chapter 7: Finance, functions and planning

Planning

34. 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?
A review of the NHS (Wales) Act 2006 planning duties should be carried out if there is duplication with the new Acts.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
New governance arrangements need to dovetail with existing governance arrangements to reduce the challenge for those commissioned to provide services. These organisations may be Statutory sector, private or Third Sector services. Clear guidance and regulation on governance which is reported on as part of the annual quality statement could meet the needs without legislation. Partnerships must include the Third Sector and need to have the flexibility to select the most suitable people/organisations as partners. As the external environment changes, so the suitability of collaborators may change, therefore there should be as little red tape as possible.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
In our opinion, the inclusion on the Boards of the Health Boards of an Independent member from a voluntary organisation remains important in order to have the voice of a large number of charity and community groups heard at the highest level. The lack of mention of the Third Sector in this Green Paper demonstrates the need for our voices to be clearly heard at the highest strategic levels. This should continue to be the Boards themselves. This lack of acknowledgement by Welsh Government is especially concerning when there is so much focus on preventative and wellbeing services. The Third Sector have developed programmes such as Friendly AdvantAGE which provides befriending services in Cardiff and the Vale and the interim report evidences the impact of this on wellbeing and prevention. More engagement between clinical boards and stakeholder groups enables wider scrutiny. This should be developed further and be applied to all boards within health. This enables private, third sector, all areas of statutory sector to consider and scrutinise developments and provide possible solutions to assist the Health Board Boards to fulfil their scrutiny functions better. Local Authorities have scrutiny committees that question the Cabinet decisions; the stakeholders could have the same role for the Health Boards.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
Community representation could be achieved through the citizen panels. If a representative were to be elected from the community then they would need to be linked closely to the citizens' panels so they can represent a large range of values. The danger of having one individual is that they represent only their views and not those of the community. There needs to be a structure to support them and enable views to be shared, and which can act as a communication channel for improving transparency.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
The Green paper already lays out (133) how expert professional and clinical advice is already being carried out. If the advisory committees are providing nothing additional and costing money

then this could be a saving to go towards frontline services. However, it is important to ensure that the removal of the advisory committees does not limit the range of voices and opinions which enable co-production.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
There is a danger in using the words 'expert professional advice' as this immediately makes people think of clinicians. In fact, the 'experts' may be the patients, carers, citizens or third sector organisations providing services in this area. The Welsh Government should make use of the national and regional citizen panels as well as WCVA, Community Housing Cymru and Cymorth Cymru. Limiting input to clinicians and university professors is likely to stifle the development of preventative services which are hard to evidence unlike medicines and therapies.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
This section of the Green Paper appears to be referring mainly to what is managed in Wales and what is signed off by Westminster. The Green Paper is missing an opportunity to tackle the main problem for the NHS in Wales, which is a shortage of nurses, doctors and other staff. This is going to become more of an issue with the cuts to adult education. There needs to be a more joined up approach between Welsh Government departments when planning legislation. For example education and health over cutting adult education, where places for nurses, doctors and other staff could have been protected.

WGGP087 – Dr Matthew Sargeant
Tref / Town – N/A
Sefydliad / Organisation – N/A

General comments

The reduced life expectancy, on average, with "any" form of cancer is 12.5 years. With schizophrenia the average reduced life expectancy is 20-30 years.

There is much work to do to improve health services, mental health care and treatment as well as to respond to changing patterns of demand and the demanding change that innovations in treatment and care signify. Mentally ill and intellectually disabled people require the same high standard of care as others as patients in health and social care. Progress in delivering physical health care should also be progress in delivering physical and mental health care to those with mental illness, those at risk of mental illness and those with an intellectual disability.

There is more to the work of improving healthcare than telling people, telling people to try harder and more carefully and also "laying the law down" to raise standards.

The enquiries concerning the difficulties in healthcare just keep coming, as they have done for years especially since the Merrison Enquiry in 1982. The homicide and suicide enquiries have not stopped either. there are also enquiries relating to unexpectedly substandard care.

Staff on the front line have been trying as hard as they can for so long.

Health (and social care) are sociotechnical systems (Emery and Trist).

Achieving efficiency and effectiveness in a timely and readily accessible firm are hand maidens of safer and more sustainable services for people to improve their health and reduce the risk of illness as much as improving the betterment of those who succumb to illness and disease.

Describing and comprehending the predictive significance of preclinical and clinical situations firm the foundation to first try do no harm.

In bioethical terms this relates to respecting the autonomy of individuals who themselves respect the common property/ resources of health and social care. To do good and not to do bad is a very difficult balance to provide just healthcare: not least for politicians who direct resources and the clinicians who use them and patients who consume them.

Invoking authorities such as Law (statute and common law) and standards and guidance is important. Good positive law contexturalises the original

position of people (in this situation) in the sociotechnical system of the NHS. Resolving disputes, complaints and the harmful unintended outcomes in health care is a tortuous business.

Good law intends a beneficial effect and is consistent with not only systems of authorities but the behaviour of people in an ethical and moral society.
Daniel Kahneman differentiates humans and econs in behavioural economics. Humans are fleshy, psychological and illogical and creative problem solvers, econs are mathematical macroeconomic constructs.

The NICE guidance on Adherence 2003 and the notion of behavioural control recognise the behaviour of people/patients.

W. Heinrich in 1931 in recognised the importance of considering people in his Scientific basis of Industrial Accidents. It went to three further additions. His central messages from the insurance and loss injury still stand the test of time.

M. Viteles in 1932 writes about the "Human factor" in work from a psychological, social and economic viewpoint in industrial psychology.

Hywel Murrell coined the term "Ergonomics" in 1947: a Welsh man who later returned to UWIC. The Chartered Institute of Ergonomics and Human Factors has the Murrell prize.

The Berwick Report (2013) consequent on the Mid Staffs enquiries offered a promise to learn. Do we learn from enquiries and investigations from clinical incidents. What should we learn from? and how?

The Andrews Report (2014) investigates a system in which staff were trusted to care

Rene Amalberti wrote a book about Navigating Safety 2013
Erick Hollnagel ...System 1 and 2 Safety 2014
Sidney Dekker ..... Safety Differently 2014
"No health without mental health health" is the contributory wise direction of the Royal College of Psychiatrists.

There is a difficult set of relationships between quality science and it's initiatives, patient safety science, cognitive engineering, human performance, planning, design, human factors / ergonomics, occupational psychology and industrial psychology. All have very valuable contributions to make in healthcare improvement in safety, effectiveness and efficiency. Of all of the perhaps erogonomics/ human factors and design have inherently social and economic perspectives. Industrial and occupational psychology have social and economic considerations too. There are different views as to what those relationships are and any potential overlaps.
Peter Pronovost in patient safety science recognises the economic impact of patient safety initiatives and noted that there is a failure to view delivery of healthcare as a science.

Lucien Leape has focused on the role of systems theory in healthcare.
Ergonomics/Human Factors is a science to achieve economic gains for patient safety through design of systems.

Three definitions of Ergonomics/Human Factors are
1 Human factors and ergonomics, also known as comfort design, functional design and user friendly systems, is the practice of designing products, systems or processes to take proper account of the interaction between them and the people who use them.
2 Chartered Institute of Ergonomics and Human Factors definition is:- the scientific discipline concerned with the understanding of interactions among humans and other elements of a system , and the profession that applies theory, principles , data and methods to design in order to optimise human well being and overall system performance.
3 Dr Ken Catchpole re Clinical Human Factors:- Enhancing performance through an understanding of the effects of teamwork, tasks, equipment,workspace, culture, organisation on human behaviour and abilities, and application of that knowledge in clinical settings.
The Health and Safety Executive recognises that people are involved in all aspects of work which is why the HSE recognises the importance that human factors can play in helping avoid accidents and ill health at work.
The terms ergonomics and human factors are not easy : a common understanding is needed for bioethical benefit provided by all. Ergonomic design principles have a strategic astuteness not inherent in planning.
Winifred Hacker and Pierre Sache (Allgemeine Arbeitpsychologie 2014) write that ergonomics is not a psychological issue but an economic one....the effective utilisation of relatively scarce resources consistently resonant with Viteles' work 80 years before.

The green paper makes no reference to ergonomics/ human factors or economics in the context of
a)Education of health care professionals
b)Intelligent and regulation and investigation
c)High resilient and reliable organisations (mindful organisations not mindless).

Being careful and prudent in healthcare are integral to a sustainable and safe service. Using the humans and econs differentiation: individuals make microeconomic decisions and those responsible for fiscal and monetarist policy have a large amount of statistics to help them make decisions (macroeconomic).

From government, non government policy and regulatory organisations, to boards in health care provider organisations (the blunt ends) and the clinical shop floor (the sharp end) design needs a place at strategic process table as well as planning, standards and law.
This is no magic solution but purposeful ergonomic design has a contribution to make to organisational effectiveness delivered through the sharp end. For

every explicit purpose in action there are intended and unintended consequences that need regular evaluation.

Changing attitude, culture and psychological climate in organisations is a major set of economic issues related to organisational growth and change for the sake of our health in our NHS service.

The sharp end (those staff dealing with direct patient care) needs support to explore mature risk taking and creativity in the context of a joined up sociotechnical environment purposefully designed.

As on page 17 of the Berwick report 2013 (A Promise to Learn - a commitment to act: improving the safety of patients in England) a set of behaviours to do with leadership is a good signpost. Having very high level representation, of mental health and learning / intellectual disabilities at Health Board level (and indeed in professional training bodies across all health and social care), may very likely help promulgate such behaviours to deliver mental health for effective healthcare throughout those organisations. Mental health and learning/ intellectual disabilities has a very large and influential effect.

The British Psychological Society Produced a report in November 2014 re occupational psychology in the NHS.

Ergonomics invites a collaborative approach in fitting the task to people and to what extent people can adapt to task healthy fashion.

Training and education improve task performance especially when frameworked by a curriculum supported by reciprocal interaction in guidance and supervision. In this way error can be central to learning and accuracy to intended outcomes so design can account for active human error, human error fosters creativity to problem solving. It is productive to safety to design systems purposefully embracing human error. Then better safety is delivered the more users expect/ demand it. Zero tolerant systems to error can be counterproductive in the complex non linear systems of health care. The safety horizon is resonant with affordances of unwanted/ unintended outcomes and creative successful solutions allowing recovery from mistakes, threats and undesirable states it takes something like ergonomic design to capitalise on such processes. To provide accurately delivered healthcare is not easy.

To get the balance loaded too far in relying on adaptation to work from training, education, instruction and teaching can narrow aspiration too much to protect narratives of being careful and intolerant of error which creates culture and climate putting operatives at risk of undue blame. That undue blame is founded on a " training debt" given how differently people/ professionals react across complexity, time compression, risk acceleration, communication difficulties and individual processing capacity. Further the balances between cognitive learning, motor learning, attitude development, interpersonal work social competency and the contemporary continuous

development of expertise require boards and middle management to have a sophisticates approach to engendering front line creativity. 1000 lives and IQT are initiatives in X such directions. While politics and organisational change take time the front line experiences time compression, complexity and risk management difficulties respond to a very different agenda. Organising and designing time to care safely and effectively is part of the concern of ergonomics/ human factors (eg Chapter 12 Performance Time Prediction Methods in Stanton et al Human Factors Methods 2013). The CIEHF and HSE recognise that healthy staff are integral to successful high output organisations.

Complexities In healthcare also relate to it's many industries / disciplines / agencies stretched across the huge benefits of research and innovation, the expert craft of professionals delivering healthcare (managers, professionals and other staff) and also the very valuable high reliability deliverables (beyond the limits of expertise).

The training and standards debt currently accrued with needs to balance by designing everything around those in healthcare accepting the huge benefits (but risks) of innovation, clinical craft and the proper place of highly reliable performance.

We cannot just try to fit the human to the system nor merely compel such compliance (only). Human being are of much more economic benefit to the community when they are healthy.

Ian Kennedy in 2006 wrote "Learning from Bristol". A key point he made was about atomism in healthcare and it's attendant risks. Not least Mental Health and Learning / Intellectual disabilities services needing board representation to mitigate against current fragmentation (atomisation) in teams, specialisms and diagnoses.

Those at the sharp end continually design and problem solve with creative solutions in healthcare and our good healthcare will be promoted by systems which support them to do so especially from the blunt ends the boards and NHS Wales leaders. Organisations may be designed to promote situational awareness across and within all levels to build futures amongst people albeit with human, technical, social and economic realities. The nuclear industry, the oil industry, the gas industry, aviation, and other high reliability organisations have learned such lessons assisted by ergonomics. Our health and our health service would better owned and developed with the assistance of such scientific methods as in ergonomics and human factors not least of which the need to create an integrated health service for those with mental health and learning/intellectual difficulties. The best way to predict the future is to design it.

The enquiries just keep happening each with many recommendations.
Standards in aviation raised through the Civil Aviation Authority investigations and in the USA through the National Transport Safety Board could be mirrored in some thing like a "National Clinical Safety Board" (see Public

Administration Select Committee report March 2015 in England "Investigating Clinical Incidents in the NHS") with independent authority to investigate clinical events/themes with a view to improvement through the promise to learn independent of governmental conflict of interest. "Organisation with a Memory" was published fifteen years ago and from 2013 the NPSA was disbanded.

Ergonomic design differentiates error investigation techniques as design of a system progresses as opposed to accident investigation techniques. Clinical governance is a way of promoting secondary learning from analysis of clinical activity data as well as learning the more immediate lessons in a primary fashion. The more individuals conscious memory is relied on as the strength of the system the weaker and more mistake prone it becomes. It is not so much why is a particular professional guilty of some slip or lapse but how was the system not designed to protect patients from such threats, undesirable states and events.

A paper was produced in England in 2011 making suggestions for human factors involvement and development on healthcare organisations. Participatory ergonomics for safer healthcare was envisaged.

Law and standards are needed but also a new ergonomic emphasis to education of healthcare professionals, intelligent investigation and regulation and the development of high reliable and resilient organisations.

Complex urgent situations in healthcare with time compression show making any change on healthcare is not "Just a Routine Operation" (which is well worth a look at on you tube). Suicide, poor physical health, social exclusion are major challenges for health boards requiring experienced leadership at the highest level using amongst other things ergonomic/ human factors methodology to provide safer more effective and efficient healthcare.

Response to specific questions

No response to specific consultation questions.

WGGP088 – Andrew Mullinex – The Royal College of Surgeons of Edinburgh
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The Royal College of Surgeons of Edinburgh (RCSEd) believe that a sustainable NHS must be able to meet the needs of the wider population in their own communities. Where practicable, the College supports preventative measures to help ensure less demand on services, especially those that keep patients out of hospital. It must be accepted that any preventative measures may not realise significant benefits for a number of years. As such investment in these areas should be seen as additional and not come at the expense of other essential services.

2. If so, what changes should be given priority?
Any legislative changes must be based on firm evidence that unequivocally demonstrates clinical need, and priority should be given to those changes which build on services that people already use. For example, we believe that new services are more likely to be utilised if located in an established walk in centre. Services provided outside of the hospital setting need to be as convenient as possible to ensure they result in lower A&E attendance on a consistent basis.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
RCSEd has no comment to make on this point.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Whilst legislation has a role in shaping service change, RCSEd believes that real changes to services come as a result of workplace and cultural changes that are devised and led by NHS staff. As recognised in the NHS Wales Governance Framework, legislation should then reflect the practical needs

and recommendations of clinical staff. However, this needs to be properly funded as not to undermine the provision of other services. Patient participation groups are also a powerful tool in engaging communities with change management, especially with regards to changes in service provision of configuration. We would therefore support giving such groups a more formal legal status. It is also important that the groups had sufficient status that they were taken seriously and not just a talking shop or a forum for people to air complaints.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
RCSEd believes that there should be a statutory basis for a requirement of permanent engagement. However, all patients and lay representatives should be supported to fully understand the clinical need for service reconfiguration in order to counteract the natural conservatism of local communities. This is particularly important when the closer or reconfiguration of specific services is required. All engagement mechanisms will only be a success if they are seen to be a help, as opposed to a hindrance, by the wider workforce. If those responsible do not see the value and receive constructive feedback, it is likely that these exercises could become a way to tick a box rather than genuine engagement that allows those involved to actually achieve influence and change. The distinction between patient and lay contributions must also be noted, as there should also be a role for lay advisers.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Whilst the College believes that a national expert panel would be able to deal with some referrals – and would welcome any opportunity to participate - there will always be evidence based arguments for increasing a particular area or specialism. This means that it may be difficult to strike an appropriate balance in the context of limited budgets without input from Ministers. The key benefit of a national expert panel is that it can triangulate expert opinion in order to make decisions based upon evidence of clinical need. It would also help avoid any political or personal conflicts of interest. However, any expert panel should in no way remove responsibility for NHS Wales from the Minister, who, along with the Assembly, should be fully accountable to the electorate on these issues.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
RCSEd believe that fundamental clinical standards should be underpinned by legislation and should not be open to being undermined by voluntary agreements. However legislation by itself is not a catch all solution to the issues faced by the NHS in Wales. Real change must be consensual and come from the bottom up. Therefore, cultural changes are as important as legislation and RCSEd is committed to ongoing clinical support and development through a range of training and education activities as well as initiatives such as the Faculty of Surgical Trainers and Faculty of Pre-Hospital care. RCSEd would welcome all opportunities to work with NHS Wales on a more formal basis to develop further initiatives.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Whilst clinicians have an important role in leading cultural change from within the NHS, senior management also have a part to play. Consideration should be given to extending the notion of a “responsible individual” (below) to management and establishing appraisal and revalidation to such roles. The linking of quality to appraisals and objects can be seen as the best way to focus minds on this duty.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
Following the Francis Report, RCSEd unequivocally supports the views of the Academy of Medical Royal Colleges as articulated in the “Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients” (June 2014). We believe that consultants should have responsibility for the entirety of a patient's care during their stay in hospital, including adopting best practice to ensure continuity during a handover between different doctors. Consultants should be supported by a nurse acting as the primary point of contact providing patients, their families and their carers with information about their care. The guidance can be found at http://www.aomrc.org.uk/general-news/academy-publishes-guidelines-on-responsible-consultant-clinician-the-name-over-the-bed.html

11. What would be the advantages and disadvantages of legislating for a “fit

and proper persons" test, and to whom should it apply?
RCSEd has long since supported the concept of revalidation for clinicians working for the NHS in England. If applied correctly, these assessments can provide an opportunity to support staff to improve as well as to determine where sanctions are necessary. These tests, tailored to each job role, should apply to all staff. However, to be able to make a fully informed response on this matter RCSEd would require a clear understand of what is meant by a 'fit and proper persons' test and to whom it applies.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
RCSEd believes that further integration of health and social care is vital to providing a sustainable NHS that meets the needs of the population and welcomes any change that can help bring this closer to realisation. Further, RCSEd would like to see a strengthening of inter-professional education and multi-professional collaboration. This could be achieved through a NHS portfolio that all registered healthcare professionals could access to allow multi source feedback, reflection and uploading training events would formalise the expectations of revalidation and provide space for users to demonstrate professional development and best practice.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
RCSEd would welcome any chance to engage in greater detail on any standards that are established for use in the NHS.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
As RCSEd has considerable experience of developing and implementing surgical standards worldwide, we believe that it is vitally important that all standards are universally applied to all providers, irrespective of the nature of the organisation.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
As mentioned above, revalidation is a vital tool in ensuring that the NHS workforce is properly equipped to deliver effective patients care. Peer review is an important part of any revalidation process and accreditation also

increases the resiliency and flexibility of a system when it allows for retraining and reskilling.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
RCSEd believes that legislation to put a responsibility for facilitating peer review onto the Trusts would ensure that all clinicians have access to this vital tool. However the Colleges can pay an important role in building networks where best practice and innovation can be shared, exemplified by the recent creation of the RCSEd Younger Fellows Network to assist those making the transition from junior to consultant grade. The RCSEd Faculty of Surgical Trainers would welcome any opportunity to assist with the adoption of best practice in this area.

17. What arrangements should be put in place for self-employed health professional registrants?
The College strongly believes that self-employed health professional registrants should have the same opportunities and be held to the same standards as all NHS staff in equivalent jobs. For instance temporary and locum staff should be supervised by and report to a responsible officer. They should also be required to produce objective data in order to audit their performance and their outcomes published in a specialist register.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes, and RCSEd have strongly advocated a duty of candour in other parts of the UK. Again, given our UK wide membership, RCSEd can help facilitate the sharing of experience and information from where duties of candour have already been implemented.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Whilst written in the context of the English NHS, RCSEd endorse Sir Robert Francis' "Freedom to Speak Up" report (February 2015) as an important guide to improving transparency amongst staff and normalising the process of staff raising concerns. Options suggested included a named person in every hospital to provide independent support to staff and hold boards to account if they fail to act on patient safety issues.

Full details can be found at: http://webarchive.nationalarchives.gov.uk/20150218150343/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf However we reemphasise the need to encourage bottom up change within the health service to engender a culture based on transparency, teamwork and patient centred care.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
As per above, RCSEd endorse the "Freedom to Speak Up" report and its recommendations.

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
RCSEd believes that patient and lay representatives provide a vital external perspective, so would welcome any moves to increase the dialogue between these groups and key decision makers within the NHS.

Chapter 7: Finance, functions and planning

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
The College believes that transparency helps drive improvement across the NHS, whether that be on the part of an individual clinician or an entire trust.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Whilst it is recognised that the attributes described above come about as a result of the culture within the NHS, and therefore are unlikely to be stimulated by top-down legislative change, there are a number of initiatives that can be implemented to support the development of this culture, namely;

1. A Duty of Candour

2. Guaranteed time for training with the context of the European Working Time Directive

3. Universally applied standards

4. Non-technical training [See RCSEd's NOTSS course - http://www.rcsed.ac.uk/education/patient-safety-and-notss/notss.aspx]

Robust appraisals which measure performance against key priorities, including those outlined in points 1 to 4.

WGGP089 – Alastair Gittins – UNISON
Tref / Town – N/A

General comments

Chapter 1: The changing shape of health care

1. The pursuit of services being delivered closer to home and away from hospital settings has been a preoccupation of many administrations in many countries for a number of years. Undoubtedly this is a laudable goal, where this can be done in a way that benefits patients – in terms of the quality of their care and the patient experience – and which potentially saves the health service money.

2. However, it is fair to say that there is little concrete evidence on the savings to be made from such moves, certainly in the short term. Moreover, in order for such moves towards greater prevention to be successful there needs to be a commitment to upfront investment to ensure that community or home-based services are set up in advance of any plans to wind down hospital services. A failure to do so often results in feelings of fear and insecurity on behalf of the workforce, and concern from communities, whether well-founded or otherwise, that much-loved hospitals are to be closed or downgraded.

3. UNISON is of the opinion that such moves, in common with the wider integration of health and social care, should be carried out primarily in the pursuit of improving the quality of care for patients and service users, while any potential financial savings that might accrue should be considered a bonus.

4. In addition, UNISON is supportive of the organisations boundaries being coterminous with the existing Health Board boundaries. Such an organisational alignment will assist in the necessary process of integrating health and social care services.

5. The Welsh Government's primary care plan includes a welcome desire for the active involvement of the public, patients and carers in decisions about their care and wellbeing. And the principle set out by the Bevan Commission, and endorsed by the Health Minister, of involving the public, patients and, crucially, staff as equal partners should be the bedrock of achieving meaningful and sustainable service redesign.

6. The Green Paper includes a welcome restatement of the importance of the planned healthcare system in Wales and the fact that patient choice is not based on an individualist or consumerist model, as it is in England for example. This is a distinctive element of the Welsh NHS that absolutely must be protected.

7. The Green Paper helpfully highlights some of the potential drawbacks of set piece consultations; there is a danger that they can be seen as part of a tick box culture, rather than fostering genuine engagement and participation.

8. The distinctive Welsh culture is also worth preserving with regards to Community Health Councils (CHCs). Since abolishing CHCs in 2003, the English NHS has suffered a glut of continuing reorganisation in patient and public involvement, with a general consensus that the patient voice has been progressively weakened through the use of Patient and Public Involvement Forums, then Local Involvement Networks, and now HealthWatch.

9. There is much to be gained from the use and further use of patient participation groups. Putting these or patient panels on a statutory basis could be a means of adding greater strength to the patient voice, although there could be a danger that such bodies then risk being associated too closely with the institution they are attached to rather than having a genuine independent voice of scrutiny and challenge. Perhaps more important than establishing them on a statutory basis is to ensure that there is some tangible means of such bodies being able to exert an influence – potentially through health boards or NHS trusts being required to report on how they have responded to requests for action or complaints from such bodies.

10. We can see the value in the use of a national expert panel acting as a mid-way point between local health concerns and the Health Minister. There is certainly merit in having experts in place to adjudicate and assist in the process of complex and often emotive issues around reconfiguration. However, any final decision would need to go to the Minister to endorse or reject the expert panel's recommendation to ensure democratic accountability is maintained. Furthermore, we believe the expert panel's decision should be made public before the Minister endorses or rejects it. The Minister would need to give substantial reasons for rejecting any independent panel recommendation.

Chapter 2: Enabling Quality

11. As a general rule, attempts to boost the quality of care are probably best addressed in a non-legislative manner and relate more to the culture of care that is fostered in health systems. A prescriptive model is not necessarily the best way to improve outcomes when dealing with healthcare, which will always be a human, caring service. It is worth noting most professions are covered by a code of practice which places duties upon them (for example, the NMC Code of Practice). In this context perhaps a further area that needs consideration is the registration of the healthcare workforce.

12. It most certainly should be the case where the independent sector is providing a service to the NHS, or is licensed by the NHS, then the standards for the NHS should apply to them as if they were an NHS organisation.

13. We must also recognise that the question of care is directly related to the staff who provide it and we return to the case we have made previously in relation to adequate staffing levels deployed in all professions across all settings.

14. While accountability is undoubtedly important, there are drawbacks with the "responsible individual" model. Namely, that it encourages a perception that the success or failure of a health body is down to one person, which neglects the importance of the wider workforce in delivering quality healthcare. UNISON's One Team campaign[9] is set up explicitly to tackle the need for more emphasis being placed on the importance of the whole healthcare team.

15. There is more merit in the "fit and proper persons" test if this is used as a means of rooting out inappropriate individuals from taking on positions of power or influence in our health bodies. In England UNISON has argued for a stronger application of the fit and proper persons test by the regulator Monitor in terms of it being used to block individuals with chequered histories and private operators from getting a foothold in the NHS. The "protected duties" of such posts could be clearly stipulated to grant post holders legal protection in carrying out their duties. However, we have concerns that specifying the details of this with the precision required will prove difficult in practice given the corporate nature of board governance and see little to be gained by this approach which is not already covered by existing selection processes and role specifications.

Chapter 3: Quality in Practice

16. A common standards framework covering both the NHS and the independent sector is a sensible idea as it would provide consistency across the system and clarity for patients and the public (see also comment in 12, above). Traditionally the independent sector has been relatively under-regulated, which often places the NHS at a disadvantage so anything to remove this discrepancy would be welcome.

17. In this area we agree with the Socialist Health Association who have argued in their submission that we should be clearer about whether standards are set by Welsh Government or Health Boards as commissioners or Boards and Trusts as providers.

Chapter 4: Openness and honesty in all that we do

18. The Green Paper helpfully recognises that moving towards a culture of co-production requires openness, honesty and shared responsibility between professionals and citizens. The stated desire to do more to promote openness about the performance of the NHS in Wales is also welcome.

[9] www.unison.org.uk/our-campaigns/one-team-for-patient-care

19. UNISON supports Keith Evans' Review recommendation that a legal duty of candour should apply to the NHS in Wales as a whole, rather than on individual members of staff. This is the right approach for any further plans for a statutory duty of candour – they need to adequately tackle system failure, rather than individual error. In line with the work of Don Berwick for the NHS in England, it is important that the principle of a no-blame culture is retained and that staff should not be personally penalised for being open and honest where mistakes occur.[10]

20. Vital to ensuring high standards of care is the ability of staff to feel confident that reporting failings will be taken seriously and will be acted upon and that they will not suffer detriment as a result of doing so. UNISON recommends that systems must be implemented that allow this to happen.

21. We believe that improving joint investigation of complaints across Wales would benefit hugely from assimilating the boundaries of Health Boards with those of Local Government and to merge the departments across Health and Social Care that deal with complaints (see also comment in the point above).

Chapter 5: Better Information, Safely Shared

22. Clearly the health service needs to be able to share patient data to ensure that a patient can be treated appropriately by the NHS if they are taken ill in a different part of the country. However, incompatible IT systems seem to be a barrier to this. As a guiding principle, everyone's confidentiality and consent should be respected, while every use of a medical record should be safe, consensual and transparent.

Chapter 6: Checks and Balances

23. There is a strong case for the integration of the health and social care regulators (CSSI and Healthcare Inspectorate Wales). We believe this would ensure consistency of standards across both settings. This should include revising the way reports are made, and allowing staff and unions to submit complaints in addition to users or family members. UNISON also recommends the new integrated inspectorate should also be able to investigate both outcomes and processes to give a more rounded view of complaints. Importantly, union members must be empowered to hold care companies to account over employment conditions on rotas, such as when they schedule difficult rotas which have an obvious negative impact on users.

24. In relation to Community Health Councils UNISON strongly believes that the primary focus should be on representing the patient voice and on providing advocacy services. At present CHCs only operate with the NHS but as we develop closer health integration with social care services then it would make sense for the CHC to not only be the voice of the patient in the NHS but also of the service user in social care. We assume that such a change would require legislation.

[10] https://www.gov.uk/government/publications/berwick-review-into-patient-safety

Chapter 7: Finance, functions and planning

25. Giving health boards borrowing powers may, as the Green Paper suggests, provide greater flexibility for boards to fund capital expenditure. However, there is a need for a note of caution before the Welsh NHS goes down the English route, where foundation trusts have been able to borrow more freely for the past ten years. There needs to be a consideration as to what is to be gained above and beyond health boards being able to access capital funding from the Welsh Government as they do now. No one wants to see health boards getting in to debt problems as a result of excessive borrowing at a time when the NHS is already under severe financial strain.

26. With regard to accounting systems, we have no specific comment on legislative requirements in this area. However, the content and layout of financial reports used should be common for Boards as commissioners and for Trusts and Boards as providers so that comparative assessments can be easily made.

27. We agree with the Socialist Health Association that LHBs as commissioners, along with Welsh Government should remain the main engines of planning as far as clinical Trusts are concerned. However, Trusts should have a legal power to require LHBs to include in their plans and annual reports any concerns which Trusts feel should be placed in the public domain - for example where commissioners have not been able to respond to Trust requests for funding for existing or new services - accompanied by an explanation as to why such requests have not been met.

Chapter 8: Leadership, Governance and Partnerships

28. UNISON sees no reason to legislate to strengthen leadership, governance and partnerships in the NHS though these are hugely important areas that require consistency and good practice across all Health Boards and Trusts.

29. We do not have a specific view in relation to the current size of Health Board membership, however we would support division within the Board on its commissioning and providing roles.

30. We are not in favour of the direct election of community representatives onto Health Boards as this could lead to the election of ‘single issue candidates’ with a specific agenda, rather than a wider interest in priorities around service reconfiguration. We note we have democratically elected local politicians sitting on Health Boards at present.

31. Finally, there is a case to be made for additional trade union representatives on Health Boards and Trusts. This has been reduced in recent years and this is a retrograde step when considering the importance of partnership working in NHS Wales.

32. UNISON Cymru Wales is supportive of joint appointments across Health and Local Government where this will lead to more cohesive service provision but which does not involve introducing a further layer of management.

33. UNISON believes that the current NHS Wales Partnership Forum (WPF) works well. The recent change to tripartheid chairing arrangements between trade unions, NHS Employers and Welsh Government is a welcome move and ensures all partners take ownership of the work of the Forum. We have, however, made our concerns known previously that, by and large, employer's representatives do not attach enough importance, and therefore do not prioritise attendance at the WPF. We know this is being addressed and we look forward to improved employer participation. We have also raised concern that the high level partnership working does not always cascade to local level. Again, this has been recognised in the amended constitution for the WPF which seeks to ensure that there is a connection between what is done at National (all- Wales) level and what is done at local (Health Board and Trust) level.

34. One of the biggest concerns around Partnership Working within Wales is facility time for trade union representatives. With some employers, there are very good arrangements, with full-time release being afforded to the most senior local union representatives. This undoubtedly aids partnership working as representatives are able to respond to issues raised by employers within a timely fashion. However, there are almost universal difficulties with other, usually departmental reps, getting approval for time off to attend union meetings, engage in recruitment activities and even represent fellow workers. It is also true that some Health Boards and Trusts (notably Ambulance), facility time arrangements, even for senior reps, are ad hoc and this inevitably causes problems. It would be helpful to have a consistent approach to this across Wales. In submitting this comment, we are mindful of the provisions in the UK Government's Trade Union Bill in relation to paid time off for union representatives and we hope that Welsh Government will continue to fight these very damaging proposals which will go to the heart of our partnership working arrangements.

35. At UK level, we have the NHS Staff Council which oversees the work of Agenda for Change terms and conditions and other workforce issues on a UK wide basis. However, devolution has exposed the difficulties of a UK body dealing with issues that are devolved. UNISON always has been an advocate of 4 nation pay and terms and conditions bargaining, but we have also always acknowledged the devolution dimension which means that, whatever discussions take place at a UK level, devolved governments must have the final say in the application of any changes to pay and terms and conditions given that Health is a fully devolved matter. This has meant that, in reality the NHS Staff Council has become an English Staff Council. Quite often representatives from the devolved nations (just one each) will sit as "interested observers" as trade union colleagues and Department of Health representatives discuss matters that have no relevance to us. The most recent case in point was the English pay deal. From that pay deal, issues

around terms and conditions were “agreed” and discussed in the NHS Staff Council but they do not apply in the devolved nations. Within Wales, we must now have separate discussions on some of those issues as they do impact on us, even though they have not been agreed by us. We have made our views on this known within the Staff Council, and to our union colleagues there, that it is unacceptable that English only matters are agreed and discussed with a UK wide Staff Council. Our English colleagues argue that, unlike the devolved nations, there is no all-England body that can deal with pay and terms and conditions across the whole of that nation and so, de facto, the UK Council has become the English Council. This is something we believe we need to address urgently and seriously if we are to maintain a 4 nation approach to pay and terms and conditions. Having token representation from union reps, employers and government officials from devolved nations in a UK body is no longer acceptable.

36. UNISON is not advocating the abolition of the NHS Staff Council as there is much work that still goes on there (e.g. Job Evaluation, Pensions, Working Longer Review), but there needs to be a more effective balance between each of the nations input into the Staff Council and maybe a different structure that ensures that the devolved nations have a stronger voice at the table. If this doesn’t or can’t happen, then we would have to question the value of the NHS Staff Council continuing in its current form.

37. We note the work of the Workforce Partnership Council in relation to closer co-operation between public services around workforce mobility and planning. These are welcome developments and greater use should be made of all-Wales cross-public service opportunities such as the development of the NHS Wales Shared Services Partnership to provide payroll, legal, procurement and Personnel services to other public sector organisations. This should provide economies of scale and great efficiencies in these areas.

WGGP090 – Robert Williams – Cwm Taf University Health Board
Tref / Town – N/A

General comments

Developing the LHB's Response
As part of the consultation process, Welsh Government have been holding a number of stakeholder events and have also provided a slide set to help inform the consultation and engagement process. The Health Board took the opportunity to discuss the 'Green Paper' at its Board Development meeting in August 2015. In addition broader engagement and discussion with the Stakeholder Reference Group, and other sub Committees of the Board have taken place, along with wider circulation across the University Health Board, which generated a range of comments and feedback which have been summarised within this response.

The Wider Context
The Board consider it important to take into context the current funding arrangements for NHS Wales and the implications of austerity across the Health and Public sector generally. As a consequence it will be important to consider the affordability of services, not least to manage expectation but to also ensure any proposed changes help strengthen and maximise the efficiencies of health and social care, as opposed to adding costs.

It is also important to consider and recognise the current planned system which NHS Wales has been developed on and strengthened further since the 2009 NHS reorganisation, where the purchaser / provider split has been removed. In any planned system of healthcare there is a need for central leadership, management and direction, which informs the local, regional and national delivery of Welsh Government Strategy and Policy.

The environment in Wales is not easy when we go against local opinion when consulting and/or engaging on local service change agenda, and this can undermine decision making processes, especially when the greater good of the local population is considered to be better served by a regional solution.

Links with other legislation/reports
It is important that this Green Paper is considered within the context of the Social Services and Well-being (Wales) Act 2014, the Regulation and Inspection of Social Care (Wales) Bill 2015 and the Well-being of Future Generations (Wales) Act 2015 as these legislative changes will be fully effective from 2017. It is also important to be cognizant of the recommendations made within the Williams Review 2014. ***(The report of the Commission on Public Service Governance and Delivery January 2014).***
It is important to recognise the implications of the Social Services and Well-Being (Wales) Act and the Well-being of Future Generations (Wales) Act, the

totality of which are not yet fully understood, their introduction will transform the way the health and social care systems operate in the future.

This, in turn, will be further impacted by the development of other important networks e.g. GP clusters/community networks. It will be important to ensure that any proposed legislation as a result of the NHS Green paper will not be developed in isolation and will be drafted to compliment and be consistent with these emerging legal frameworks.

As health and social care services increasingly work together within a framework of agreed aims and objectives through Local Service Boards, Health Social Care & Well Being Boards, Regional Collaborative Boards and Public Service Boards, the current governance and management models operated by the NHS and local government in Wales may require further change. The role of Welsh Government (in its broadest sense) in leading and managing this transformational change is pivotal and clarifying this as part of any legislative change would be helpful. Any new legislation drafted should positively encourage the delivery of a truly integrated health and social care system across Wales.

Ongoing engagement with the public, patients and partners remains critical, and ensuring best practice across Wales is captured and used to inform any proposed changes, would need detailed consideration. The developing arrangements through locality / community based clusters through to Local Service / Public Service Boards requires clarity, not least to mitigate the potential for duplication.

In the context of quality it will become increasingly important to consider how we ensure consistent quality and safety standards are in place across the health and social care system and if developed and agreed as a way forward, would also impact on the role and function of the current regulatory arrangements, e.g. HIW/ CCSIW.

Assuming fully the implications of the Social Services and Well-being (Wales) Act 2014 the Regulation and Inspection of Social Care (Wales) Bill 2015 and the Well-being of Future Generations Act, along with the outcome of the Commission on Public Service Governance and Delivery, will be essential to informing any changes to the current system, including whether this requires any further legislative change.

Culture

There is perhaps a further dimension which is not fully explored in the Green Paper, that is the culture, values and behaviours that we are looking to develop and mature. Evidence clearly indicates that it is culture that may have a more profound and positive impact on the way services are provided than legislative change alone. There is some evidence that legislative change can have the opposite impact leading to unintended consequences encouraging adversarial behaviours leading to poor decision making.

Perhaps the critical factor is that legislation alone will not necessarily lead people to modify and change behaviour to achieve the desired outcomes.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority? 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The Welsh NHS is a planned system and is not based on the principles of commissioning and providing competition as it is in England. A review of the legislative arrangements may be helpful to ensure the planned system is appropriately embedded, which should include consideration of the anomalies in the current system in relation to Hosted Bodies; NHS Trusts and whether there is scope for a single national organisation that could also oversee and support hosted bodies. The Health Board recognises and welcomes the current legislative changes taking place in Wales, this includes the Public Health (Wales) Bill, the Social Services and Well-being (Wales) Act 2014, the Regulation and Inspection of Social Care (Wales) Bill 2015 and the Well-being of Future Generations Act, all of which reinforce and strengthen the requirements for closer collaborative working between health and other public services. It is important to recognise the implications of the Social Services and Well-Being (Wales) Act and the Well-being of Future Generations (Wales) Act, the totality of which are not yet fully understood, their introduction will transform the way the health and social care systems operate in the future. As such we do not currently think that additional legislation is needed specifically to strengthen local collaboration for planning. What will be important is for clear guidance to be available to Health Boards and other public services to inform stronger planning across public services that is informed by a clearer and common understanding of the opportunities and requirements created by the new legislation. This would help to enable, notably the Wellbeing of Future Generations Act. This will enable the Health Board and partners to maximize the opportunities around local collaboration. Collaborative planning requires not only the recognition and adoption of common priorities and outcomes, but a framework and timetable that facilitates joint commitment and resource. Current planning cycles across public service and notably across health and local government are not fully aligned.

As health, local government and other public service partners continue to strengthen and develop their collaborative and partnership working through Public Service Boards, the current governance and management models notably operated by the NHS and local government in Wales may require further change. Some of it may be dependent on legislative changes but it is also important to first consider the scope of the current statutory instrument(s). Welsh Government would need to consider its responsibilities and role in overseeing and directing this planned system of healthcare and whether its current performance management and accountability arrangements would also need to change to reflect this. The role of Welsh Government (in its broadest sense) in leading and managing the system going forward is pivotal, not least to develop and apply systems of reward and sanctions to influence appropriate organisational behaviours. The Health Department at Welsh Government will also need to be structured to better respond and interact with the NHS in Wales in any changed system. Ongoing engagement with the public, patients and partners remains critical, and ensuring best practice across Wales is captured and used to inform any proposed changes, would need detailed consideration. The developing arrangements through locality / community based clusters through to Local Service / Public Service Boards requires clarity, not least to mitigate the potential for duplication. The implications of the recent and impending legislative framework e.g. Social Services and Well-being (Wales) Act 2014, the Regulation and Inspection of Social Care (Wales) Bill 2015, the Well-being of Future Generations Act and the Commission on Public Service Governance and Delivery, need to be considered in detail before any further health based legislative changes are proposed. It is therefore very important to take into consideration, that the existing governance structures established across NHS Wales, which are already complex are not added to by legislative changes considered as a consequence of the consultation on this NHS Green paper.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
The continuous engagement of patients and the wider public in the planning and provision of health services is increasingly important. Before consideration of any legal changes, there is a need to think through the attitude and scenarios where there is already excellent public engagement and consultation, and yet the public remains resistant to change. The NHS in Wales needs to consider how we as a nation address service change issues that span and cross local Health Board boundaries.

Health Board's already have a duty under the NHS Act to ensure that local populations are consulted on service changes and there is already significant case law in relation to the requirement to consult.

Each and every service change proposal needs to be considered on its merits. The duty lies with each organisation and governance arrangements should be robust enough to determine when consultation is required.

The main issue often lies in the interpretation of WG Guidance on Engagement and Consultation – and particularly in relation to the definition of "substantial". It is not therefore felt that further legislation is required but that the guidance needs to be revisited and made more explicit.

However, at a time when partnership working is increasing and the health impact of changes made by all public service bodies needs to be understood it would be beneficial if a similar process could be adopted across health and social care as at present the requirements to consult appear different in local government.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
It is important for Welsh Government to articulate more clearly their role in discharging responsibility for strategy and policy direction across NHS Wales. The role of Health Board is clearer and Health Boards are already under a duty to involve and consult local people and their representatives in the planning and delivery of health services and some Health Boards, in collaboration with their Community Health Councils, do this very well. The option of patient panels has been in operation elsewhere in the UK for some time and there are issues of credibility and legitimacy that need to be considered. The role and authority of such groups would need to be clearly defined – particularly in terms of whether they are advisory or whether their views must be acted upon (the latter then raising questions in terms of the Board's accountability within existing legislation). Should we not express a strong view that they should be advisory – how could they be otherwise? The other issue relates to the role of the CHC – which later in the Green Paper is put forward as the voice of the public. That premise could seem to be at odds with introducing another statutory group. Health Boards already have Stakeholder Reference Groups acting in an advisory capacity but their constitution can create a tension between representation and advising versus "vested interests" being to the fore in discussions on engagement and consultation. Similar issues could arise with another group being introduced with a similar remit. It is the view of the Health Board that further legislation is not needed which

could potentially tie the hands of Health Boards in the use of existing, established and any other innovative engagement methods.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
There are a number of considerations in relation to a permanent national panel including, membership and the extent of such, depending on what the panel is asked to consider, local knowledge, authority and accountability (particularly in relation to the outcomes of any formal consultative process), the role of the CHC and the scope of its work. NHS Wales has previously had some experience with the National Clinical Forum although there were some who perceived that this group did not always reflect local circumstances and on occasions put forward views which on occasion reflected a pure standards driven service model going forward, without taking account of other factors (e.g.: deprivation, rurality etc.). If such a panel were to be constituted it must be under the premise that referral to the Minister is removed as the default option.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
In the current arrangements there are differences between the nature of the financial and quality duties, with the former more easily defined and measured. Culture and ultimately quality is driven by leadership, values and behaviours. Legislative measures merely outline the process and therefore to continuously improve quality and outcomes for patients improved real time performance data through an integrated dashboard would be a better way forward, linked to the development of organisational and NHS Wales culture. The Health and Care standards provide some clarity in what is required. How we measure and self assess our practice against them requires further consideration.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
In relation to service change we should consider establishing a duty to undertake a quality impact assessment. We need to make better use of tools that already exist in the NHS, which evidence the quality and safety of care.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Quality of care is highly influenced by attitude, behaviours, values and cultures of Individuals and organisations. Leadership is a key factor in setting what is and isn't tolerated and this is essential regardless of any legislative measures. A more integrated approach across health and social care where there is clarity of meaning about quality.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
The current Accountable Officer arrangements are fit for purpose. It is difficult to see how any one individual could be held wholly responsible or accountable over and above the existing accountability arrangements of the accountable officer.

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
Following well publicised failings in managing quality and care standards within the NHS the principle of the introduction of a "fit and proper persons" test is supported. However, this should not distract from the primary responsibility of the employer to check that their Board members are competent in discharging their roles and responsibilities effectively and that they behave in a fit and proper manner and continue to do so for the tenure of their employment.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
It is not felt that we need to further strengthen existing legislation to promote quality through the NHS planning framework as there is already adequate provision to promote quality. Perhaps what is more important is how this is integrated with health & social care and embedded in practice at a local level. The development and integration of services has to be progressed through strong partnership and engagement work between service users, service providers and the wider population so that services are configured to meet local need. We need to develop our service planning, behaviours and language to align with prevention and clinical pathways in whatever the most appropriate setting for patients under the umbrella of prudent healthcare, regardless of setting ((Primary, Community, Secondary, Tertiary care settings).

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
This needs to be considered in relation to the responses under the quality section. It may be helpful to have standards that apply across the health, social care and independent care setting. This is more relevant in light of the impending legislative changes that impact upon Health, Social Care and Wellbeing, referred to earlier in our response. However, unintended consequences might result from this and the potential impact would have to be carefully considered in advance.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
A common set of standards would be supported recognizing that this will also have implications for the role and function of regulators. However, it would also be considered helpful if there is clarity and differentiation between statutory / mandatory standards and those considered to be best practice.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Peer review and accreditation systems are important aspects of providing assurance to the public. Whilst there is no appetite for further legislative change in this area, the current system would benefit from review to ensure duplication is minimised and arrangements are effective. The Welsh Government / NHS Wales would also need to be clearer about the distinction between peer review and accreditation and also what actions might it be prepared to take in responding to failures or concerns.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Appropriate access to clinical supervision should be integral to lifelong learning for all healthcare professionals. This in turn, will lead to improvements in recruitment and retention. Legislation should not be necessary as an enabler to ensure access to Clinical supervision, but a more mandated approach to ensure this takes place should be explored.

17. What arrangements should be put in place for self-employed health professional registrants?
There are a number of regulatory gaps which could be addressed through the requirements for clinical supervision, mandatory training and revalidation.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
The introduction of this statutory duty is supported. The Francis Inquiry Report made 290 recommendations including: • openness, transparency and candour throughout the healthcare system (including a statutory duty of candour), fundamental standards for healthcare providers • improved support for compassionate caring and committed care and stronger healthcare leadership Promptly identifying negligence and providing redress for the patient and their family should be encouraged. Doing so quickly and efficiently will reduce expenditure on legal costs and should provide a better experience for the patient and their family. Professional standards across all clinical specialties should generally be sufficient to ensure that there is a tacit duty of candour but clearly failings such as those covered in the Francis Report show that this is often not the case. The proposal is therefore supported – recognising that there will be training and culture implications that would need to be addressed and the relevant professional bodies would also have to recognise such a duty in their own standards. A national standard/policy would ensure uniformity across NHS Wales. This should be supported by safe havens for whistle blowers which will support staff to be open and raise concerns.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
It would help if there is clarity about what elements of performance are being referred to as 'not transparent'. Clarity of expectation from Welsh Government in stating what organisations are required to report (compulsory versus optional) and its readability (for a public audience) would greatly assist. Transparency will be greatly enhanced by the provision of real time information as many of the current systems in healthcare take an extended

period of time to produce meaningful data. Data capture and reporting of information is clearly within the gift of the UHB and is an area to be strengthened, but there are also potentially resource and cultural issues to be addressed. Whilst transparency of performance information is a must, it is unclear how legislation in isolation would improve transparency. A performance management framework for Wales could be used to drive improvement in terms of transparency and openness and assist Welsh Government and the NHS in Wales in taking a more consistent approach.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
There are already some well-established good practices in place for the joint investigation of complaints albeit there is variability across Wales. The principle that there should be integration across Health and Social Services is supported and aligns with other legislation. The complaints process should be an integrated process which ensures that the same principles and processes are followed. Health Boards already work across health boundaries and the current system allows for organisations to agree the lead organisation and respond to individual complainants. There is an opportunity as part of the review of PTR that this also includes primary and social care. It is felt important to ensure that PTR applies to all public bodies and healthcare providers.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
The Data Protection Act provides a legal framework for allowing organisations to share information appropriately taking into consideration the privacy and confidentiality of individuals. However, it is often through a lack of understanding by an organisation, or staff, through a lack of training, that the legislation is used to prevent sharing. Due to a lack of published national Information Governance Standards in Wales, there is often a lack of trust between organisations to ensure that once their information has been shared, similar systems, processes and security measures will be applied to that information to help prevent damage to the

organisations reputation, or application of a financial penalty.

It is not felt that further legislation is required but that a different culture and risk appetite needs to be adopted by organisations in an integrated service environment which functions under the auspices of the requirements of existing legislation (DPA).

22. How can we consider breaking down any barriers?
The main issue relates to consent and the reluctance to share personal information without explicit consent. However, many serious incident reviews highlight the lack of communications between organisations as a root cause. Organisations already have the ability to interpret Data Protection legislation from a position of wanting to share information rather than withholding information – but often they take a negative approach at the outset. The introduction of published national standards around information governance, security and compliance with WASPI etc. would led to increased confidence between organisations and encourage more effective sharing, ultimately benefiting the patient and the care they receive. The use of a single electronic patient record will help to break down barriers but may conversely also create some new challenges.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
It is vital that our patients have confidence in our ability to protect their privacy, comply with the law and safeguard their personal health data. Data holders within the health service must ensure that they obtain information about their patients properly, keep it secure and handle it in accordance with the well-established rules of medical confidentiality and the provisions of the Data Protection Act 1998. In addition, the Caldicott 'Report on the Review of Patient-Identifiable Information' identified weaknesses in the way parts of the NHS handled confidential patient-identifiable data and as a result all health boards and trusts were required to appoint “Caldicott Guardians” with a specific responsibility to ensure patient-identifiable data was kept secure and used in accordance with the Caldicott principles. Therefore, All patient-identifiable information, relating to living or deceased patients is confidential and must be treated in accordance with the Caldicott Principles. Research which makes use of existing patient identifiable data (and stored samples) must comply with NHS Caldicott Guidelines and have the

permission of the health boards' Caldicott Guardian. There are already well established Research Risk Governance arrangements in place across NHS Wales which include appropriate arrangements for guiding the use of Personal Identifiable Information. Researchers should always be able to justify and provide risk assessments for requiring identifiable information. However, where possible anonymised information should always be a preferred option.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
Yes in the context of capacity given the size of Health Organisations in Wales. At times this is further diluted by the duplication of effort of the community health council as their work programmes are developed independently.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
There is support for the health & social care system in Wales to have a strong independent regulator and consideration of the role and functions of both HIW and CSSIW should take place, to enable a more integrated and consistent approach and to also develop and strengthen competency, skills and capacity shortfalls across both bodies. It will also be important to take into considering the impending Regulation and Inspection of Social Care (Wales) Bill 2015.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
There is currently duplication and sometimes confusion as to who is regulating what. The Welsh Health & Social Care System would benefit from one integrated regulatory body working within one framework. It's more than joint working. It needs legislative change with common standards and a common framework.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
As above. Mainly clarity and ease of understanding across sectors. There is some confusion currently with WAO; HIW and on occasion the Delivery Unit and/or CHC undertaking what some may regard as regulatory / inspectorate work.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The role of the CHC is an important one which should be maintained in some form. However, Health Board's are already required to continuously engage with the local population and consult with the population when appropriate and to take these views into account when making decisions. The role of the CHC in "representing the patient voice" therefore needs to be clarified. If this relates to wider engagement then that would seem to cross over the statutory duty of NHS organisations. If it relates to the complaints/advocacy role then that is wholly appropriate. It is felt that the CHC Role should in the main focus on; • Advocacy and putting things right support; and • Big service change. Whilst it is recognized that local engagement is necessary for the CHC to represent the patient voice in the NHS there should also be a balance between local visits / inspections, as they don't with a strengthened inspectorate need to be doing the latter.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
We need to retain CHCs in Wales and learn from the mistakes of other nations. Refocusing their role on representing the patient voice and improving advocacy services seems appropriate and is supported, providing that clear mechanisms and related structures are established. The current membership of the CHC is drawn largely from lay people and this perspective is important when considering whether service change is for the benefit of the wider population. The CHC role in terms of scrutiny of healthcare and their links to HIW needs to be addressed. Currently, both organisations work largely independently. It would also make sense if a suite of data is more prudently captured for those with an assessment / regulatory role and this would avoid excessive duplication.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Any proposal to provide health boards with borrowing powers would need to be strongly aligned to the current IMTP planning and approval process and WG Performance Management arrangements and be considered under the flexibilities being promulgated by the Welsh Government for those with approved plans, within a strict regime of control that also clearly articulates Welsh Government's role. The benefits of allowing borrowing would be four-fold: 1. Borrowing will give much greater local flexibility; 2. Health Boards could invest in accelerating capital investments, where these demonstrate a clear revenue saving and payback; 3. It will instil a discipline of longer term planning and assessing business cases on a more commercial footing, securing an even greater focus on due diligence even in areas where borrowing is not required; 4. It will clarify current arrangements surrounding finance leases and PFI arrangements where Health Boards do, in effect, borrow to fund future developments. Careful consideration will need to be given to the NHS Wales policy framework in this area to ensure that Health Boards do not become exposed to over borrowing. System changes may also be required. For instance, there may be a need to review the process of capital charges and cash allocations to Health Boards. Currently, additional capital charges from capital investments are funded by the Welsh Government and so are not "real" to Health Boards. This does not support the efficient use of capital resources across NHS Wales. The system could become perverse if publicly funded capital investment had no "real" capital charge cost to Health Boards, while capital investment funded through borrowing would inevitably have a very high capital charge cost. Within a commercial context, depreciation revenue charges support delivering operational cash surpluses to repay any loans. This would be challenging within the current arrangements. There may also be an opportunity to clarify the Primary Care Development / Estate requirements within any revised arrangements.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
There is an opportunity to review, simplify and streamline the entire reporting arrangements and processes currently in place across NHS Wales.

At an NHS Wales level, we would agree that producing separate NHS Wales Trust and Health Board summarised accounts provide very little value, and do not reflect the current state of the NHS landscape. A summarised NHS Wales account as a whole will provide a far clearer understanding to the public of the activities of the NHS. Within the Health Board, providing summarised accounts are important in terms of demonstrating transparency and accountability to the general public, although the timing of publication (September) detract from this value. There may be an argument that the timetable for Annual Reports and Annual General Meetings to be shortened to create more timely reporting. Crucially, any change in reporting should encourage more meaningful and understandable analysis. There should also be consideration given to the Annual Report as a whole, to ensure that it can become a document which is understandable and accessible by the general public.

32. 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?
Yes, as highlighted above.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
There should be an equivalent statutory planning duty for NHS trusts as we have for health boards. This would ensure the seamless planning of activities to improve health and for meeting patients' needs across the pathways of care.

34. 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?
Generally the Health Board is supportive of one planning duty across health and social care, which may as a consequence require review of the 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.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
There is a need for clarification of the responsibilities and role Welsh Government undertakes in leading and directing NHS Wales, which operates within a planned system. In planned healthcare systems it is crucial that there is in clear oversight of the system to deal with governance issues across the system and between individual bodies. This role needs to be effectively defined. The current governance arrangements supporting the NHS in Wales are overly complicated and complex in nature (as highlighted by the WAO) and warrant review. The current governance arrangements could be simplified greatly if an all Wales body was created to manage / host current all Wales services that sit within and amongst a number of Trusts / Health Boards. In order to strengthen leadership, governance and partnerships the need for clear accountabilities is required, with a route of escalation if concerns arise built on sound principles with clear expectations and outcomes. There is already in place an escalation and intervention process in place for NHS Wales which means that there are clear consequences of how HB's or Trusts are moved into a position of escalation and that this is applied systematically and consistently.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed? 37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors? 38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation? 39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services? 40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
The current Health Boards have been in place since 2009 and whilst all HBs have faced challenges, some have faced considerable quality and safety issues, as well as financial and professional challenges. The current size and configuration of Health Boards are generally supported. The main focus should be on the competence and capacity of board members to discharge their duties. Whoever is appointed whether it be cabinet members from the new LAs, it is essential that first and foremost they need to

be competent to deliver what is required and not simply appointed on the basis of being elected. It is also important to recognise that the current Independent Members of the Board are there to reflect the views of the communities they serve and not be representative of communities and that is an important distinction. It is also important to preserve that status because it is in the interests of the public that non officer members bring their independent experience and expertise to the decision-making.

There is a need to recognise the growing demands and expectations on the roles of Independent Members which far exceed the notional contractual commitment of their roles and this requires further review as a consequence of this Green Paper. There should also be caution against considering smaller Board membership without seriously considering the training, experience and time commitment of fewer Independent Members.

The Commission on Public Service Governance and Delivery commented that Health Boards must be accountable and responsive, accessible to their local populations and provide excellent leadership and direction to their senior executives (and by extension the rest of the workforce) and hold them to account. The need to separate clearly those who make decisions and those who scrutinise them means that the role of a Health Board's independent members is a particularly challenging one.

Consideration also needs to be given to how a trade union and staff perspective is brought to the board if the current board composition changes. There is a value in having a TU member from the employing organisation at the board – a different internal perspective to that of the Executives. The advantage of having a full board member is that the individual will have been through the full public appointments process and should therefore have the necessary skills and abilities to undertake the role; however there are inevitable tensions when the TU view may differ from that of the board.

Having local knowledge of the organisation and the communities it serves is something that is valued and therefore needs to be built into the final determination.

Support should be extended to developing a wide range of potential opportunities for people to develop skills and experience in order to apply for Board membership in the future.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed? 42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
There would need to be better alignment and consistency of arrangements between HBs and Trusts.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
There is support for ensuring the role of the Board Secretary is strengthened and its importance recognised within NHS Wales. Whilst there is not support for this to be enacted via legislation, the role could be strengthened through Standing Orders. The key requirement to strengthen the role and its importance and place it on a level footing with other Officer Members of a Board is to strengthen the status of the role which includes title. The current NHS Job Evaluation and Grading System, makes it difficult to fully recognise the role of the Board Secretary, although the role requires the post holder to act as the conscience of the Board and to challenge / advise Director colleagues (and the Chairman and Accountable Officer) as appropriate.

44. If so, what aspects of the role should be additionally set out in law?
Linked to the above response. Additional aspects could include the Board Secretary role as a statutory role with a specific job description that would be included in standing orders so as to avoid deviation of duties across different HBs/Trusts. The role would be directly accountable to the Chair of the Board and indirectly to the CEO.

45. How could potential conflicts of interest for the board secretary be managed?
There would not be conflicts of interest if the role is clear, professionally discrete, with no broader operational management responsibilities. The importance and status of the role may also be strengthened if there was a professional head within Welsh Government. Making the role accountable to the Chairman of the Board and providing the role with powers to challenge the Board and CEO team if required, as currently available for Monitoring officers in Local Government.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Yes. There is a disconnect between national groups / committees and local decision making. This includes the lack of focus for health professional forums as advisory committees of Health Boards which have limited value and impact

currently. These long standing issues need to be resolved.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
This has to relate to the nature and speed of the advice required. Advice from speciality bodies in Wales could be accessed through a reformed clinical network system given that networks engage multi-professional groups service users and members of the third sector. The advice should also be gleaned from other Professional Bodies including Royal Colleges, and National bodies such as NICE. Legislation could ensure appropriate consultation with advisory structures/networks.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
It would also be essential to fully understand the impact of new legislation on this area of NHS work before considering any further legislation. The architecture of workforce partnership needs to reflect the policy framework set by Welsh Government.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
The is a lack of understanding with the current complex governance arrangements that span health bodies that also host other bodies e.g. Shared Services Partnership Committee; NWIS. WHSSC and EASC. There are also differing accountability and reporting arrangements which the current system has created and which could be simplified without recourse to legislation but through the use of or amendments to statutory instruments. It is essential that Health Boards/Trusts fully understand and can convey the accountability and reporting arrangements for such services. Any such governance should be strengthened through service level agreements with Health Boards to ensure that the entity is fully responsive to the needs of the service and individual clients and can demonstrate it provides value for money for all customers.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
There is a significant agenda for NWSSP within an NHS Wales context and the service continues to mature as a comparatively new entity. There are significant risks that a wider expansion will make the service less responsive to the needs of the Health Service, which would need to be carefully managed.

WGGP091 – Sarah Rochira – Older People's Commissioner
Tref / Town – N/A

General comments

1. Older people are the largest users of health and social care services across Wales, and the Welsh NHS has a duty of care to get it right for older people. The growth in the number of people living with dementia, and the increase in the number of the oldest old who are living with complex and high acuity needs means that older people using health services can be increasingly vulnerable.

2. The health service needs to respond to this by ensuring that: its staff are sufficiently trained and supported, its environments are appropriate, individuals' voices and experiences are listened to and acted upon, and systems are in place to recognise and react to risks – all in order to maintain and improve the quality, safety and dignity in care.

3. However despite a great deal of improvement activity, through my own scrutiny[11], the conversations that I have with older people across Wales and the individual case support that I provide through my office, I am aware that there is still a great deal of improvement needed in the access to, and experiences that older people have, particularly those living with dementia or a sensory loss, whilst receiving both health and social care. This is supported by a number of reports that have been published recently that highlight the poor treatment and experiences of older people in some hospital environments[12] and also while attempting to raise a concern or complaint[13].

4. Therefore, as the independent voice and champion for older people across Wales (currently almost 800,000 people aged 60 years and older), I welcome efforts made to improve the quality of care and experiences that older people receive, and the opportunity to respond to the Welsh Government's Green Paper: 'Our Health, Our Health Service'.

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[11] Older People's Commissioner for Wales, A Place to Call Home? A Review into the Quality of Life and Care of Older People in Care Homes in Wales, 2014; Dignified Care? The Experiences of Older People in Hospital in Wales, 2011; 'Dignified Care? Two Years On', 2013

[12] Professor June Andrews & Mark Butler, Trusted to Care, An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board, 2014 ; Donna Ockenden, External Investigation into concerns raised regarding the care and treatment of patients, Tawel Fan Ward, Ablett Acute Mental Health Unit, Glan Clwyd Hospital, 2014

[13] Keith Evans, A REVIEW OF CONCERNS (COMPLAINTS) HANDLING IN NHS WALES "Using the Gift of Complaints", 2014

5. There are a number of overarching comments that should be considered through the whole of my response to the Green Paper:

    - A rights based approach
    - Imagery and language used
    - Quality in healthcare – the role of patient experience
    - Connections with other legislation

A rights based approach

6. Through my own scrutiny and the conversations I have with older people, it is clear to me that many of the issues raised about the quality and experiences of healthcare could be addressed using a rights based approach.

7. As Commissioner, I want to see due regard for the UN Principles for Older Persons on the face of future legislation that may arise from this Green Paper.

Imagery and language used

8. On October 1st 2015 I launched my 'Say No to Ageism'[14] campaign, and highlighted the prevalence of negative language used to refer to older people.

> "Negative stereotypes of older people are still very common, as is the derogatory and disrespectful language that is often used to describe people once they reach a certain age. Frailty and dependence are not inevitable as people grow older, yet this is the image that sadly prevails."
>
> Older People's Commissioner for Wales, Commissioner calls on Wales to say NO to ageism, 1st October 2015

9. The Green Paper unfortunately uses such negative portrayals and describes growing older and frailty as synonymous - by stating that: 'Frail and older people increasingly have more complex needs'.

10. Furthermore, the Green Paper also states that 'More people are being diagnosed with one or more preventable health conditions, such as type 2 diabetes and dementia'.

11. The term 'dementia' is used to describe the symptoms that occur when the brain is affected by specific diseases and conditions.[15] There are many types of dementia, some which may be preventable but many of which are not. It is disappointing that the language used in the Green Paper does not adequately articulate this.

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[14] Older People's Commissioner for Wales, Say NO to Ageism , 1st October 2015
[15] Types of dementia, Alzheimer's Society

12. As an active member of the national collaborative programme Ageing Well in Wales, it is disappointing that Welsh Government have missed an opportunity to more strongly introduce the concept of a preventative approach as a national quality marker for the NHS in Wales. A focussed approach on prevention throughout the NHS could enable people in Wales to age well through slowing down the onset of frailty, and reduce expenditure of the NHS. However, the current narrative simply reinforces the stereotype that growing older is something to dread and fear.

Quality in healthcare – the role of patient experience

13. The Green Paper refers regularly to the concept of quality of healthcare, and defines this as 'providing the right care, in the right place, at the right time and in the right way'.

14. When talking about healthcare, very many of the conversations I have with older people, and the problems that I found in my own work[16] and other reports[17] centre around the final point – providing care in the right way.

15. It is the core business of Health Boards and Trusts, and all other bodies delivering healthcare to ensure that patient care is safe and effective, that they are treated at all times with dignity, care and compassion and are supported to feel safe and cared for.

16. Understanding the experience of individuals and the impact that poor care can have – and using this patient experience and feedback to continuously drive forward improvement is central to achieving quality in healthcare. This must feature prominently in any future legislation or policy going forward.

Connections with other legislation

17. Older people often say things to me like 'why don't people talk to each other', and 'why does a crisis have to occur before anything happens'. Issues relating to an improved integrated approach between health and social services, including inspection, will be touched upon throughout my response.

18. However, I welcome the recognition in the Green Paper that you will "seek to dovetail any actions within the NHS with the powers and duties contained in the Social Services and Well-being (Wales) Act 2014, and the proposed

[16] Older People's Commissioner for Wales, Dignified Care? The experience of older people in hospitals in Wales, 2011, One & Two years on updates, 2012, 2013

[17] Professor June Andrews & Mark Butler, Trusted to Care, An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board, 2014 ; Donna Ockenden, External Investigation into concerns raised regarding the care and treatment of patients, Tawel Fan Ward, Ablett Acute Mental Health Unit, Glan Clwyd Hospital, 2014

measures being taken forward through the Regulation and Inspection of Social Care (Wales) Bill."

19. I would add that consideration should also be taken to dovetail with provisions within the Wellbeing of Future Generations (Wales) Act 2015.

20. There are a number of specific areas where I will focus my response, and additional comments in relation to the remaining parts of the Green Paper can be found towards the end of the document. My key areas are:
    1. Continuous engagement with older people
    2. Quality in nursing care homes
    3. Role of the Community Health Councils
    4. Board Governance and accountability
    5. Outcomes based reporting and Board scrutiny

1.Continuous engagement with older people

"Continuously engaging with citizens (Chapter 1 p.14-15)"

21. Following significant representation from older people about the proposed changes to NHS services in Wales, I issued formal guidance to Health Boards in February 2013[18] (under Section 12 of the Commissioner for Older People (Wales) Act 2006), and undertook scrutiny of the engagement and consultation with older people during NHS reconfiguration. This work was then used to support Ann Lloyd in her 'Lessons Learnt' review.

22. In correspondence to Health Boards in November 2014[19], I again, emphasised the importance of proactive and ongoing engagement with older people to plan healthcare services.

> "Older people are more likely than any other section of the population to use the NHS. The NHS in Wales must, therefore, ensure that it really understands the needs of these people who are not a homogenous group but as diverse a group as any other section of the population. As people become older their needs become more complex and it is important to understand how needs, and solutions to meeting those complex needs, interact as well as understanding how older people experience the delivery of care and services designed to meet such needs.
> "The best people to ask about efficient and effective delivery of care and services are older people themselves. Without doing so, Health Boards are less able to understand the needs of a large portion of their population and ill-

[18] Older People's Commissioner for Wales, Best practice guidance on assessing the impact on older people in Wales of changes by Local Health Boards to policy and provision of services, and best practice guidance for engagement and consultation with older people on changes to health services in Wales , February 2013

[19] Older People's Commissioner for Wales, Letter sent to Health Boards and Welsh Government regarding NHS Reconfiguration, November 2014

equipped to deliver services that meet those needs. Furthermore, without proactive and ongoing engagement the Health Boards will be unable to have truly open conversations with patients about the future of healthcare in general, but also the specific care and treatment that is best for them. These open conversations are needed for the achievement of individual outcomes, and form a central feature of the Welsh Government Prudent Healthcare policy."
Older People's Commissioner for Wales, Letter sent to Health Boards and Welsh Government regarding NHS Reconfiguration, November 2014

23. The Green Paper recognises the need to continuously engage in service planning, so that patient and public experience informs decision making – and I welcome this.
24. The Green Paper states that that 'the mechanisms are therefore already in place to ensure effective engagement on service changes and this should become the norm for the health service in Wales'.
25. However following my scrutiny in this area, despite recognition that improvement is needed, I remain concerned that in-depth engagement with older people is not ongoing, and that in reality, engagement and consultation is still predominantly carried out with older people for specific events.

"I expect to see in all of the Health Board's work:

- "Ongoing and proactive engagement with older people, that not only supports open conversations about the future of health services but enables the achievement of agreed, individual outcomes.
- "Improved consideration of the needs of older people who are carers, living with dementia and with protected characteristics through Equality Impact Assessments, and clear evidence of any mitigating action taken to address any negative impacts that were identified.
- "Earlier consideration of the impact that service change will have on transport and community services, and the role that they have in achieving improved outcomes for older people.
- "Clear, consistent and accessible methods of feeding back the outcomes of consultation and service change to older people."

Older People's Commissioner for Wales, Letter sent to Health Boards and Welsh Government regarding NHS Reconfiguration, November 2014

26. The Green Paper asks whether permanent engagement mechanisms should be set up on a statutory basis, such as patient panels or participation groups. In light of my scrutiny work in this area, there could be a place for permanent engagement mechanisms to continuously engage with, listen to, and act upon the voices of older people. However, these must be as part of a whole package of continuous engagement methods and not become the only method used.

27. Furthermore, I have been clear that the method of continuous engagement used by Health Boards must not act as a barrier to hearing the voices of all people, especially those who are seldom heard. For example those people living with dementia or a sensory loss, those who are carers, or those who may also find that transport or digital technology excludes their involvement must be appropriately supported so their voices are heard.

28. Future legislation (primary and secondary) that may arise from this Green Paper must state explicitly how this will be done, with reference to best practice guidance such as my 'Best Practice Guidance for Engagement and Consultation with Older People on Changes to Community Services in Wales'[20], and my 'Best practice guidance on assessing the impact on older people in Wales of changes by Local Health Boards to policy and provision of services, and best practice guidance for engagement and consultation with older people on changes to health services in Wales'.

2.Quality in nursing care homes

Enabling Quality, Quality and Cooperation (Chapter 2 p.16-18)

29. The Green Paper recognises that the current model of promoting quality within the NHS is based on older structures, and has focussed on acute hospital and directly provided services. I welcome this recognition, and note that for many older people, they receive the majority of their services or interactions in non-acute settings.

30. My Review into the quality of life and care of older people living in care homes in Wales[21] clearly demonstrated that there needs to be a greater focus on the quality of health services provided in non-acute and independent settings, or settings that are commissioned by a Health Board – for example in nursing care homes. Therefore, quality monitoring and promotion needs to adequately reflect all settings.

[20] Older People's Commissioner for Wales, 'Best Practice Guidance for Engagement and Consultation with Older People on Changes to Community Services in Wales', July 2014; Older People's Commissioner for Wales, Best practice guidance on assessing the impact on older people in Wales of changes by Local Health Boards to policy and provision of services, and best practice guidance for engagement and consultation with older people on changes to health services in Wales , February 2013

[21] Older People's Commissioner for Wales, 'A Place to Call Home? A Review into the Quality of Life and Care of Older People Living in Care Homes in Wales', November 2014

"CSSIW do not have responsibility for inspecting healthcare delivery in care homes, which is a key part of an individual's quality of life.
"While Healthcare Inspectorate Wales is the body responsible for inspecting healthcare in Wales, they stated in their evidence that they do not inspect the standard of health care delivery within care homes as this falls outside of their remit.
"We don't do work in the homes ourselves. We don't have an on-going day to day responsibility in the inspection of how that's done within homes, or the way in which LHBs commission." Healthcare Inspectorate Wales (Oral Evidence)
"This means that there is currently not appropriate or effective scrutiny of the delivery of healthcare in nursing care homes."
Older People's Commissioner for Wales, 'A Place to Call Home? A Review into the Quality of Life and Care of Older People Living in Care Homes in Wales', November 2014

31. Furthermore, my own scrutiny work that I undertook last year following the publication of the 'Trusted to Care'[22] report showed that only a small number of the responses from Health Boards explicitly recognised the relevance of Trusted to Care to non-acute setting such as residential nursing care homes, despite the strength of the read across given the vulnerability and the high acuity levels of older people living in non-acute residential settings.
32. The Green Paper states that the existing duty of quality in the NHS could be built upon better to reflect our planned system and one which is more explicit about quality across all aspects of the system wherever health services are provided. I welcome this, and call for a revised duty of quality to include the provision of healthcare services in independent settings such as nursing care homes. This is important where provision has been commissioned by a Health Board, but my Care Home Review also shone a light on the need to improve the focus on monitoring quality of healthcare provision for individuals who fund their own care.

Quality in practice, Meeting common standards (Chapter 3, p.20-21)

33. The Green Paper recognises that currently, the recently reviewed Health and Care Standards (April 2015) envisage their application across all NHS funded services, including independent contractors, but that there is no legal obligation on providers to do so. Legally, there are different standards that apply to independent providers.

34. I support the application of common standards in all settings by law, to all health bodies and also to services commissioned by the health service but provided by an independent organisation. In light of my findings in my Care

[22] Professor June Andrews & Mark Butler, 'Trusted to Care: An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board', 2014

Home Review, I have been clear that an extension of such standards should also include the provision of healthcare within nursing care homes and provision that has been commissioned by a Health Board.

35. The Green Paper references the opportunity to join healthcare standards with those proposed through the Regulation and Inspection of Social Care (Wales) Bill for residential and domiciliary care. I welcome a holistic, outcomes based approach to standards in both health and social care, with clear read across to the National Outcomes Framework[23].

3.Role of Community Health Councils

Checks and balances, Representing patients and the public (Chapter 6, p.31-32)

36. The Community Health Councils carry out a valuable function as an independent representative and champion of patient voice. This includes the important role of advocacy but also an ability to inspect premises and represent patient voice during service change.

37. It is my view that their understanding of the patient voice and patient experience from a lay viewpoint, brings an incredibly valuable perspective to the system that is looking at the quality of healthcare provision. They can provide insights from an individual's point of view, making the checks and balances that are in place far more robust as a result. Furthermore, their independence from other organisations also ensures they are able to focus on representing the patient voice.

38. The Community Health Council's also possess local knowledge that can be used to improve the understanding of patient experience and healthcare quality. It is for these reasons that I wish to see Community Health Councils to continue in all of their functions.

39. Clear evidence of my continued support for these important functions, and use of these in the provision of healthcare within care homes, can be found in my Review into the quality of life and care of older people living in care homes in Wales[24].

> "Evidence from the Board of Community Health Councils in Wales (CHCs), who have the power to monitor the delivery of NHS funded care and identify areas in which improvements must be made, stated that they could potentially address this gap as they have access to 400 community volunteers with a knowledge of the health service and a willingness to enter residential settings and monitor the delivery of healthcare. However, they

[23] Welsh Government, The National Outcomes Framework for People who Need Care and Support

[24] Older People's Commissioner for Wales, 'A Place to Call Home? A Review into the Quality of Life and Care of Older People Living in Care Homes in Wales', November 2014

> have received conflicting legal advice from the Welsh Government and independent lawyers about the extent to which the powers under their legislation allow them to enter care homes to monitor the delivery of healthcare. This means that the potential for CHCs to monitor healthcare within care homes has not yet been explored…
> "Utilising CHC members to undertake monitoring work in care homes would also introduce a broader lay-perspective into the inspection system, something that has been successful in other parts of the UK and would support the Welsh Government's aim to 'actively engage citizens within our regulation and inspection regime', something that is currently being explored as part of work around the forthcoming Regulation and Inspection Bill."
> Older People's Commissioner for Wales, 'A Place to Call Home? A Review into the Quality of Life and Care of Older People Living in Care Homes in Wales', November 2014

40. I have made clear in my Care Home Review that the benefit of using lay inspectors within the system of checks and balances far outweighs the cost associated with the system, and the cost to an individual in respect of poor care. Not only must CHC's inspection role within NHS premises continue, but they must be utilised within alternative settings where healthcare is delivered such as within care homes.

41. I welcome the 'Operational Protocol between Healthcare Inspectorate Wales and the Community Health Councils in Wales'[25], and would wish to see this positive joint working continue across all healthcare services to ensure this valuable lay input is fully utilised. For example, in an increasingly integrated system we need to look beyond hospital wards and begin exploring the how the checks and balances, including a lay perspective, can take place when healthcare is delivered within a dispersed community setting.

42. Furthermore, we need to consider how these checks and balances are undertaken when healthcare is delivered as part of a continued patient pathway, which is connected to the delivery of social care. I see the CHCs, and the valuable lay perspective that they bring, as being well placed to bridge the gaps that I have identified.

Checks and balances, A seamless regime for inspection and regulation (Chapter 6, p.29 – 31)

43. The Green Paper outlines the role of Health Inspectorate Wales (HIW), particularly in the context of the recent Ruth Marks review[26] and its interface

[25] Operational Protocol between Healthcare Inspectorate Wales and the Community Health Councils in Wales, March 2015
[26] Ruth Marks, The way ahead: to become an inspection and improvement body, November 2014

with other inspectorates and regulators such as the Care and Social Services Inspectorate for Wales (CSSIW).

44. There are clearly instances where the quality of life and care of individuals could benefit from joint working between inspectorates, for example where healthcare is delivered in a care home setting. My Care Home Review demonstrated how important it is for the appropriately qualified individuals to have 'eyes on' the delivery of healthcare outside of the hospital ward setting. In an era of increasing integration between health and social care, there must be a consistency in the approach and standards used during inspections across both HIW and CSSIW.

4.Board Governance and accountability

Enabling Quality, Quality and Cooperation (Chapter 2 p.16-18)

45. The Green Paper recognises that recent failings in quality of care and standards, such as those at Tawel Fan raise questions about whether the system for accountability is right, and I welcome this.

46. I undertook my own scrutiny last year following the publication of the 'Trusted to Care'[27] report in order to seek assurances from Health Boards regarding the quality of care of older people within their hospitals.

47. I would expect every Health Board in Wales to be in a position to provide assurances, from an outcomes focussed perspective, at any point in time or certainly to the day of their last Board meeting. It is a key function of the full Board to clearly understand the quality of care provided, where there is unacceptable care and the impact of this on older people.

48. However, following receipt of information from Health Boards it appeared to me that there were a number of governance issues that the NHS in Wales must now address, which are as follows:
    - The consistency and clarity of definitions of quality of care and the extent to which these reflect the perspective of older people.
    - The robustness and effectiveness of Board scrutiny regarding the quality of the care provided by their organisations.
    - The robustness and effectiveness of the mechanisms that Health Boards and the Trusts have in place to evaluate the quality of care.
    - The sources of Board assurance regarding the identification and remedying of unacceptable care.
    - The openness and transparency of Board performance against their core business.

[27] Professor June Andrews & Mark Butler, 'Trusted to Care: An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board', 2014

49. For example, while Health Board's provided me with some assurances and a significant amount of information in respect of process, audit and improvement work, the language used in some responses by Health Board's made it difficult for me to fully form a view of the quality of care, and in particular if there is unacceptable care. A number of Health Boards made reference to their awareness of:
    - "wards causing concern"
    - "some areas need improvement"
    - "areas for continuous improvement"
    - "some shortcomings"
    - "some variations between clinical areas which are being addressed"
    - "potential for these standards not to be maintained in all wards at all times"
    - "subject to further assurance work"
50. It was impossible for me to judge the scale or impact upon individuals of these "shortcomings", or when a "shortcoming" becomes "systemic". There was also little evidence of when these "shortcomings" would be rectified or how the impact and risk in the interim was being minimised.

51. A number of responses made the point that their assurances needed to be seen in the context of supporting data and assurance mechanisms that needed to be reviewed or reconsidered in respect of their robustness. For example:
    - "cannot guarantee that the assurance model would pick up every instance' of poor care"
    - assurance mechanisms "may not, in isolation, prevent unacceptable levels of care"
    - "assurance system must be developed further"

52. Whilst no assurance system can reduce all risk, there must be clear and standardised confidence levels across Health Boards. It is difficult to see why, given the consistency of core NHS Wales business, different assurance models would exist. It is clear responses that there is a significant level of activity in place to drive up quality of care. However, there is a real danger that we do not deliver a consistent approach that should sit at the heart of a national health service, or that we do not share learning and use limited resources to best effect.

53. Further commentary on a way forward from here is included later in this paper, in the section 'Outcomes based reporting and Board scrutiny' below.

Enabling Quality, Quality and Cooperation: Responsible Individual & Fitness to Practice (Chapter 2 p.16-18)

54. The Green Paper refers to concepts such as the 'responsible individual' (RI), as set out in the Regulation and Inspection of Social Care (Wales) Bill, and the 'fitness' (fit and proper person test) of senior leaders which is present in England.

55. As in the section above, I believe there are, a number of governance and accountability issues present within the NHS that need to be addressed and I welcome the intention to strengthen corporate accountability. However while not without potential, it is unclear how a responsible individual would work within the NHS and healthcare settings as distinct from social care provision.

56. There are a number of questions as to how this intent will translate into practice and what real difference would it make where poor care has taken place. For example, would this would be per hospital, per ward, per 'type' of service? What is stopping another member of the Board from becoming the RI? Whilst this may remove the individual it will not change the culture at the top. Similarly, where a person in a leadership position such as Chief Executive or Ward Sister is a RI, would they be replaced in this role as well as the 'RI' role if they needed to be removed as 'RI'?

57. I have raised similar questions in respect of the 'RI' role within the Regulation and Inspection of Social Care (Wales) Bill.

58. The implementation of a fit and proper persons test that is consistent with that proposed within the Regulation and Inspection of Social Care (Wales) Bill, and comparable to that found within 'The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014' (clause below) could apply to managers and directors at a senior level.

> "the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and…"
> Part III, Section I, Regulation V (III)(d), 'The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014'

59. This could ensure that an individual who was responsible for, or been privy to, such poor care (such as that exposed in the 'Trusted to Care' report) would not be able to hold similar positions in another health body.

5.Outcomes based reporting and Board scrutiny

Leadership, Governance and Partnerships (Chapter 8, p.38-39)

60. The Green Paper recognises that recent reports and inquiries have highlighted the effectiveness of board scrutiny regarding the quality of care, and the openness and transparency of board performance against their core business.

61. I have been clear that it is the core business of Health Boards and Trusts to ensure that patient care is safe and effective, that they are treated at all times with dignity, care and compassion and are supported to feel safe and cared for.

62. I expect Boards and Trusts to have a fundamental grasp on the safety, effectiveness and quality of their services, with the views of patients and staff integral to this understanding. Furthermore, they should be able to provide the public with the assurance of what they have a right to expect: either that care is acceptable or that areas for improvement are recognised and improvement is swiftly being delivered.

63. I highlighted in the section 'Board Governance and accountability' a number of governance issues within the NHS that my scrutiny work has uncovered – such as the use of vague and opaque language to describe the quality of care, assurance systems that are in need of development and my concern that there has not been a consistent approach to resolving these concerns.

64. To complement this analysis and support the development of accessible and understandable public reporting, in February 2015 I developed twelve key areas which I expect Health Boards and Trusts to report on, and provide commentary. I am working with Health Boards to take this forward. This is attached in Annexe A.

65. These currently apply to the quality of care, and experiences of older people whilst in a hospital setting. This is however, with a full recognition that there are key areas within a primary and community setting upon which strengthened reporting is also needed – and does not remove the need for specialist and technical dashboards for Board use. There is currently insufficient data on the performance of health services and the experiences of individuals within a community setting. In the context of increased services being delivered outside of an acute hospital setting, and in order to continually drive quality up, such data is desperately needed.

66. I understand that a national performance measurement framework will now be developed to be used alongside the Health and Care Standards (April 2015) and will continue to engage in its development. A key expectation of mine is

the inclusion of these twelve key areas within a national dashboard, and should the Health and Care Standards be placed on a legislative footing I would expect to see national, standardised and outcomes based reporting sit at the heart of their implementation, and at the heart of all of the checks and balances.

Openness and honesty in all we do: Being open about performance and when things go wrong (Chapter 4, p. 23-25)

67. The Green Paper references the need for health services to be open and honest, especially when things go wrong. The need for openness, especially when things go wrong is clear. I have publicly welcomed the publication of Health Board, and NHS Wales Annual Quality Statements and have provided detailed critiques on these.

68. I recognise from my conversations with older people and the case support that I provide, that many negative experiences with health services are fundamentally down to a need for honest and accessible communication, recognition of the experience that an individual has had, and clear routes forward when something has gone wrong. The Green Paper asks whether a duty of candour should be introduced, and I would welcome such an introduction.

Additional comments:
The changing shape of health services: Promoting health and wellbeing (Chapter 1, p.11-13)

69. The Prudent Healthcare principles are referenced throughout the Green Paper, and in particular, in relation to co-production and the need for openness and honesty. I support this principle, and welcome that the document recognises the need to listen to the patient voice and experiences, in order to plan future care and also learn from and act on this information.

70. In order to support patients to play an active role in their own wellbeing, and to act effectively on their concerns and experiences, the workforce must be supported to gain the necessary skills to listen to and support all individuals, in particular those who are seldom heard such as those living with a sensory loss or a dementia or those who are carers. This would include access to independent advocates where appropriate.

71. If the workforce is not given this support, then I am concerned that the positive aim of ‘co-production’ is at risk of not being achieved – and this is relevant in both the delivery of care and also the dealing of concerns and complaints.

72. Alongside planning and delivering health care provision with individuals, the Green Paper also refers to planning models for the wider population such as that for primary care and also that under the Social Services and Wellbeing (Wales) Act 2014. I have been clear that a holistic approach is needed to plan for the health and wellbeing of a population, this must include the current and future social care needs and also the vital role that housing, and community services have to play.

73. As the largest users of health and social care services across Wales, planning of our health, housing and social care services must understand their varying needs. Older people are not a homogenous group, and will have a wide and diverse range of needs, concerns and priorities. It is crucial that joined up, holistic planning and population assessments contain sufficiently detailed information on the needs of older people within an area.

Openness and honesty in all that we do: Making it easier to raise concerns in an integrated system (Chapter 4, p.25)

74. I recognise from my conversations with older people and the case support that I provide, that many negative experiences with health services are fundamentally down to a need for honest and accessible communication, recognition of the experience that an individual has had, and clear routes forward when something has gone wrong.

75. In an increasingly integrated system, there needs to be consistency in how concerns and complaints are managed in both health and social care.

76. Understanding patient experience and recognising and addressing an issue as swiftly as possible is needed in order to prevent an individual from feeling that a formal complaint is the only route through which they can progress. Furthermore, the access to independent advocacy needs to be improved in order to support those seldom heard to have their voices heard and acted upon.

The changing shape of health services, staffing and workforce (Chapter 1, p.10-11)

77. The Green Paper notes that there are more staff than ever before working in the NHS in Wales. However, I am concerned that this does not reflect the current difficulties faced by healthcare services and nursing care homes of hiring sufficiently qualified nurses, nor does it reflect the difficulties that we know exist in the General Practice workforce – particularly in rural areas. In order to present a full picture as a basis for any future policies or legislation, these current challenges must be reflected.

78. For information, I include below the comments that I made in response to the Welsh Government consultation on the 'Planned Primary Care Workforce for Wales'[28].

> "My care home review 'A Place to Call Home' found that a number of workforce challenges were present within care homes and contributing to the experiences and quality of life of older people. For example, a shortage of qualified nurses to work in these settings and the level of support, training and supervision that they receive must be considered within the planning and development of the primary care workforce. Furthermore, staff capacity and the skills and development needs of the care staff working within care homes (and also within private homes as domiciliary care workers) must be considered alongside this.
>
> "My care home review also found that older people were sometimes not able to access healthcare services, such as oral health care, whilst living in a care home. Therefore, primary workforce planning must also take into account the ability of the workforce within a locality to reach older people living in a care home environment….
>
> "I am aware of the difficulties in recruiting and sustaining GP practices, and have been contacted by older people particularly in relation to provision in rural areas. I am concerned about the significant impact that this can have on the ability for older people to access the most basic of healthcare services. It is important to remember that while a lack of access to GP provision is a problem in itself, there will also be a knock on impact on pressures being placed on intermediate and secondary healthcare."
>
> Older People's Commissioner for Wales, Response to: A Planned Primary Care Workforce for Wales, August 2015

Annex A
Older People's Commissioner for Wales: Quality & safety of health care services: reporting and scrutiny
February 2015

It is the core business of Health Boards and Trusts to ensure that patient care is safe and effective, that they are treated at all times with dignity, care and compassion and are supported to feel safe and cared for.

I expect Boards and Trusts to have a fundamental grasp on the safety, effectiveness and quality of their services, with the views of patients and staff integral to this understanding. Furthermore, they should be able to provide the public with the assurance of what they have a right to expect: either that care

[28] Welsh Government, A Planned Primary Care Workforce for Wales

is acceptable or that areas for improvement are recognised and improvement is swiftly being delivered.

The Annual Quality Statement is the method through which Boards and Trusts will provide the public with these assurances. My analysis showed that whilst there were large improvements from the previous year, there are still a number of areas which need to be strengthened further, including the success of accessible and understandable public reporting.

In addition to this, I raised concerns following the publication of the 'Trusted to Care' report that there are a number of governance issues that the NHS in Wales as a whole must now address, which are as follows:

- The consistency and clarity of definitions of quality of care and the extent to which these reflect the perspective of older people.
- The robustness and effectiveness of the mechanisms that Health Boards and the Trusts have in place to evaluate the quality of care.
- The robustness and effectiveness of Board scrutiny regarding the quality of the care provided by their organisations.
- The sources of Board assurance regarding the identification and remedying of unacceptable care.
- The openness and transparency of Board performance against their core business.

To complement this analysis and support the development of accessible and understandable public reporting, I have developed twelve key areas which I expect Health Boards and Trusts to report on, and provide commentary. These currently apply to the quality of care, and experiences of older people whilst in a hospital setting. This is however, with a full recognition that there are key areas within a primary and community setting upon which strengthened reporting is also needed – and does not remove the need for specialist and technical dashboards for Board use.

I expect all Health Boards and Trusts to report quarterly at each Board meeting, and annually in their Annual Quality Statements on the following:

1. The number of older people who have lost their continence whilst in hospital, as an avoidable consequence of their care - including the impact upon the individuals wider health and well being and ability to live an independent life.

2. The number of older people who have become dehydrated or malnourished whilst in hospital, as an avoidable consequence of their care - including the impact upon the individuals wider health and well being and ability to live an independent life.

3. The number of older people who have lost their physical mobility and ability to self care whilst in hospital, as an avoidable consequence of their

care - including the impact upon the individuals wider health and well being and ability to live an independent life.

4. The number of older people who have fallen whilst in hospital and the impact of that fall upon them – including fatalities, the impact upon the individuals wider health and well being and ability to live an independent life such as the ability to return to the place from where they were admitted and additional length of stay.

5. The number of older people who have acquired hospital infections as an avoidable consequence of their care – including the impact upon the individuals wider health and well being and ability to live an independent life such as an additional length of stay.

6. The number of older people who have developed skin ulcers or whose skin has been damaged whilst in hospital, as an avoidable consequence of their care - including the impact upon the individuals wider health and well being and ability to live an independent life such as an additional length of stay.

7. The number of older people who have been discharged from hospital between the hours of midnight and 6am.

8. The number of Protection of Vulnerable Adult (POVA) referrals originating from Health Board/Trust wards.

9. The key issues in relation to the patient experience, both positive and negative, with a particular focus on issues raised by people living with dementia and cognitive impairment, people living with sensory loss and carers - including the specific action taken to address negative issues.

10. The adequacy of staffing levels of registered nurses and health care support workers to enable the provision of safe, compassionate and dignified nursing care to patients at all times.

11. The percentage of staff on A&E, acute medical, surgical, orthopaedic, care of the elderly, mental health (and other relevant) wards who have received specific training in the needs of people with dementia, cognitive impairment and sensory loss.

12. The number and percentage of staff who report that they,
    - are unable to deliver the standard of service they aspire to,
    - have raised concerns regarding the safety and quality of patient care and any near misses and incidents,

- and their belief that action will be taken to eliminate risk and ensure that incidents do not happen again.

Reporting should:

- Be clearly benchmarked against best practice targets,
    - with a clear time frame for when performance against best practice will be achieved,
    - with details of any mitigating action taken in the mean time to reduce potential risks to individuals.
- Where possible, make reference to the numbers of individuals within the context of the total numbers using a service.
- Be time relevant to the Board meeting at which it is discussed.

I recognise that at present, Health Boards and Trusts may not have the data to report on the above, both at quarterly intervals at Board and annually within the AQS. Where this is the case a qualitative narrative should be given, and it should be made explicit how and when data will be sourced to provide a quantitative view. I am happy to provide comments at draft stage of the 2015/16 AQS regarding whether I believe any narrative commentary is sufficient and meets the needs for public reporting on these key issues from the perspective of older people.

To ensure an integrated approach, I have taken care to link my work in this area to the many changes that are currently underway at national level, such as the Welsh Government review of the NHS Healthcare Standards Framework and the development of the NHS Outcomes Framework. In line with my extensive work on the Annual Quality Statements, and following the 'Dignified Care?' and 'Trusted to Care' reports I have strongly made the case for a consistent, standardised national performance dashboard or framework.

I understand that a national performance measurement framework will now be developed to be used alongside the Healthcare Standards Framework and will continue to engage in its development. A key expectation of mine is the inclusion of these twelve key areas within a national dashboard.

Whilst there is emerging good practice across Wales, which I recognise is being developed and delivered under pressure and significant resource constraint, reporting on the quality and safety of health care services, and the associated scrutiny is, in my view, an area that still needs to be strengthened and standardised. Delivery of the above will go a considerable way to provide me with the assurances I require in relation to the quality of care within NHS hospitals.

WGGP092 – John Kell – Motor Neurone Disease Association
Tref / Town – N/A
Sefydliad / Organisation

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
We support proposals to update the legal and institutional frameworks of the NHS in Wales to reflect practice since 2009. We feel, however, that the green paper's focus on institutions is not matched by detail on healthcare itself, to the extent that the implications of some of the proposed changes for users of NHS services in Wales are hard to divine. The Welsh Government is clearly right to address the major issues arising from demographic change, and the need to shift from a hospital-based model to a greater focus on community services. The description in the green paper of a new focus on 'primary care' does not entirely address the issue, however: for people with MND, well co-ordinated multidisciplinary care is essential, and this usually occurs across a combination of hospital and community services. On the community side, much of this is tertiary care rather than primary, and care coordination may often be undertaken by an appropriately qualified therapist or nurse rather than by a GP or district nurse; care direction will often be by a neurologist or palliative care consultant. The ostensible focus on primary care does not capture this, and runs the risk that such provision might be accidentally designed out of the system – although as noted, without further detail it is hard to say how substantial a risk this is. The interface between such services and specialised care is also not considered, but can be vital to securing an effective package of support for people with MND. We also support the proposed greater focus on prevention, although we reiterate our concern that the ongoing reforms to social care in Wales will allow charging for preventative social care services. We believe this is counterproductive, and advise against it.

Continuously engaging with citizens

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
We appreciate the dilemma posed by mechanisms that refer to ministers as a

last resort: on the one hand, this risks unhelpfully politicising a decision that may be both contentious and highly technical; on the other, clear political accountability for such decisions may be desirable. If a panel were to be instituted to take such decisions, we would wish there to be clear mechanisms and governance for the submission of evidence to it and processes for how it approaches decision-making. Ultimately we would expect such a panel to remain accountable to ministers. This should aid transparency, and avoid problems increasingly evident in both health structures and regional devolution in England, where there is a growing lack of clarity about how decisions are taken and who is accountable for them. This is an undesirable situation, and Wales will be well advised to avoid duplicating it.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set? 14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
We would support such a change. We also urge that the Government considers the usefulness of information and data published about healthcare in Wales, whether in quality statements and other transparency initiatives as raised in this part of the discussion, or as part of efforts to share data with partners and stakeholders as discussed subsequently. It is important not only that data about NHS performance is made transparently available, but also that it is of high quality, and presented in a form that is readily usable by stakeholders.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
We would support such a change. We also urge that the Government considers the usefulness of information and data published about healthcare in Wales, whether in quality statements and other transparency initiatives as raised in this part of the discussion, or as part of efforts to share data with partners and stakeholders as discussed subsequently. It is important not only that data about NHS performance is made transparently available, but also that it is of high quality, and presented in a form that is readily usable by stakeholders.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?

We support the focus on co-production as discussed in the green paper, but note that the role of the voluntary sector was not discussed. Health charities and patient groups can have an important role in advising on best practice and raising standards through training, information provision and other support. This should be recognised in work taken forward as a result of the green paper. Comments might usefully have been invited on this issue, in addition to the related, and very welcome, focus on transparency.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
We agree with the green paper that it is important to break down barriers to the appropriate sharing of data for both direct care and research purposes. The cultural issues discussed in the green paper are undoubtedly a significant, and possibly the main, barrier.

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice? 29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
Little detail is given in the green paper of what any such changes might look like in practice; depending on this, we would potentially support such a re-focusing of the role of CHCs. To date, we have found them helpful at some times, and less so at others. In order to succeed as representatives of the patient voice, they need to be able to influence decisions at both local and national levels. As a matter of principle, we would not wish to see their currently clear statutory role in representing the patient voice removed or diluted in the process of operational change.

Chapter 7: Finance, functions and planning

Planning

34. 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?
We would support such a review.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
We believe that such a provision has the potential to be extremely helpful.

WGGP093 – Dr Ron Walton – Vale of Glamorgan 50+ Forum
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Changes to the law should be kept to the minimum, confined mainly to public health measures and regulatory arrangements. Most of the problems faced by health services in Wales are not caused by deficiencies in legislation.

2. If so, what changes should be given priority?
Public Health e.g. minimum pricing for alcohol; reducing sugar content in food; food labelling. Regulation: considering amalgamating health /social care regulation and inspection; extension of Community Health Council duties; Duty of Candour.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The "Paying for Care "issue needs to be resolved. There will always be limits to working together while continuing health care is free and social care is means-tested.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Law is not the best means; it is cultural attitudes which need changing i.e. seeing citizens and patients as an invaluable resource in shaping services.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
All Health boards have such mechanisms now. The question remains – how much influence do they have? For example the role of Strategic Reference Groups and various patient/citizen panels needs to be evaluated to see what, if any, impact they have.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
The Minister already has the power to establish groups of experts to advise on thorny issues. The suggested "national expert panel" is a cumbersome device. It would need to establish sub-panels on particular issues and create a whole new bureaucracy. Ultimately the Minister needs to take responsibility for awkward decisions.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
No.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
Do not use legislation. Work with NHS staff to develop high clinical standards and patient care.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
None.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
The role of "responsible person" has the great disadvantage of seeming to absolve the Health Board as a whole of responsibility. All members of the Health Board for the quality and effectiveness of health services in the area they serve.

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
Existing requirements for public appointments are adequate if implemented properly.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote

quality through the NHS planning framework?
The planning cycle has only just moved from one to three years. This is far too short. The health service needs needs a minimum of a rolling 10 year planning cycle if it is to respond to changing demographics and needs adequately. Few large companies the size of Health Boards could survive on such a short term planning base.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
The same standards should apply to public , private and charitable health services.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Speedy roll-out of accreditation and revalidation for medical and nursing staff is needed. Peer review should be part of the revalidation system requirements.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Legislation is not needed. Consultation with professional bodies is required to ensure that revalidation requirements include peer supervision. Job descriptions should reflect peer supervision responsibilities and the potential costs (time allowance for staff) addressed.

17. What arrangements should be put in place for self-employed health professional registrants?
Self-employed registrants are subject to the same revalidation requirements as other registrants.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
We strongly support a statutory “Duty of candour” in the NHS in Wales.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Legislation is not the priority. We have many measures of hospital and GP performance but need to develop more effective measures of community health services and public health services.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Where investigation of a complaint involves health and social care there needs to be a single investigation. Already informal arrangements are made to achieve joint investigations and it would be helpful to regularise this as a standard procedure.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Lack of trust; incompatible IT systems.

22. How can we consider breaking down any barriers?
Joint education/training in health and social care; interdisciplinary teams; co-location; short attachments to other services.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Patients have the right to be informed and if they have not given a general consent they should be asked for consent for each piece of research.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
HIW already has very extensive powers.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
We would favour full statutory independence and merger with CCISW i.e. a single regulatory body with two divisions.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
This recognises the expertise which has been developed in the different fields of health and social care. Short term attachments across the health/social care divide could help.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
The main advantages would be for joint inspection of residential and nursing homes and economies in back office functions. There could be benefits in sharing and evaluating inspection systems.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
There is merit in strengthening the CHC's advocacy role and ability to represent the patient's voice. However, unless CHC members have first had the opportunity to experience health care provision through monitoring visits, they are unlikely to perform the role effectively. Greater clarity is needed on the differences between "inspection" and "monitoring". The CHC's current involvement in planning and ability to challenge changes to services is essential and would be strengthened by greater input from the general population. The CHC's role should be extended to cover residential/nursing homes.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?

The CHC has an important role at the local health Board level. It needs to develop a stronger voice at the all-Wales level, using local evidence to compile a national picture of patient concerns.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Yes. This would give Health Boards scope to engage in longer term planning and invest in community and preventive services.

Summarised accounts

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

32. 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?
Is legislation necessary? The key issue is for citizens to have clear information on how their money is spent and that the health service is efficient in its use of resources. Health Boards should make more effort to provide not only the detailed audited accounts but simplified versions for the general public.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes

34. 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?
There should be a review but it is an open question as to whether further legislation is needed. It is clear that the Welsh government has not used its legislative powers in a co-ordinated way when so many new laws overlap. Where possible non-legislative means should be used to reduce duplication.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Any proposed measures should be in the context of the question "What are the existing impediments to leadership , governance and partnership?" Unless there is clear evidence that legislation would produce substantial benefits the emphasis should be on cultural change, including sharing best practice, patient oriented values and clear benefit to patients.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Health Boards are undemocratic institutions. Their membership is broadly inward-looking and focused on how to manage sickness rather than creating a healthier community. We would support a review of the structure of Health Boards and their membership. Local authority and independent membership should be stronger to reflect the importance of promoting healthy living and stronger community health services. It would also be valuable to consider a scrutiny committee system similar to scrutiny in local government. Scrutiny systems could strengthen the role and effectiveness of non-executive directors. At present Strategic Reference Groups are ill-equipped to perform a scrutiny function.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Yes.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
This could increase the democratic flavour of Health Boards and raise the profile of health issues with the general public.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
In the Vale of Glamorgan we already have a joint appointment for adult social care and health services which is proving very effective. Joint appointments should be actively considered where there is a clear benefit to patients and the community. It would help if a list could be drawn up of operational areas where joint appointment should be considered.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Election of non-executive directors; strengthening the role of n on-executive directors. CHCs to have the right to speak at Board meetings and to put items on the agenda.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
A further review is needed of the size and composition of Health Boards. At present public and patient views have very limited impact on Board decisions. In Cardiff and the Vale UHB patient stories have been a part of Board meetings for some time. There is much of value in this practice , but in general it does not influence key Board decisions on policy and allocation of resources.

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
See 36-41 responses.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
New legislation not needed.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Legislation should be reviewed as to the statutory obligations on Health Boards to provide services. A case in point is the responsibilities of Health Boards towards pupils who need health input who are in special schools. As it stands at present Health Boards can reduce or even withdraw provision if their funds for statutory provision are reduced to such an extent that the cannot afford non-statutory provision. Where partnerships are ineffective on a good will basis they may need to be strengthened through legislation or regulations. In general partnerships between health and social care appear to be more positive than between health and education services and it would be positive to review partnerships in this area.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
See 48 response.

WGGP094 – Sara Moran – Diabetes UK
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Diabetes UK Cymru would recommend a statutory duty which would require health boards to host condition-specific patient groups. There are currently two types of diabetes-specific participation groups per health board in Wales. They operate on a tiered system, with the more localised Patient Reference Groups (PRGs – made up primarily of patients) feeding into Diabetes Planning & Delivery Groups (DPDGs – made up of patient representatives, third sector organisations, health board staff, clinicians and other stakeholders) at health board level. A key aim of prudent healthcare is that healthcare should fit the needs and circumstances of the citizen. It should be person-centred care that is respectful of and responsive to individual patient preferences. Health boards are responsible for hosting and administering both PRGs and DPDGs, but this does not always happen and cannot be described as constituting a 'permanent engagement mechanism'. Diabetes UK Cymru has observed several meetings being cancelled/rescheduled at short notice, as well as a petition submitted by diabetes patients to the National Assembly for Wales to re-establish patient input in the Powys Teaching Health Board after a two year hiatus. A real challenge for prudent healthcare is establishing effective ways to apply it's methodology in practical terms. Making patient consultation and partnership in decision making work is central to the prudent healthcare ethos. To make it work does not require the creation of a new network of patient interfaces across Wales. Rather, it means making what already exists work in a better and in more consistent manner. Clarity of role for these groups and how they are supported and resourced would be a simple and practical way forward. We would like to see this system embedded as a statutory duty on health boards, as we strongly believe that this would guarantee regularity and

continuity in both types of meetings and enhance patient engagement and trust in diabetes service provision.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Diabetes UK Cymru recommends and encourages the introduction of a statutory duty of candour within the NHS in Wales. Recommendations made in the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013)' and in the 'Review of concerns (complaints) handling in NHS Wales – Using the Gift of Complaints (Keith Evans, June 2014)' are supported by Diabetes UK Cymru. We would expect any statutory duty for Wales to replicate the duties, content and language of the *Regulations 2014: Regulation 20 of the Health & Social Care Act 2008 (Regulated Activities)* legislation introduced in England. Two high profile cases involving diabetes patients making complaints about care received through NHS Wales merit brief mention. The Public Services Ombudsman for Wales upheld the complaints lodged by the family of Mr David Joseph who died after errors occurred in his care through Hywel Dda health board. The ombudsman criticised the health board for not following the correct procedures in dealing with the family's concerns and delaying the process of acknowledgement and investigation unnecessarily. There were also assertions made that incriminating paperwork was deliberately lost to hamper health board investigations when they did finally occur. The repercussions of criminal proceedings being brought against nurses in Abertawe Health Board in relation to alleged falsification of blood glucose readings and other poor aspects of care evidenced in Prof June Andrews report 'Trusted to Care' (2014) occurred after issues were raised by a number of families starting in 2012. Some of the families have liaised with Diabetes UK Cymru and a consistent concern was the apparent unwillingness of the health board to take their concerns seriously and investigate thoroughly when matters were initially raised.

WGGP095 – Dr. Karen Gully – Assistant Medical Directors
Tref / Town – N/A

General comments

Health Board size and membership:
There is a concern that Boards are remote from primary and community care issues whilst active service redesign requires a strong contribution from this area. The role of Director of Primary Community and Mental Health is a significant portfolio but is often combined with other roles such as COO. This must not reduce the focus on rapid development of primary and community services and should be supported by strong professional input. This is particularly important to ensure the potential of Cluster development.

Consideration should be given to the value of formal primary care committees/ Boards including non officer representation

Advisory structure
It may be helpful to review the relationship with Local Medical Committee in the context of any new professional advisory arrangements

Response to specific questions

No response to specific consultation questions.

WGGP096 – Berwyn Llewellyn-Davies
Tref / Town – N/A
Sefydliad / Organisation – N/A

General comments

Response to specific questions

Chapter 3: Quality in Practice

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Introduction To address the first question there is need for a definition. The NMC (2008) state that: *Clinical supervision is a practice-focused professional relationship involving a practitioner reflecting on practice guided by a skilled supervisor.* I would add that the practitioner is able to choose their own supervisor and that supervision is based on the development of a supportive and trusting relationship. The inclusion of the word 'peer' I am assuming refers to non-managerial supervision. The word 'skilled' in the NMC definition infers a trained supervisor. The following comments address the question of standards for clinical supervision and how they relate to the above definition together with some opinions on how the standards could be applied in practice. These proposed standards informed the discussion of a series of meeting of an All-Wales group set up to investigate the supervision activity across Wales resulting in the publication *Setting standards for the practice of clinical supervision –a Welsh perspective.* It can be found in Driscoll J (2007) *Practising Clinical Supervision – A reflective approach for healthcare professionals Second Edition* Elsevier: Philadelphia. Provisional Standards for Clinical Supervision (Rafferty and Jenkins 2000) The standards were arrived at by using the Delphi technique. A panel with specialist knowledge and expertise worked on several rounds of surveys gathering data and opinions that led to consensus. The data was subjected to content analysis leading to category creation. Nine standards were identified and these could be divided into three areas: • Professional Support

- Learning
- Professional Accountability

Professional Support (Restorative Function)
Time
Giving commitment and honouring the time for the task

Comment
Many healthcare professions have protected time for reflective activity and supervision. This is not the case in the Nursing and Midwifery profession. Admittedly Midwives were required to receive statutory supervision the primary purpose of which was the protection of the public rather than the provision of professional support. Nurses working a shift system on wards, in a now bygone era, had an overlap of staff each afternoon where there was time for activity such as teaching and where supervision could have taken place. This time has completely eroded and with it, I believe, the loss of reflective space. If this reflective opportunity is to be supported by government legislation then to cover the time, in parity with other professions, it will mean an increase in the workforce estimated at 2.5%. It will also be necessary to train as supervisors one in four of the current workforce in order to offer the service.
Lack of time has proved to be the main barrier for nurses to engage in clinical supervision.
Winstanley (2000) has provided research evidence on best practice and, she concludes, for supervision to be most effective it needs one hour at least once a month.

Environment
Securing a venue fit for the purpose in terms of comfort, privacy, absence of interruptions
Comment
The provision of a place to meet especially in the general hospital setting has proved a major obstacle for those attempting to implement a supervision service. This has led practitioners who value supervision making do with staff canteens, local cafes, pubs and hotel foyers usually in their own time. There needs to be a fit for purpose bookable room and, if clinical supervision becomes a requirement for all staff, then there will need to be a booking system with efficient administration. Again, Winstanley (2000) found that for supervision to be most effective it needs to be conducted away from the workplace.

Relationship
Establish an egalitarian working relationship based on mutual trust
Comment
The supervision provided must be ‘good enough’ or none at all. The supervisor must be skilled in building facilitative, supportive relationships based on qualities of honesty, respect and sensitivity. Importantly, the supervisee chooses their supervisor rather than one being allocated (Winstanley, 2000). In experience of ABUHB the initial training of supervisors

took place over three days. This fell well short of instilling feelings of confidence and competence to offer a service. The training now takes place in monthly sessions over a year. Cottrell (2004) defines a good enough supervisor as one who is able to support and challenge appropriately, pays attention to their own emotions and have an affiliative working style. Within this process the supervisee is able to grow professionally. This is supported by anecdotal evidence gathered following one year in supervision.

Learning (Formative Function)

Focus

Attention is given to the expression of professional practice and reflection on its meaning

Comment

The supervisee sets the agenda which can be anything they would like to talk about provided it is focused on work. On a developmental level, supervision offers a space to understand the predominate questions that a practitioner may ask themselves e.g. for a novice it may be 'How do I do my job and what are my options?' Whereas one who is experienced may have more ethical or philosophical issues: 'Who am I in my job and how do arrive at my judgments?'

The advantage of 1-1 supervision over the group model is that, based on the depth of mutual trust, the conversation and reflections can be open and honest. Often topics that need to be worked through do not involve patients or clinical issues but cover interpersonal team dynamics that prevent efficient working or those that cause personal stress.

Knowledge

Search for meaning and gathering perspectives driven be empirical knowledge and experience from practice

Comment

Healthcare professionals require skills that allow them to respond to often complex situations and often these decisions are made from an accumulation of knowledge gathered from experience. This type of reasoning from experience is usually outside self-conscious awareness. Here clinical supervision helps bring that reasoning and the knowledge and theory informing the process into conscious awareness. Also, it is a place where gaps in knowledge and blind spots can be identified and worked on. This is a type of learning is important in supervision as it helps the supervisee develop their own 'internal supervisor' and with it the habit of reflection-in-action.

Interventions

Affirm appropriate practice, support professional esteem and offer achievable challenges based on a secure relationship

Comment

The two givens within supervision is that the supervisee brings something on which to reflect (A) and they go away with something to do, an achievable challenge (B). What makes the supervision space unique is the way in which the journey from A to B takes place. To train supervisors to employ clinical

supervision models is important as they have the potential to offer a much deeper level of reflection capturing, as they do, material that the supervisee brings to the session that is out of their immediate awareness. Psychodynamically informed supervision models such as Hawkins and Shohet (2012) offer a more creative experience than the more linear reflective cycles. Many different concepts are employed of which one example is called 'reframing'. It involves looking at the situation from another point of view e.g. one exercise involves the supervisee being asked to imagine that the situation they are describing is taking place on a desert island. The supervisor asks a series of questions about life on the island that usually elicits rather nuanced responses. These are then reflected upon as to the meaning which usually serves up different insights to the supervisee which in turn informs the 'achievable challenge' to be taken away.

Professional Accountability (Normative Function)

Organisational support

Provides the necessary will and resources to enable clinical supervision to take place

Comment

By supporting the implementation of CS is one way in which the organisation has an opportunity to demonstrate how it values its staff. It is an opportunity to clear up suspicion, misconceptions by making a statement such as: 'Our organisation want you to take an hour as time-out from your practice every month, to go and sit down with someone you can trust and talk about your work...' There are a myriad of ways in which a practitioner's work is monitored audited and inspected and therefore we can afford to offer a mechanism which is supportive rather than one of appraisal and monitoring. What needs to be in place, however, is a system whereby benefits to practice can be communicated to the corporate body (also evidence of higher staff morale and less burnout and sickness when CS in embedded in work culture). Also, CS is one of the few outlets of expression that the supervisee may have within their working environment. As such, what issues emerge within the session are sometimes both important and worrying (a common example is the level of bullying that apparently goes unreported). The themes, suitably anonymised, from CS need to be collated by supervisors and a report delivered to a corporate learning group on a regular basis.

Recording

An agreement is reached about the minimum content, ownership and access to any record kept

Comment

The question of record keeping is dependent on the purpose of the supervision. If we are to adopt a purely supportive model of supervision then the minimum content of the record of the event is that both supervisor and supervisee have attended. As clinical supervision is an umbrella term for very diverse activities, a continuum with policing at one extreme and staff wellbeing at the other, then the level of recording must reflect the risk for public safety or liability to litigation.

Competency

Use of appropriate authority and recognition of personal and professional boundaries. Support for supervisory practice and development

Comment

The monitoring of a supervisor's performance would be best served by the supervisors having their practice supervised. This method is certainly adopted in the supervisors' training but it might be advisable to be addressed as a periodic agenda item within their own sessions as a supervisee. Ongoing development can be addressed by a regular supervisors' forum where sections of the meeting could concern the collating of data to inform reports (Professional Accountability); small group work to reflect on supervision practice (Professional Support); external speakers, presentation of research papers etc. (Learning)

Further notes

The UKCC (1996) 'Position Statement on Clinical Supervision' followed by a word-for-word repeat of the position by the NMC (2008) acknowledged its worth but fell short of backing its full implementation. Throughout its twenty year association with the Nursing and Midwifery profession, since the Beverley Allitt affair and the subsequent Clothier report, enthusiasm has ebbed and flowed in response to reports of wrong doing, poor practice and scandal within the NHS. Unfortunately, this has given rise to the belief that supervision follows as a consequence of such events and is therefore, understandably, viewed by practitioners with suspicion.

The stance we have taken in ABUHB Mental Health and Learning Disability Division is that all staff should have access to clinical supervision but it remains a choice. There is a problem with this, however, that when supervision is freely available and there is top down encouragement to participate, those staff who choose not to engage would have to defend that choice in an inquiry or court appearance.

Taking the bold step to legislate will be expensive and there is a dearth of research evidence of its impact on patient outcomes. However, there is much more material available to show that clinical supervision is a beneficial mechanism for staff wellbeing, with the subsequent benefit for staff to maintain their ability to be compassionate care givers (taking care to give care).

If legislation is to be considered it should be prefaced by pilot studies, to include control sites, in order to measure comparative outcomes.

Refs

Cottrel S (2004) *The influence of attachment style on clinical supervision in nurses and allied professions* unpublished MPhil Thesis University of Bangor

Hawkins P; Shohet R (2012) *Supervision in the helping professions 4th edition* Maidenhead: Open University Press

NMC (2008) *Position statement on clinical supervision for nursing and health visiting* Nursing and Midwifery Council London

Rafferty M; Jenkins E (2003) Developing a provisional standard for clinical supervision in nursing and health visiting *Qualitative Health Research* 13:10 1432-1452

UKCC (1996) *Position statement on clinical supervision for nursing and health*

visiting United Kingdom Central Council for Nursing Midwifery and Health Visiting London
Winstanley J (2000) *Clinical Supervision: The development of an evaluation instrument* School of Nursing University of Manchester

WGGP097 – Paul Mason – South Wales Fire and Rescue Service
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Austerity has impacted considerably on all public services, third sector organisations and other agencies that are able to assist with the health and well being of individuals in Wales. Although, any changes in law must be communicated across all sectors, be clear and unambiguous, relevant and fit for purpose for the direction of travel in Wales. Many organisations can have a profound impact in society's health and well being but are excluded at the early stages, which in turn hinder appropriate preventative measures and result in costly intervention. Any further changes should also dovetail the well being of future generations.

2. If so, what changes should be given priority?
As previously indicated austerity has impacted considerably on all public sector providers, with this in mind it is imperative that all public sector agencies & third sector partners work across cross cutting areas of service delivery. This will impact culturally for all practitioners and users, although joined up working and services is the way forward in meeting the needs of communities for the 21 century. This is a priority and must be addressed accordingly and wholeheartedly by all.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Ensure such engagement is embedded across all public sector agencies and if necessary implemented as legislation where appropriate. This fits in with the well being of future generations act, although time for action is required now.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement

mechanisms, such as patient panels or participation groups?
Yes, consideration should be given but not at the detriment of appropriate / timely decision making.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Yes.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Culture, tradition and bureaucracy / red tape. Individuals and organisations steeped in tradition and not looking at the holistic approach in meeting the needs of the communities served. Greater collaboration through partner agencies could enhance the well being of future generations and safety of individuals within the community. This would then potentially reduce the burden across a whole host of services providers, which in turn could provide a more proficient and cost effective service through joined up working and approach. Scope for other agencies to add value to the process by providing additional services to identified users within the community i.e. Fire and Rescue Service could provide Home Fire Safety Checks (HFSC's) and potentially other risk assessments for individuals identified as at risk within the community or returning to the community environment if they were provided with sufficient data for these individuals. Appropriate preventative measures assist in reducing the Intervention stage ensuring agencies work smarter together, reducing risk and improving efficiency and effectiveness across sector agencies. HFSC's can influence the healthy homes agenda and the emerging trends of slips, trips, falls and healthy eating within such environments.

22. How can we consider breaking down any barriers?
Communication is key to improved direction of travel and continuous improvements, but must be driven strategically by Welsh Government and Public bodies alike, with a wholehearted commitment to the goals set centrally by Welsh Government through shared services and shared goals.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Sharing of patient information across broad spectra within the community should be allowed if it would make improvements to the health, safety and well being of the individuals / society. This information exchange is vital in improving a joined up approach within the public sector environment, although appropriate systems and guidelines need to be implemented. Some good work already exists through partnership working and should be explored and shared with others. No need to re-invent the wheel. It's not just about information sharing but more about how and what information is shared through secure means.

Chapter 7: Finance, functions and planning

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes.

34. 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.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Too early to say at present.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
If it has been identified that better opportunities exist, which are more fit for purpose then 'yes'.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
Any changes must meet the needs of the 21st century and needs of the service / users.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Not all partnership working is fit for purpose and one should continuously look for opportunities to make improvements fit for the 21st century and direction of travel. If amending the law is required to facilitate this then this would and should be appropriate.

WGGP098 – Dr Penny Dobson MBE – Paediatric Continence Forum
Tref / Town – London

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The Welsh Government should encourage collaboration *between* the health service and other services, such as education. Existing and planned legislation focuses largely on collaboration *within* health services, which does not recognise that children with long term conditions like bladder and bowel dysfunction, must manage their conditions in educational settings. Moreover, it does not recognise that staff in educational settings will be required to work with health professionals on a frequent basis.

2. If so, what changes should be given priority?
Co-operation and collaboration with other areas like education should be a focus, in addition to collaboration between health boards and local authority public health officials.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The Welsh Government should consider providing stronger encouragement to use guidance which encourages multidisciplinary working, such as that produced by NICE.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
The Welsh Government should consider legislating to develop an information hub where patient groups, clinicians and respected bodies and so on can submit guidance and best practice designed to inform and improve service redesign. This guidance can be made available to health commissioners and politicians to read and utilise. The PCF has produced NICE accredited guidance on the commissioning of paediatric continence services – the Paediatric Continence Commissioning

Guide – but found that there is no reliable way of ensuring that health commissioners are made aware of it or using it. This means that knowledge to improve services may not be utilised.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
The Welsh Government should establish permanent engagement mechanisms, but involvement in these groups should be advertised online. Those who are unable to take part in these groups on an ongoing basis, which may constitute a notable number of people, should be enabled to contribute by way of evidence submissions, email exchanges and so on.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
There is a risk that a national expert panel would not be democratically accountable and would not likely be required to engage with the public in the same way that a Minister would. The possible advantage is that a national expert panel may have better knowledge than ministers due to their background, which may be clinical, patient or third sector. Should a national expert panel be established, their names and contact details would have to be published and there would need to be measures to ensure that they listen to the viewpoints of those outside of the panel. The PCF expects any national expert panel to have capacity for public engagement.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Partially. Whilst legislation and accompanying accountability measures can lead to improvements in the quality of care and are welcome, financial restrictions and pressures on time mean that they do not always work as intended in practice. NHS bodies must be properly resourced to implement legislation properly and redesign and deliver services in ways which enable the best quality of care to be delivered. Some of the PCF's partners have tried to encourage quality improvement using the Paediatric Continence Commissioning Guide, but have been told by NHS bodies that they lack of time or financial capacity to fully implement the

guidance. Legislating for the implementation of clinically approved guidance would not entirely solve these problems, but it would lead to greater incentives to implement the guidance.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
The Welsh Government could require NHS bodies to utilise clinically approved guidance. This could be done through strengthening requirements to adhere to NICE guidance, which is currently advisory.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
The Welsh Health Standards Framework should be made statutory to drive service improvement. The Standards Framework requires continence care to be appropriate and discreet, taking into account people's specific needs and privacy. This is important as one in 12 children has some form of continence problem, based on a UK-wide assessment by the Department of Health.

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Yes. The PCF agrees with the recommendation in Professor Marcus Longley's 2012 report, *Moving Towards World Class? A Review of Community Health Councils in Wales*, which recommends more diversity in CHC membership. In particular, we agree that each CHC should discuss with local partners in the voluntary sector and local government how to increase and retain greater diversity of membership. More members from the voluntary sector should help set priorities, instead of local authorities, which the report noted had a "variable level of input", or councillors who have "limited availability to contribute to the work of the CHC".

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Yes, there should be a statutory provision for joint appointments between local authorities and the NHS in new arrangements for public health services. However, we are keen to avoid the current situation in England, where the transfer of commissioning responsibilities for public health from central to local government led to continence being withdrawn from the list of school nurse duties. This happened as directors of public health determined continence to be a clinical need rather than public health need, with clinical commissioning groups reluctant to accept this designation and commission effective paediatric continence services. This meant that continence became something caught between the two – any changes must ensure that this does not happen in Wales.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Advisory groups can play a role in supplementing the groups listed in paragraph 133, and are useful as they directly provide written and/or oral evidence to the Welsh Government. They should be reformed to enable the groups in paragraph 133 to feed into these committees in an easier manner, for example, by allowing public engagement with these groups.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
The Welsh Government should develop an information hub where the groups listed in paragraph 133 can submit clinically approved guidance, or other useful guidance, which can be vetted by Welsh Government officials and used to inform policy development.

WGGP099 – Amanda Richardson – Action Cerebral Palsy
Tref / Town – London

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Collaboration and planning must take place both within the health system and between other important areas in a child's life, notably the education system. This is particularly the case for children with cerebral palsy, who have multiple needs that cannot be addressed alone medically, and must be addressed through sustained educational intervention. The Welsh Government should legislate to make clear the responsibilities of health bodies to work with education bodies to deliver outcomes for such children. A UK parliamentary inquiry conducted by Action Cerebral Palsy in the summer of 2014, reporting in January 2015, found that specialist educational intervention was being neglected due to lack of specialist provision and lack of awareness by both health and educational generalist to refer to existing specialist. There was little understanding in the health system of the need for specialist educational intervention – something which resulted in worse outcomes for children with cerebral palsy.

2. If so, what changes should be given priority?
Requirements of the health service to work with other public and other independent/voluntary services, such as educational settings, educational psychologists, specialists centres e.g. conductive education and bobart, respite centres and hospices.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Data collection on the number of children with cerebral palsy and the provision of services is poor. This must be improved, along with information sharing, to enable more effective working between all agencies and for better provision planning.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Requirements for NHS bodies to consult with other bodies offering public services, like education and social services, will result in integration and therefore better health and wellbeing outcomes for people with conditions like cerebral palsy and their families. The terminology in the green paper suggests an atomised health service focused approach towards health commissioning – something which is best avoided in the future if integration is to be achieved.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Patient panels and participation groups should be formed, but consider that charities like Action Cerebral Palsy, who have the time, resources and expertise to make the biggest changes, should be invited to participate. The Welsh Government should consider setting up an internet page of potential panels or participation groups, allowing those who want to get involved. These groups should also make the most of video-conferencing and email exchange, to enable those who cannot travel to get involved.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Any expert panel must have strong accountability measures and be required to engage with the public. If this is not the case, then third sector organisations like Action Cerebral Palsy, and broader stakeholders in general, are less likely to have their opinions heard when it comes to service redesign and agenda setting. Ministers may not be specialist clinicians, but are at least accountable and should respond to other parties.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Legislation to require health bodies to work with public, statutory and appropriate voluntary services will address the reluctance to work mutually, which has resulted in a fragmented system for children with cerebral palsy.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?

The Welsh Government should require the health service to work with public services. Health and educational practitioners must come together and consider a child as a whole rather than as something requiring a series of interventions.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
The Welsh Government could require all bodies to adhere to NICE guidance.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Making the Wealth Health Standards Framework mandatory rather than advisory would better ensure adherence.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes, provided it was designed to incorporate best practice guidelines and transparent information sharing.

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Yes, but CHC's should also be required to recruit members from areas outside of health. This will ensure that the health system is not considered the only driver in improving patient outcomes. CHC's should ensure that the needs and views of children and young people are represented as well.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
By requiring specialists in areas outside of health care.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Yes, it is very important that there is a statutory provision for joint appointments between local authorities and the NHS. Children with cerebral palsy interact with the NHS, local authorities, and schools and so on. Having appointments which involve all or most bodies responsible for patient outcomes will engender a more integrated service.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Advisory groups should stay, provided the groups in paragraph 133 have more open and easier opportunities to feed into these groups.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
The Welsh Government could consider making NICE guidance statutory, as this contains advice on service delivery and sometimes policy.

WGGP100 – Judy Henley – Community Pharmacy Wales
Tref / Town – N/A

General comments

Community Pharmacy Wales (CPW) represents community pharmacy on NHS matters and seeks to ensure that the best possible services, provided by pharmacy contractors in Wales, are available through NHS Wales. It is the body recognised by the Welsh Assembly Government in accordance with *Sections 83 and 85 National Health Service (Wales) Act 2006* as 'representative of persons providing pharmaceutical services'.

CPW represents all 716 community pharmacy contractors in Wales. These include all the major pharmacy multiples as well as independent businesses. Contractors are located in high streets, town centres and villages across Wales as well as in the major metropolitan centres and edge of town retail parks.

CPW is pleased to have the opportunity to respond to this important consultation on NHS quality, governance and functions. CPW recognises the importance of a strategic review of these key areas and taking the opportunity to standardise the approach, where this is practical.

As the Green Paper is wide reaching in its aims, it would not be appropriate for CPW to comment on areas outside of its remit or expertise and therefore this response is limited to those areas of the consultation that have the potential to impact directly on the community pharmacy network and the delivery of services to patients.

Community Pharmacy is one of the most highly regulated sectors of NHS Wales, with areas of its activity open to inspection by the statutory regulator, Health Boards and CHCs.

As is the case with our sister medical and nursing professions, the UK Health Departments have established a statutory professional regulator, the General Pharmaceutical Council (GPhC) to ensure that the regulation of the profession is of the highest standard and patient safety is the number 1 consideration. Unlike comparable governance and regulation in other parts of NHS Wales, the General Pharmaceutical Council (GPhC) has the powers not only to regulate both pharmacists and pharmacy technicians; it also has the power to set standards relating to the actual premises from which care is delivered. Regulation takes place against a broad range of published standards and the GPhC employs a team of inspectors to carry out this function. In line with the UK wide regulatory role of the GPhC, the UK Health Departments are fully consulted on the development of standards and the Welsh Government regularly takes the opportunity to ensure that proposals are in line with NHS Wales requirements.

Where services are delivered as part of the Community Pharmacy Contractual Framework (CPCF), the quality of service delivery and the meeting of contractual requirements is directly controlled by the Health Boards who have full powers to inspect pharmacy premises. Both Clinical and Information Governance requirements for the provision of community pharmacy services are contained within the CPCF requirements and are reported on annually. In addition CHCs in Wales have the powers to inspect community pharmacy premises to assess the patient experience.

While CPW fully supports the need for standardisation of inspection across NHS Wales, it is clear that the setting of standards of quality and governance in community pharmacies is at a higher level than would be achieved by any attempts to standardise practice across Wales and as an unintended consequence, any movement in this direction is likely to result in lower standards than currently exist. CPW is confident that the existing mechanisms for regulating the pharmacy profession will not only meet but also exceed any NHS Wales wide standards that may be introduced and, should this not be the case for any reason, then an update of GPhC standards is all that is required to bring standards into line.

In line with the principles of Prudent Healthcare, CPW would not wish to see any further increase in regulation of the community pharmacy network as this will only result in wasteful dual inspection and take community pharmacists and their teams away from direct patient care at a time when NHS Wales is already struggling to manage demand.

CPW fully supports the aims of the Green Paper in seeking to improve NHS quality, governance and functions and recognises the desire to introduce common standards and control mechanisms. CPW does not have any complaints against the GPhC as it operates in Wales and so sees no need to make changes at this point. We are sure that additional resources would always be welcome for the Welsh GPhC operation. CPW is content that the current statutory regulation, undertaken by the General Pharmaceutical Council, together with regular inspection and monitoring by both the GPhC and Health Boards, achieves a standard that will meet and may even exceed any minimum Standards the green paper seeks to introduce and therefore community pharmacy should be exempt from any new requirements if dual inspection and regulation is to be avoided and pharmacy teams are not to be taken away from patient care.

In its response CPW has highlighted areas such as improved community pharmacy representation and expertise on Health Boards and removal of barriers to accessing the Individual Health Record that will support community pharmacy in playing a greater role in the delivery of primary care services within the developing prudent healthcare world.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority? 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
CPW fully supports the move towards a greater promotion of health and well-being. As community pharmacies are the most visited and most accessible part of NHS Wales, then they have the potential to play a significant role in achieving these strategic aims. However, current commissioning of health improvement services from pharmacy is patchy and the potential of the network is regularly under-realised. CPW recommends that local delivery and planning should be on the basis of consistency of specification and quality across Wales. The consultation poses the question as to whether changes to legislation could strengthen local collaboration. As many of the lost opportunities, as far as community pharmacy is concerned, arise as a result of community pharmacy not being represented at the time that strategic decisions are being made, a legislative requirement to engage with key groups, of with community pharmacy would be one, would support improved engagement and, through this, increased quality of outcomes. CPW recommends that Welsh Government uses the opportunity of this consultation to ensure that community pharmacy is represented in all Primary Care Cluster leadership teams.

Continuously engaging with citizens

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
If the decision is taken to introduce a national expert panel to which referrals may be made, rather than to Ministers, then it is essential that community pharmacy has a seat on this panel. Although to add another tier between the Minister and both healthcare providers and citizens would not be seen to be within the principles of prudent healthcare.

Chapter 2: Enabling Quality

Quality and co-operation

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales? 11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
CPW recommends that there are lessons to be learned from the approach taken to the setting of standards in community pharmacies where each pharmacy operates under the control of a Responsible Pharmacist when any service is being provided and from the introduction of 'fitness to practice' requirements.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
CPW has no difficulties with the creation of a legal duty of candour. As far as the practice of pharmacy is concerned, the GPhC has published a joint statement, with the other regulators of healthcare professionals, confirming that it will be introducing this requirement into standards in the near future. CPW recommends that Welsh Government consider the GPhC model rather than creating a new one.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information? 22. How can we consider breaking down any barriers?
CPW agrees that there is a need for all NHS organisations and healthcare providers to share patient information and the key to providing quality services as part of joined up integration. The potential for community pharmacy to better contribute to the care of patients and the optimal use of medicines is limited by the current lack of access to the Individual Health Record. CPW fully supports the statement in the consultation, of the seventh Caldicott Principle, that 'The duty to share information can be as important as the duty to protect patient confidentiality:

health and social care professionals should have the confidence to share information in the best interests of their patients'. CPW strongly recommends Welsh Government uses this opportunity to ensure that initial work to give community pharmacy access to the Individual Health Record is now progressed with the minimum of delay and that inappropriate barriers to effective patient care are removed.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
CPW has, on a number of occasions sought to reduce the impact on patient care caused by unnecessary dual inspection of community pharmacy premises. There are a number of examples where a community pharmacy will be inspected by GPhC and by the Health Board, with both parties having inspected the same activity. In England this has been addressed by a formal memorandum of understanding which has facilitated the sharing of information with the objective of reducing the impact on patients caused by dual monitoring. CPW recommends that Welsh Government uses the opportunity of this consultation to put in place formal arrangements for the sharing of information where there is more than one body engaged in the monitoring of healthcare services.

Representing patients and the public

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
CPW is encouraged to see that the consultation is looking at the remit of Community Health Councils (CHCs) and considering whether CHCs should 'step back from activities which may be better carried out by others, such as inspections and service change proposals'. CPW would strongly support the removal of community pharmacy inspection from the role of CHCs as experience has shown that the lack of understanding, of what is a complex specialised role, adds little to improved patient care and often results in considerable impact on the effective functioning of the community pharmacy when detailed explanations are required. CPW recommends this action as also being in line with prudent healthcare principles.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed? 37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors? 38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation? 39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services? 40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
CPW is similarly encouraged to note that the consultation covers Health Board membership, as CPW has long lobbied for the role of Pharmacy Director to sit alongside the Medical Director and Nurse Director as senior executive members. Pharmacy is the third largest profession in NHS Wales and, as the Welsh Government looks to move more services in the community, it was clearly an oversight in the original structures not to include a Pharmacy Director. As with others at this level the Pharmacy Director would be a member of the Board. This would also restore the removal of pharmacy from the Board level that was an unintended consequence of the last reorganisation. CPW recommends that the Welsh Government uses the opportunity of this consultation to correct this initial oversight. CPW is also aware that the network saw improved clarity of commissioning with the reduction of 22 Health Boards to 7 and would not want to see any major increase from this number. There has also been an improvement in the development of NHS Welsh national community pharmacy services during this period with the Health Boards' role being clearly to deliver locally services agreed nationally. We would recommend that this format is continued and enhanced with strong guidance provided to Health Boards to fully commission services in all areas. This also has the advantage of clarity in patient communication.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the

statutory status of the advisory committees? 47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
CPW feel that if Welsh Government chooses to abandon the statutory advisory bodies that efforts must be made to ensure that any replacement adequately provides a balanced view from both the managed and independent sector. We appreciate that there is a role for government to have an occasional sounding board from the professions and providers on key issues. The role of the advisory bodies in relation to government must also be clearly distinct from the role of the statutory negotiating bodies, such as CPW with their responsibility for the maintenance, promotion and development of the NHS contract.

WGGP101 – Disa Young – Welsh Independent Healthcare Association
Tref / Town – London

General comments

WIHA is a voluntary association of independent acute, mental health and learning disability hospitals in Wales. WIHA is the Welsh arm of the Association of Independent Healthcare Organisations (AIHO), which is the UK-wide trade association for independent hospitals.

The purpose of WIHA is to represent the collective interests of member hospitals and to make a positive contribution to the development and review of public policy regarding healthcare in Wales. WIHA's main areas of focus are quality, workforce, regulation and education.

As discussed with Pat Vernon and Matthew Tester, the following response concentrates on those areas of direct relevance to WIHA members.

However, as a general comment on the Green Paper, WIHA does not believe that the role of the independent healthcare sector in Wales is considered sufficiently. Patients continue to make choices about their healthcare and these choices often involve access to care, treatment and advice from independent providers. It is important therefore to work together to ensure as far as is possible a consistency of message and approach.

Response to specific questions

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Legislative measures have in the past been proven to be effective in changing behaviour in different contexts, e.g. seat belt laws. However WIHA believes that leadership plays a critical role in embedding a quality culture in healthcare organisations. The concept of a 'Responsible Individual' is a good one and is usefully employed in Scotland through the 'Accountable Officer' framework. WIHA is aware that the Care Quality Commission is exploring how it might strengthen its guidance on the accountabilities of its 'Registered Manager' position.

10. What would be the advantages and disadvantages of setting out in

legislation the role of “responsible individual” for health bodies in Wales?
See comments above.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
WIHA has followed the introduction of the ‘fit and proper persons test’ in England, but understands it is too early to say what the benefits have been. Sir Mike Richards, Chief Inspector of Hospitals at CQC has however recently reported that, based on anecdotal evidence, he believed the test was having a deterrent effect in preventing certain people applying for leadership positions in healthcare. One of the criticisms of the ‘fit and proper person test’ has been the amount of extraneous information that has been submitted about certain individuals and the challenge of identifying relevant information.

Chapter 3: Quality in Practice

Meeting common standards

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
The principle of a common standards framework for the NHS and independent sector has merits, not least that it would presumably simplify the regulatory framework for Healthcare Inspectorate Wales. It would also be beneficial from a public perception point if both sectors were regulated according to the same standards. Furthermore, there are fundamental aspects of care that are equivalent whether in the NHS or independent healthcare sector, e.g. nursing care. The Care Quality Commission has adopted this approach and asks five key questions of all healthcare providers which are then broken down into further ‘key lines of inquiry’: Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led? WIHA’s only comment is that we understand from our partner trade association in England (the Association of Independent Healthcare Organisations) that the single framework is not without its challenges in applying certain aspects to independent hospitals settings, which tend to be considerably smaller than NHS hospitals and do not offer the same range of services as a typical NHS hospital.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes, and this should be broadened out to apply across the independent sector also.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
WIHA is aware that the PSOW is currently seeking to extend his remit to investigate complaints where a patient's care pathway includes both the NHS and independent sector and is supportive of this proposal. Patient complaints processes are often overly complicated and therefore confusing for patients and WIHA believes that simplifying the process as much as possible is desirable. All changes then need to be communicated effectively to patients.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
WIHA can comment on this from the point of view of sharing information between NHS and independent sector settings. WIHA members are keen to share information and this is obviously fundamental to patient safety when patients move between the two sectors. On another level, WIHA members submit annual workforce data to the Welsh Government to support national workforce planning. However, even when a willingness to share information exists, IT systems and data collection processes can create technical barriers that prevent different healthcare bodies sharing information and this can be an obstacle to overcome in terms of finances and resources.

22. How can we consider breaking down any barriers?
By creating an agreed information sharing protocol across HIW registered Healthcare providers (NHS and Independent sector).

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
A clear prerequisite is the consent of the patient for it is their data. In addition, the purpose would need to be clarified so that it was used for recognised and carefully approved and recognised health and research benefits and not for commercial gain.

WGGP102 – Huw Vaughan Thomas – Auditor General for Wales
Tref / Town – Cardiff

General comments

I welcome the opportunity to comment on the Green Paper.
Whilst some of the specific questions posed within the Green Paper address matters of policy on which it would be inappropriate for me to express a view, my responses to the remaining questions are set out in the attached Annex. I also set out below the key issues that I consider would benefit from further thought before the paper progresses further.

Summary
As the UK Government's "austerity" agenda continues to place increasing demands across the entire Welsh public sector to do things differently, the timing of this paper is apposite. However, in my view any further significant changes to the governance of NHS Wales should not be made without first considering the significant opportunities afforded by both the Well-being of Future Generations (Wales) Act 2015 (the WFG Act) and the Social Services and Well-being (Wales) Act 2014 (the SSWB Act) to overcome long existing cross-sector barriers and to secure the engagement of key partners.

The Paper focuses on the potential for detailed legislative changes that might drive improvements in quality and governance in the NHS. I would suggest that, before considering the need for further legislation, a different set of questions should be posed: what are the intended outcomes; why are these not currently being achieved; and, what are the opportunities to enable or break down the barriers to that end?

To my mind the current body of legislation is not itself the barrier to improvements to NHS quality and governance. The WFG and SSWB Acts, taken together, provide ample legislative provision that both allow (the powers) and require (the duties) the NHS and its partners to work and plan together. These two major pieces of recent legislation will take time to bed in, and I would therefore suggest that the Welsh Government might best focus on incentivising the "system" to achieve the intent behind both of these Acts. This is likely to involve promoting and developing the values, behaviours and mind-sets required to do business differently across the public service. Further legislation in this area should perhaps best be viewed as a last resort, rather than the tool of choice. These two Acts should be used as springboards for further thinking regarding the overarching architecture of the NHS and the potential for improvements to strategic service planning and commissioning on an all-Wales basis.

Linked to this, I would suggest that the relative lack of high-quality commissioning skill-sets across NHS Wales needs urgent consideration. Cross-border issues, the increasing use of private providers in social and secondary care, internal purchaser and provider splits within NHS bodies and

partnership working all inevitably place the quality of commissioning decisions closer to the heart of improvement.

A coherent and clear NHS Wales governance framework is needed to drive the right behaviours, values and mind-sets. To my surprise however, the paper contains no real consideration of the weaknesses in the current framework, which in my view is overly complex and not underpinned by consistent principles. My memorandum to the Public Accounts Committee on NHS Governance1 provided an overview of the various structures, policies and accountabilities within the current governance frameworks across NHS Wales. That memorandum highlighted that, whilst the necessary structure and processes are largely in place, the creation of large integrated health boards has created specific governance challenges given the size and complexity of these organisations. The governance challenges experienced by Betsi Cadwaladr University Health Board and Abertawe Bro Morgannwg University Health Board demonstrate that there should be no complacency on the part of either NHS Wales or the Welsh Government in ensuring that governance arrangements are fit for purpose. Notably, the Welsh Government's own role in NHS governance does not feature in the green paper, and it is also silent on the pros and cons of the dual role of the Director General and NHS Chief Executive being held by the same individual.

Finally, I would add that in due course, and in the context of the WFG and SSWB Acts, there would be value in consolidating the raft of current legislation which covers the NHS in Wales, to simplify the accumulated layers of primary and secondary legislation, policies, directions and duties with which NHS bodies must comply.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority? 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Both the Well-Being of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014 already clearly set out both the intent and requirement for partnership working / local collaboration. I am not therefore convinced that additional legislation is required at present to strengthen local collaboration. Instead, consideration should be given to what is currently preventing better collaboration, what will help the existing legislation work as intended and how to incentivise bodies to apply the spirit of the legislation in practice.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change? 5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups? 6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Current legislation already requires consultation and public engagement and there are many existing mechanisms to engage. Consideration should instead be given to an evaluation of the effectiveness of these mechanisms, and then to providing additional clarity regarding the level and / or type of service change which requires formal consultation. In considering the establishment of an expert panel the Welsh Government should consider and be clear about its effect on the primacy of decision making (both on NHS bodies and on the exercise of Ministerial discretion). The impacts of recent judicial reviews of NHS service changes would also need to be considered carefully in this context.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section? 8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system? 9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
As already stated, I am not convinced that additional legislation is the answer to drive improvements in quality. The Well-Being of Future Generations (Wales) Act 2015 requires public bodies to set and take steps to achieve objectives that are „designed to maximise" their contribution „to each of the well-being goals". In my view, the current NHS Outcomes Framework does not provide an adequate vehicle for NHS bodies to demonstrate how they are maximising their contribution to each goal. This will need to be addressed. In addition, I would advocate the need to balance scrutiny on financial performance with appropriate assessment of the quality of service delivery. Opportunities for achieving this exist within the scrutiny of IMTPs,

independent validations of NHS bodies‟ self assessment against healthcare standards and an evolution of the current Tier 1 targets to achieve a more explicit focus on outcomes and experience, as opposed to “process measures”.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Before any further legislative change is considered, I would suggest that the NHS Planning Framework needs to reflect fully the context of the Social Services and Well-being (Wales) Act 2014 and have at its core the need for a patient-centred approach. Getting the requirements of the NHS Planning Framework right should negate the need for changes to legislation.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set? 14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens? 15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
In my view, there is a strong case for changing the basis under which healthcare standards are set, and also for using a common set of standards to ensure that the focus is directed at frontline services. Careful thought needs to be given in the development stage as to whether those standards should be set at the “baseline‟ or “aspirational‟ levels, and also for whom and for what the standards are primarily intended (i.e. self-learning, regulator assessment, user expectations / choice). In my view, it may be best to set a “baseline‟ expectation that can then be gradually ratcheted up, rather than an “aspirational‟ expectation which may not be met. Clear definitions will be required for “safe‟ and “high quality‟ care. I would also suggest considering the resurrection of a “Patient’s Charter‟ as a means of providing the public with an accessible and easy to understand set of high level commitments that the NHS is signed up to terms of quality and safety of care. (Also see my response to Questions 7-9 above).

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales? 19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
In considering the way forward on these issues the aim should be to be as open and transparent as possible, with absolute clarity about whether „candour‟ is in regard to individual professionals and/or to the NHS body as a whole. The duty of candour recently put in place in England is intended to overcome the cultural barriers to transparency, and merits consideration in Wales.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Before opting to legislate, consideration should first be given to tackling the practical and cultural barriers which are preventing this from happening effectively now.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information? 22. How can we consider breaking down any barriers? 23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
The issues were clearly identified in both Ruth Marks‟ and Paul Williams‟ reviews as being „technical‟ and „cultural‟. Education, including a refresh of WASPI, would be beneficial as would work to clarify and consolidate in one place all of the governance and information requirements around patient data sharing. It is also essential to be clear about the benefits of sharing and incentivising such behaviour. The collection and sharing of patient-identifiable information for non-direct patient care purposes must, in my view, be underpinned by informed consent.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they? 25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW? 26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change? 27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
I consider it almost impossible to find a compelling reason why a body such as HIW should not have full statutory independence. Any legislative steps to achieve such an aim, should, however, be part of a much wider exercise to consider how best to deliver independent inspection of health and social care services. If the policy aim is to deliver integrated and seamless health and social care, then it follows that the external review regime for these services should be equally seamless, and have as its backdrop a set of common standards as highlighted earlier. Such seamlessness could be achieved through a merger of HIW and CSSIW which would bring additional advantages in terms of rationalising the existing inspection and regulation regime and promoting consistent and joined up review. Balanced against that would need to be considerations of the agility of the organisation, and the disruption, cost and timescales that are associated with such mergers. In addition, the benefits of the inspection process following the patient pathway should not be undervalued.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice? 29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
CHC activities currently vary considerably between the regions and would benefit from being refocused, perhaps within an agreed framework, to ensure a baseline level of activity or outputs for patients wherever they may be resident across Wales.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Whilst it would be inappropriate for me to comment on the merits of this policy proposal, I would suggest that consideration of the following issues will be required: a. Unless existing Westminster legislation is changed, a proportion of the existing (£ finite) borrowing powers of the Welsh Government would need to be delegated to the Health Boards. This would necessarily restrict the WG‟s own ability to use its borrowing powers, and would effectively be a „zero sum game‟ for the Welsh block; b. If Health Boards were to borrow from external sources (rather than from the Welsh Government) it is likely, given their poor financial track records and absence of a credit history, that the rates would be unattractive and potentially at a premium; c. Any Health Board borrowing would have to be consolidated into the Welsh Government's "parent‟ accounts, i.e. on balance sheet; d. Whether the requirements of the Investment Infrastructure guidance are applicable to business cases funded by borrowing, and whether such borrowing will only be authorised if the business case is approved; and e. What requirements or controls, if any, would be applied to Health Board borrowing for revenue purposes.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant? 32. 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?
It is important that the Welsh public and the National Assembly has access to clear information on the financial performance and cost of NHS Wales. The two sets of summarised accounts do not currently show a complete picture of NHS Wales. However, to remove the existing legal requirement for them without an effective replacement would result in a reduction in transparency, would hamper scrutiny and accountability and would not therefore be in the public interest. The requirement to prepare summarised accounts should therefore only be removed once a suitable alternative (for example, an "NHS Wales‟ set of accounts, or more detailed disclosure of NHS Wales expenditure within the notes to the Welsh Government's own accounts) has been established.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards? 34. 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?
I consider that there should be an equivalent statutory planning duty for NHS Trusts as for health boards. Rather than looking at simply aligning the 2006 Act, the wider planning approach needs re-framing in the context of the requirements of the 2014 and 2015 Acts.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
See summary response.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed? 37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors? 38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation? 39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services? 40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
See summary response. In reviewing these issues, the Welsh Government should consider: - local structures; - executive portfolio balance and deliverables; - independent member capacity; and - the risks of independent members scrutinising their own decisions.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision?

If not, how might NHS trust boards be reformed? 42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
See summary response. In reviewing these issues, the Welsh Government should consider: - local structures; - executive portfolio balance and deliverables; - independent member capacity; and - the risks of independent members scrutinising their own decisions.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity? 44. If so, what aspects of the role should be additionally set out in law? 45. How could potential conflicts of interest for the board secretary be managed?
Although the Board Secretary role is prescribed in Standing Orders, there is a conflict of interest risk where the Board Secretary undertakes specific additional projects or holds another post / responsibilities (as is often the case across NHS Wales). In my view, the Board Secretary role would benefit from being set out in statute, with consideration given to: - restriction of additional responsibilities, to prevent conflicts of interest and to allow full focus on the core role, which has the scope to add significant value to NHS bodies; - introducing accreditation, to ensure each Board Secretary has appropriate skills and the potential benefits of the role are delivered; - introducing a responsibility to report to the Board and to the external auditor where unlawful or potentially unlawful decisions have/are being made by the NHS body or one of its officers. (I refer you to section 114 of the Local Government Finance Act 1988 as regards the equivalent approach in Local Government).

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services? 50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Careful thought will need to be given to governance and accountability, particularly when service provision spans across or between sectors. Such services are often bedevilled by an inherent lack of clarity, which only become apparent when operational problems are encountered. I would therefore suggest that independent evaluation of any proposals should be obtained.

WGGP103 – Freda Lacey – Powys Association of Voluntary Organisations
Tref / Town – Llandrindod Wells

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
In this instance, we feel that strengthening the emphasis and/or making it imperative that local collaboration happens between Health, Social Care and the Third Sector would be valuable as currently, our involvement is seen as important but not legislatively secured and while we are now invited to participate in planning decisions, there are still instances where we are not seen as equal partners in decision making processes. We are also instrumental in recruiting citizens to local planning boards and this is still viewed by certain statutory organisations as not being a crucial part or choice in local planning of services.

2. If so, what changes should be given priority?
Legislation needs to be joined up which includes the 3rd sector (local compact) scheme Expecting 3rd sector to pick up support for community based services looking to the prevention/early intervention model of care needs, but not enough consideration is given to resources and the shift from statutory services to local community based services, the impact on services currently providing community based initiatives and ensuring that when funding or contracts are withdrawn that this is all regarded and taken into account. Consideration needs to be given to cross-border issues as in Powys, so many services are provided in England (just across border), Powys does not have a District General Hospital for example.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Community engagement needs to be inclusive, reaching harder to reach people within a rural context and ensuring that the first point of call for service needs, GP's, local hospitals, Third Sector agencies/organisations are all

joined up and particularly that Primary Care needs to work more collaboratively with Third Sector.

Our belief is that this could be strengthened by legislation as currently, it is viewed somewhat as important, but the joint working is ad hoc.

A care pathway that includes the third sector and community services as part of the care package, referral directly to these services, would strengthen this working together.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
PAVO believes that an inherent part of developing/improving services is ensuring that the widest engagement of stakeholders happens which includes citizens/people using services. As this question may come from a lack of equality of engagement across Wales, the need for any statutory requirement to enforce engagement with citizens should not be needed as health boards and NHS trusts should WANT to engage with people as part of their fundamental duty of care rather than it being based on statutory requirements. There currently exists a model of patient forums/groups, in some areas provided by the CHC. What may need strengthening is the need for reviewing the recruitment and nature of these groups and look to see whether they are fit for purpose and as representative of “patients”, are they engaged enough with constituents and are there a variety of engagement methodologies used, for example on-line forums vs face to face meetings which not everyone can attend easily (carers for example). PAVO would advocate strengthening policies around the recruitment and support of these patient groups but not through legislation.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
No, we believe that if contract’s monitoring were working in the best way possible, that quality issues would be/should be picked up through this monitoring and legislation would not be needed. There should be minimum level of Quality standards set and these should be adhered to otherwise, funding is withdrawn/or not provided.

Chapter 3: Quality in Practice

Meeting common standards

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
We believe that a common standards framework would be beneficial, for NHS, independent sector, third sector and social care. There should not be any difference in the standards set apart from specific clinical standards (if required) in clinical settings. The fact that a new set of "Health and Care Standards" have emerged that are heavily clinically focused and yet Third Sector organisations "should comply" if commissioned means having to constantly go through a "remapping" of standards. If a common standards framework existed for all organisations providing care, then issues such as discrepancies relating to Counsellors recruited within the Third Sector vs NHS Counsellors and perceived governance discrepancies would not exist. It is not a "level playing field" and there is unfairness currently within the system.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
PAVO have recently looked at Nursing Collaboration between NHS, Independent Sector and Third Sector (Nursing homes) and are using peer Clinical supervision and peer reviews to enhance collaboration and best practice.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
It does not need legislation, again see above. PAVO responded to a need from the Third Sector and pulled the right people together. The partners sitting around the table WANTED to do this because they cared about the service they were offering and wanted to grow professionally. This should be picked up as part of "revalidation" and professional development.

17. What arrangements should be put in place for self-employed health professional registrants?
Any self-employed health registrants should be required to follow the same guidance as employed professionals and given opportunities to collaborate and join in with local schemes. This should form part of the policies within Health Boards and Care agencies.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
No, we believe that changing culture (which is at the basis of this) is not based on legislation changes and/or should not be a statutory duty. It should be about a wanting and need to own up and be responsible if something goes wrong and a culture of putting thing right as quickly as possible.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
If we look at the amount of outstanding claims – settlements and compensation claims, this proves an underlying need to change culture within the NHS. Whilst there will always be complaints, we need to look at how the lessons are learned and changing service(s) directly as a result. We believe there should be an independent Ombudsman Role and a focus on this vs legislation. Reducing time to complain, from 14 years to a lot shorter. Candour, as a trait/skill, needs to rest with staff, you can't legislate the truth. This seems to be a contradiction in terms. This entire consultation is fundamentally looking at compliance vs commitment and it is commitment that will transform Our Health and Our Health Services going into the future. We would suggest that this should apply to the 3rd Sector and that in commissioning the 3rd sector, there should be a power to investigate complaints, looking at openness and investigating issues/complaints within much shorter timescales. Recruitment of staff is important in terms of underlying commitment to how people are cared for, long term employees need to change their culture. Can this truly be enforced or is it inherently cultural? If anything, there should be empowerment built into having legislation about a "Duty of Candour". People should feel the need to be open/transparent so this counter acts the need for secrecy, but there does need to be protection of staff in this.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
- There is a perceived danger from the public in sharing of information - There is no control over where information goes - We hear about the hacking of information and this is perceived as a barrier What checks/balances are used uniformly?

22. How can we consider breaking down any barriers?
One system used, and whenever information is going to be given to a new person, patient is asked permission and knows exactly how this information is being used/only for this purpose. Database, permissions, processes and system of checking all need to be robustly pulled together. The patient needs to be kept informed consistently about what is being done with their information. Ideally in the future, patients should be able to "log into" their own record through a citizen portal and see what is being done with their information, what action has been taken, i.e., information sent to third party or consultant for appointment, or Doctor for review. This would also keep patients up to speed on what is happening with referrals for treatment, etc. and would cut out wastage in letter writing and make the system far more efficient. The NHS is spending a great deal of money on a new single database system for Wales across Health and Social Care. Next development should be Third Sector input and citizens themselves!

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Organisations using this already and using this adversely in some situations. People are not aware of how information is used (please above points). Consent needs to be far more specific. Issues such as people being treated out of county – continuity of transferring information is important, people shouldn't have to fill in forms in three/four different areas with the same information. Risk factors need to be considered in staff giving information and the need for transferring information to the Third Sector, for example. There are perceptions from health colleagues that they can't share information as the Third Sector is not seen as 'NHS', whereas direct referrals ARE made without any crucial information sometimes (evidence/examples of this in mental health settings for example). But this is also an issue within services (i.e consultants giving information to each other).

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
There is no coherence to inspectorates. There is the: • WAO • HIW • CCSIW • CHC's – Seek to engage but is it on different terms depending on where in Wales they operate? (wide sector feedback). - What engagement practices do they all sign up to as this is not uniform. - Not resourced – in terms of equalities? - There is a big push on integration, AND it also has to happen on this level. Where do commissioners fit in and how are these joined up as inspectorates? • Older People • Young People • Welsh Language

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
All inspectorates need to be independent, especially from Welsh Government. They all need to join together and become one inspectorate with different departments focused on different areas of need.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
Single Inspectorate, saving on costs of back office functions, saves on difference of legislation/inspectorate processes.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
PAVO does not believe that the CHC should be the only avenue of representing the patient voice. We see the Third Sector as crucial in representing the independent citizen voice as so many of the sector

organisations do this as part of their commissioned services and naturally as independent campaigning organisations representing the voice of people, including patients of the NHS. We see this consistently in "Carers organisations, Advocacy, Mental Health Organisations". CHC may be seen to duplicate some of the work of Third Sector organisations although hold statutory powers so are asked to champion a patient's rights where needed and can hold statutory organisations to account? We are curious about the (lack?) of systematic approach across Wales in how CHC's operate. For example, does each CHC provide Advocacy and/or facilitate their own Patient Groups or are these facilitated/ managed through local health boards or other independent agencies. We do not believe that this is uniform across Wales and so would advocate an independent review to determine what is working, what is not and propose a uniform methodology, underpinned by national principles of engagement and sharing best practice.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
Should the function of the CHC be incorporated into the overall inspectorates function as it appears that some of their service provision could be seen as an overlap with other inspectorate agencies? If they provide a different function, i.e., representing patients, carers, then this should be very clearly distinguished from other functions. Currently, it appears that each CHC is independent and can decide how/what they do as per their own remit?

Chapter 7: Finance, functions and planning

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
There are four different "Trusts" in Powys, not sure how they can join together easily.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes.

34. 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.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
The opportunity to ensure the widest range of skills, innovation and leadership in terms of the role of executive directors should be developed and encouraged.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Yes, this would be considered advantageous and bring the integration agenda closer to reality.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Health Board officers should be able to challenge more and have opportunities to challenge the direction of the Health Board more. Independent members are currently drawn/ recruited to have specific specialisms. However they should perhaps be drawn from specific groups within the area they serve, such as the opportunity for more community representation. It should not just be people who are retired or not working that only have an opportunity to be considered, it should be job based and funded correctly. The requirements of being on the Health Board should be considered adequately, i.e. the time pressures, skills needed (the documentation alone for digesting is vast). There should be greater links with the Council and Third Sector, local business population and truly representative of local population needs. Far more emphasis should be given to people being recruited who have lived experience of being patients in different health care settings, who are innovative in their practice, wider representation from protected characteristics (population), more equal opportunities to apply should be prioritised.

WGGP104 – Helen Rogers – Royal College of Midwives
Tref / Town – Cardiff

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
There already exist a huge body of legislation and policy documents and we cannot see the value of introducing further legislative changes. There may be a case to do so in order to add clarity and better reflect the situation in Wales but we do not feel that the case has been well enough made in this document.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Cultures, in terms of public services duties, must be addressed to ensure that there is meaningful engagement by and with all parties. There must be a consistent message that results are best achieved through co production and collaboration.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Health Boards already have a duty to consult local populations in relation to service changes. Rather than reforming the law we would support a process of continuing engagement with the public and clear definitions as to what should be consulted on and what level. All engagement should be open, transparent, and with the improvement of health and well being at its core. There should also be a recognition that we all as citizens need to take some responsibility for our own health and well being.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Health Boards already have a duty to consult and seek involvement from the local population when planning services. This could be strengthened to ensure consistency and transparency. There are many examples of where services already endeavour to ensure that there is good local participation., for example in maternity there are well established Maternity Service Liaison

Committees. However despite enthusiasm from services, women and their families there are still many challenges in ensuring strong and meaningful representation. Even if permanent statutory engagement groups were established there is no guarantee that this situation would improve. It is more appropriate that resources are put into finding ways to better engage, such as the use of technology and social media and that when we engage it is with those that are truly representative of the service being considered. We would want to see Health Boards engaging with and listening to their staff in order to ensure high quality care is provided. Staff need to be empowered to make and embrace change.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
We would like to see more detail as to how this might work. We would support an expert panel that was independent and had appropriate representation to make meaningful decisions. However there is a danger that this could lead to another layer of bureaucracy and delay in decision making. However on a positive note it could mean that the Minister only got involved as a last resort. If there is meaningful, ongoing dialogue within local well informed populations then decisions could be made through consensus rather than constant referral to another body or individual.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Legislation cannot and should not be seen as the only way to 'fix' the NHS. We must ensure that there is a culture of partnership and respect where the contribution of all staff is valued. Organisational structures must be such that they support high quality care and not individuals or organisations. All professionals are bound by their respective codes and are accountable for their actions and there should be an environment to support them. The vision, values and behaviours in NHS Wales should support and promote high quality care and the emphasis should be on this rather than introducing yet more legislation. There may be a case to extend regulation to those staff not yet regulated, such as Health Care assistants.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
We need to learn from previous investigations and reports, build on existing systems and focus on quality and safety.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
We do not believe that there is a need for more legislation. Regulation and codes are in place already and unless the underpinning cultures and values promote high quality care with staff who are empowered to deliver it, legislation will not provide any added value.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
It is not clear what these are and how this role is envisaged in practice.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
We would like to see more detail around this proposal and we would not want to see a reduction in diligence on behalf of the Health Boards to ensure that Board members are competent and effective. There is the possibility this could help enhance the quality of leadership and therefore we would support it in principle.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
We do not believe that the case has been made that IMTP’s are not functioning adequately at the moment. We would want to see a culture where those providing care, whatever the setting, are supported to do so.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
There is currently a raft of standards with the potential to duplicate reporting on them. This is unhelpful. We would welcome a review of those that exist and would want to see those that have recently been refreshed (Health and Care Standards) properly embedded and reviewed before more changes are made.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
We would welcome a common standards framework as this could provide consistency and clarity for providers and users of the service.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
We support peer review. There may be scope to use these mechanisms but unless adequate resources, both in terms of time and money, are put in place they will not be effective and will not ensure quality.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
We support clinical supervision and peer review. Following the King's Fund report on midwifery supervision, which recommended that it should be removed from statute, the RCM has considered what the future post supervision might look like and has produced a working paper. The incidents at Morecambe Bay did not occur because of legislative failings but because of poor practice and culture. There is no guarantee that legislation would facilitate a culture of supportive and learning environment. In our paper on reframing supervision, we have stated: "Given the recent identification of failures in the provision of safe and compassionate care within the health service and the self-regulation of the professions, it is timely to consider a complete reframing of supervision for all healthcare professionals. For midwifery, however the likelihood is that the regulatory and statutory aspect integral to midwifery supervision will cease to exist in the future. The current climate makes it an ideal time to seize the opportunity to shape a new model and framework for effective clinical midwifery supervision…. "The overall benefit of supervision as recognized in the literature and by the PHSO and King's Fund reports, is sufficient to merit continued investment in clinical supervision for midwives. The investment currently dedicated to the statutory supervision of midwives should be maintained although clinical supervision is likely to require less resource than currently. "A framework of clinical supervision should be developed to support midwives to maintain and promote standards of care in accordance with the NMC Code including revalidation, lifelong learning and professional development and enable them to provide high quality safe care to women in a continuing changing service environment. "A system for clinical midwifery supervision should be determined nationally, included in the NMC professional standards, the NHS education commissioning bodies standards and health systems regulators standards for the provision of health services." (RCM, *Re-framing midwifery supervision: a discussion paper*, March 2015).

17. What arrangements should be put in place for self-employed health professional registrants?
The NMC revalidation process provides guidance for self-employed registrants.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
The Nursing and Midwifery Code already states that midwives have a duty of candour. The RCM agrees that there should be a statutory duty of candour. Please see comments below from a previous response to a consultation on duty of candour in England: The RCM supports in principle the proposal that the harm threshold [*when the duty of candour is triggered*] encompasses death, severe harm and moderate harm. However, we strongly recommend that further work is undertaken to ensure that the concept of moderate harm is clearly defined. The draft regulations set out some examples of what moderate harm may encompass; however some of the definitions, such as “significant, but not permanent harm”, could be interpreted in different ways. This could lead to providers effectively operating different thresholds when determining whether there is a need to be candid or not. The RCM would also recommend that both clinicians and service users are consulted when drawing up the definitions which underpin the harm thresholds. We feel it is particularly important to do this in order to understand how both those who provide services and the people that they care for perceive different definitions of harm.... The RCM believes that where a patient or service user has been harmed, that care providers should make an honest acknowledgement to patients or their families, apologise for what happened and, if needs be, provide them with professional support. We therefore agree with the proposed reporting requirements on providers." (RCM response to Duty of Candour consultation, April 2014)

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Whilst performance measures remain process not outcome focussed legislation will not improve transparency. Outcome focussed performance measures that allow real-time reporting on and ensure patients have the opportunity to contribute on what those measures should be has the potential to improve transparency.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
We are not convinced that legislation is needed. It is imperative that the

complaints process is focused on allowing women and their families to make complaints in the knowledge that they will be addressed in a supportive environment and as speedily as possible. Processes should be user focused rather than organisation focused. Clinicians and organisations should be prepared to admit fault and learn from mistakes to ensure that they do not happen again.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Currently IT systems are not set up so that they can link or communicate with other systems i.e. Myrddin maternity module now used in only four of the seven health boards in Wales. If a pregnant woman from one goes to another all her data has to be re-entered into the system, there is no capacity to retrieve the data from the other system, despite it being the same.

22. How can we consider breaking down any barriers?
We need a fully integrated IT system for Wales that allows access to patient data wherever the patient presents.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
There needs to be public engagement as to what identifiable data should be collected and why this is happening. The MBRACE reports are an example of where data is collected and put to good use. However too often there is no clarity of purpose, opt out options are unclear safeguards to prevent data breech may be weak. Mechanisms must be in place to ensure not only that the data can be collected but also that it is then used in order to improve quality and health outcomes.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
We would welcome a review of HIW in order to have assurance that it is working as effectively as possible.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
There is a case to merge CSSIW and HIW.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
A merger would possibly require legislative change.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
One corporate body may be easier to understand from the public's perspective. There would need to be adequate resources for all of the functions and a watchful eye that some are not seen as important as others. We would welcome further exploration of this.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
This would make sense but there must be clear guidelines and parameters in place, they must be representative of the local population and there must be adequate funding to make the CHC effective.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
We would welcome further exploration of this and it seems timely to review CHCs.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
This could give health boards more flexibility but we would be cautious as to their current financial position.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
It appears not and this could be an opportunity to review these reporting

arrangements.

32. 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?
This is an opportunity to review reporting arrangements.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
This seems sensible.

34. 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?
This would be sensible as long as it did not make the process more complex and difficult which we believe is a possibility.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
We would suggest that an open and honest culture where staff feel listened to and valued improves patient outcomes and quality. We need to strengthen clinical leadership and the voice of the professional in order to enable staff to speak out when they have concerns and for all staff to work in partnership to learn from mistakes. The RCM/RCOG Undermining Behaviours workshops have now been rolled out across Wales and all Health Boards should buy-in to this process.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
It is important that the size and configuration allows the board to have the expertise required to make decisions and fulfil its obligations and accountabilities. It is important that there is a strong clinical voice and expertise at board level which covers the full breath of health professions. However this should be balanced with the need for the board to have other expertise as well. We recognise that the role of the Independent members can

be challenging but they play an important part in the decision making process. We see value in having a Trade Union member from the employing organisation. They can bring local knowledge and a different perspective to that of the other executives. We recognise that there may at times be tensions but view the public appointment process as being a positive one. We would like to see University representation to be from a senior level. We would support further exploration of the findings of the Williams Commission.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
This should be looked at in light of the Williams Commission.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
This suggestion has potential. However there needs to be very robust processes in place for appointment and clear criteria for the role.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
This would be sensible as it could promote a partnership approach to heath care provision and encourage joined-up thinking and decision making.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
We would welcome greater statutory clarity and further review of this role in order to ensure independence and avoidance of conflict of interest.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
We have supported the establishment of the Maternity Network and recognise its value in terms of collaborative working. It also enables a multi-professional approach on an all Wales basis. It seems reasonable to consider changing the statutory status as long as networks are recognised as the most appropriate body to provide the expert professional and clinical advice.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
There must be a recognition that high quality, safe services can only be

delivered if the professional voice is listened to and respected at all levels – in NHS organisations up to and including board level and within government.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
We believe that the current arrangements are fit for purpose. Whilst we recognise that devolved arrangements can be advantageous at times we do not believe that it is in our Nation's interest to move away from UK negotiations on issues such as pay and terms and conditions. We need to ensure that Wales remains competitive with the rest of the UK and is seen as an attractive place to work and grow professionally and thus retain high standards and high quality safe care.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
We believe that better clarity can be achieved by having less complex systems, consistent models for hosting and shared services and a clear robust governance framework. We do not believe this requires legislative measures.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
We do not currently have enough information on the current effectiveness of NWSSP to comment but would welcome an evaluation of current working arrangements.

WGGP105 – Mike Wade
Tref / Town – N/A
Sefydliad / Organisation – Hywel Dda University Health Board

General comments

I wish to respond to the above consultation paper and a governance change to NHS Charities.

With regards to the governance structure of NHS Charities I wish to register the option for independent charitable status to be included in the revised legislation as an alternative option to the current corporate trustee status. Independent status is currently not allowed under NHS Wales legislation where it is allowed under English NHS legislation. There is evidence in England where there is a clear benefit in some circumstances to have independent charitable status. Changing the legislation in Wales will provide the same opportunity as NHS Charities in England.

It may be the case that at the moment there is no desire for any Wales NHS Charities to seek independent status, but should they wish to in future there is no current legislative framework to allow it. If it is not included at this point it would seem very unlikely that there would be any legislative change just to address that point in future. To introduce the option at this point would seem opportune and fully cover any future NHS Charities wishing to go independent.

At this point I'm not aware of any organisations wishing to go down this route, but that doesn't mean there won't be in future.

Response to specific questions

No response to specific consultation questions.

WGGP106 – Eleri Butler – Women's Aid
Tref / Town – N/A

General comments

As you will be aware, Welsh Women's Aid is a membership organisation that supports 24 independent, specialist services in Wales which provide a range of support, advocacy and prevention services for women and families affected by domestic abuse and other forms of violence against women. We also provide direct services to survivors across Wales via the Live Fear Free Helpline and services to survivors in North Wales (Colwyn and Wrexham).

We are writing to you today with regard to the Green Paper *Our Health: Our Health Service*. We would like to highlight the importance of linking work to end gender inequality and violence against women, with improving the workings and structure of the NHS.

The link between violence against women and the NHS' best practice response to this area, needs to be embedded and acted on throughout the NHS structure. The Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 outlines a series of obligations which the NHS must fulfil to tackle violence against women. These obligations include secondary legislation that will be issued for professionals to 'Ask and Act', and to train members of staff, at all levels. Welsh Women's Aid note that the Wellbeing of Future Generations (Wales) Act 2015 and the Social Services and Well-being (Wales) Act 2014 have both been highlighted in the consultation as legislation which will shape changes to the NHS. We would further include the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, given the legislative duty under which NHS will be accountable to.

The Wellbeing of Future Generations (Wales) Act 2015, the Social Services and Well-being (Wales) Act 2014 and The Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 all contain provision for indicators, and create boards, on which NHS staff have been given the duty to be members. Welsh Women's Aid would recommend that these overlaps in both measure and duty should be aligned to ensure a strategic and holistic approach is adopted by NHS Wales and any duplication of efforts is prevented, whilst at the same time, not treating tackling violence against women as an 'add on' to other duties.

Welsh Women's Aid supports the suggestion for a requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups. If this suggestion isadopted, it is vital that those who are experiencing, or have experienced, any form of violence against women should be provided safe spaces to express their views; this includes the need for information shared to be treated as confidential. There is a need to also ensure that those who are experiencing or have experienced violence against women from marginalised communities

are also engaged with these panels and groups. It may be beneficial to adopt mechanisms which allow engagement on an individual basis, such as an interview or a questionnaire.

Welsh Women's Aid would welcome a common standards framework covering both the NHS and the independent sector to better deliver improved outcomes and experience for citizens. Survivors of violence against women have expressed mixed views on the treatment they have received from health care professionals[29]. A common standards framework would help to ensure that all patients have good experiences when being treated by the NHS.

The consultation points to the importance of ensuring that there is collaborative working between third sector organisations. We agree with this point, especially with regard to tackling violence against women. Welsh Women's Aid and our specialist member groups are in an ideal position to collaborate with the NHS in its response to tackling violence against women on both national and local levels.

Response to specific questions

No response to specific consultation questions.

[29] Women's National Commission (2010) 'A Bitter Pill to Swallow', DH

WGGP107 – Rachel Podolak – General Medical Council
Tref / Town – Cardiff

General comments

The General Medical Council (GMC) welcomes the opportunity to respond to the Our Health, Our Health Service consultation.

Before providing comments on the Green Paper, we thought it might be helpful to reiterate the role of the GMC. We have an office in Wales and have done so since 2005. We are an independent organisation that helps to protect patients and improve medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee UK medical education and training.

- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.

- We take action when we believe a doctor may be putting the safety of patients, or the public's confidence in doctors, at risk.

Every patient should receive a high standard of care. Our role is to help achieve that by working closely with doctors, their employers and patients, to make sure that the trust patients have in their doctors is fully justified.
We are independent of government and the medical profession and accountable to Parliament. Our powers are given to us by Parliament through the Medical Act 1983.

Whilst many questions fall outside our role and remit, we have endeavoured to provide information where appropriate.

Co-production

The General Medical Council welcomes the move towards co-production as set out in this Green Paper. Our core guidance and the professional standards for all doctors, Good medical practice, explicitly states that doctors "must work in partnership with patients, sharing with them the information they will need to make decisions about their care." Accordingly, we agree that the emphasis on coproduction and collaboration as set out in this Green Paper is in line with our guidance and is to be welcomed as reinforcing the existing duties of every doctor.

Enabling High Quality Care

We also welcome any move towards providing and enabling high quality care. In our role as a regulator, we oversee standards of medical education and training in the UK, and issue guidance for doctors to ensure that the level of care and treatment they provide to patients is of a high standard.

Our national training survey is a powerful tool which helps us and other organisations understand the experiences of doctors in training and where there may be concerns about the delivery of care or to highlight where good practise may exist. The survey is completed on an annual basis by all doctors in training across the UK. This year, for the first time, the survey results show us how supportive training environments are; how fairly doctors in training think they're treated, and if their posts help build confidence. We work with NHS Wales, HIW and the Wales Deanery to help them analyse and use the survey results to identify and act on areas of concern.

Clinical Supervision and Revalidation

In the section regarding Clinical Supervision, the Green Paper states that "currently there is no consistent clinical peer supervision or support from employers for health professional staff undergoing revalidation." We are disappointed to learn about the lack of consistency that is described. In 2013, we issued Effective governance to support medical revalidation: A handbook for boards and governing bodies. This handbook was published jointly with other regulators, including Healthcare Inspectorate Wales. The handbook states that "Responsible Officers (RO's) should ensure that all doctors are familiar with appraisal arrangements and that all doctors participate in annual arrangements and that all doctors participate in annual appraisal. Appraisal must cover a doctor's whole practice, and take account of all relevant information relating to the doctor's fitness to practice." It is worth noting that in Wales the Responsible Officers are the Medical Directors of the NHS Health Boards and NHS Trusts, independent organisations also have their own Responsible Officers.

To help Responsible Officer's execute their statutory role, the GMC employs an Employer Liaison Adviser (ELA). The ELA for Wales works with ROs to support them with any issues surrounding Revalidation and Fitness to Practice. Alongside the work of our ELA and our handbook for Boards, we also issued The Good medical practice framework for appraisal and revalidation. This framework sets out the broad areas which should be covered in a medical appraisal, following the principles set out in Good medical practice, our core guidance.

In addition to the guidance we have issued, the Wales Deanery has also issued the "Designated Body" Medical Appraisal Policy. This document states that the "policy of the Designated Body is to promote the value and worth of appraisals to all employees and contractors." Health Boards and NHS Trusts are Designated Bodies in Wales. It is worth noting that the Health Boards and NHS Trusts helped to formulate this policy as members of the Revalidation and Appraisal Implementation Group (RAIG) subgroup.

I would also like to bring your attention to the All Wales Appraisal Quality Management Framework which was approved by RAIG in May 2014.

It is important to stress that there is a difference between Clinical/Peer Supervision and appraisal. Doctors must undergo an annual appraisal as part of the revalidation process. This is undertaken with a trained appraiser and is

an opportunity for doctors to reflect on their practice and ways they may be able to improve. However, revalidation does not replace or override existing procedures for performance supervision, which may include performance management or remediation at a local level.

Duty of Candour

With regard to the statutory duty of candour set out in the Green Paper, it might be helpful to note our recently published guidance for all doctors and nurses practising in the UK, Openness and honesty when things go wrong: the professional duty of candour which we jointly issued with the Nursing and Midwifery Council. The guidance is attached as an Annex to this submission for ease of reference. The guidance covers a doctor or nurse's duty to be open and honest with patients in their care, or those close to them if something goes wrong as well as their duty to be open and honest with their organisation, and to encourage a learning culture by reporting adverse incidents that lead to harm, as well as near misses. Doctors are professionally accountable to the GMC and have a duty to raise concerns to us as set out in our Raising concerns guidance.

As well as issuing the joint guidance with the NMC, in 2012 we launched a confidential helpline for doctors which enables them to seek advice on any issues they may be dealing with and to raise concerns about patient safety when they feel unable to do so at a local level. We recently published our 2015 edition of the State of Medical Education and Practice. Chapter 3 of this year's edition shows that in 2014 our confidential helpline received 135 calls from doctors raising concerns.

In March this year we published an independent review undertaken by Sir Anthony Hooper QC into how we deal with complaints about doctors who have raised concerns. Sir Anthony made eight recommendations and we've published an action plan indicating how we are acting on those recommendations. This work reflects our commitment and contribution to this area and we therefore welcome its inclusion in the Green Paper.

Healthcare Inspectorate Wales

The General Medical Council has no comment on the legislation that underpins Healthcare Inspectorate Wales, although we would like to highlight our strong working relationship with HIW in terms of improving patient safety and information sharing, which is facilitated by a Memorandum of Understanding, Information Sharing Agreement and our joint membership of the Wales Concordat. We hope that if there are any changes to HIW – be it legislative or through a merger with another body – that this positive relationship is maintained.

Response to specific questions

No response to specific consultation questions.

WGGP108 – Siobhan McClelland and Stephen Harrhy – Emergency Ambulance Services Committee
Tref / Town – N/A

General comments

As the Chair of the Emergency Ambulance Services Committee and Chief Ambulance Services Commissioner (EASC) we are writing in response to the Green Paper. Whilst the Green Paper makes some reference to WHSCC it does not refer to the more recently established EASC and we think it is important to describe the role of EASC and the relationship to the Wales Ambulance Services Trust (WAST) as the provider of services. It is, we believe, important that this is considered in respect of any changes particularly to LHBs and NHS Trusts and governance arrangements. We also describe the development of our Collaborative Commissioning approach which we believe addresses key issues in respect of the development of national standards for clinical outcomes, patient experience and value for money and is now finding wider application in unscheduled care and a range of other services.

The creation of EASC followed The Strategic Review of Ambulance Services (2013). The Review was underpinned by a vision of the delivery of a robust **clinical** emergency ambulance service that is a fundamental and embedded component of the wider unscheduled care system. This was to be accompanied by clear lines of funding and accountability between Welsh Government, Local Health Boards and WAST. The recommendations of the Review were broadly accepted by Welsh Government and were taken forward within the Ambulance Reform Programme.

From the three strategic options identified in the Review the Minister for Health and Social Services identified a national commissioning model where WAST **provides** services on behalf of LHBs who **commission** emergency ambulance services jointly based on local need.

From April 2014 LHBs were statutorily required to work together to form a joint committee – the Emergency Ambulance Services Committee (EASC). EASC is provided in line with the Emergency Ambulance Services Committee (Wales) Regulations 2014. These regulations require that "*seven Local Health Boards in Wales work jointly to exercise functions relating to the planning and securing of emergency ambulance services*"

Additionally a role of the Chief Ambulance Services Commissioner (CASC) was created tasked with holding responsibility for the commissioning of ambulance services and working with LHBs to ensure sufficient resources to allow WAST to deliver against the agreed commissioning framework. EASC is comprised of an independent Chair (Professor Siobhan McClelland), the CASC (Stephen Harrhy) and the Chief Executives of the 7 LHBs with associate membership from Velindre NHS Trust, PHW and WAST. The

Committee is supported in its work by the CASC and a small Collaborative Commissioning Team.

Emergency ambulance services commissioning in Wales has been a collaborative process underpinned by a national collaborative commissioning quality and delivery framework. All seven Health Boards have signed up to the framework. The framework provides a mechanism to support the recommendations of the 2013 Strategic Review of ambulance services. It puts in place a structure which is clear and directly aligned to the delivery of better care. The framework introduces clear accountability for the provision of emergency ambulance services and sees the Chief Ambulance Services Commissioner (CASC) and the Emergency Ambulance Services Committee (EASC) acting on behalf of health boards and holding WAST to account as the provider of emergency ambulance services.

WAST is required to meet a number of quality standards, core financial requirements and outcome indicators under each step of the innovative ambulance service care pathway – the 5 step model.

The ambulance service care pathway (5 step model) is as follows:

The 5 step model of ambulance service delivery is measured by the 23 Ambulance Quality Indicators.
We believe that the successes that EASC has been able to achieve in adopting a collaborative structured all Wales approach based upon best practice principles and by ensuring that Health Boards and WAST work

together within a clear governance framework can be built upon in an integrated health and potentially health and social care system.

This structured collaborative approach has also proved successful when adopted in formal framework agreements with the independent sector. An example of this is the framework put in place for low and medium secure mental health patients placed in independent and English NHS hospitals across England and Wales which has seen improvements in patient care and safety and a reduction in cost.

Work is also underway with All the Health Boards in Wales and sixteen of the twenty two Local Authorities to establish a similar framework to that described above for individuals of working age with mental illness who need residential care. By working collaboratively using the methodology that has been tried and tested elsewhere it is possible to improve quality and patient care at a reduced cost and realise the benefits that we have and will develop from an integrated system of health and health and social care.

It can sometimes be tempting to look at large scale structural and governance change and it could be argued that some change is necessary. However, we believe that it is prudent to ensure that our efforts should be concentrated on getting the maximum benefits from the existing arrangements particularly around collaborative commissioning.

By adopting this approach we can ensure that any changes are targeted at those areas that would most benefit from them, that collaborative commissioning rather than a top down centralised approach which has proven to be less than effective in the past is adopted to support improved patient care better patient experience and best value for money within an integrated system that is operating collaboratively.

Response to specific questions

No response to specific consultation questions.

WGGP109 – Susaznne Scott-Thomas – Royal Pharmaceutical Society

General comments

Chapter 1: The changing shape of Health services

- We welcome the emphasis placed on multidisciplinary team approaches. We strongly believe that the skills of each healthcare profession should be recognised and used optimally for patient care at a local level, ensuring the NHS is making the most effective use of all skills and resources available.

- We are supportive of the drive to re-shape primary care through cluster development in order to provide more integrated health and social care, closer to people's homes. In the Scottish parliaments health and sport committee report it is stated that 'on average, it costs £4,600 a week to keep somebody in an acute hospital in Scotland and around £300 a week to treat a person at home. For those with serious chronic conditions, the average is probably nearer £800 or £900. It makes economic sense to treat people at home, but the really important point is that, where that has been done, patients' health outcomes have substantially improved.'[30]

- The RPS is supportive of the intention to progress primary care clusters from a collection of GP based services to a fully integrated model for primary care, encouraging services and professionals to collaborate more effectively. To help facilitate this, we firmly believe that pharmacist engagement is needed in local strategic planning and decision making processes. We ask for a commitment to establish a medicines management lead at cluster level which we believe will significantly contribute to the strategic leadership needed to help clusters develop and reach maturity.

- As the third largest health professional group after Doctors and Nurses, the pharmacy profession offers further opportunities to increase access for patients to pharmaceutical care. Advanced practice and independent prescribing pharmacists have the potential to undertake more clinical work in both community pharmacy and GP practice settings within primary care.

- Pharmacists can free up appointments in primary care by supporting patients with their treatment following diagnosis by their GP. Those people with chronic conditions requiring ongoing management will benefit from having their care shared between their GP and their pharmacist. Not only will this allow GPs to focus on more complex caseloads but each patient will benefit from access to the right expertise at the right time. In order for this to happen, GPs and pharmacists must share key parts of the patient health record to enable appropriate dialogue between healthcare professionals and the patient.

[30] http://www.scottish.parliament.uk/parliamentarybusiness/report.aspx?r=9519&mode=pdf

- The RPS is supportive of the need to establish a more robust understanding of the Welsh language capabilities amongst our healthcare workforce in order to better support the language needs of the Welsh population. Several pharmacy initiatives have been recognised by 'More than just words', the Welsh Government's strategic framework for Welsh language services in health, social services and social care. They include the Pharmacy department in Ysbyty Gwynedd who raised awareness of the 'active offer', and materials and protocols were developed to help give staff and patients a language choice. Cardiff University, School of Pharmacy and Pharmaceutical sciences was also recognised for it's contributions, setting up a welsh language provision group to amongst other activities, help develop additional sessions for students to focus on consultation skills through the medium of Welsh.

- The discharge medicines review (DMR) service has encouraged pharmacists to work closely across primary and secondary care to support the patients' transition of care as they move from one care setting to another. The evaluation of the DMR service highlighted that of the 252 DMRs reviewed, 82 unintended discrepancies were found. It was estimated by the expert panel that 32 patients would have been admitted to a hospital Emergency Department as a result of the discrepancies if it were not for the DMR service.[31] The RPS would like to note the importance of highlighting this service for patients when admission and discharge plans are put in place.

- We fully appreciate that different clusters will have different priorities based upon local population and service development needs. We therefore would support the intention outlined in the primary care workforce plan strategic document to develop a national set of core governance standards for clusters and establishing a more structured approach to sharing best practice across cluster areas.

- Medicines are one of the most common interventions in today's NHS, helping people to overcome short term and longer term illness, stabilising long term conditions, managing multiple medicines for multiple health conditions (polypharmacy), alleviating pain and managing acute and life threatening situations. As the health profession specifically trained in medicines, pharmacists have a vital role to play in the multidisciplinary team. Patients and the public have yet to benefit from access to the full range of benefits that the pharmacy team are already well equipped to deliver. For example, a cohort of the pharmacist population in Wales are trained as prescribers. Yet these skills are not being fully harnessed in all areas across the NHS to enhance patient care and shift caseloads and capacity within the healthcare system. Such investment in skills and training now needs to be better utilised and maximised through the development of new and innovative services. Pharmacist prescribers would be ideally placed to tackle the growing demands on primary care services in Wales, supporting patients with the medicines management of their chronic conditions.

[31] EVALUATION OF THE DISCHARGE MEDICINES REVIEW SERVICE March 2014

- A pharmacy-led Welsh Chronic Conditions Medication Service would allow people with chronic conditions to benefit from structured support, advice and a review of their medicines from a pharmacist who has spent a minimum of 5 to 7 years studying the effects of medicines on the human body and how different medicines interact. It is vital that where a medicine is prescribed to a patient, a pharmacist is involved. Once a patient is diagnosed by a doctor the pharmacist is best placed to support the patient and the doctor with medicines information. This approach will ensure the greatest synergy and utilisation of the skills of the two professions. Advanced pharmacy services such as a Chronic Conditions Medication service could take place in a GP practice or in a community pharmacy setting, ensuring patients are treated close to their homes.

- The RPS would advocate that pharmacists can help patients make better use of other healthcare professional services by direct referral from community pharmacists to other healthcare professionals other than the GP, including physiotherapists, optometrists and social services.

- If a national expert panel was established for referral rather than direct referral to the minister, the RPS would seek assurance that there would be fair representation of healthcare professionals and experts on the panel. Their decision making should be auditable and transparent.

Chapter 3: Quality in Practice

- The RPS agrees that accreditation and peer review are useful tools in assuring and assessing quality. As a professional body The RPS has developed a faculty which is our professional recognition programme. The RPS Faculty provides pharmacists with support networks, access to experts and mentors across all sectors, and at all stages of their professional careers, alongside opportunities to develop professionally, to build a portfolio of transferable knowledge and skills that is widely recognised. Available to RPS members who have completed their first two to three years of practice post registration, the Faculty will support them throughout the whole of their career as an advanced practitioner and offers employers and others assurance of the pharmacists level of practice. We would advocate that the Welsh Government could work with all royal collages and professional bodies to see what level of assurances are currently provided and could be further explored.

Chapter 4: Openness and honesty in all we do

- The RPS agrees that the statutory duty of candour should be introduced within the NHS in Wales. For all pharmacists and pharmacy technicians in Wales, as registrants of the General Pharmaceutical Council (GPhC) the duty of candour is already an essential duty. Along with other regulators of health professionals, the GPhC has signed a joint statement on openness and honesty – the professional duty of candour

- In order to learn from errors, it is essential that all health care professionals are encouraged to report errors and feel supported when genuine errors occur. Health care professionals should also feel safe and protected if they need to raise any concerns regarding other health care professionals, a patients care or their working environments.

Chapter 5: Better Information, Safely Shared

- We strongly believe that safe and effective multidisciplinary care must be underpinned by the utilisation of technology, enabling the sharing of appropriate real-time information between healthcare professionals. Access to accurate patient information is vitally important when patients migrate through the health and social care system and when prescribing decisions are made or reviewed. An electronic system to enable the sharing of information is of paramount importance to ensure that all registered professionals responsible for the patient's care have read and write access to all relevant information, ensuring the maintenance of accurate records and ultimately improving patient safety.

- The RPS believes that governance procedures must be in place to build public confidence and ensure all healthcare professionals accessing the patient record are working to the same standards and principles.

Chapter 6: Checks and balances

- The RPS believe that the membership of both HIW and CSSIW should be reviewed to ensure appropriate representation of Health and Social care professionals.

Response to specific questions

No response to specific consultation questions.

WGGP110 – Nick Bennett – Public Services Ombudsman for Wales
Tref / Town – N/A

General comments

I welcome the opportunity to respond to the Welsh Government's Green Paper on "Our Health, Our Health Service". As Public Services Ombudsman for Wales (PSOW), I investigate complaints made by members of the public that they have suffered hardship or injustice through maladministration or service failure on the part of a body in my jurisdiction. As such, I have a unique perspective on the provision of public services in Wales, driven from the views of members of the public who have been dissatisfied with the service they have received. In particular, grievances about healthcare account for a significant number (currently 36%) of the complaints that my office receives. It is in this context, therefore, that I am responding to the consultation and my comments on various aspects of the Green Paper are set out below.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Encouraging agencies to work together requires a cultural change which legislation cannot bring about. It is my view that legislation should state that there must be standards, but the standards themselves should not be legislated. It should impose a degree of regulation for agencies to collaborate but allow agencies to decide locally how this is done. I believe this also highlights an enforcement issue as it is unclear who oversees that agencies are working collaboratively.

Chapter 2: Enabling Quality

Quality and co-operation

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
From my experience of health complaints, it appears that an individual patient's care is overseen by a number of people, and there is no one person who takes overall ownership of their care. Addressing this issue would be far more beneficial for the patient than simply designating someone as the

"responsible individual" for health bodies.

Chapter 3: Quality in Practice

Meeting common standards

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
I would welcome a common standards framework covering both the NHS and independent sector. This would provide clarity during the consideration of a complaint as to whether there had been an occasion of poor service, or indeed service failure. Furthermore, as I am also able to consider complaints about social care provided by the independent sector (included self funded care), having consistent standards extended out to cover social care too would also be beneficial to my investigations. Beyond the benefits to my office, I can only see this as being a positive development for those receiving health care and social care services. It should not be necessary for those in receipt of care to have to undertake a 'compare and contrast' exercise to understand what standard of care they are entitled to when moving from one type of service provider to another.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
I agree that there should be appropriate clinical peer supervision for registrants. However, there are already standards produced by the General Medical Council which state that this should be the case. Therefore, rather than developing new legislation, health professionals should adhere to current guidance and standards where they exist.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes, a statutory duty of candour should be introduced for whole organisations. I have previously put forward the argument that organisations should take responsibility of their own governance. Often, despite the findings from my investigations, senior management in organisations claim that nothing is wrong**.** Whilst I recognise that there already exists the GMC/NMC professional statutory of candour for individual practitioners, which is applicable across the UK, a statutory duty for health bodies in Wales as corporate entities would reinforce this.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
I have expressed on a number of occasions my view that there needs to be a common approach to data gathering amongst health boards, so that potential differences in performance can be identified. The NHS Redress Measure 2008 and the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 already provide that health bodies must publish annual reports containing relevant data on the complaints received and the lessons to be learnt from them. My experience is that whilst health boards collect data, these are all in different formats or in differing levels of detail/analysis. Health boards also have different ways of using the same system (Datix). This means that data is not easily used, analysed or aggregated across the Welsh NHS. The National Assembly for Wales has recently issued a draft Public Services Ombudsman (Wales) Bill, which would provide the Ombudsman with a complaints standards role. If this comes to fruition, I would look to work with the Welsh Government on this problematic area.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
The Model Concerns and Complaints Policy and Guidance issued by the Welsh Government in 2011 addresses this issue, Public service providers should have appropriate procedures in place for the conduct of investigations involving more than one service provider. The issue of joint investigations is also referred to in 'A guide to handling complaints and representations by local authority social services' issued by the Welsh Government in 2014. However, I would welcome any development to make joint investigation across the NHS and social services in Wales a statutory requirement.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
Whilst HIW is a body within my jurisdiction, I also have interaction with the Inspectorate in a different capacity. This extends to me on occasion referring to the HIW my investigation reports concerning other health bodies within the NHS, in particular those in respect of Local Health Boards. The reason I do this is to ensure ongoing monitoring of effective implementation of my recommendations.

In relation to providing HIW with full statutory independence, from the experience of my office I am of the view that the Inspectorate could operate more effectively if it had full statutory independence. I cannot see any persuasive arguments against providing HIW with full statutory independence. I will address the issue of implications for CSSIW in response to question 27 below.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
I would reiterate here comments previously made by this office during the review of HIW back in 2013. The nature of health care in Wales has changed enormously since HIW was founded. Large proportions of health care are now provided in the community and private nursing homes. I would suggest, therefore, that any review of the Inspectorate also needs to look at the current pattern of delivery of care where this takes place in a nursing setting or via domiciliary care. CSSIW increasingly employs health care professionals to enable it to carry out its work. I would, therefore, suggest that in view of the increasing overlap between health and social care, an arrangement of two separate inspectorates is no longer fit for purpose. The fundamental issue facing services is how to support people, whether in relation to illness or disability. The configuration needs to be built around the rights of individuals to lead fulfilling lives in their own community where they are properly protected. It is my view that there should be one inspectorate, covering both health and social care, provided with full statutory independence from government bodies. Such an inspectorate could also have the potential to bring about cultural change along with new processes.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The advocacy role of the CHCs is a valuable one and the experience of this office is that this element of the service that they provide, on the whole, works very well. CHC advocates can play an important part in helping complainants put their complaint to health boards/trusts and also, if the complainant remains dissatisfied, to this office and support them through the complaints process. In fact, I agree with the conclusions of the Williams Commission, that rather than duplicate some of the activities of other inspection and scrutiny bodies, CHCs should focus on the advocacy services and 'patient voice' aspect of their role. In fact, it is my view that there is scope to extend the role of CHCs in this regard to include a similar service in respect of social services.

Chapter 7: Finance, functions and planning

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
I broadly support the proposal of an equivalent planning duty for NHS trusts and suggest that Trusts involve Health Boards when planning and vice versa. Trusts and Health Boards deliver similar patient-focused services and therefore it seems logical that they would have the same responsibilities in terms of planning for the delivery of those services.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
From the point of view of holding the executive to account in relation to complaints and learning lessons, I believe that the current 'unified board' approach to the membership of a Health Board (that is, membership including both executive directors and non-executive directors) is problematical. I have already referred above (*see response to question 18*) to the fact that senior management on occasion refuses to acknowledge when things have gone wrong. The current level of executive presence on health boards makes independent scrutiny difficult and, I would venture, is not in keeping with good governance. This places an even greater onus on the non-executive members of the Board, who at the same time lack the dedicated support necessary to provide them with, or obtain for them, sufficient independent advice to enable them to suitably challenge the executive/management. To that end, I believe that the nature of the membership of health boards should be revised to enable proper independent scrutiny of the executive, and that they be provided with suitable independent support to conduct their governance and scrutiny duties.

WGGP116 – Helen Evans – Neath Port Talbot Council for Voluntary Service
Tref / Town – Neath

General comments

- Neath Port Talbot CVS recognises the importance and need to engage with citizens continuously in service planning. However it is important to acknowledge that there are existing structures in place, and that these should not be duplicated. A Regional Citizen Panel is being constituted for the Western Bay region. There are also patient participation groups in existence, as well as a wide range of service user forums and networks and Third Sector forums and networks. These are already used as a mechanism for engagement in service planning. For example, the Regional Third Sector Health, Social Care and Wellbeing Network for the ABMU Health Board region is seen as the mechanism for engaging with the Third Sector and wider community on service design and delivery. It would be important that any new legislation strengthens, and not undermines the processes that have been developed.

- It is important to acknowledge that permanent engagement mechanisms could be static and not reflect the changing demography or viewpoints. Some engagement mechanisms may simply mean that you engage with certain groups, e.g. those with the time and confidence to get involved. This needs to be considered in developing engagement mechanisms.

- With regards to the recently reviewed Health and Care Standards, Neath Port Talbot CVS is aware that Third Sector organisations are required to work towards relevant standards as part of their service level agreements with the Health Board. It would seem appropriate that these common standards apply to all NHS funded services, and that they are expected to comply with them.

- Neath Port Talbot CVS would support the notion that a common standards framework which covers both the NHS and independent sector would deliver a focus on improving outcomes and experience for citizens.

- Neath Port Talbot CVS would welcome the introduction of a duty of candour within the NHS in Wales.

- The joint investigation across health and social care of complaints would be supported, and this would fit with a move towards the integration of health and social care, particularly for community services.

- There is a fear preventing statutory organisations from sharing information, particularly with Third Sector organisations who are supporting the delivery of services in the community which benefit the same individuals they are working with, often those who are the most vulnerable. These barriers need to be broken down. It is important to consider the needs of individuals and what is in their best interests. Information sharing should not be used as a barrier to joint working.

- In order to strengthen the patient voice, and the CHCs role as the patient voice, there is a need to consider the membership of the CHC. The recruitment process and demands placed on members' means that the membership of the CHC is not typically representative of the local population. A different approach to membership, or a range of different roles, may help ensure a membership of the CHC which is more representative, and therefore a more accurate reflection of the patient voice.

Response to specific questions

No response to specific consultation questions.

WGGP117 – Dr Jane Fenton-May – Royal College of General Practitioners
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Yes.

2. If so, what changes should be given priority?
In some areas, the local structures, clusters, as well as general practices are struggling with the increasing demand for clinical services. GPs have limited time or facilities to look at planning services. GPs have a good understanding of the effectiveness of systems and their impact on individual and public health. Improved mechanisms are required to enable GPs and other local primary care leaders to participate in the planning and enable them to improve collaborative working. This may include provision of back fill or facilitating different working patterns to enable time for GPs to be part of this important work. Currently there is limited sharing of information between health and social services. This can lead to duplication, and safe ways of sharing information about patients' need to developed. Social services and health need to learn to talk in a common language and to enable true sharing, the budgets need to be combined. Legislation should ensure effective participation in planning by community organisations and third sector organisations. There needs to be more support for elderly and vulnerable patients, who are potentially admitted to hospital due to health problems which could be managed with support from social services, or emergency respite admissions to care or nursing homes. This could be improved by increased ease of access to social care and social workers, particularly in evenings and weekends. Improving planning and access to social care from general practice would fit well with Prudent Healthcare and the concept of treating patients closer to home. To enable this to happen there need to be alternative robust mechanisms to transfer care to others, and enable the patient to be involved in decisions about their care. Carers' needs must be considered; additional care or respite may be a need for the carer as well as the patient. This must

be incorporated in planning. The legal requirements need to be reviewed on a regular basis to ensure that the local planning area continues to have suitable boundaries for the services provided.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Preventative health care is broader than provision of health services and needs to be part of general education, public campaigns and public health including health assessments of local and national government policies. The duty of local authorities to provide a health prevention strategy must be upheld. Although needs assessments are required for localities potentially in some areas, there may be cases of rarer conditions. There need to be mechanisms to anticipate need for more specialist services from outside the locality or cluster, or even outside the health board area, or even from outside Wales.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Yes as below.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Yes. Welsh Government needs to look at ways that can help and support patients and carers taking part in these groups by providing/enabling appropriate mechanisms for expenses, support and respite care which does not affect the receipt of benefits. For some, formal meetings are not only difficult to attend and comprehend but some patients and carers may need support in voicing their opinions in a large group of health and planning professionals. All health boards, clusters and Trusts should have statutory public and patient panels who should be represented on boards.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Yes. Membership should be by public appointment approved by the independent public appointments committee. We would strongly recommend inclusion of a health professional with a primary care background. The Minister must, however, retain overall responsibility for Health and Social Services.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
No, quality should be driven by the need to provide population oriented, patient centred care. This can be done through appropriate public health outcomes and patient experience. Better quality care will provide better outcomes. Legislation may suppress the need to identify good outcomes and a culture of continuous quality improvement.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
Strengthen the focus of the Annual Performance Framework on broader outcomes rather than processes.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Good robust clinical governance should be at the core.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
This may make clearer the role and responsibilities of the CEO vis a vis the Chair of Boards. There needs to be flexibility in precise definition to allow for different functions of NHS and social care organisations. Also, there will need to be joint responsibility for integrated care.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
As per 10 above.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
There must be a legislative requirement on NHS and Care organisations to deliver in relation to a robust NHS Planning Framework, focused on meaningful, person centred and public health outcomes. There must be a requirement for Welsh Government to consult with and respond to NHS Wales and the public in drawing up the annual planning framework. Longer term planning is required across health and social care as recommended in the Health Professionals Education Investment review published earlier this

year.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Yes.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes, but the standards will need to be adapted for different settings e.g. primary, secondary and social care and explained in clearer terms. It may, however, be wasteful and time consuming to complete large forms or computer templates which are not relevant to the group using them, with the resultant disengagement of the workforce so things would have to be simplified for users.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
The standards should be incorporated with accreditation and peer review which needs to be subjected to quality assurance. Accreditation must be more than a tick box exercise or achievement of targets. Any process should be piloted, as accreditation bureaucracy may actually distract organisations from provision of care. We are not convinced the current completion of Quality statements are of value in improving quality. Good peer review has been shown to be of value as it creates a culture of reflection, comparison and desire to improve. It must be based on trust and openness.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
This should arise from a culture of focus on quality and improvement. A requirement on organisations to continually improve meaningful health and wellbeing outcomes will necessitate focus on ensuring the best use of staff and caring for staff and staff effectiveness. Legislation should not be needed. Time needs to be provided within work plans to enable this to be conducted and it should include some face to face time with a peer, trained and given funded work time to perform the task. Mechanisms must be in place to ensure that clinical supervision is separate from performance management. For those

found to be in need of additional training or education there should be funding streams to support this both in work time and educational fees from the NHS. Doctors in training receive clinical as well as educational supervision via the Deanery and GPs have elements of clinical supervision via their annual appraisal developed via the Deanery.

17. What arrangements should be put in place for self-employed health professional registrants?
Similar arrangements need to be in place for self-employed professionals and there need to be mechanisms for the costs to be claimed either by increased fees/ reimbursement or other suitable mechanisms. This includes self-employed independent contractors, and there must be mechanisms for funding remedial, education courses and for back fill if appropriate.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
This should be done through the National Planning Framework which should include markers of transparency and complaints handling. There should be standardisation of reporting and data collection across the NHS. There is still anxiety in the health service of a blame culture around significant events and adverse incidents and this needs to be improved. An improved mechanism to protect and support whistle blowers needs to be developed.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
It would help to have legislation to standardise complaints mechanisms across all health and social services in Wales with a requirement for reporting (without naming individuals concerned).

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Incompatible IT systems, inconsistent coding within departments and organisations, different coding in general practice and secondary care. Some information governance processes are too inflexible and bureaucratic. Consent systems are not always clear.

22. How can we consider breaking down any barriers?
Continue work to develop the individual patient record with patients to enable access (and share) their own records if they wish to, and develop facilities for the record to be corrected if appropriate. Developing shared coding mechanisms, improving secondary and community care IT systems and ensuring they are compatible with each other and general practice would also be beneficial.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Currently, if patient identifiable information is to be shared for non-direct patient care, then explicit consent for each use must be sought from the patient. Part of the contract between patients and the NHS in a publicly funded system, should be agreement to sharing of information for approved research (for the public good) with clear guidance (and ease) to opt out. There should be more public involvement in research governance and ethical approval.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
HIW must be independent of government and care providers. Any inspectorate system must have links to UK Professional Regulators. There must also be mechanisms, including central funding to enable remediation or re-education of groups or individuals identified via inspection. In general practice this needs to be linked to a robust occupational health service to support doctors who are fighting health issues to maintain services.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
The constitution and appointment of the governing body of any inspectorate must be transparent and free of political interference.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
A single inspectorate would be preferred. Otherwise a concordat for collaborative and joint working that avoids duplication but allows an assessment of total care.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
The advantages are simplicity for the public to access reports and the reduced chance of services falling between the two systems. It will allow a better assessment of whether joint working is in the client/ patients' best interests. The disadvantage is the system may become too complex and unwieldy to cover both systems.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Yes. A strong patient voice is needed and at present this is often disjointed and is difficult to source in an unbiased manner. HIW should include the patient viewpoint in its inspections. Dual inspections are inefficient and disruptive. There is nothing to stop CHC members contributing to HIW inspections and this would help with their insight into service provision.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
Yes, but it will need further development to incorporate support for citizens in a more holistic sense. CHC members are not "experts" so their advocacy role for example could also apply in social care situations. In order to ensure advocacy work results in change they must have roles in inspection and representation on health bodies.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
No.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
Yes, as they are legal entities.

32. 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?
Yes.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes. There must be transparency of approach. All Trusts are already providing IMTPs.

34. 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. Old legislation should not get in the way of enacting improved legislation.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Improved training and funding for training. Working in partnership with social services and third sector is new to many in healthcare and there needs to be support for this type of work, including a mechanism to share new ways of working and research to see if these are effective to enable evidence based development.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
LHBs should continue to have a small majority of non exec directors to ensure that execs cannot control the board. The director of PH should not be directly employed by the LHB but should be a non-exec director who should hold the exec to account to deliver the local public health needs. There needs to be an exec director focused on primary and community care to ensure the needed shift in effort to primary care occurs.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Yes, although we would prefer to see the same structures and titles at higher level in LHBs. It is difficult for outsiders to understand the differences and that can lead to delays in passing information to the right people.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
The community should be well represented but we prefer that they are appointed by community groups rather than open public election.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Yes, that is the only way we will get a truly engaged approach to integration.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Yes. Any alteration should be to enable local authorities to be co-terminus with local health boards.

NHS Trust size and membership

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
No.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
Yes, given the uncertainty expressed in the green paper.

45. How could potential conflicts of interest for the board secretary be managed?
Transparency is paramount to the board and to the public. Potential COIs should be declared and considered whether they significantly impair effective decision making or integrity. Potential COIs should not be an absolute bar to effective functioning.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
No. It is important that Welsh Ministers and NHS leaders receive expert professional advice formally through defined groups which are politically neutral and these groups have a statutory requirement to enable the views of those they represent to be presented to Ministers and NHS leaders in a transparent and equitable fashion. This is the role and reason for the current advisory mechanism. To be effective these need to be supported by the Welsh Government in terms of time and potentially, financially.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
There must be a statutory requirement to consult. The number and constituency of the statutory groups needs revising and reducing. Advice should be multidisciplinary but areas of difference should not be hidden.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
We need more detail. We agree that partnerships must take account of increased devolution and prudent healthcare approach.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
We would favour a single body responsible to LHBs and NHS Trusts for all

national support services.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
A new board and governance structure that ensures the organisation is primarily accountable to the boards and Trusts. Although the hosted arrangement has worked reasonably well, we can see that this arrangement may distract Trust boards from the services they directly provide and it is less clear how LHBs can consistently influence the workings of the shared services.

WGGP118 – Estelle Hitchon – Welsh Ambulance Services NHS Trust
Tref / Town – N/A

General comments

Introduction

The Welsh Ambulance Services NHS Trust welcomes the opportunity to respond to the proposals outlined in the Welsh Government's Green Paper, *Our Health, Our Health Service*.

The primary focus of the Green Paper on issues of quality and governance is significant, as these are the backbone of a strong, accountable and effective NHS in Wales.

In addition, the Green Paper consultation process has had considerable value in stimulating debate across the NHS, and more widely with stakeholders and the public, about the future shape of the health service in Wales. This is important in light of the current and future challenges faced by the NHS in terms of demography, finance and public expectation.

Given the unique role of the ambulance service in NHS Wales as a bridge between the emergency services more broadly and the unscheduled and scheduled care systems, we have reflected carefully on the questions posed in the Green Paper consultation document.

We summarise below some generic observations on the content of the Paper and respond to those questions posed in the response framework. Since the Welsh Ambulance Service has also contributed to, and supports, the very detailed response submitted by the Welsh NHS Confederation, we have not repeated its content here.

As a result, and given our status an all-Wales Trust with a relatively narrow service base, we have sought to target our emphasis on those areas where we feel our observations can help inform debate and decision-making, an approach that we hope is helpful to Welsh Government as it seeks to ensure that quality and good governance are at the heart of the health service in Wales.

Generic Observations

The Welsh Ambulance Services NHS Trust recognises and applauds the ambition of Welsh Government in wishing to secure a health service in Wales which "promotes physical, mental and social wellbeing" and one where we "do the right thing for people".

Similarly, a culture founded on continuous improvement and where consistently high standards are the norm is the shared ambition of the

overwhelming majority of staff who work in the NHS, and who show such dedication to caring for those most in need every day.

Therefore, we would contend that the basic premise of the Green Paper, i.e. that developing a policy framework and developing a culture across NHS Wales where this ambition can be realised, is to be welcomed.

What is less clearly defined in the document is the future vision for the NHS in Wales and this is something on which the Welsh Ambulance Service would welcome future debate. This is particularly the case as, in considering our responses to the proposals outlined in the Green Paper, particularly as they relate to legislation, it is perhaps difficult to consider the validity, or otherwise, of proposed changes to the legislative framework without this important context, given the role of legislation in enabling change.

The Welsh Ambulance Service is keen to engage with Welsh Government, health service partners, patients, the public and the many stakeholders who have an interest in the future shape of the NHS in Wales in developing such a vision and is committed to playing its full part in this important work.

Demography, advances in clinical care and the availability of treatments, financial austerity and growing public expectation have been features of the NHS planning landscape in recent years. The convergence of these factors has led to increased political, public and media scrutiny of the NHS in Wales, which, in turn, has stifled attempts to reconfigure services to deliver in the optimum way within the resources available.

By developing a clear direction of travel for the NHS in Wales, the major policy and other decisions which need to be made by Government and by the service to move further towards that vision can be more easily addressed, with the pace and cohesion needed to reflect societal and clinical developments.

It is in this context that the legislative proposals outlined in the Green Paper should be viewed. The development of a shared vision of the future of the NHS in Wales which is co-produced with the people of Wales, and which clearly sets out the steps that will need to be taken to achieve a health service that supports the health and well-being of the nation sustainably and effectively, will inform any future changes to the legislative framework.

On this basis, the legislative proposals currently outlined in the Green Paper may not, ultimately, deliver the anticipated benefits. On a broader note, it is a moot point as to whether legislating for “quality” will, in fact, provide the necessary focus on quality when the delivery of quality rests almost entirely on developing a culture of quality, rather than on delivering a process.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Given that the full impact of the Well-Being of Future Generations (Wales) Act is as yet unclear, and is likely to play a significant role in driving collaboration between the NHS and other public services in terms of the planning and delivery of health services, it would not be helpful at this stage to introduce further legislation without allowing sufficient time for the most recent developments in this area to bear fruit. In addition, it is important to note that collaboration between NHS organisations also needs to be strengthened to deliver optimum benefit for patients. Again, while legislation is not the solution here, there is a role for Welsh Government in enabling a culture and climate of collaboration, where genuine collaboration is recognised and rewarded. The latter may be considered as part of a review of the NHS Planning Framework. The Welsh Ambulance Services interfaces with health organisations across the country and is committed to partnership and collaboration with the wider NHS in Wales, as well as with the other emergency services and other stakeholders. This is a function both of need and of culture, rather than of legislative requirement, but is certainly an area where WAST recognises the benefits of a strengthened approach.

2. If so, what changes should be given priority?
While further legislation is not necessarily a solution, there is an opportunity to ensure there is clarity of purpose, both within the NHS in Wales and between health and other public services, to ensure that the expectation of working collaboratively to deliver better outcomes for the people of Wales is clearly and unambiguously articulated. In times of austerity, it is often the case that organisations retrench into silos in order to protect their services and budgets, which can sometimes be to the detriment of partnerships and the wider benefits which such collaboration brings. On this basis, behaviour change will be far more powerful than legislative infrastructure.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
As outlined above, the critical issue here is to allow time for the impact of the existing and, in some cases new, legislative framework to be fully understood. A constantly evolving legislative base does little to support integration, collaboration and improvement and serves only to impede progress by destabilising established structures and relationships. As outlined above, Welsh Government can play a helpful role in enabling a climate where

strengthened collaboration and partnership are supported and recognised.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Again, legislation does not provide the answer to the issue of public understanding and acceptance of service change. However, the co-production with the people of Wales of a shared vision of the NHS in Wales would assist considerably in effecting meaningful dialogue with communities. A national debate on the future of the NHS in Wales and the changes needed to deliver sustainable improvement is something which Welsh Government may wish to consider in the next Assembly period.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
All health organisations have a duty to work closely with their populations and to listen and act on the feedback they receive. The Welsh Ambulance Service's Partners in Healthcare Team discharges this responsibility for WAST very successfully. The key to effective community engagement lies in the NHS in Wales investing appropriate levels of time and resource into working with its many stakeholders to achieve shared understanding, shared ambition and improved services. In addition, as the Evans Review identified, concerns and compliments also provide a rich opportunity to learn and to work with the public on improving services. The challenge for the NHS in Wales is to create the dynamism and resource within organisations to engage patients and the public effectively. From a WAST perspective, establishing 'physical' patient panels or participation groups on an all Wales level is complex. This would require additional resources (human and financial). The administration of patient panels would also be potentially burdensome. When we have tested out the idea of local patient panels, we found representation was not as balanced as we would have liked .We would question the value of a patient panel and its representativeness across the different communities we serve, particularly when trying to achieve this on an all Wales basis. We agree with a continuous engagement model, but suggest that models and techniques need not be prescriptive. WAST currently uses multiple techniques, in line with the National Service User Experience Framework; for example, we have a virtual network of stakeholders who we know are diverse in their nature and cover all of Wales.

We are also committed to working with the full gamut of patient groups and CHCs as we drive forward our continuous engagement agenda.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
While this might seem an attractive option, securing representation on such a Panel that is suitably impartial, reflective of the population and which adds value to the process would be problematic. In the final analysis, referral to the Minister should be a last resort and is indicative of a process which has failed. This is a position which is rare and which could, and should, be averted through better planning, a more positive approach to engagement and clarity of vision. Therefore, introducing an additional level of bureaucracy would seem to add little value, especially given that it would be required, ideally, only infrequently.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Ultimately, enabling quality is about instilling a culture where quality is owned at every level of an organisation and by each person within it. It is about doing the right thing, in the right way, for the right person, every day. This is what the overwhelming majority of NHS staff strive to do every day, sometimes despite of, and not because of, corporate structures and approaches. In this respect, one of the key enablers are the Health and Care Standards which, if properly embedded within an organisation, have the potential to be a key quality driver. There is also the opportunity to refresh the Standards so that they extend across NHS and independent sector boundaries. On this basis, WAST is of the view that a great focus on behavioural and cultural change would be of greater benefit than attempting to legislate for quality.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
As detailed above, legislative intervention in the quality agenda is not deemed to be the most appropriate mechanism for instilling a culture of quality and improving services for patients.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
As detailed above, while legislation is unlikely to deliver the anticipated benefits in terms of further embedding a culture of quality within the NHS, there is merit in ensuring that mechanisms such as Quality Impact Assessments are mandatory across all agencies providing health and social care. This is a tool which WAST has used to good effect and which is helpful in supporting the development of a quality-based, patient-focus, clinically-led culture throughout the organisation.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
In introducing the role of "responsible individual", there is a risk that Boards of health bodies abrogate their responsibilities in relation to quality and good governance. This would be a retrograde step given the significant progress that has been made in recent years to develop the scrutiny and challenge function of Boards at non-executive director level and the embedding of the quality agenda across organisations, which has certainly gained much traction at both executive, non-executive and leadership levels in WAST. Investing this responsibility in an individual also seems to contradict basic principles of good governance and shared corporate accountability.

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
While the "fit and proper persons" test proposal has value, it needs to be considered in the context of the recruitment requirements at Board level, expectations around behaviours and competencies and the standards for individuals in public office set out in the Nolan Principles. At this stage in its development, it is unclear how this proposal might result in more effective, competent and positive leadership within NHS Wales.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
As outlined above, furtherance of the quality agenda is unlikely to be delivered by additional legislation.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Properly implemented, the Health and Care Standards have great merit in nurturing a culture of quality across the NHS. There is scope to further review the Standards to ensure their appropriateness and, following any such review, a more concerted focus on their implementation would deliver significant benefit in progressing the quality agenda.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Extending the Health and Care Standards to the independent sector would be a helpful means by which the improvement of outcomes and experience for citizens could be achieved.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Utilising peer review in sharing good practice and identifying areas of improvement is a key method in improving inter-agency collaboration and relationships. Such an approach could support the extension of the Health and Care Standards to the independent sector, in the interests of cross-sector learning and collaboration.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Clinical peer supervision, delivered well, is to be welcomed. Delivered well, such supervision provides important assurance to patients, the pubic and to individuals themselves. WAST is of the view that the development an All-Wales register of supervisors, supported via the roll-out of accredited courses to those who wish to fulfil the supervisory role, would enable registrants both to provide and receive supervision. However, this needs to be set against the role of existing national and professional bodies in provide accreditation to ensure there is no duplication.

17. What arrangements should be put in place for self-employed health professional registrants?
The effective clinical supervision of self-employed health professional

registrants could be effected through cross-sector supervision or peer review arrangements between the NHS and private practitioners.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
In light of recent concerns across the NHS about governance, accountability and openness, this is broadly welcomed. As outlined earlier, such a duty has to be taken together with the need to support the development of a culture of transparency and authenticity. It is also to be noted that professional groups already have a duty of candour placed upon them.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
At this stage, it is unclear to which elements of performance this refers. In terms of the Welsh Ambulance Service, its performance is one of the most heavily scrutinised in the Welsh NHS. Since October, WAST has been piloting a new clinical response model, the focus of which is on the appropriateness of the clinical care of patients as measured by a suite of clinical indicators. This is perhaps a model which could be adopted elsewhere in the NHS, in terms of focusing on clinical outcomes for patients rather than simply waiting times for treatment. This would provide greater accountability plus improved information for patients.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
The simplest way of achieving this is to standardise the process across organisations. The Putting Things Right process, while well intentioned, has done little to make it easier for patients to raise concerns. Given that this process is currently under review, it would seem sensible to look at shared opportunities with social services to bring systems and processes closer together. This is likely to become more important as the integration agenda moves forward and more concerns are likely to involve two or more agencies.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
This is largely a cultural rather than a process issue. The Data Protection Act provides the legal framework for the sharing of data between organisations. However, it is also often used, unnecessarily, as a reason not to share data, sometimes because of lack of knowledge of its provisions among staff, or simply because of a nervousness that data may be shared inappropriately. Also, concern over information governance has gained traction in recent years and this has added to a perceived reluctance to share information. Coupled with this is a straightforward inability or difficulty in sharing data because of the limitations and/or incompatibility of computer systems which "don't talk to each other". Resolving this will require both significant investment in IT systems and also a cultural shift in ensuring that there is both a clear understanding of the provisions of the Act and a willingness to share data where it is clearly in the interests of the patient to do so.

22. How can we consider breaking down any barriers?
As outlined above, investment in IT and in information security is important in this regard. In addition, further development of the Wales Accord on the Sharing of Personal Information (WASPI) arrangements and clear standards as to their adoption would also assist.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
This is supported, on the premise that the collection of the data complies with legislation and that the research supports the improvement of patient care.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
Effective mechanisms of regulation and inspection are critical in supporting public confidence in NHS Wales and, as such, it is important that the inspection regime is effective and credible. On this basis, it would be helpful to streamline the inspection regime and, given the move towards further collaboration and integration, a merger of HIW and CSSIW might be preferable. This would result in an inspection regime

which covered those public services focused on the maintenance of independence and well being, rather than drawing a fairly arbitrary line between health and social services' provision.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
An independent inspection body is to be welcomed in supporting greater public confidence in the regulatory process.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
This is an area where legislative change is supported to create a single inspection body. However, in the interim, it is acknowledged that a shared inspection framework and closer alignment with the work of community health councils would add value.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
Simplifying the process for the public can only add value. Many people are not aware of, and care little about, the distinction between health and social services provision and, in any event, further integration is beginning to blur those lines. On that basis, this would be a positive development.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
In WAST's view, the role of the CHCs is in helping people to navigate the system and supporting them to resolve issues when something has gone wrong. In this respect, it is about advocacy, recognising that this will bring with it a wealth of information and patient experience which should be used as part of the patient experience/organisational learning process. Similarly, the inspection role of the CHCs has merit in bringing a lay perspective to the quality agenda, which has considerable value. Currently, the CHC role is somewhat ambiguous in terms of its "patient watchdog" and advocacy roles. Being clear about the purpose of the CHCs would assist the public in using their services effectively, their brand recognition and potentially improve relationships between individual health bodies and CHCs.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
In developing a CHC model which works within an integrated system, the key must be a consistency of approach determined centrally, with shared standards and expectations, devolved to local level for implementation. Similarly, that cycle of communication needs to work from local level back to the Board of CHCs. In this respect, the Board of CHCs has a revitalised role to play, with the support of Welsh Government, in being clear about the role and expectations of CHCs at local level, recognising some of the synergies with the scrutiny and community leadership roles of local authorities at county, town and community level. The inspection/scrutiny role of the CHCs needs to be reviewed in tandem with any review of HIW.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
WAST is supportive of the borrowing regime being standardised across health bodies in Wales.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
This requirement is no longer relevant and WAST would be supportive of greater flexibility in this regard. A summarised NHS Wales account as a whole would provide a far clearer understanding to the public of the activities of the NHS.

32. 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?
As detailed above, WAST would support greater flexibility in terms of summarised accounts and acknowledges that any simplification of the reporting requirements would also be welcomed.

Planning

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

As an NHS Trust, the Welsh Ambulance Service would welcome an equivalent statutory planning duty for trusts, in the same way as health boards. This would support further collaboration and consistency across WAST's planning interfaces.

34. 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?
Given recent legislative developments, there is now an opportunity to ensure that planning duties are aligned to ensure consistency and facilitate better, more integrated planning. This does not require additional planning duties to be introduced, but rather a need to ensure that guidance is clear and consistent.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
The introduction of legislation to strengthen leadership, governance and partnerships is unlikely to deliver the step change or the anticipated benefits that are needed to create the culture of accountability, quality and collaboration on which an effective NHS is predicated. Legislation does not create the right conditions for cultural shift or behavioural change, and is likely to result only in additional administrative burden, rather than in delivering a more responsive and dynamic health service. However, a clear operating framework for NHS Wales, with clearly articulated incentives and sanctions, would help to drive improved performance and, by extension, drive better leadership, more robust governance arrangements and a culture where collaboration and partnership are the norm.

<u>LHB size and membership</u>

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
As a generality, the current size and configuration of health board membership is appropriate. However, collaborative decision-making across health boards with accountability for local populations remains a challenge.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
More flexibility to recognise the integrated nature of the NHS in Wales through

Executive roles would be welcome. For example, Chief Operating Officers have a critical, system-wide leadership role but do not fit easily within the current Executive Director regulations. A mix of clinical and non-clinical Executive Directors, rather than specifying exact posts, would be helpful in this regard.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
Notwithstanding WAST as a Trust, the all-Wales remit of the ambulance service would make it difficult to secure community representation and would result in a level of unwieldiness that would stifle effective decision-making.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Joint appointments are to be welcomed and supported, as there is considerable value to be added through such innovation. Whether this requires statutory provision is a moot point. Much of the lack of progress in this area can be regarded as a result of cultural intransigence rather than legislative obstruction. On this basis, it is an area which requires further exploration to understand the barriers to creating and sustaining joint roles and whether there is an alternative to a legislative solution.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
WAST has nothing further to add beyond what is already outlined in our responses above.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
In looking at the configuration of Trust Boards, the most significant factor is the ability of the Trust to flex its composition, particularly in light of the changing needs of the service, to better reflect organisational need. The current Trust Board composition of 13 members, of whom five are Executive Directors, does not allow for such flexibility. The Trust would be supportive of an increase in the number of Executives on the Trust Board to a minimum of six, with the Trust retaining the right to decide to which strategic areas of the Trust's activity it should accord Executive status. For example, the Director of Operations (a critical leadership role within the service) currently does not have Executive Status accorded to it. The Trust is strongly of the view that the composition of the Board is changed to enable

this to happen, whilst retaining Executive status for Directors of Workforce, Finance, Quality and Medicine. Similarly, given the criticality of the planning agenda for the Trust, with many partners across Wales, there is an argument for this position also to be accorded Executive status. The key message here is that flexibility to make changes to reflect current priorities would be welcome.

In extending the number of Executive Director posts, it is important to recognise that this may result in a potential imbalance between Executive and Non-Executive Director roles which would also need to be addressed.

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
In addition to the points made above, the ability to appoint formally a Vice-Chair would be welcome. The composition and membership of the Trust Board is set out in Standing Orders and is regulated by the National Health Service Trusts (Membership and Procedure) Regulations 1990 and subsequent amendments. Section 2.4(1) of Standing Orders enables the Trust to appoint one of the non-executive directors of the Trust to act as Vice-Chair on an annual basis. However, the role of Vice-Chair, as set out in Standing Orders, is not a statutory role and has no specific duties and responsibilities attached to it other than to deputise in the absence of the Chair. As such, no additional time is allocated to fulfil the role and no additional remuneration is provided. The same arrangements exist in the other two NHS Trusts within Wales. The situation in the seven Local Health Boards is different. The post of Vice-Chair is specifically established by regulation and carries with it duties and responsibilities beyond simply deputising in the absence of the Chair. For example, the Vice-Chair of a Local Health Board has specific responsibilities for primary care and mental health issues. The Vice Chairs of the Local Health Boards also meet independently as an all-Wales group and have regular diarised meetings with the Minister for Health and Social Services to discuss and develop the issues associated with their role. This is reflected in an additional time commitment and an increased level of remuneration. The post is also subject to a specific recruitment and selection process managed through the public appointments process. In recent years, the role and function of the Vice Chair of WAST has changed significantly. This in part reflects the more expansive role which non-executive directors are fulfilling more generally. However, it also reflects changes in the external environment which means that the Vice-Chair is being called on routinely to participate in collaborative and partnership based activities on an all-Wales basis. In particular, the Vice Chairs of all three Trusts are now routinely invited to join the Local Health Board Vice-Chairs for their meetings with the Minister and the associated tasks and activities which

emerge from them. It also fair to say that the Vice Chair is being asked more often to deputise for the Chair, whose role has similarly expanded as the Trust has become more integrated within the wider NHS. On this basis, provision to appoint formally a Vice-Chair, achieving parity with health boards, would be welcome, recognising that this may necessitate changes to remuneration and alterations to recruitment, by making the role of Vice-Chair a public appointment via the formal public appointments process.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
The role of the Board Secretary was clearly defined in 2009. Since that time, the role has evolved and, in some cases, has become closer to a Director of Corporate Services. Given the role of the Board Secretary in providing counsel to the Chair, Chief Executive and wider Board on matters of legislative and statutory compliance, it is important that steps are taken to ensure that there is a return to the original role descriptor to ensure that governance matters are adequately resourced. However, at this stage, moves to accord the role greater statutory clarity would be premature, as organisations have within their gift the opportunity to return to the original spirit and purpose of the role.

44. If so, what aspects of the role should be additionally set out in law?
As outlined above, further legislative steps should be considered only if, in future, the Board Secretary role drifts from its intended purpose and comprises the governance of an organisation or the impartiality of post-holders.

45. How could potential conflicts of interest for the board secretary be managed?
As outlined above, the role descriptor of the Board Secretary was clearly articulated in 2009. Assuming this is adhered to, there should be no conflict. Conflict is likely to occur only when the role also assumes operational responsibilities which potentially compromise the impartiality of the role/post-holder.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
WAST is of the view that the statutory status of the advisory committees needs review. There is an argument that they no longer encompass the broad

nature of advice that is required and that a review would be helpful in ascertaining the future nature of advice required, how and from whom this is sought.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
This needs to be reviewed on a broader basis which encompasses the role of clinical networks, professional bodies and other groups, for example, public and patient involvement groups, stakeholder reference groups etc. It should be noted that access to clinically expert advice should not be limited to that available only in Wales. For example, there is national network of ambulance service medical directors, facilitated via the Association of Ambulance Chief Executives (AACE), which provides expert opinion and challenge on matters as they pertain to ambulance services.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
It is currently not deemed appropriate to legislate to improve workforce partnership arrangements. The success or otherwise of such relationships is largely predicated on investing sufficient time in effective dialogue and on building relationships based on mutual understanding and respect.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
As an organisation which is set to host the 111 pilot and one which has a significant element of its work commissioned (via the Emergency Ambulance Services Committee - EASC), WAST fully acknowledges the complexity of the governance arrangements which such structures impose. A clear accountability and governance framework, coupled with consistent models of hosting, commissioning and shared services, would be of significant benefit to the Welsh Ambulance Service in this regard. By way of positive example, the commissioning and accountability framework which WAST has developed collaboratively with EASC, Welsh Government and the Chief Ambulance Services Commissioner provides clear accountabilities and performance indicators which minimise conflict and provide clarity to the organisations involved as to roles and responsibilities.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?

While WAST acknowledges and supports the principle and potential of a public sector-wide shared services function, it is believed that further sharing of services within the NHS should remain and assume a greater significance and focus.

There is clearly potential for NWSSP to move into this broader space in the medium term and proposals at an appropriate future juncture would be welcomed.

WGGP119 – Mark Donovan – Boots UK
Tref / Town – N/A

General comments

We fully support the ambition, set out by the Minister for Health and Social Services, for "a huge shift towards preventative and primary care" in which pharmacy, eye health and hearing care will play an important part. We are pleased to respond to this Green Paper on the future for the health service in Wales.

Chapter 1: The changing shape of health services
In general, the current legislative structure around community pharmacy, community ophthalmic services and community hearingcare works reasonably well. It has allowed a well-developed and competitive market to develop in which businesses compete on accessibility and quality of service to provide comprehensive NHS services to patients in Wales. The reasonable stability and predictability of the market gives businesses confidence to invest in staff, premises and services.

However, there is still considerable room for improvement in the development of a full range of "preventative and primary care services". We would like to see the wide definition of primary care expressed in the Green Paper – going well beyond just GP practices – translated in to full recognition and action at a local level.

For example, we would like to see community pharmacies able to deliver standardised public health services at scale to benefit the whole population. We would also like to see NHS audiology services delivered in primary care locations, delivering services that are both more accessible to patients and more cost-effective.

In addition, we would like to see all contractors providing NHS primary care services in the community represented and involved in Primary Care Clusters. In this way, the skills and accessibility of a wide range of healthcare professionals and their teams can be harnessed.

This is especially true for preventative health, including screening, vaccination and public health services. There are many patients who rarely visit GP surgeries. They (or their families and carers) are much more likely to be frequent visitors to community pharmacies or optical practices, providing opportunities to deliver health messages, brief interventions or preventative health services that support the prudent healthcare principles of achieving health and wellbeing through co-production. NHS Wales will achieve its aims for preventative health more effectively and quicker if it does not have to rely solely on already over-worked GP practices.

Although the Green Paper naturally focuses on the legislation that is within the control of the Welsh Government, it should be recognised that healthcare professionals and independent contractors to NHS Wales also have to operate within a wider frame of reference. This includes legislation (such as on medicines or employment) set at a UK, GB or England & Wales level and professional regulation that is set at a UK or GB level, and which is frequently drawn from frameworks set out in European Directives. Healthcare professionals need to be aware of their responsibilities in all these aspects. Welsh Ministers may often have influence over how these regulations and frameworks are prepared and what they contain.

In our view, these cross-border arrangements are working well for NHS Wales and for businesses operating in all parts of the UK. They provide security and assurance for patients and professionals and help reduce inappropriate variations in care.

Chapter 2: Enabling quality

There is already a considerable volume of regulation, at both Welsh and UK levels, around safety and quality of health and care services. We are not persuaded that more regulation will, of itself, increase or maintain quality. It may even serve to divert activity towards process rather than patient care.

Community pharmacies have legislation[32] that sets out the requirements for a "Responsible Pharmacist" in charge of each pharmacy. All pharmacy companies (other than sole traders) have to have a Superintendent Pharmacist who has corporate responsibility for quality and safety across the business. We do not see any requirement for additional legislation in this area.

The Public Health (Wales) Bill, currently being debated by the National Assembly for Wales, will bring in a requirement for Local Health Boards to prepare Pharmaceutical Needs Assessments (PNAs). These will set out current provision of pharmaceutical services in an area, anticipated future population needs and any gaps that could be filled by additional services or, as necessary, new pharmacy openings. We would like to see the PNA process being included in the Integrated Medium Term Planning (IMTP) framework.

Chapter 3: Quality in practice

Although we understand the desire for common standards across all health services, including primary care, we find it difficult to envisage how this could be applied at anything other than a very high level of ambition across all healthcare settings.

Health services are provided by a huge variety of organisations (from large hospitals through to individual independent contractors) and these have an enormous range of corporate structures (from NHS bodies and charities through to multi-national corporations). As such, we anticipate that it would be

[32] Responsible Pharmacist Regulations 2009

very difficult to frame legislation that was sufficiently flexible to cover all these scenarios while still bringing any meaningful degree of harmonisation.

In this respect, the focus needs to be more on the quality of the service experienced by individual patients and the outcomes that follow rather than any organisation structures and processes.

As mentioned above, healthcare professionals have to operate within professional legislation and guidance that is normally set at a UK level. It would be unhelpful if there were any perceived conflicts between these, especially in terms of each professional's responsibilities for the patients in front of them.

In terms of clinical supervision, all community pharmacies (other than sole traders) are required to have a Superintendent Pharmacist, with overall responsibility for clinical and professional issues.

The General Pharmaceutical Council (GPhC) is planning to bring in professional revalidation (now generally referred to as "continuing fitness-to-practise") in line with other health professional regulators, and in light of their experiences. This is expected to start in 2018. We would not see this area as being within the legislative competence of the Welsh Government and would certainly not expect to see different professional requirements being set up across the UK.

Chapter 4: Openness and honesty in all we do
A statutory duty of candour has been introduced in England and Scotland and would support the Welsh Government's agenda as well.

Chapter 5: Better information, safely shared
The main barriers to sharing information are technical and cultural. Each needs to be addressed in different ways.

Technical solutions to allow information sharing are being put in place. These need to recognise the wide variety of corporate structures outlined above and not assume that all health providers are NHS bodies. They also have to be aware of other regulatory requirements around corporate and information governance, including that data may pass through systems established on a UK-wide basis.

Technological barriers can normally be overcome with time and effort. The much bigger barriers are cultural. There are two major issues that need to be overcome in this. The first is "ownership" and the second is "sharing".

Ownership We observe that there is a long-standing and widely held belief among medical professionals that they "own" the data in patient records and, because of this, they own the patient (and any associated funding). This mindset inhibits the wider sharing of clinical information.

It would be in keeping with the principle of co-production if the Welsh Government clarified publicly that **patients "own" their own health records**, wherever these are stored or held. All health professionals have a right and indeed a duty to be contributing to health records, including having professionally-appropriate read/write access to electronic systems. Patients should have an expectation that their data is available to all healthcare professionals involved in their treatment (with consent from the patient).

Sharing Alongside ownership, there also appears to be a very commonly held belief that "data protection" makes it impossible to share any personal or health-related data.

Again, the Welsh Government needs to make it clear that, where appropriate and with consent, **sharing patient records or data is permitted** for healthcare professionals and that clinical information should not be withheld from others without good reason.

It takes time to change deep-seated beliefs, but the Welsh Government has an import role to play in standing alongside patients to say that, with their permission, information can and will be shared so that they don't have to go through the frustrating process of continually repeating themselves and that, by sharing information, it will improve the quality of the care they receive.

We believe that the deeper and broader shared clinical records become, the more useful they will be to patients and healthcare professionals. Community pharmacists, eye health and hearingcare professionals all have information and knowledge to add to records and, in turn, their clinical decision-making will benefit from access to data, observations and test results conducted by others. The work being done to underpin the Common Ailment Service is a good example of how wider sharing of records and information will help patients and healthcare professionals to deliver the most appropriate and prudent levels of care. We believe that this should be rolled out across Wales as quickly as practical.

Chapter 6: Checks and balances

As in Chapter 1, the Green Paper concentrates on the "third line of defence" that exists through regulation in Wales. This needs to be seen and developed in conjunction with what we might call a "fourth line of defence" that includes regulatory bodies operating on a UK-wide basis. These include health professional regulators and bodies such as the Medicines and Healthcare products Regulatory Agency (MHRA).

We recommend that Healthcare Inspectorate Wales (HIW) should have have fully-developed memorandums of understanding with these regulators to avoid duplication of inspection and to ensure that warning signs of poor quality care are widely shared.

In terms of Community Health Councils (CHCs), these seem to be working well in relation to community pharmacies, eye health and hearingcare

providers. Very few complaints are made to CHCs about these services and we are unpersuaded of the need for any radical change in this area.

Chapter 7: NHS finance, functions and planning
Our main comment in this area is that the current structure of seven Health Boards appears to strike a good balance that supports local involvement while also reducing duplication of effort – a demonstration of the principles of "do only what is needed, no more and no less" and a contribution to reducing inappropriate variation. We do not believe that there is any pressing need to increase the number of Health Boards

Chapter 8: Leadership, governance and partnerships
We believe that the statutory Welsh Pharmaceutical Committee serves a useful purpose in bringing together a wide range of pharmacy bodies from across the sector, including NHS, pharmacy contractors, professional bodies and specialists, to give comprehensive advice to the Minster. We understand that this advice is valued. We are unpersuaded of any need for change and would be extremely disappointed if this statutory body was to be abolished in favour of more informal structures that lacked the same wide-spread involvement and credibility.

Response to specific questions

No response to specific consultation questions.

WGGP120 – Pam Wenger – Welsh Health Specialised Services Committee
Tref / Town – N/A

General comments

1. WHSSC, as an organisation, although focused on the commissioning of specialised and tertiary services, is keen to foster a mature, holistic view of the broader healthcare landscape. Efforts in primary and community care may ultimately reduce the demand placed on a range of tertiary services such as bariatric & cardiac surgery. This is to be welcomed.

2. The Integrated Medium Term Planning process should serve as a mechanism to ensure quality and to develop learning cultures at an organisational level.

3. In the context of commissioning services outside of NHS Wales, it is important that the barriers to sharing identifiable information between NHS Wales and NHS England are overcome. Any changes must be taken into consideration alongside the Cross Border Protocol.

4. There is a strong argument for the merger of HIW with the Care and Social Services Inspectorate for Wales (CSSIW) or, at very least, a move to a greater degree of collaboration. This is likely to remove undue complexity and to provide far greater clarity for patients and other service users.

5. CHC's should be retained as one of several vehicles for patients to express their views. It should be ensured that they are properly representative of the communities that they represent. Further, given the move toward closer co-operation between services, some alignment between CHC's and service user bodies charged with the oversight of local authorities could be advocated.

6. There are different arrangements in place across the Joint Committees such as NWSSP, WHSSC and EASC and it would be helpful if there were clearer accountability and a consistent approach across Wales.

7. The independent members of the Joint Committee occupy their positions by virtue of being independent members of the health boards. This presents a potential conflict of interest at times which could be avoided if independent members were appointed directly to the Joint Committee.

8. Each Board should be allowed to vary its own structure and make-up. Current regulations will need to be altered in order to realise such a change in practice. Discretion in this area would allow for a useful degree of flexibility.

9. The structure of the Joint Committee is set down in the Directions and Regulations which includes the Trusts as Associate Members. It would be

more beneficial if there was greater flexibility for the Joint Committee to appoint Members to meet the specialised commissioning needs of Wales.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The HSC&WB Act and Well Being of Future Generations Bill need to be implemented and embedded before consideration is given to further legislation. It will be important to assess the effectiveness of joint planning arrangements and clarify the governance arrangements of the revised arrangements.

2. If so, what changes should be given priority?
See above.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The existing governance structures within NHS Wales are complicated and not easily understood. However, the goodwill of individuals or collective agreement on common goals will often circumvent these complexities. There is a risk that the introduction of further legislation may only serve to make the position more complicated and complex. The Green Paper provides the opportunity to review, remodel and, where applicable, rationalise existing models and structures. This should take place before any further legislation is considered. This is essentially about building relationships. From the specific perspective of WHSSC, the dual role of health boards as both commissioner and provider sometimes creates conflicts of interest to joint working between health boards.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
With the development of GP clusters and new models of care in line with the principles of Prudent healthcare the level of service change is likely to increase. It would be helpful to define the level of service change that requires engagement and/or consultation. At a time when partnership working is increasing and the health impact of

changes made by all public service bodies needs to be understood it would be beneficial if a similar process could be adopted across health and social care as at present the requirements to consult are much different in health than local government. NHS Wales has established a number of Joint Committees and Collaborative arrangements which makes the process of engagement often complicated. Further work is required to understand where the responsibility for engagement and consultation lies. There have been previous examples where decision making has been delegated and clarity is required whose responsibility it is to consult on service proposals/changes where they affect the wider NHS population.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
As the Green Paper states, Health Boards are already under a duty to involve and consult local people and their representatives in the planning and delivery of health services. Whilst we agree there is a need to ensure consistency and best practice across Wales, we believe that this can be done through the existing mechanisms that are already in place rather than through legislation. It is important in specialised services to be clear where engagement is with patients or representatives of users of specialised services and where engagement is with the public or their representatives. The views of these two groups are likely to be different and both need to be understood and considered throughout the planning process. As referred to in the section above, further clarity is required in terms of the process of engagement where services are commissioned on a pan Wales basis. Clear criteria should be agreed to ensure consistency across Wales, however, this could be undertaken locally.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
It is important for NHS Wales to consider previous arrangements which have involved a panel approach and which have not assisted the NHS with service change / reconfiguration. While this could be construed as an additional tier of bureaucracy, the view of independent experts could assist in making difficult decisions greater transparency on the consideration of longer term impacts as well as political commitments and the timing within election cycles.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
If legislation is introduced, it should make quality the focus for the integrated systems rather than, as is now, other measures such as finance. We recognise that in the NHS quality is paramount and there is an escalation and intervention framework now in place across NHS Wales. However, there is an imbalance between the financial and quality duty, with the former more easily defined and measured that need to be addressed in any changed approach.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
In considering service change there is currently no requirement to complete a quality impact assessment, whereas there is for finance; equality; health needs etc. In the existing economic climate, the reality of the situation is that there is a balancing act to be achieved in considering financial pressures with maintaining quality of service provision. Therefore the gap that needs addressing is making “quality” count and matter. The Health and Care Standards were introduced to focus on quality and improving patient care, however there are no tangible repercussions if you do not meet all of the healthcare standards, however there are significant consequences if financial targets are not met.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
We need to be clear what we mean by quality, especially in an integrated health and social care environment. In considering service change there is currently no requirement to complete a quality impact assessment, whereas there is for finance; equality; health needs etc. The views of the experts and the public are much different on this and the need to engage with people on this was stressed in Trusted to Care. It may be more appropriate to consider how we could establish safe standards that could ensure consistency across the system and would have the same monitoring and audit arrangements that apply to the financial systems and the Annual Quality Statements would then have primacy and would be resourced accordingly.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
Given the issues above regarding quality it is difficult to see how such an individual could be responsible or accountable. Accountability lines within the NHS Wales at HB / Trust level are already clear , but it may be helpful to highlight the importance of health board’s responsibilities for quality of services for their residents in their commissioner role as well as there provider role.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
Following the aftermath of recent failings in managing quality and care standards within the NHS the principle of the introduction of a “fit and proper persons” test is supported. However, this should not distract from the primary responsibility of the employer to check that their Board members are competent in discharging their roles and responsibilities effectively and that they behave in a fit and proper manner and continue to do so for the tenure of their employment.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
The term integrated planning refers to the integration of the systems within the NHS, whereas the HSC&WB Act and Well Being of Future Generations Bill is aimed at broader service integration and quality (however defined) needs to be seen in this context. Many of the quality targets set down by Welsh Government are related to accessing services and it is the core Tier 1 targets on which health organisations are held to account. There is very little reference to commissioning of services and we need to ensure this is integral to our core business. If quality is to be promoted as indicated this needs to be the core requirement within the planning framework and guidance. This will then lead to a full focus on quality throughout the system.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
This should be viewed in light of the section on quality. As indicated there may be merit in setting safety standards that can be easily monitored.

Again the standards apply to the NHS and it would be helpful to have an integrated set of standards across Health and Social Care. This is particularly important given the changes in legislation such as Health and Well Being Act. The standards are mainly provider led and as integrated organisations it is important that reflect all the accountabilities of HBs/Trusts.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
A common standards framework would be supported across Health and Social Care including the Independent Sector. This has implications for the function and role of regulators. Work has been undertaken in terms of the commissioning frameworks for CAMHS/ Adult Mental Health which has set out an agreed set of standards of care, this works needs to be applied to all equivalent NHS provided services and the procurement framework approach extended to all contracting arrangements with the Independent Sector.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Peer Review is an important process and whilst there have been examples of how this has been used across the service, it is time consuming and important that it is seen as an integral part of a role/s and not an add on. This could be a role of new Wales Clinical Networks but there are already a number of national bodies that provide accreditation and these need to be utilised fully to avoid the risk of duplication. There would be a need to consistency of approach which would be agreed by the Health Boards and apply across Specialised Services. Whilst this would have much benefit across the whole system, this is a decision that could be taken at a local level and does not require any changes to the legislation framework.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Do not support the suggestion that this should require legislative changes as this would create more of a burden on organisations and individuals and this needs to be linked to the introduction of revalidation for nurses (from April 2016), and other professions to follow. There would be significant resource impact (in particular, on time) if this would to be legislated and this would require additional funding to health boards to ensure appropriate resources are allocated to undertake the role of Clinical Supervision. There must be a clear framework to avoid duplication.

17. What arrangements should be put in place for self-employed health professional registrants?
Nothing specific to add, although broadly, indemnity should be considered.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
We are broadly supportive of the introduction of a statutory duty of candour. Candour (and its close allies openness and transparency) permeates throughout Mr Francis' report. Out of his 290 recommendations, several are drafted with those themes in mind. It is difficult to dispute that these are laudable recommendations. Promptly identifying negligence and providing redress for the patient and their family should be encouraged. Doing so quickly and efficiently will reduce expenditure on legal costs and should provide a better experience for the patient and their family. It is likely that health boards/trusts will be required to draft candour and disclosure policies to ensure all staff are clear about what their obligations should be in order for them to avoid liabilities arising. While criminal sanctions may arise for senior individuals, trusts may also be held vicariously liable for the actions of their employees. However, there are other forms of redress and remedies that already exist for potential claimants and which may be more easily proved in a civil claim. Training on such policies may also be required.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Unclear how legislation could improve transparency, as this needs to be cultural/behavioural change. The performance framework for NHS Wales should ensure that NHS organisations are measured in terms of their transparency and openness. Performance is regularly monitored by the Joint Committee, however there is a need to ensure that this links with the Health Board's performance reports. National IT systems should be available to allow NHS organisations to make their performance information publicly available and reportable. Need to be clear and align as much as possible with the current information systems and requirement in England as the commissioning of specialised services for welsh resident is often from a mixture of providers in NHS Wales and England.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
There are already well established good practices in place for the joint investigation of complaints e.g. WHSSC and Health Boards. The principles that there should be integration across Health and Social Services is supported. The complaints process should be an integrated process which ensures that the same principles and processes are followed. Health Boards work across health boundaries and the current system NHS Re-dress allows for organisations to agreed the lead organisation and respond to individual complainants. There is an opportunity as part of the review of NHS Re-dress that this also includes primary and social care.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
There are many perceived barriers to sharing patient information across the health and social care system. These are set out in the ICO response, these issues may increase as joint information systems are developed.

22. How can we consider breaking down any barriers?
The main issue here relates to consent and the reluctance to share personal information without explicit consent. The Welsh government has recently moved to a position of presumed consent for organ donations, following consultation and the adoption of a similar approach for personal information would create a paradigm shift in behaviours and approach.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
It is vital that our patients have confidence in our ability to protect their privacy, comply with the law and safeguard their personal health data. Data users within the health service must ensure that they obtain information about their patients properly keep it secure and handle it in accordance with the well established rules of medical confidentiality and the provisions of the Data Protection Act 1998.

Research which makes use of existing patient identifiable data (and stored samples) must comply with NHS Caldicott Guidelines and have the permission of the health boards' trusts Caldicott Guardian. For WHSSC there are specific arrangements with the Host HB. However, it is worth considering whether separate arrangements should be in place for Specialised Services.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
The role of HIW needs to be reviewed in the light of the move towards integrated health and social care provision. The role of the regulator in the English NHS is seen to be much more powerful than in Wales due to both the way inspections are carried out and the sanctions they have.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
The NHS needs a strong and effective Regulator and it is likely that the Public would have more confidence in the Regulator if it was independent (not arms length) from Welsh Government.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
As indicated previously clarity is required about what is being inspected and whether this relates to core minimum safety standards. If these are joint standards between health and social care then a single inspectorate would be advantageous.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
With clear minimum standards and a single inspectorate it would mean the arrangements are easy to understand. The main advantage to citizens would depend on the methods of working and the way people can be engaged in the monitoring processes.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to

strengthen the CHCs role as representatives of the patient voice?
The role of the CHC is an important one which should be maintained. Refocusing their role on representing the patient voice and improving advocacy services seems an appropriate way forward, providing that clear mechanisms and structures are established. In order to do this effectively their membership will need to be reviewed and be representative.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
There is a lack of clarity in this field which may lead to duplication.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Yes – providing Health Boards with borrowing powers, within defined limits, would provide a better incentive for boards to use capital investment as part of their strategic plans. Local borrowing could enable greater flexibility to implement service change particularly as the balance of care changes. Borrowing may also incentivise boards to make more efficient use of capital resources which otherwise be seen as a free good.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
As a hosted body, WHSSC accounts are consolidated into the host body and reported through their governance arrangements.

32. 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?
Greater flexibility regarding NHS Accounts for Health Boards would be welcome particularly in the context of three year financial duties.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
The Health Boards should be accountable for the planning of services for their resident population the role of Trusts is different. However, there should be a

similar duty which expects Trusts to have approved plans and strategies to deliver services against the commissioning plans of health boards. There should be a planning duty on Trusts in order to ensure that planning for Trust services is more directly linked in with the commissioning plans of health boards.

34. 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?
Nothing further to add than what is already covered in this section. Support the principles of a one system approach across Health and Social Services and the impact of this new legislation should ensure alignment. Do not support the review of the act to create even more complex governance structures than what already exist. Provision of planning and delivery of social care should be integrated more closely with health services.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
As indicated earlier the governance arrangements in NHS Wales are complex, as highlighted by WAO recently. The governance arrangements could be simplified greatly if an all Wales body was created to manage All Wales service matters. As currently stands, a number of Joint Committees have been established with directions and regulations. These different governance models can often make decision making complex and difficult to understand. Each of these governance structures has a range of governance document to support their operations including standing orders, standing financial instructions etc. A recent review of WHSSC governance arrangements highlighted several areas which could be strengthened to some effect. The review indicated that confirmation of delegated responsibilities would be beneficial. It was also recommended that consideration be given to the notion that WHSSC be hosted by a national organisation. Furthermore, there is a need to ensure that the role of the Director of Specialised Services is consistent with that of the lead officers at the other hosted bodies. Currently, this role does not have accountable officer status and the Director is required to report to both the Chair and the CEO of the host organisation.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
The current Health Board membership is based on a stakeholder model. This has advantages but does not mean there is an effective focus on decisions. The current Board configuration of 21 members is considered too large. As a Joint Committee of the 7 Health Boards, the Independent Members are drawn from the Health Boards, some of who are major providers of specialised services. This can cause a conflict of interest at times as the individuals are directly accountable to the Chair of the Health Board. The Joint Committee model for WHSSC supports the principles of Independent Members, however to be truly independent these should be appointed by the Chair of WHSSC and held to account for their role. A further complication is that the commitments of existing members often do not allow for the appropriate time to be allocated to WHSSC duties.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
The regulations for WHSSC set out the number of Directors which are Officer Members and Members of the Joint Committee. This does not account for the Director of Planning, and as a commissioning organisation is an oversight. WHSSC should have the discretion, as the Trusts do, to appoint a number of Directors to meet the needs of the organisation. Given the differing size and complexity of Health Boards some flexibility in terms of director roles is essential, but a common core would ensure a level of consistency.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
The utility of such suggestions depends, to a large degree, on whether there is an intention to move more towards stakeholder Boards.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Local organisations will need to determine the extent to which alignment is appropriate once the nature of Local Government reform can be fully appreciated. Enacting legislation than requires closer alignment at this time may be more restrictive than empowering.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Health organisations should be given more freedom to appoint independent members with the skills that the board feels it needs rather than the current model, which is prescriptive.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
Nothing specific to add.

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
Nothing specific to add.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
The role could be set out within the SI. The Local Government (Wales) Measure also provided a statutory resource to support the Monitoring Officer is undertaking his/her duties, specifically the appointment of a “Head of Democratic Services” role to fulfil the corporate requirements of the role. The Board Secretary should be competent and possess the relevant qualifications and be professionally accountable to Welsh Government consistent with other board level posts. The most important issue is more related to the status of the Board Secretary and changing the role title may assist in ensuring the role is perceived at a senior level e.g. Director of Governance or Corporate Services.

44. If so, what aspects of the role should be additionally set out in law?
Linked to the above response additional aspects should include the BS role as a statutory role with a specific job description that would be included in standing orders so as to avoid deviation of duties across different HBs/Trusts. Further clarity is required whether the role of Board Secretary equally applies to the Committee Secretary role for the Joint Committees.

45. How could potential conflicts of interest for the board secretary be managed?

There would not be conflicts of interest if the role is clear, professionally discrete, with no broader operational management responsibilities. The importance and status of the role may also be strengthened if there was a professional head within Welsh Government.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
The role of the current statutory advisory committees and supporting infrastructure is complex and not transparent to the public. There are strong arguments to simplify the structure and make it and the advice, more transparent and accountable. This may require change to the statutory status of the current committees. The Clinical Networks have also been reviewed recently and it is important that the work led by the service is integrated into any proposal to change the way in which the Ministers obtain clinical advice.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
Nothing specific to add.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Nothing specific to add.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
There is a need for a set of common definitions unequivocally describing the precise nature of hosted, joint and shared services and for clarity in respect of the associated governance arrangements. The current framework does not allow for Health Boards to host organisations unless set by Direction. All NHS Wales organisations should be given this power. The increasing number of hosted bodies, committees, etc. has created complex governance arrangements which are often difficult to operationalise. The collaborative arrangement for some committees is difficult with Providers and Commissioners as part of the decision making process and independent members drawn from the Health Boards.

A review of the current arrangements will enable simpler governance arrangements, more consistency across Wales and also integration where feasible. The complexity and differential governance arrangements in place for NWSSP, WHSSC and EASC create confusion and could be greatly simplified.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Nothing specific to add.

WGGP121 – Chris Whitehouse – Urology Trade Association
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
There should be a requirement for health boards, primary and independent health service providers to consider patient choice as part of the local planning process and through its work with Community Health Councils (CHCs) Patient choice is important for patients with continence issues who rely on having access to a wide range of products to meet their specific needs. Patients being unable to access products that meet their own specific needs can lead to product wastage, an increased incidence of urinary tract infections due to the products invasive nature, and an increased reliance of health and social care services – leading to increased costs to the NHS and putting patients' lives at risk. The UTA is concerned that patient choice is restricted due to CCGs introducing local formularies to steer patients towards cheaper products. Inappropriate products can hinder independence and increase reliance on the health service and costs in the long-term. There is therefore a need for health boards to implement long-term decision making which focuses on the best interests of the patients as well as the impact on budget across the whole health service.

2. If so, what changes should be given priority?
Statutory requirement to consider patient choice as part of the local planning process. Health boards should also be encouraged to fully plan to achieve long-term cost savings.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
While legislative change may not be required, health boards should be encouraged to raise awareness of the management of continence care for those with neurological and other long-term conditions, as part of any local

services plan. Healthcare professionals should also be trained on these issues so that those with neurological and long-term conditions are able to talk opening with trained health professionals about their conditions.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Yes. There is often inconsistency in the provision of continence services across local health boards which impacts on the estimated 150,000 people living with continence problems across Wales. Establishing a permanent engagement mechanisms as described will not only ensure that patients are fully involved with decision making, it will also allow patient views to be represented in the design and provision of continence services. The Urology Trade Association believes that patients should be at the heart of the NHS, encouraging better engagement though open and transparent consultation processes.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
The Health and Care Standards framework provides a good foundation for delivering good standards of care. This is however undermined by the fact that NHS organisations are not legally required to comply with it. Continence patients within Wales must be supported to manage their continence problems independently where possible. Intimate healthcare needs often inhibit patients' ability to self-care and can impact on A&E admissions and in-patient stays, due to increased infections and reliance on the health service, and should be prioritised to support best outcomes for the patient and the NHS. A report published by the Unplanned Admissions Consensus Committee in November 2015 found that there was a general lack of knowledge amongst GPs of continence care and that they were unable to tell the difference between products. It also found that the NHS spent £434 million in 2013/14 treating 184,000 patients with unplanned admission related to UTIs. The framework requires health services to ensure that continence care is appropriate and discreet, and that prompt assistance is provided as necessary, taking into account people specific needs and privacy. Making it a statutory requirement to meet the standards set out within the framework would help ensure that all providers deliver consistent standards of care across the NHS in Wales.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes. Currently, there is a statutory obligation for independent healthcare services to meet the National Minimum Standards for Independent Healthcare Services in Wales. These standards make no references to continence care. Consolidating the standards within the framework, with a legal obligation to comply with them, will ensure there is consistent care across the NHS in Wales. Consolidation will reduce the variation in services across Wales and allow patients to have access to a wider range of products, leading to better use and management of NHS resources. We urge the Welsh Government to enforce baseline standards of care across all services to guarantee consistency of care.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes but it should deal with systemic failings rather than just individual or team failings. The Welsh Government should also ensure that there is a portal for patients to make incident reports.

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Yes. Streamlining the duties of CHCs will allow for more capacity and divert resources to representing the patient voice, advocating for people wishing to raise concerns about care. This will reduce waiting times for meeting with patients and the bureaucratic pressures it currently faces as a result of its duty to carry out inspections and propose service change.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

39. Local government reform is underway; should there be a statutory

provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
A statutory provision for joint appointments will allow for better needs assessment and integrated preventative action for public services.

WGGP122 – Jamie Woodward – Faculty of General Dental Practice UK
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Yes. After 15 years of trying, the concordat between Health Boards and Social Services remains extremely tenuous.

2. If so, what changes should be given priority?
Whilst cost pressures are evident within both the health and care sectors, it is imperative that there is more joined-up thinking. Common metrics between health and social care, and the sharing of budgets where appropriate, are priority areas.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Integrated leadership and goal setting must be a top priority, for instance area-wide leads covering health and social care, rather than health authorities and local authorities operating separately. While in some areas, there are existing good examples of joined-up working across the health and care professions – for examples, dentists visiting care homes to educate staff in the importance of cleaning patients' teeth – there are many other patient groups, such as all people in care, young people, and disabled people, who could equally benefit from integrated care approaches. Despite the example above, in general staff work in silos, budgets are separated, and aims and objectives are not aligned. A national approach is required to ensure such integration happens on the ground.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
There is a need for public involvement by right - rather than merely by

expectation - in decision-making processes and in the development of strategy, and the law could be reformed to achieve this.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Yes.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
No. The minister should retain control and accountability.

Chapter 2: Enabling Quality

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Yes

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
An array of different bodies within dentistry have stated aims which include the improvement and application of standards, however they often use different standards, leading to confusion within the profession. For each organisation to devise their own standards implies the standards of other organisations are either inadequate or improper, which is not the case. There are organisations such as the Royal Colleges whose specific role is to improve quality and set standards. It is time their standards were used universally in order to halt the confusion.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Peer review and audit were previously contractual requirements. There is a robust system within dentistry at postgraduate level. It is important that this is maintained and thought given to ensure all members of the professional team can participate.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
The maintenance of the role of the CPD tutor within dental postgraduate departments is essential. If legislation is required to do this, then we would support it.

17. What arrangements should be put in place for self-employed health professional registrants?
FGDP(UK) does not believe that all self-employed dentists need on-going clinical supervision. There is currently a gap in the monitoring of competencies, and the identification and addressing of poor performance. However, we believe that sufficient data is already collected to identify poor performance, and therefore that the means of addressing such performance is by continuous monitoring and targeted supervision using this data.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Whilst there is no Duty of Candour in Wales, FGDP believes that the wealth of data already published as a result of the culture of openness within governance which has existed for many years, means there is no need to use legislation as there is already sufficient transparency on performance.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
There is a lack of IT infrastructure, and a lack of overarching system design, which leaves health care professions other than medicine without access to secure information sharing, electronic referral and standardised open information.

22. How can we consider breaking down any barriers?
Barriers could be broken down by integrating Information Technology to improve infomatics throughout the system; allowing all health care professionals access to secure information sharing, electronic referral, Summary Care Records and open information which is standardised on RTT times, success rates and public health information.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
There is no need for patient identifiable information to be collected and shared for purposes other than direct patient care, including research.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
There are currently a number of different inspectorates which use a variety of standards. It would be helpful for the dental profession and the public if inspectorate bodies used a common set of standards. The Royal Colleges are probably the most appropriate source of such standards.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
As stated, it is important that inspecting bodies use common standards. FGDP would support change to this effect regardless of the structure, but believes that with appropriate direction from government, it is achievable without the creation of a combined inspectorate.

Chapter 7: Finance, functions and planning

Planning

34. 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. FGDP supports efforts to create more integrated planning. If reviewing the alignment between the planning duties in the named Acts will help achieve this, we support it.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
No. Dental representation on LHBs should be re-introduced. The absence of dental representation at board level is presenting barriers to delivering effective of Oral Health Action Plans. At a time of increasing cost pressures on the health economy, a full range of health care professionals, in particular covering more primary care settings, is more needed than ever in order to improve commissioning, integrate management and deliver patient care in the most appropriate environment.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Yes.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Yes. As above, dental representation on LHBs should be re-introduced in order to deliver effective of Oral Health Action Plans.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the

statutory status of the advisory committees?
No. It is perverse that consideration is being given to the disruption of the professional groups that provide advice to Welsh Ministers and NHS leaders when professional input is increasingly essential if patients are to benefit from improved access provided in the most appropriate environment.

WGGP123 – Victoria Lloyd– Age Cymru
Tref / Town – N/A

General comments

Introduction
Age Cymru is the leading national charity working to improve the lives of all older people in Wales. We believe older people should be able to lead healthy and fulfilled lives, have adequate income, access to high quality services and the opportunity to shape their own future. We seek to provide a strong voice for all older people in Wales and to raise awareness of the issues of importance to them.

We welcome the opportunity to comment on this Green Paper with its focus on quality, continuous improvement and prevention, keeping more of us well for longer. We are keen to support the Welsh Government in endeavours to deliver a properly integrated and appropriate health service that is able to support the population.
Our comments relate to Part 1 of the Consultation Paper.

General Comments
Wales has a population with the highest proportion of older people in the UK and health services must adapt and respond to the fact that more people are living longer, often with chronic conditions in older age. Older people are the main adult users of most health and care services; however, from education and training to the organisation of care, the NHS and health services often do not appear to be designed with older people's needs in mind.

Older people, wherever they live, should have free and fair access to health and care services that maintain and promote their physical, spiritual and mental health, treat illness, and support those living with chronic conditions. This principle applies to all older people wherever they are – in their own homes, in care homes, or in hospitals. Health services should be designed to support people's wellbeing and independence, but our NHS often appears to be set up purely to treat illness on a 'condition specific' basis with a goal of 'curing disease' rather than focusing on the complete needs of the person.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority?

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
We would welcome proposals that focus health priorities on achieving wellbeing to complement those pursued through the Social Services and Well-being (Wales) Act (SSWWA) and the Future Generations Act as a positive step forward. We believe that a focus on wellbeing would support the development of a more proactive health and care system that seeks to provide services to people who are likely to be impaired without support, rather than one that is solely focussed on helping those that have already become impaired. Preventative health care services play a key role in promoting the health and wellbeing of older people. Within this we would include access to services such as optometry, audiology, dentistry, physiotherapy and podiatry which are essential to the maintenance of good health. In particular, access to foot care services across Wales must be improved; they are vital to keep older people active and independent and to reduce the risk of falls. Action is also required to ensure that older people in residential care have access to the same standards of healthcare services as the wider community. Early intervention and a reablement approach to supporting people can help to maintain independence at home and delay the need for high end residential care. We believe that both the third sector and the general public must be included in the development of local planning and commissioning strategies to improve appropriate preventative service provision across Wales. Better involvement of service users individually and collectively at national and local levels is central to achieving better integrated services that will meet the health and wellbeing needs of our communities. We also support change to strengthen collaboration. Single services rarely meet the full needs of an older person and for those who rely on multiple services and professionals just to manage their daily living, a lack of joined-up working can have devastating effects on wellbeing. The reality is that services spanning both health and social care are vital to daily living. Yet the many entrenched barriers between these services make it extremely difficult to deliver whole-person care. For example, moving someone out of hospital is not simply a case of addressing their health needs, it is also ensuring social care and support services are in place to return them to the best possible level of well-being. If the agencies involved in a person's care are not working together, their full needs cannot be met. Making wellbeing the purpose of collaboration could provide the impetus for leaders across sectors to innovate and improve collaboration. Integration or collaboration is not just about structures or pathways, it is also about harmonising professional practice. Better co-ordinated care for individuals relies to a large extent on the willingness and ability of professionals to adopt a person-centred approach and ensure effective communication across boundaries. The purpose and benefits should be

clearly articulated in professional education and training and in workforce development.

Considering the potential complexities of care pathways, administrative and commissioning requirements, and the separation of health and social care budgets, there is no simple solution to integrating services. Arguably there should instead be a focus on the overall outcome: delivering a seamless service that maintains wellbeing and independence.
In Wales, research has shown that there is a range of integrated care models operating that are:

- contributing to improved service outcomes and are promising efficiency savings over the medium term (the formative nature of some approaches, with phased implementation, means that some impacts will take longer to come to fruition); and
- illustrating a limited number of ingredients that can contribute to integrated approaches to service delivery having an early impact.

But that there is more to be done to ensure:

- the impact of integrated working, including quantifiable efficiency savings, is measured; and
- where high potential service models are identified, their wider application is actively encouraged.

We would welcome further consideration of the barriers that governance arrangements and shared accountability appear to pose to joint working and collaboration. The degree to which local service boards are able to use joint commissioning as a vehicle for driving change however will depend on the degree to which they are able to hold local bodies to account.

Health sector colleagues have expressed reticence with regard to commissioning third sector and other external organisations to undertake work on their behalf as they will be held accountable and responsible if the other party fails in service delivery. While such a reticence persists it will be difficult to achieve the ambition of service where a 'wide range of public and third sector organisations work side by side with people who use services as a coordinated and integrated team'

Creating consistent partnership working between the NHS, Local Government and the third sector has proved difficult in the past. The problems have often been cited as a lack of a shared vision or leadership from top management, poor governance, being bolt on rather than core activity, and lack of funding. The lack of flexibility in shared funding has also been a constraint as has legislative constraints that prevent local authorities from employing staff as nurses.

The inability to share information and get separate computer systems to work together is repeatedly raised as a major stumbling block to joint working. Primary care must also be included in this work. The majority of older people in Wales are registered with a GP, who are usually the first point of contact in an individual's pathway through the system. Therefore it is vital that primary

care services are involved in integration.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change? 5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups? 6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
We support proposals to establish permanent engagement mechanisms that would link to the governance structures. These mechanisms should be designed to enable - Genuine citizen voice - Openness and transparency, and - Should be continuous Such arrangements should have a specified link to the governance of local health boards. This would ensure that engagement is embedded in practice, gathering and utilising views from individual service users to inform a collective view. However, information must be used in transparent and accountable fashion so that public involvement enhances rather than undermines public trust (the opposite can be true if it is perceived that citizen engagement is being used to validate a decision that has already been taken or if it is perceived that the exercise is merely to tick a box). We believe that this practice should be further informed by the use of expert patient groups. In her review Ann Lloyd pointed out that expert patient groups were previously used extensively in Wales in helping form policy but they seem to have declined in influence nationally. We support the position that these should be revitalised. Informed, engaged patients make better choices and are able to work in partnership with professionals to make better decisions and deliver better quality, better outcomes and sometimes reduced cost. Better engagement is a prerequisite of co-production. We also support the perspective that third sector networks should be utilised to link with hard to reach groups and should be more formalised for the future. These networks will be particularly useful in establishing continuous engagement fora. Formal engagement mechanisms should also provide for effective links with stakeholder groups including the third sector to enable effective two-way communication around issues such as capacity, training and quality as part of the review of local population health needs.

In the context of continuous engagement the role, importance and impact of local service boards needs to be made clearer to the public and service users to improve understanding and confidence in the system.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section? 8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system? 9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations? 10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales? 11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
We would welcome consideration of measures that ensure quality is considered across all aspects of the system wherever the health service is provided. We believe a clear focus on outcomes is important here. We would further support consideration of a 'fit and proper persons' test on the basis of consistency and underpinning corporate accountability. Given the recent introduction of the test in England, it would be useful to draw on the experience there to inform the potential introduction in Wales.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set? 14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens? 15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
We would support measures to ensure that all organisations are subject to the same consistent standards of delivery. Even where a standard may be subject to different legislation, it should be possible to achieve a position where the actual requirement is uniform regardless of the sector or organisation delivering the service. It is important for service user confidence that they can expect consistency of quality. A common standards framework should support improved outcomes and

experiences for citizens as it has the potential underpin shared expectation, language and approach across sectors.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales? 19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
We welcome the commitment to promoting a culture of openness and transparency. This has been a central theme in several reports in recent years including Sir Robert Francis QC's Inquiry Report, the Ockenden Report into the Tawel Fan, and the Andrews Report. We believe it is particularly important that a proactive approach to a duty of candour be developed. This duty should explicitly state that the NHS will not wait for complaints to be lodged but will provide information where it is appropriate to do so. We believe that the duty of candour should operate on the basis that if significant harm has occurred which the reasonable patient would wish to know about, then in the normal course it is the responsibility of a doctor to inform the patient of that significant harm, and the way in which it was caused. Such honest and transparent information provision is important but must be achieved in a tactful and sensitive way, which takes full account of a person's circumstances, so as not to cause any harm.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
We would strongly support steps that make it easier to facilitate joint investigations between the NHS and other service providers. This is particularly important as we move towards a more integrated system of care and we believe that this would be helpful in providing both answers and redress where there have been failings that involve more than one service.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
We are concerned that issues such as data protection should not prevent the sharing of patient information. We support the principle cited in the Welsh

Health Circular regarding the importance of sharing information in the best interests of patients.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they? 25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW? 26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change? 27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
We believe that there may be advantages of a single inspectorate covering the roles and responsibilities of HIW and CSSIW. These advantages should be considered in the context of integrated care, so that inspection is both effective and efficient. In the absence of a single inspectorate we believe that inspection regimes and methodologies should be aligned. This will enable registered services to keep records in a consistent fashion that will satisfy both inspectorates.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice? 29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
The role of CHCs in providing advocacy services must be retained as we believe it is vital that there is an organisation with this specific remit. The role of CHCs in representing patient voice needs to integrate with any new mechanism for continuous engagement considered earlier in this consultation document.

WGGP124 – Darren Hughes – General Pharmaceutical Council Tref / Town – N/A

General comments

The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and registered pharmacy premises in Great Britain. It is our job to protect, promote and maintain the health, safety and wellbeing of patients and the public who use pharmaceutical services in England, Scotland and Wales.

We welcome the opportunity to respond to the consultation on the quality of health services and the governance and functions of the NHS in Wales. Whilst the proposals as a whole are of interest to us, we have limited our response to comments on the chapters and sections where we feel our work is directly relevant. We are happy to continue to contribute to future discussions on how we can all play our part in improving the health and wellbeing of patients and the public.

We are responsible for defining the education and training requirements for pharmacists and pharmacy technicians. We also set standards for pharmacy support staff, including dispensing assistants and medicines counter assistants.

Our statutory role as set out in the Pharmacy Order 2010 is:

'To protect, promote and maintain the health, safety and well-being of members of the public and in particular of those members of the public who use or need the
services of registrants, or the services provided at a registered pharmacy, by ensuring that registrants, and those persons carrying on a retail pharmacy business at a registered pharmacy, adhere to such standards as the Council considers necessary for the safe and effective practice of pharmacy.'

Consistent with other health professional regulators, our legislation makes explicit that our purpose is that of patient protection. We are unique amongst the UK health professional regulators as we have a statutory role in relation to 'system' regulation (i.e. regulating the provision of services by registered pharmacies) as well as the regulation of individual pharmacists and pharmacy technicians.
Our main work includes;

- setting standards for the education and training of pharmacists, pharmacy technicians and pharmacy support staff, and approving and accrediting their qualifications and training
- maintaining a register of pharmacists, pharmacy technicians and pharmacies

- setting the standards of conduct and performance that pharmacy professionals have to meet throughout their careers
- setting the standards of continuing professional development that pharmacy professionals have to achieve throughout their careers
- investigating concerns that pharmacy professionals are not meeting our standards, and taking action to restrict their ability to practise when this is necessary to protect patients and the public
- setting standards for registered pharmacies which require them to provide a safe and effective service to patients
- inspecting registered pharmacies to check if they are meeting our standards

Our Standards for Registered Pharmacies and all other standards relating to the behaviours of registrants and pharmacy staff can be found on our website. In the next section of this response we have made comments on a chapter by chapter basis.

Part 1 Quality First and Foremost
Chapter 1. We have no comments.

Chapter 2. Enabling quality
The GPhC sets out the standards of conduct, ethics and performance that all pharmacy professionals must follow. Pharmacy professionals are pharmacists and pharmacy technicians who are registered with us. It is important that they meet our standards and practise safely and effectively. Their conduct will be assessed against the standards and failure to comply could put their registration at risk.

If concerns are raised about our registrants we will consider these standards when deciding if we need to take any action. Other professional regulators also set standards for their registrants working in Wales.

Quality and co-operation: The GPhC has a Memorandum of Understanding with Healthcare Inspectorate Wales to support the sharing of and to maintain patient safety and confidence in pharmacy services.

In our standard of conduct, ethics and performance we require our registrants to “Develop your professional knowledge and competence” and to “Maintain and improve the quality of your practice by keeping your knowledge and skills up to date and relevant to your role and responsibilities.” This duty placed on our registrants is in-line with Welsh Government’s aim of placing similar duties on organisations.

Integrated planning: We have no comments.

Chapter 3. Quality in Practice

Meeting Common Standards: All GPhC registrants that work within NHS Wales, or in other sectors, are required to meet professional standards set out in our Standards of conduct, ethics and performance.

Clinical supervision: We believe continuous lifelong learning is a vital part of career development and improved outcomes for service users. We will be introducing new arrangements in 2018 to show the public that pharmacy professionals continue to meet the standards for safe and effective practice throughout the course of their careers.

The GPhC's Council found the arguments for the introduction of the continuing fitness to practise framework compelling to maintain public confidence in the pharmacy professions.

- Opinion polling has repeatedly shown that the public believe health professionals are already subject to regular reviews or assessments of fitness to practice.
- Evidence from the Bristol Inquiry Report showed that competence did not always grow with experience and could diminish over time, and that there was no system in place to spot waning competence, to support those professionals or to protect patients.
- As the independent pharmacy regulator, the GPhC has a duty to assure fitness to practise of registrants from the point they come onto the register. The Bristol Inquiry underlined that waiting for things to go wrong did not protect patients adequately, and that there was evidence of suboptimal performance within the medical profession.
- Despite seeking a more flexible and tailored approach to meet a common standard, the Westminster government still expects the health professional regulators to provide evidence on this subject and a clear direction of travel.

The GPhC Council have agreed some draft principles, subject to review due to ongoing work, in relation to the continuing assurance of fitness to practise of pharmacists and pharmacy technicians:

- The focus should be assurance of continuing fitness to practise and not a fixed point assessment.
- The model should be consistent with the generic principles agreed by the Non Medical Revalidation Working Group
- The model will need to consider more than one source of information
- Some form of assessment will be required and will need to be made against a standard
- That standard should be based on the standards of conduct, ethics and performance which apply to all registrants
- The model must take full account of the structure of the pharmacy workforce

- Any model would need to be appropriately costed and subject to testing, including piloting

The GPhC expects our registrants to undertake continuing professional development (CPD) as an important assurance to patients and the public that pharmacy professionals are keeping their knowledge and skills up to date and reflecting on their practice. CPD will be an important element of the new framework alongside peer discussion and evidence drawn from professional practice.

Chapter 4. Openness and honesty in all we do

Along with other regulators of healthcare professionals, the General Pharmaceutical Council (GPhC) has signed a joint statement on openness and honesty - the professional duty of candour. The statement reflects the GPhC's requirement that pharmacists and pharmacy technicians need to be open and transparent at all times, and serves as a reminder that candour is an essential duty for all professionals.

This duty for pharmacy professionals to be candid with patients and others is already reflected in our regulatory framework; both in our standards and in our guidance. However, this joint statement was a further step forward in promoting a wider culture in healthcare where openness and transparency is the norm.

The statement also supports our ongoing work around strengthening the current requirements for openness and transparency for pharmacy professionals. For example, our review of the Standards for conduct, ethics and performance will reflect on how we can be more explicit about the need to be candid. It will also be considered as part of the work we are taking forward around our new Initial Education and Training standards.

The proposal to introduce a statutory duty of candour is in-line with our position.

Making it easier to raise concerns in an integrated system.
As mentioned earlier in this response the GPhC has a Memorandum of Understanding with Healthcare Inspectorate Wales setting out how we will share information and investigate together where apropriate.

There is no mention in this section of the role of the professional regulators in addressing concerns relating to the performance or behaviour of registered professionals inside or outside the NHS. The GPhC Standards of conduct, ethics and performance place obligations on our registrants in Standard 7 to:

- Make sure that there is an effective complaints procedure where you work and follow it at all times
- Make the relevant authority aware of any policies, systems, working conditions, or the actions, professional performance or health of others if they may affect patient care or public safety.

- If something goes wrong or if someone reports a concern to you, make sure that you deal with it appropriately
- Co-operate with any investigations into your or another healthcareprofessional's fitness to practise and keep to undertakings you give or any restrictions placed on your practice because of an investigation.

This obligation placed on GPhC registrants and similar obligations placed on other registered health professionals are vital if any changes to systems regulation are to work effectively.

Chapter 5: Better Information, Safely Shared
The GPhC places responsibilities on registrants relating to the safe sharing of information in its Standards of conduct, ethics and performance in Standards 3.5, 3.7 and 3.8 and gives further information in our Guidance on patient confidentiality which is set out below.

"We believe that giving patients the choice to allow pharmacy professionals to access their records can help them to receive better care. The pharmacy professionals supporting them will have access to important information about their medical history and their medicines and will be able to work more effectively with other health professionals involved in their care.

Pharmacy professionals in some settings, including hospitals and GP surgeries, are already accessing records and using this information and their expertise to improve the health and well-being of their patients. As the pharmacy regulator, we can assure patients that pharmacy professionals and community pharmacies have to meet our standards when accessing patient records. These standards make clear the responsibilities of pharmacy professionals and pharmacy owners, including in relation to holding patients' information securely, obtaining patients' consent before accessing their information and respecting their privacy."

Chapter 6: Checks and Balances
Whilst this chapter mentions regulation and inspection it mainly looks at inspections and the role of HIW and CSSIW. All of the establishments inspected and overseen by HIW and CSSIW have registered health and care professionals working within them who have professional responsibilities and who are accountable to their own regulator. There is no mention of the role of the professional regulators nor any mention of an obligation of the inspecting bodies to work with them.

The GPhC has a memorandum of understanding with HIW and has regular meetings to share information as appropriate. It would seem sensible to put in place regulations to ensure that all systems regulators and inspecting bodies share information and work together where appropriate to do so.

There is no mention of the Wales Concordat Cymru which exists to:

- Provide a forum to share high level information, new approaches and ideas about improving the impact and effectiveness of regulation, inspection, audit, scrutiny and service improvement.
- Identify trends in regulation, inspection, audit and scrutiny and broader service improvement policy and practice.
- Share good practice and influence policy makers collectively, when appropriate.
- Share experiences and identify opportunities for collaboration.
- Further develop and refine the systems and for sharing more detailed information between relevant bodies; through bilateral agreements and protocols when appropriate.
- Foster a collaborative ethos that encourages both proportionality and effective risk assessment and management.

Members of this forum individually and collectively make a contribution to quality, safety and improvement in healthcare and their roles should be considered in the development of any new legislation.

Representing patients and the public: The GPhC engages with the CHCs at a board and local level and very much values their contribution and input to our work in Wales and more widely. We consider patient and public input into policy development and their role in raising concerns vital for us if we are to regulate effectively.

Part 2: Strong Organisation and strong governance

Advisory Structure: The GPhC is a member of the Welsh Pharmaceutical Committee and we are therefore interested in this area of the paper. We feel that this committee provides a valuable forum for informing the Chief Pharmacist and other government officials of key issues and concerns within all sectors of pharmacy across Wales.

Response to specific questions

No response to specific consultation questions.

WGGP125 – Fiona Jenkins – NHS Directors of Therapies and Health Science Peer Group
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The Social Services and Well-Being Act (2014) and the Well-being of Future Generations Act (2015) have been introduced very recently. Both Acts are designed to strengthen local collaboration in planning and meet the needs of people. There has been insufficient time to evaluate the implementation and embedding of both Acts. Following the implementation of the Acts, it may be opportune to evaluate whether the legislation has facilitated achieving the intention of both Acts and consider the streamlining of legislation, rather than adding to its complexity. In order to assist the organisations in implementing both Acts, clarification of the governance arrangements would be welcome.

2. If so, what changes should be given priority?
Establishment of a collective responsibility for a single needs assessment with all parties bringing their data and expertise. Improved informatics and analysis capacity within the public sector is pivotal to this as it would provide real, powerful data and subsequently reduce waste within the system.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The existing governance structures within NHS Wales are complicated and not easily understood but operate through the hard work of those charged with working together. There is a risk that the introduction of further legislation may only serve to make the position more complicated and complex. The Green Paper provides the opportunity to review, remodel and, where applicable, rationalise existing models and structures. This should take place before any further legislation is considered. **Wigs** Following a task and finish group to develop an equitable solution across Wales to delivering NHS Wigs the main findings were:

To deliver a solution that patients are happy with would require a change in primary legislation to allow Health Boards to implement a voucher or equivalent in the provision of Wig services. The NHS Quality, Governance and Functions legislation in the new Assembly term would seem the obvious mechanism to address the legal issues surrounding wig provision. Therefore it is felt that this would provide the most effective solution to continuing the service the patients are happy with, make it equitable across Wales and provide a completed policy for Shared Services tendering solution.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
We would caution that it is very difficult to find representation that truly reflects all views, and the danger that a few voices can then skew the nature of services provided and the apportioning of resources

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Legislation can be useful but given the response above it is debatable whether it is the most effective tool. It is a blunt tool and unless well crafted can lead to ambiguity that requires case law to settle. Legislation does not provide specific direction or answers. It is questionable whether legislation is a solution particularly with concepts such as quality. Any legislation should make quality the focus for the integrated systems rather than, as is now, other measures such as finance.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
In considering service change there is currently no requirement to complete a quality impact assessment, whereas there is for finance; equality; health needs etc. assessments are required. In the existing economic climate, the reality of the situation is that there is a balancing act to be achieved in considering financial pressures with maintaining quality of service provision. Therefore the gap that needs addressing is making “quality” count and matter. The Health and Care Standards were introduced to focus on quality and improving patient care, however there are no tangible repercussions if you do not meet all of the Healthcare Standards, however there are significant consequences if financial

targets are not met.

Dichotomy between “quality” and “safety”, too much focus on quality in isolation. Need to factor in the safety element especially in light of the Mid Staffs review and the Andrews report.

This is not just an NHS priority but this should be a joint H&SC priority
The Social Services and Well-being (Wales) Act provides legislation on a citizen centred approach and how this can be achieved through partnership and integration. Before further legislation is developed a review of the impact of this Act should be undertaken to ensure that it has facilitated a citizen focused integrated delivery of care and that the citizen’s are satisfied with this within the coproduction agreements and maintaining prudent health and care. ‘The Prudent Citizen’.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
We need to be clear what we mean by quality, especially in an integrated health and social care environment. In considering service change there is currently no requirement to complete a quality impact assessment, whereas there is for finance; equality; health needs etc. The views of the experts and the public are much different on this and the need to engage with people on this was stressed in Trusted to Care. Any legislation should focus on integrated standards as this would facilitate and enable quality to be at the forefront of decisions and joint decisions of health and local authority organisations. It may be more appropriate to consider how we could establish safe standards that could ensure consistency across the system and would have the same monitoring and audit arrangements that apply to the financial systems and the Annual Quality Statements would then have primacy and would be resourced accordingly. Under the Social Services & Wellbeing Act there is an element that health services have a duty to participate in relation to the standards for Social Services.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
Given the issues above regarding quality it is difficult to see how such an individual could be responsible or accountable. Accountability lines within the NHS Wales at Health Board/Trust level are already clear.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?

Following the aftermath of recent failings in managing quality and care standards within the NHS the principle of the introduction of a “fit and proper persons” test is supported. However, this should not distract from the primary responsibility of the employer to check that their Board members are competent in discharging their roles and responsibilities effectively and that they behave in a fit and proper manner and continue to do so for the tenure of their employment. Advantage – it will provide assurance to Welsh Government and also to the Health Board Some questions to consider: 1. How will the test apply to those Directors who occupy a professional as well as corporate role (concern regarding dual regulation)? 2. How will the test differentiate between those who are clearly the decision makers versus the responsibility of a Board? Disadvantage (dominant position) – it would potentially create another layer of bureaucracy to regulate health practitioners. This will include an industry setting standards and also time out of practice in order to be evaluated against these standards. This will be in addition to regulation that is already in place by the appropriate health regulators e.g. HCPC NMC, GMC. It will also be in addition to other systems in place in the workplace e.g. capability policy.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
The term integrated planning refers to the integration of the systems within the NHS, whereas the Health, Social Services and Well-Being Act and Well Being of Future Generations Act are aimed at broader service integration and quality (however defined) needs to be seen in this context. It would be helpful if this was set in the context of an over arching health and social care plan for Wales. Many of the quality targets set down by Welsh Government are related to accessing services and it is the core Tier 1 targets on which health organisations are held to account. If quality is to be promoted as indicated this needs to be the core requirement within the planning framework and guidance. This will then lead to a full focus on quality throughout the system. As Health Boards improve the quality of their plans, the promotion of quality will develop and be much stronger. The danger of trying to legislate for this would be to impose further complexity onto an already complex process and the subsequent risk of reducing the quality of the plans. Rather the main requirement in a cultural change in mindset and legislation is not the answer. Therefore we do not believe that legislation is needed to further strengthen the NHS Planning framework.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
This should be viewed in light of the section on quality. As indicated there may be merit in setting safety standards that can be easily monitored. Again the standards apply to the NHS and it would be helpful to have an integrated set of standards across Health and Social Care. This is particularly important given the changes in legislation such as Social Services and Well Being Act. The standards are mainly provider led and as integrated organisations it is important that these reflect all the accountabilities of Health Boards/Trusts. The Health and Care Standards have just been refreshed and these need time to be embedded and to be reviewed.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
It is important to ensure development of such systems provide assurance to the public. Peer Review is an important process and whilst there have been examples of how this has been used across the service, it is time consuming and important that it is seen as an integral part of a role/s and not an add on. There are already a number of national bodies that provide accreditation and these need to be utilised fully to avoid the risk of duplication. There would be a need for consistency of approach which would be agreed by the organisations. Whilst this would have much benefit across the whole system, this is a decision that could be taken at a local level and does not require any changes to the legislation framework. Mandatory accreditation across the sector would require the appropriate resource to support the cost of the accreditation process. Current accreditation processes while an important quality drive do require a large resource and extending them would require funding to be identified and would have workforce planning implications

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
We support the principles that this should be implemented as an integral part

of health professional practice. We do not support the suggestion that this should require legislative changes as this would create more of a burden on organisations and individuals This needs to be linked to the introduction of revalidation for nurses, and other professions to follow. There would be significant resource impact if this were to be legislated and this would require additional funding to Health Boards to ensure appropriate resources are allocated to undertake the legislated role of clinical supervision. Good clinical supervision does improve services but legislation would not ensure the quality of the supervision just that supervision activities have taken place.

17. What arrangements should be put in place for self-employed health professional registrants?
The NHS could offer mutual supervision cover with private practitioners (i.e. cross sector supervision or peer review arrangements).

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
We broadly support the introduction of a statutory duty of candour in the aftermath of the failing at Mid Staffordshire NHS Foundation Trust. 'Prompt apologies and explanations, with a reassurance they will not reoccur, may prevent a claim being brought at all'. Mr Francis' recommendation 181 provides that there should be a statutory obligation of candour on healthcare providers, registered medical practitioners, nurses and other registered health professionals where there is a belief or suspicion that any treatment or care provided to a patient by or on behalf of their employing healthcare provider has caused death or serious injury. Provision of information should not itself be evidence or an admission of civil or criminal liability, but not disclosing the information should entitle the patient to a remedy. Promptly identifying negligence and providing redress for the patient and their family should be encouraged. Doing so quickly and efficiently will reduce expenditure on legal costs and should provide a better experience for the patient and their family. Professional groups already hold this duty. If Boards could be held accountable for its emphasis and delivery this is more powerful. Legislation implies NHS Bodies do not want to be open and transparent. Putting Things Right and redress already require this and needs to be implemented fully.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Yes in line with the Foundation Trust model in England. However there would need to be tight governance arrangements around this process. With appropriate assurance in place this could provide an engine for transformational change by allowing LHB's to invest to save and drive improvements in both quality and efficiency. It would also help LHBs develop better relationships with the private sector and allow LHBs to work in similar ways to universities. This could provide a particularly exciting opportunity to contribute more fully to the Life Science Sector in Wales, creating wealth to reinvest in health. The three year planning cycle process – Health boards need to be able to start from a level playing field and not constantly trying to play catch up against historical deficits. This mechanism allows internal 'invest to save' but some investment is very difficult to map out a specific financial saving. It is inevitable that some 'pump priming' will be required to develop service changes.

Planning

34. 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?
Alignment of all relevant Acts, which result in more streamlined, less complex government structures which support the principles of a one system approach across Health and Social Services would be welcome.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
With the need to deliver across Health & Social Care and pressures in one area impacting on the other, combined with the need find the solution to this challenge, we need to work as an integrated system. LHB's working co-terminus with Local authorities to deliver on aligned strategy from WG would support delivery of services to better meet the needs of the population. There may be an opportunity to explore the role of legislation to further

improve current NHS Wales 'generic' infrastructure such as workforce policies, governance arrangements and IT systems which span organisational boundaries. However this would only be required if the Well-being of Future Generations Act (2015) does not drive the required change at sufficient pace to support the transformational healthcare system level changes to ensure safe and sustainable NHS services which meet the needs of the people of Wales.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
When considering the Board membership it is necessary to consider the breadth of portfolios required by health organisations to deliver against the current policy drivers. Board membership needs to give adequate Board level resource to allow robust fulfilment of each portfolio item and ensure Board members can fulfil their obligations and accountabilities. This includes ensuring appropriate skills base on Boards, particularly to cover complex professional issues across the entirety of Health Professions, and to ensure there is a strong, clinically focused cohort of Board members. NHS Boards should not be so large as to be unwieldy, but must be large enough to provide the balance of skills and experience that is appropriate for the organisation. Evidence from Mid Staffs etc. has suggested that Executive Boards need to engage staff with a compelling vision that inspires them to work towards a common goal (Stewart 2014). The future workforce are going to have to be more flexible and adaptable, working easily across health sector boundaries (Primary, community, secondary and tertiary) and also other sectors such as social care and the charitable sector. The Executive Director of Therapies and Health Science role brings a clinical mind-set to the Board that is creative, analytical and holistic. The uniqueness of the Directors of Therapies and Health Science is that as Executive Director they are ideally placed to: • Provide a Collaborative Leadership style to the Board**.** Representing more than 60 professions across the Therapy and Healthcare Sciences they represent diverse professional practice covering preventative, diagnostic and therapeutic services as well as maintaining the standards of regulated and non-regulated professions covering the third largest group of professional staff in the NHS. They ensure a synergistic work environment, where multidisciplinary groups are encouraged to work together toward the implementation of effective practices and processes.

- Promote strategic decision-making. This is an integral part of the board's role in formulating strategy and Clinical Leadership is necessary for the delivery of excellent outcomes for patients and populations. The skills and knowledge that the DoTHS bring to the Executive role through collaborative clinical leadership is essential in understanding the different professional cultures, facilitating integration and interdependency among multiple stakeholders so that working practices can achieve outcomes that are greater than the sum of individual efforts.

- Support the change in culture needed through prudent healthcare. The culture of the NHS is changing to promote a more socially directed model of care that is integrated and also able to easily cross sector and cultural boundaries. The contribution of Therapists and Healthcare Scientists is vital in realising this vision. Staff working to the top end of their competences have increasingly been taking on clinical practice previously carried out by medical trained staff, as well as expanding the boundaries of their own professional practice. Boards need to be clear about accountability for maintaining standards of care. The DoTHS provides the assurance that the systems of control are robust and reliable for the multiple professions that make up the Therapists and Healthcare Scientists that cannot be readily understood or provided by either a doctor or nurse. The registration, professional practice and cultural requirements and characteristics are quite different. It is worth noting that these challenges cover both the range of HCPC registrants and the Healthcare Scientists who fall under the Professional Standards Authorities/Academy of Healthcare Science Voluntary Registers

- **Foster a strong and healthy organisational culture.** Boards are leading NHS organisations in an enormously demanding environment. Evidence supports the critical role that the Board plays in shaping and exemplifying an organisational culture that is open, accountable and compassionate, puts patients first and hears, supports and nurtures all staff (NHS Leadership 2013). It is important for Boards to develop a good understanding of the current values, behaviours and attitudes operating within the organisation, and to work with the staff to shape the desired values, behaviours and attitudes. The importance of Board visibility in the organisation has long been recognised, a more interactive process allows board members, staff and users to shape organisational values and culture through direct engagement. The Executive DoTHS role brings a clinical mind-set to the Board that is creative, analytical and holistic. The need for the role to be a member of the HCPC regulated professions provides credibility with Therapists and Healthcare Scientists, having previously held clinical roles provides integrity and the ability to interpret the complexity that surrounds the diverse professions to support the development of the organisational shared vision and provide an authentic professional view of the Therapies and Health Scientists to the Board.

- **Encourage innovation.** Creating an organizational climate where others apply innovative thinking to solve problems and develop new services facilitates a culture of innovation

The inclusion of a representative of Social Services may support integration

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?

It is felt that total discretion should not be supported. There needs to remain core 'legislative' and professional responsibilities, supporting clear accountability. This is also vital for succession planning, i.e. development of future Board members. Outside of this some flexibility may be required to align portfolios to best suit skills and experience and deliver on the required agenda.

Of particular importance is the need to ensure the Board continues to have clinical balance and therefore the number of clinical executive directors should always be more than the number of non clinical directors.

The NHS in Wales is challenged with shifting away from a traditional medical/hospital model of approach. AHP's bring the perspective of the 'person', promoting a person centred and empowering co-production approach, very often away from the hospital setting. This brings challenge to thinking and will drive the modernisation agenda required. There is still much more these roles can offer in engaging and giving voice to the innovations and solutions sitting across these services in Wales which already have effective multi-disciplinary and multi-agency partnerships in place. The therapies and health sciences professions are intrinsic to providing the solution to the challenges NHS Wales is tasked with and visible leadership at executive level is crucial to this.

Support the change in culture needed through prudent healthcare. The culture of the NHS is changing to promote a more socially directed model of care that is integrated and also able to easily cross sector and cultural boundaries. The contribution of Therapists and Healthcare Scientists is vital in realising this vision. Staff working to the top end of their competences have increasingly been taking on clinical practice previously carried out by medical trained staff, as well as expanding the boundaries of their own professional practice. Boards need to be clear about accountability for maintaining standards of care. The DoTHS provides the assurance that the systems of control are robust and reliable for the multiple professions that make up the Therapists and Healthcare Scientists that cannot be readily understood or provided by either a doctor or nurse. The registration, professional practice and cultural requirements and characteristics are quite different. It is worth noting that these challenges cover both the range of HCPC registrants and the Healthcare Scientists who fall under the Professional Standards Authorities/Academy of Healthcare Science Voluntary Registers

The roles of Therapists will be key in managing the move of services out of hospital settings and into community settings. Healthcare Scientists will oversee the move of diagnostics into community settings and will continue to introduce novel, emergent and disruptive technologies which support self-

management and care. They will also develop appropriate QA frameworks available to assure optimised outcomes from all medical technologies used in non-acute settings. Therefore the skill sets, knowledge bases and ethos of AHPs and Healthcare Scientists are pivotal to highlight opportunities for health system improvement, generate ideas for new ways of working in community settings and designing implementation strategies for these new pathways, services and systems. Healthcare Scientists will be key in introducing and mainstreaming Precision Medicine. Genomics will be the industrial revolution for healthcare and this will continue to be overseen by Healthcare Scientists as part of wider Multidisciplinary Teams. The benefits of personalised healthcare align strongly to prudent healthcare principles. These professional groups have a strong voice at board level through the DoTHS and these opportunities are now more readily identified, exploited and benefits optimised through the focus brought by the DoTHS to the activities of LHBs.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
With respect to overall size of Health Boards (refer to Q2 response). Yes - LA and Social Services representation would better represent the needs of the population and support integration. Election of community representation is something that should be explored to ensure transparency and maintain a 'grass routes' level of understanding, supporting effective communication and management of expectations.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
In 2014 the WG undertook a review of the statutory structures. Clarity is required with regards to the status of the recommendation and any progress made to date. It is important that the Minister seeks and listens to advice and that the advice available is robust, inclusive, balanced and transparent. The statutory status of the advisory committees ensures this. The statutory status of the advisory committees also ensures that professions which are 'smaller' such as the therapies and health science have a voice and have an equal opportunity to influence as the medical and nursing professions.

There are examples of non- statutory national advisory groups not being inclusive of all relevant professions, and therefore the advice not being robust, inclusive and balanced.

There is concern that lobbying by any 'lobbying groups,' whether professional bodies or specific condition groups, can create a bias on how to organise/structure/prioritise services. Due consideration needs to be given to safeguard against this. This includes self nominated individuals, who are referred to as 'experts'.

Specific advantages of the WTAC and WSAC. These committees bring together balanced views (WTAC in particular balances NHS management and professional body view) to:

- Advice the First Minister and the Welsh Minister for Health and Social Services on general professional matters relating to health services in Wales;
- Receive for comment and advice, documents or issues referred to it by the Assembly;
- Advice on matters related to the education and training of staff in the provision of those services.
- Act as a conduit for information exchange regarding local, national and international developments pertaining to the Therapies and Health Science workforce and clinical services, including evidence based practice, quality improvement and clinical governance.
- Promote quality and consistency in the way that common issues pertaining to the Therapies and Health Science workforce are addresses
- Assist with the creation of strong and clear strategic directions for effective and co-ordinated Therapies and Health Science clinical services.
- Support effective collaboration of multiple professions represented by these committees
- Provide intelligence on innovative service delivery approaches
- Provide advice on the use of new and emerging technologies
- Provide advice on developments in evidence based practice, education, training, clinical research and professional development activities.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
One of prudent healthcare's principles is that of co-production with the end-user, whether the patient and/or the carer. Whilst it is important that policy and service delivery is based upon expert professional advice, it is only one element of the whole. Therefore, this question does not support the co-production, and therefore the prudent healthcare agenda.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do

they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Both the Social Services and Well-Being Act (2014) and the Well-being of Future Generations Act (2015) have been introduced very recently. However, there has been the insufficient passing of time to evaluate the implementation and embedding of both Acts, to inform the decision whether further changes to the legislative framework are required.

Hosted and Joint services

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
We have some concern that this question assumes all aspects of Shared Services are working well. While some do, it is worth noting that removing some functions from local control (e.g. recruitment and procurement) have created delays and reduced efficiency. Centralisation of these services can also adversely affects more remote Health Boards where normal day to day interactions and the simple conversation to address a problem are no longer able to take place.

WGGP126 – Andrew Davies/Richard Tompkins – NHS Directors of Workforce and Organisational Development
Tref / Town – N/A

General comments

Response to specific questions

Chapter 2: Enabling Quality

Quality and co-operation

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
With the Chief Executive already being the accountable officer for NHS organisations within Wales, we do not see any advantages for setting out legislation on this role. We believe that the current lines of accountability within NHS wales are clear and effective.

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
Given recent failings in quality and care within the wider NHS, it is essential that consideration is given to putting in place systems and processes which provide assurance as to the "fitness" of senior leaders and others to carry out their roles and in furtherance of this the principle behind the introduction of a "fit and proper persons test" is supported, although a more appropriate wording would be "fit and proper persons requirements". However, the onus should still be on employers to check on the competencies and credibility of their appointments through their employment checking process. Robust employment and recruitment processes are already in place, and as such there should be minimal impact on current practice in relation to ensuring that applicants are suitable for the role they are being recruited into. The type and level of checks required when NHS bodies are considering applicants, including those to Director level positions, are outlined in the Health and Care Standards, Standard 7.1 Workforce: • have all necessary recruitment and periodic employment checks and are registered with the relevant bodies • are appropriately recruited, trained, qualified and competent for the work they undertake In addition to information obtained as part of the recruitment process, such a process will need to introduce new requirements for organisations to confirm that Directors in their employment remain fit to continue to be an executive director or equivalent and similarly for Welsh Government to undertake a similar level of assessment for independent members/non-executive directors.

Continued fitness should be assessed as part of the existing appraisal process and should therefore not require employers to undertake new but rather augment existing arrangements.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
We do not believe that it is necessary to strengthen existing legislation further. The key success factor will be how the NHS Planning Framework is taken forward in practice. The development and integration of services has to be progressed through close working between service providers, patients/service users and the wider public to ensure that they effectively meet local need. Current legislation, as well as the current NHS Planning Framework makes this clear and provides adequate support and guidance.

Chapter 3: Quality in Practice

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
We are supportive of the principle but we do not believe that legislation is the way forward, as this may potentially lead to the need for additional resources. Appropriate access to clinical supervision should be a key part of continuous professional development for all healthcare professionals and aligned to medical and nursing revalidation. Management standards should require health professional registrants to be provided with appropriate arrangements to support their professional development and ensure that development supports continued registration. Whilst it is an individual registrant's responsibility to maintain their registration, arrangements must make sure that managers are facilitating this through clinical supervision which should form part of the overall support provided in the workplace. Through ensuring that such a model of support to maintain, develop and enrich careers is in place this, may in turn, have a positive bearing on some of the recruitment and retention issues currently being experienced.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
We support the principle of having a duty of candour for NHS organisations,

however a culture of openness and transparency should be locally driven with success depending on effective engagement and communication with staff.

The principle of a duty of candour is clear but the terminology and the need for this to be communicated to staff is less so. Many if not most of the elements which would comprise such a duty are already commonplace across the NHS. Staff are familiar with the terminology around raising concerns, apologising, reporting risks or near misses and their own professional responsibility for delivering safe care. Significant work has recently been undertaken across Health Boards and NHS Trusts on determining and communicating organisational values and behaviours. In addition, this work has been underpinned by work across the service as part of the Common Principles Project which has supported the refresh of the content of the NHS Wales Principles.

The service is not starting from scratch when it comes to handling cases in an open and transparent way and as such any development of a "duty" should be seen as building upon strong foundations already within NHS Wales and not result in bureaucratic processes that could risk distracting staff from patient care. However, it is recognised that policies and procedures, and the appropriate training, will need to be developed and introduced within organisations to support the understanding of the duty.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
We believe that transparency will be greatly enhanced by the development of a national All Wales system that can provide real time information. We are unsure if legislation alone would be able to further improve transparency, as performance is regularly and publicly reviewed at board level. We also believe that the Performance Management Framework for NHS Wales should be the vehicle for ensuring transparency and openness.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
We understand that there is already evidence of good practice in place in relation to the joint investigation of complaints. We believe that complaints processes should be integrated and ensure that all organisations adhere to the same principles and processes. Health Boards currently work across health boundaries and the current system allows for organisations to agree the lead organisation and to respond to individual complaints. To this end, we do not believe that legislative steps are necessary to improve the process.

Chapter 7: Finance, functions and planning

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes, as the three NHS trusts in Wales have a major role to play in the planning and delivery of services across NHS Wales in particular and the wider Welsh public sector. Although we recognise that health boards have a responsibility for planning services for their resident populations, we also believe that given the nature of the services provided, it would be beneficial if the trusts were put on the same statutory footing as the seven health boards.

34. 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?
It is not felt that the NHS (Wales) Act 2006 planning duties need to be reviewed. There is already in general close and effective working relationships between health bodies and the relevant local authority departments. As we move towards further integration, the effectiveness of these relationships will need to be managed as a key priority in the provision of seamless services and to realise the opportunities arising from collaboration. However, experiences in some areas suggest that although we do not believe that the Act needs to be reviewed it may be pertinent to review planning arrangements across the NHS and Local Authorities to ensure that they support integration. It should also be recognised that Welsh Government already has a Department for Health and Social Care in place which maintains an overview of and monitors planning issues.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
We would welcome a full review as suggested in the Green Paper. Since the 2009 restructuring of the NHS, some complex arrangements have been put in place with the establishment of joint committees, shared and hosted services, network arrangements and other collaborative arrangements. These range of approaches need to be reviewed, clarified and where possible streamlined. **Leadership** in relation to Boards needs to be responded to in terms of Question 36. The NHS Wales 2006 Act permits the Welsh Ministers to set in regulations the number of Executive and Non-Executive Directors for NHS Trusts (Schedule 3, Part 1, para 4(1)(c)) . There is therefore no requirement

for primary legislation to address the size of Boards to ensure they are fit for purpose.

Partnerships: the Well-being of Future Generations Act and the Social Services and Well-being Act will place a duty to integrate on Local Authorities and Health Boards and this is welcome. As a consequence, it will be advisable and beneficial to have a range of strong partnership arrangements in place via Section 33 Agreements with a shared approach to governance, risk management, performance management, information sharing and a commitment to work to align processes and procedures.

In order to strengthen leadership, governance and partnerships, the need for clear accountabilities is required, with a route of escalation if concerns arise built on sound principles with clear expectations and outcomes. There is already in place an escalation and intervention process for NHS Wales which means that there are clear consequences of how and in what circumstances Health Board or NHS Trusts are moved into a position of escalation and that this is applied systematically and consistently. Furthermore, clear principles of behaviours over and above the Nolan principles need to be further developed so that they truly reflect the principles of NHS Wales together with what is expected of all public servants. There also needs to be a greater focus on career development and succession planning.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
We believe that the current size and configuration of health boards is relatively fit for purpose. However, we also believe that the requirement to have an Executive Workforce & OD Director role at board level should be placed on the same statutory footing as finance directors, nurse directors etc. The current job description for the role of Director of Workforce & OD states that the post holder is responsible to the "LHB Chief Executive and Board for workforce development and management, for organisational development of the LHB and for professional leadership and practice in relation to the Board's responsibilities as an employer". Given the specific nature of these responsibilities we believe that the legislation should be strengthened, accordingly, to specify the specific requirement for this role rather than just identifying the requirement for a board member with responsibilities for human resources/workforce & OD. Currently, around 129,000 people are employed in the health sector in Wales – the equivalent of 8% of the country's employment – while NHS Wales itself employs around 85,000 staff. This makes the health service Wales' biggest employer, with the NHS pay bill standing at around £3 billion (more than 50% of NHS spend). These figures demonstrate the economic significance of NHS Wales to the overall economic health of Wales and the importance of the workforce within that context.

The W&OD Director also has a key role to play in ensuring organisational compliance, particularly in relation to case and statutory law, e.g. employment, equality and human rights and health and safety legislation. As the accountable professional lead for workforce and OD staff, the W&OD Director is also be responsible for significant monitoring arrangements and remedial action as required to satisfy the board that it is meeting its legal duties and statutory requirements. It is also expected that the W&OD Director will hold a professional chartered qualification awarded by the Chartered Institute of Personnel and Development.

It is also increasingly clear that a transformation in service design and the way treatment/care is delivered is required. A key aspect to making this a success is the workforce. The retention of the current NHS workforce and recruitment of staff will always be an area where challenges and significant problems will arise. With an ageing population also comes an ageing workforce, this is coupled with the fact that the present workforce is designed to deliver services within historic models of care and so this will require the development of sustainable approaches to the redesign of roles so as to ensure that we are using NHS staff in the most effective way in line with prudent healthcare principles. It is also vital that the workforce develops new ways of working and is aligned with the overall direction for the delivery of health services.

In the light of the challenges and requirements noted above we consider that it is essential for there to be a statutorily mandated workforce professional at board level in the role of Director of Workforce & OD to lead these strategic issues.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Yes, it may be useful to allow some flexibility for local determination given the different demands, demographics etc. that health board are subject to. However, as a minimum, it should be mandated that health boards should have a Chief Executive, Director of Finance, Medical Director, Director of Nursing and Director of Workforce & OD as statutory Directors on the board.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
We are not sure that further legislation is necessary. It should be up to individual areas to determine what is best for their own circumstances, bearing in mind local demographics, geography, health need etc. However, we recognise that the reform of Local Government does provide an opportunity to consider where joint/dual roles could in future prove to be beneficial although any such alignment will need to ensure that there is effective co-terminosity of Health Board/Local Authority areas in order to enable such roles and the opportunities for joint working to be effective. In relation to Directors of Public Health, if there were to be any development

of the role in partnership with local government, the co-terminosity point made above and the relationship with Public Health Wales NHS Trust would need to be clear so as to enable the opportunities for such a joint role to be realised without bureaucratic complexities which could stifle the impact of the role.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Please see response to questions 36 and 37 and 39. More local autonomy for organisations to appoint members with the appropriate skill sets to meet specific requirements of the organisation within an appropriate governance framework would enable organisations to appoint senior roles to target priorities through Board level leadership and focus.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
Independent Members and Non-Executive members play a key role in the contributing to the operation of Workforce & Organisational Development (HR) policies. This contribution is provided on Consultant Advisory Appointment Committees, Appeal Panels e.g. Grievance and Disciplinary Policies as well as a significant range of roles which are set out in the recently agreed Medical and Dental staff disciplinary procedure (Upholding Professional Standards in Wales). These roles are invaluable in providing assurance, a level of independent scrutiny and proportionality regarding decision making and ensuring adherence to processes, however they can be a significant call on an Independent Member's or Non-Executive member's time, given their broader board accountabilities. Accordingly, consideration needs to be given to the numbers of IM's and Non-Execs to enable these roles to be performed or the development of associate roles which carry legitimacy and authority to support Health Boards and NHS Trusts in these important roles.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
The embedding of partnership working is axiomatic in the effective working of public service organisations. The NHS has successful partnership working arrangements which have developed and matured over the past ten to fifteen years. There is a preference for issues of commonality throughout NHS Wales to be resolved in a way that apply across Wales e.g. the mechanism for the development of employment policies which are effectively all Wales policies. The appropriateness or otherwise of existing partnership working arrangements for pay and terms and conditions of employment is dependent

upon the policy direction Welsh Government wish to set in this area.

Currently, most of the contractual arrangements for staff are either UK agreements or are underpinned significantly by UK agreements with Welsh variations to specific aspects.

Whilst the terms and conditions of most NHS staff may be determined or significantly influenced by UK processes, it should be acknowledged that there are other Welsh forums which set policy and seek to address public service issues. Notably amongst these are the Welsh Partnership Forum (NHS) which brings together Welsh Government officials, Trade Unions and NHS employers and the Workforce Partnership Council (Public Services) which brings together Welsh Government Ministers, Trade Unions and Public Service employers.

The architecture of workforce partnership needs to reflect the policy framework set by Welsh Government and the current NHS Workforce Review chaired by David Jenkins, which is scheduled to report in February 2016, is an important contribution to the determination of future policy direction in this area.

However, we should also note that NHS Wales, has already agreed changes to terms and conditions specific to Wales which were implemented following agreement in 2014 and there is currently further discussion underway under the terms of a Strategic Pay and Policy Group. All such discussions have progressed through partnership arrangements overseen by the Welsh Partnership Forum and have, where necessary, sought agreement through the NHS Staff Council such as the Amendment of National Terms and Conditions of Service (Agenda for Change) which applied from 1st January 2015. There has been some concern expressed that the above changes to terms and conditions for NHS Wales took time to approve at the UK NHS Staff Council and progress for NHS Wales was being held up by a UK partnership body. However, it should be noted, that the Health Departments and Employers within the other three counties, which are party to the NHS Staff Council arrangements, did not stand in the way of NHS Wales progressing any changes, but it was the wider TU partners which insisted on a process of presentation to the UK Staff Council as part of the ratification process.

The UK Staff Council constitution and operating arrangements are in need of revising, particularly in the light their needing to be sensitive to how the devolved parts of the UK operate. As such it would be helpful to establish a mechanism to agree changes through NHS Staff Council where Wales (or indeed one or more parts of the UK) would want to see changes. Whilst it was not necessarily the position for the recent changes in NHS Wales, UK TU union solidarity is a potential brake on progressing changes which employers/health departments would want to make and which might have a broader impact on their members. For example if there was a proposal from one part of the UK to reduce a core element of the terms and conditions of service then the TUs may see that as challenging the overall agreement

which is Agenda for Change. One way forward could be an approach which establishes the core UK elements and separates out those areas where the four parts of the UK may develop flexibilities sensitive to their particular parts of the NHS. It should however be emphasised that Health Boards and NHS Trusts in Wales wish to retain UK arrangements and to work collectively with all partners and maintain a UK approach to NHS Terms and Conditions of service. There should, however be greater flexibility built into national agreements which enable elements to be operated, and where required agreements reached and ratified within Wales without reference to UK Staff Council. The on-call agreement reached in 2012 is a good example of this process. Accordingly, we consider that the current partnership working arrangements need amending to reflect increased devolution but that such amendments should be taken forward as a reform of the existing arrangements.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
There is a potential to develop the Shared services concept further. To do this, we may need to take a more formal approach and potentially consider the establishment of a single stand-alone body. There are currently a number of organisations that provide services that may form part of this body, e.g. NHSWSSP, NWIS and NHS Wales Employers. The Service would need to ensure that the necessary service level agreements are in place to ensure that the organisation is responsive to the needs of the Service.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
NWSSP is already under significant pressure in meeting the requirements of the Service. Whilst, it is coping admirably with meeting the demands of the Service, we believe that there are significant risks to expanding its remit to the wider public sector at this time. The Partnership should be given more time to bed into its current role before any significant changes are considered further.

WGGP127 – Neil Frow – NHS Wales Shared Services Partnership (NWSSP)
Tref / Town – N/A

General comments

In compiling the response to the Green Paper consultation NHS Wales Shared Services Partnership (NWSSP) has focused on a small number of question areas within the consultation that specifically relate to shared services functions. We have therefore not attempted to comment on areas outside the remit or the current influence. The completed consultation response form is attached for information.

Given the potential models and options available for, using new and existing legislation, we would welcome the opportunity to discuss in more detail with Welsh Government Officials options that help provide better clarity, governance and flexibility to take forward the continued improvement and delivery journey of the Shared Services Partnership within the NHS and the wider public sector.

NWSSP were established in 2011 and since then the Partnership has delivered significant savings and efficiencies for NHS Wales. Initially as a virtual organisation and then as a hosted organisation since 2012 we have matured and progressed from a period of consolidation to one of transformation and modernisation.

Our aim is to support NHS Wales by creating a dedicated shared services organisation with a distinct identity which:

- Shares prudent common operating standards in line with best practice;
- Has sufficient scale to optimise economies of scale and purchasing power whilst improving quality;
- Has an excellent customer care ethos and focus on service quality; and
- Places excellent customer service at the heart of service delivery to individuals and communities

To date no other part of the Welsh public sector has achieved the scale or level of collaboration through the provision of support (professional, technical and administrative) services that has been achieved in NHS Wales following the introduction of the Shared Services Partnership. From a strategic view this is particularly relevant when considering the future opportunities for delivering wider public service shared services. Something that was clearly recognised by The Commission on Public Service Delivery (Williams Commission) who commended the work of the NWSSP and suggested it as an exemplar model for public-sector wide shared services. However, it is important to recognise that any integration with the wider public sector would need to be done in a planned way which would not impact on the delivery of existing services levels to existing NHS partners.

Response to specific questions

Chapter 2: Enabling Quality

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
We do not feel that there is any requirement to extend current legislation in respect of the current planning framework. The current arrangements should prove to be sufficient if used and embedded appropriately.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
The NHS Redress Measure already provides for a transparent, cooperative investigation into all concerns raised whether by patients, their friend and family or by NHS staff. The existing framework is therefore sufficient to promote honesty and candour in the Welsh NHS. Guidance under the existing legislation might usefully be strengthened.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
We believe that there is sufficient legislation in place.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
A starting point consideration could be given to extending the existing Putting Things Right regulations and guidance across other parts of the wider public sector.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
There are many perceived barriers to sharing patient information across the health and social care system. The current governance systems in place

should be used more effectively to challenge those perceived barriers.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
NWSSP believe that it is vitally important that patients have confidence in NHS Wales' ability to protect their privacy, comply with the law and safeguard their personal health data. Data users within the health service must ensure that they obtain information about their patients in a proper manner and that it is kept securely and handled in accordance with the well established rules of medical confidentiality and the provisions of the Data Protection Act 1998. It is important that we ensure that data safeguards are proportionate and do not become a barrier to improving the delivery of patient care or preventing the secondary use of data where appropriate to deliver benefit.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
There will be benefits from changing the law to provide health boards with borrowing powers. In particular this will provide more flexibility for boards to progress key capital schemes and thereby implement service change and efficiencies on a timelier basis. This will be particularly relevant over the next decade when capital resources are limited. There are nevertheless significant risks and It will be important that appropriate safeguards or guidelines are put in place to ensure that Boards due not expose themselves to undue risk and in particular restrict themselves to "reasonable " levels of borrowing, sensible maturity profiles, competitive levels of interest and prudent levels of collateral.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
This requirement is no longer relevant following the reconfiguration of health bodies in 2009. It would be more appropriate to produce a summarised set incorporating the results of health boards, trusts and hosted bodies. A summarised NHS Wales account would provide a clearer view of NHS activities for the public to consider.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
There should be an equivalent statutory planning duty placed on every organisation that receives public funds to deliver or commission services within Wales.

34. 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?
Given the introduction of the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 it would be prudent to review the provisions of the NHS (Wales) Act 2006 to identify synergies. Additional governance structures over and above those that already exist should only be created if there is an absolute need to do this.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
The Commission on Public Service Governance and Delivery (Williams Commission) commented that health boards must be accountable and responsive, accessible to their local populations and provide excellent leadership and direction to their senior executives and hold them to account. They questioned whether existing arrangements for health board membership, which includes Independent Members provided the level of challenge to improve service quality. If a review of the existing statutory instrument is undertaken, consideration also needs to be given to the ability of non-statutory hosted organisations to promote an effective focus on decisions, priorities and scrutiny, when there are multiple layers of governance and bureaucracy that often delays the ability to have swift decision making.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Yes it would be sensible to allow organisations a degree of flexibility in this respect so that organisations may better reflect key functions at board level. The set number of Executive Directors should be clarified within a minimum /

maximum tolerance introduced outside of the fixed roles for example Chief Executive, Director of Finance.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Under the spirit of collaborative working it would be sensible for a number of joint appointments to be made, and to this extent it would be a positive move forward.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
It is vital that any new independent members are appointed with the required skill sets that best meet the needs of the organisation in question.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
Lessons could be learnt from similar roles that already exist within other areas of the public sector for example the role of the Monitoring Officer within Local Authorities.

45. How could potential conflicts of interest for the board secretary be managed?
The potential for conflicts of interest to occur would be reduced if the remit of the board secretary was clear and consistent having no broader operational management responsibilities which could detract or conflict with the purpose of the board secretary role.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
We acknowledge the reference in point 137 of the consultation document that “partnership working arrangements have not kept pace with devolution” based on the example of the changes to staff terms and conditions that have been required to be signed off by UK Partnership bodies. However, even within the existing arrangements there is scope to ensure that the interests of NHS Wales are dealt with appropriately and in a timely manner.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
There is currently a mixed economy in Wales in respect to hosted, joint, shared services and the other provider organisations. However, it is really important that each existing separate arrangement is taken in context. In the future different solutions may well be appropriate to ensure effective governance and accountability arrangements are in place. This will help provide further clarity and consistency of approach for hosted, joint and shared services. Two of the fundamental principles that helped shape the creation of the NWSSP governance arrangements was the desire to make collaboration easier by ensuring that all partner organisations were treated equally (i.e. creating an independent model which would mean that no one organisation could have a greater influence on the services being delivered than another) and more importantly that the shared service provider focused on the strategy, delivery and management of the support services within its remit freeing up the individual health organisations boards and senior management to concentrate on delivering their own front line services. Since its inception in 2011 and the decision for Velindre NHS Trust to act as the host body in 2012, NWSSP has significantly grown and matured as a provider organisation serving all health organisations in Wales with a very clear purpose as a vehicle to support collaboration through the delivery of high quality value for money "Professional, Technical and Administrative" support services on an all Wales basis, taking advantage of economies of scale, standardisation, technology and process redesign. Given the size and complexity of the collective services delivered through NWSSP it is now larger than some if not all of the existing provider trusts within Wales and hosting may no longer be the most appropriate model for such an organisation. There are a number of potential models/options either using existing or new legislation that would help enhance and strengthen the overall governance arrangements and in particular improve strategic direction and accountability. NWSSP believe the most robust arrangement would be for the Shared Services Partnership to be established as a standalone statutory body and would welcome a more detailed discussion with Welsh Government officials on how this could be achieved. This would ensure it is able to continue on its improvement and delivery journey for the benefit of the NHS and potentially other key public sector organisations within Wales

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
To date no other part of the Welsh public sector has achieved the scale or level of collaboration through the provision of support (back office) services that has been achieved in NHS Wales following the introduction of the Shared

Services Partnership. From a strategic view this is particularly relevant when considering the future opportunities for delivering wider public service shared services. Something that was clearly recognised by The Commission on Public Service Delivery (Williams Commission) who commended the work of the NWSSP and suggested it as an exemplar model for public-sector wide shared services, it concluded that:

".....we, therefore recommend building on the achievements of NHS Wales Shared Services Partnership, a single shared services operation must be established to provide back office functions and common services across the public sector.... The Welsh Government must co-ordinate and oversee its development and establishment. This should build on the NWSSP and National Procurement Service, and clarify the relationship between the two, without duplicating the work of either".

Some professional and technical service areas are easier to deploy across the public sector than other transactional areas mainly due to system, technological and investment constraints. A more prudent option may be looking at opportunities to extend the existing NHS transactional systems covering financials, procurement and employment services which are already consistent all Wales systems covering 10 organisations.

There is no reason why the provision of such support services could still not be provided from within the health sector. However in order for this to become a reality the existing governance arrangements surrounding NWSSP would need to change and the appropriate statutory powers to provide support services across the public sector put in place. Again there are a number of options and models utilising existing and new legislation that could be used and NWSSP would welcome the opportunity to discuss them in more detail with Welsh Government officials as part of the response to the consultation process. If this process is managed carefully and in a structured "evolutionary" way benefits will continue to be realised in the NHS as well as those that would be realised for other public sector organisations within Wales, without jeopardising the quality or levels of service provided to NHS Wales.

It is therefore important that although a wider public sector shared service organisation may be some way in the future the governance and legal powers surrounding NWSSP are flexible enough to enable further collaborative working should the opportunities arise.

WGGP128 – Dr Kate Chamberlain – Health Inspectorate Wales
Tref / Town – N/A

General comments

There are gaps in the current legislative framework to enable HIW to operate effectively. Please see Appendix 1 for details.

Gaps in legislation relating to independent healthcare regulation Type of establishment	**Current position**
Pop-up Clinics (e.g. In 2013 when a company, provided a single vaccine clinic in a local hotel)	Not required to register in Wales. The CQC in England registers services, rather than establishments and agencies, so the service would be required to register.
Mobile Laser/Intense Pulsed Light (IPL) Services	Not required to register in Wales. In England, providers of laser and IPL services only need to register where: • The specific skills of a listed professional are used, e.g. where the service is part of a package of clinical care and requires specialist physiological and psychological knowledge such as use of a laser as part of plastic surgery procedures • The service is combined with other procedures that require a listed health care professional qualification, e.g. prescribing, • The service is described by the provider as carried out by someone acting in their capacity as a registered health care professional. Non-surgical cosmetic procedures using lasers or IPL are not classified as a regulated activity by the CQC. Non-surgical providers are not required to register with the CQC.
Human Branding (a form of body modification in which a mark, usually a symbol or ornamental pattern, is burned into the skin)	Not required to register across the UK. Human Branding is normally carried out in tattoo parlours, which do not have to be registered but operate under a licence from the Local Authority. Local Authority Environmental Health Officers (EHOs) can inspect premises to ensure that they conform to health and safety requirements. EHOs do not have the training or expertise to determine whether staff are adequately trained and following best practice, and neither do EHOs possess the power of sanction.

Services that receive a proportion of their funding from the NHS, (e.g. substance misuse services)	Not required to register in Wales. There are currently specific exemptions for Independent Clinics and agencies if any of the services they provide are in pursuance of the NHS Act. In England, the CQC registers NHS and independent services, so this issue does not arise.
Private Midwifery Services	Not required to register in Wales. In England, independent midwives are exempt from registration with CQC if they meet all of the following criteria: • They provide services independently (not in the NHS). • They work on their own (not as part of an organisation or partnership), and • They only provide services on an individual basis to people in their own homes.
Non-Medical Practitioner Prescribers	Not required to register in Wales. There is no remit within the current legislation to register prescribers that are not Medical Practitioners (i.e. GP's or Consultants) In England, where a nurse or a health care professional is required to administer medication, this is classed as 'treatment of disease, disorder or injury' and would result in the need for registration. A health care professional is defined and includes: Medical practitioner; Dental practitioner; Dental hygienist; Dental therapist; Dental nurse; Dental technician; Orthodontic therapist; Nurse; Midwife; Biomedical scientist; Clinical scientist; Operating department practitioner; Paramedic; and Radiographer.
Botox and Dermal Fillers	Not required to register throughout the UK. There is a specific exemption within the Care Standards Act for the subcutaneous injection of a substance or substances into the skin for cosmetic purposes. Generally, these providers are not subject to any additional regulation beyond those of the wider service sector such as the requirements set down by the Health and Safety at Work Act (1974). These regulations are enforced by Local Authority bodies such as Trading Standards and Environmental Health.
Private Ambulance Services	This is an unregulated area in Wales. Similar services are required to register with CQC in England.

Dentists	HIW currently registers individual dentists who provide any private work in Wales. This approach is inconsistent with the arrangements for regulating the provision of other independent healthcare services, whereby HIW registers establishments or agencies. The practitioner level approach is onerous for individual dentists and is a poor fit with the delivery of inspections which relate to premises. In England, NHS and private dental practices are required to register with the CQC. In Northern Ireland, private dental practices are required to register with the RQIA.
In-Vitro-Fertilisation (IVF) Service	These services currently have to register with HIW. They also have to register with the Human Fertilisation and Embryology Authority (HFEA), who carry out inspections of these services. This is a duplication of effort which is not in keeping with the Hampton Principles. The CQC no longer register these services in England.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority? 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Under the provisions of the Well-being of Future Generations (Wales) Act 2015, the Public Service Board for each local authority area must produce a local well-being plan, which includes an analysis of the state of well-being of people in the area. As integral members of the Public Service Board, the local authority and the health board should collaborate to ensure the local well-being plan reflects any needs assessment of the local population. Primary legislation therefore currently exists which requires agencies to work collaboratively and take an integrated approach to identify and meet needs of people in a local community. HIW does not believe further legislation is required to strengthen local collaboration in planning and meeting people's health and well-being. It is essential the legislation already in force is supported to ensure the law becomes a reality.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change? 5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups? 6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Central to the issue of engaging with citizens is the need for effective planning. NHS organisations are required to produce a number of plans under current legislation. Plans are required pursuant to the NHS (Wales) Act 2006; the Well-being of Future Generations (Wales) Act 2015; the Social Services and Well-being (Wales) Act 2014; and the NHS Finance (Wales) Act 2014 and associated NHS Wales Planning Framework, which require health boards to produce Integrated Medium Term Plans (IMTPs). It would appear to be sensible to ensure that planning activities for health boards and trusts are not duplicated unnecessarily, and that legislation is clear as to what should be considered in these plans. In order to productively and meaningfully engage with citizens, health boards and trusts need to have robust and effective systems for planning which devise realistic options which can be communicated clearly to citizens. By engaging with citizens transparently with considered, reasoned plans, potential conflict and opposition could be reduced. Plans should aim to meet the needs of the population, whether services are provided directly by the NHS or provided on behalf of the NHS through commissioning arrangements. However, in order to ensure the quality and efficacy of any plan, it is essential that the issue of planning capacity and capability is addressed. Improvement in strategic planning capacity was identified as a recurring theme in HIW's joint governance review with the Wales Audit Office of Betsi Cadwaladr University Health Board in 2013 and our follow up review in 2014. We note that this section of the Green Paper is specifically concerned with citizen engagement with regard to the future shape of services. It is important to recognise that engagement mechanisms such as patient panels or participation groups will also have a great deal to contribute in terms of their experience and understanding of current service delivery and quality. There is an argument for the introduction of some pan-Wales strategic planning capacity, which would mean that specialist, consistent planning expertise would be available to health boards across Wales in producing good quality, realistic plans. There will inevitably be a tension between the public desire to access high quality care and support as close to home as possible and the need to ensure

low volume specialist services, able to treat complex cases, are provided in centres with the right expertise and resilience. There have been well publicised examples of this including Betsi Cadwaladr University Health Board's maternity services and the closure of the special care baby unit at Withybush General Hospital. A national independent expert panel which can draw on professional expertise may be an effective way to resolve these differences. However, the role of the panel would need to be carefully considered and will need to be clearly articulated. For example, should the panel have a final arbiter role when there are differences of opinion or should the panel be purely advisory?

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section? 8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system? 9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations? 10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales? 11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
Legislation may not be the most effective tool to ensure quality of care and is certainly not the only tool. Quality of care depends on many factors, such as organisational culture, training and education. Resources also play a part in the quality of care an organisation is able to provide. For example, if an organisation cannot provide safe staffing levels, it cannot provide quality of care. It is imperative that any new legislation for the NHS should be sister legislation to that enacted in relation to social services. Legislation for health needs to dovetail with legislation for social services in order for an integrated system to work effectively. The concept of a statutory role of 'Responsible Individual' which mirrors the provisions in the Regulation and Inspection of Social Care (Wales) Bill, would appear to be sensible. This would align the NHS with independent healthcare settings and with social care services. Under the Independent Health Care (Wales) Regulations 2011, a Responsible Individual should be someone "who is a director, manager, secretary or other officer of the organisation and is responsible for supervising the management of the establishment or agency." Under the Regulation and Inspection Bill, where the service is a local authority, the Responsible Individual needs to be "an officer of the local authority designated by the authority's director of social services". It would be important for the Responsible Individual in an NHS organisation to be a

person of a similar standing to that defined in these pieces of legislation. It would also be important to consider what enforcement provisions would be applicable against the 'Responsible Individual' of a health board or trust. Under the provisions of the Independent Health Care (Wales) Regulations 2011 the establishment or agency needs to have a Registered Provider. This can be an individual, but in the case of a company or organisation, the Registered Provider needs to appoint a Responsible Individual and a Registered Manager. Any enforcement would take place against the Registered Provider and/or the Registered Manager. The Independent Health Care (Wales) Regulations 2011 describe the qualities required in a Registered Provider and Registered Manager so that they are 'fit' to carry on or manage the establishment or agency. These provisions include being of suitable integrity and good character; being physically and mentally fit; not being adjudged bankrupt; and undertaking training to ensure they have the skills necessary to carry on or manage the establishment or agency. We note that the concept of a 'fit and proper' person has not been introduced into recent social care legislation. As stated above, we believe that legislation for health should mirror legislation for social care wherever appropriate to avoid creating arbitrary sectoral distinctions. Consideration would therefore have to be given to how this provision would work in practice, especially in integrated services.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Refer to answer under 'Continuously engaging with citizens'.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set? 14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens? 15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
We agree with the principle of a common standards framework. In order to provide the citizen with joined up, integrated care there should be a consistent framework of standards across all health and social care settings, whether care is provided by the NHS or by independent services. We believe it would

be possible to devise high level, base line standards which revolve around the care of the citizen, and which could reasonably be expected by a citizen wherever they receive care. Examples of such standards could relate to hydration and nutrition, where at present social care services are required to meet the specific National Minimum Standards applicable for that type of service (e.g. care home for older adults; care home for younger adults; adult placement scheme); NHS settings are expected to meet the Health and Care Standards; and independent services must adhere to the National Minimum Standards for Independent Healthcare Services in Wales. Whilst the sets of standards all cover broadly the same content, for example expecting that people are offered a choice of food and drink which is prepared safely, each of the standards contains a different level of detail about what exactly is required.

In order to improve clarity, outcomes and the experiences for citizens, services will need to be inspected and regulated in a consistent way to monitor and ensure application of those standards.

We believe there should be a consistent obligation on providers of services to apply those standards. It could create possible tension in the system if the same standards apply to an independent nursing home and to an NHS hospital, and the nursing home is required to adhere to the standards by law whereas the NHS hospital is not. There could also be tensions where a service provides a mixture of NHS and independent care, for example care homes, some independent hospitals, and dental practices, where sometimes the proportion of privately paying patients might be very small. Those settings would be expected to adhere to standards by law, whereas settings who provide exclusively NHS care would not.

HIW considers peer review to be an effective mechanism for driving improvement. HIW is involved in a peer review programme of cancer and palliative care services in Wales. This is a quality assurance programme that assesses the quality of the service being delivered by multi-disciplinary teams and health boards and palliative care services in Wales. Assessments are set against a framework of specific healthcare standards and national guidelines. The peer review programme is collaboration between HIW, the South Wales Cancer Network (SWCN), the North Wales Cancer Network (NWCN) and the Palliative Care Implementation Board (PCIB). The Welsh Government is now responsible for leading these programmes of peer reviews. HIW supports peer review by observing the peer review process to ensure that it is fair and impartial and that the outcome of the review is communicated openly and transparently. During 2015-16 Welsh Government has undertaken to review the arrangements in place to oversee all peer review work within the Welsh NHS.

HIW considers that health services should be actively engaging in peer review and robust assessments of their own services. Where a service is engaged in robust and independent peer review, this could be an indication of a lower risk service, which could result in the need for a lighter touch from the inspectorate.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how? 17. What arrangements should be put in place for self-employed health professional registrants?
Many health professionals have regular clinical supervision, which is necessary for professional revalidation processes. However, HIW finds clinical supervision isn't always embedded into services, especially where the health professional is self employed, for example dentists in general dental practice. We understand revalidation is being considered for dentists as it has been for doctors, nurses and midwives, and HIW will work with professional regulators as they develop their revalidation systems.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales? 19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
HIW supports the principle of a duty of candour, as the importance of openness and transparency cannot be underestimated in helping to build a culture focused on quality and learning. However, any statutory provision relating to the NHS should be consistent with social care otherwise this could cause tension. For example in an integrated community mental health team, health workers and the health part of the service would be subject to a statutory duty of candour but social workers and the social care part of the service would not. Recent legislation has not introduced a statutory duty of candour for social care services. There is a professional duty of candour for Social Care workers contained within the Care Council for Wales 'Code of Professional Practice for Social Care' (July 2015). This is consistent with the professional duty of candour already in place for doctors, nurses and midwives. In order to identify whether legislation is required to improve transparency on performance in the Welsh NHS, it is perhaps first wise to consider why this is not presently felt to be happening. It may be that the desired outcome could be achieved through encouragement and support of cultural change within organisations. If this were not successful, then legislation may be required to drive change.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Organisational boundaries should be invisible to the citizen who is receiving care from both health and social care services. There needs to be joining up at all levels, including complaints. A citizen should be able to complain only once, not make two separate complaints: once to health and once to social care, navigating two different complaints systems. Consideration needs to be given to how integrated systems can be put in place. Whether this requires legislation to achieve is unclear. Where a patient requires support to make their complaint about the NHS, they can access advocacy support through the Community Health Council. The remit of the CHC advocacy service should be extended to social care so that wherever citizens are receiving care, they are able to access support to make a complaint should the need arise.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information? 22. How can we consider breaking down any barriers? 23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
As far as HIW is aware, there is nothing in the law which prevents sharing of appropriate information in an appropriate way. However, staff can be unclear about what they can and cannot share. Work is therefore required to train staff and resolve any cultural issues which may be a barrier to the sharing of information. There are also technical issues to overcome as controls and firewalls in computer software sometimes prevent systems from communicating and therefore prevent the effective and timely sharing of information. There also needs to be greater clarity for the public about what information will be shared and with whom. Anecdotally, the public often assumes that their health information is shared between professionals. For example, that the pharmacist would be able to access their health record. Public expectations should be managed about how information would be shared. HIW has no objection to the collection and sharing of patient identifiable information for research purposes. However, this needs to be precipitated by an open and transparent conversation with the public about the purpose for which such information will be used and why. It will also require clear communication on how confidentiality will be protected.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?

Legislative gaps

There are gaps in the current legislative framework to enable HIW to operate effectively. Please see Appendix 1 for details.

Consideration will need to be given to the principle underpinning regulation of independent healthcare, and integrated services. The provisions of the Regulation and Inspection of Social Care (Wales) Bill mean that social care will be regulated on a service based model of registration whereas under the provisions of the Independent Healthcare (Wales) Regulations 2011, health services still need to be registered as 'establishments and agencies'. It is important that this is addressed.

Joint working with CSSIW

Given the increasingly integrated nature of health and social care it is clearly important that HIW and CSSIW work effectively together. Both Inspectorates are currently located in the same part of the Welsh Government and have headquarters in the same building. Where joint work is undertaken there are no organisational barriers to bringing together joint teams. There is currently work in progress to look at joining up more effectively on functions such as intelligence and communications. Structural or legislative change should therefore not be necessary in order to further improve joint working.

Independence

Whilst there are controls in place to protect HIW's independence within Welsh Government (and these are mirrored for CSSIW), a distinction needs to be drawn between operational independence and the perception of independence. It is not enough for HIW to be independent; it must also be seen to be independent if its work is to have credibility in providing the public with assurance.

At times the desire not to be seen to influence HIW's work programme risks creating reluctance on behalf of the Welsh Government to request that HIW examine specific matters of concern.

Giving full statutory independence to HIW would assist in addressing the

perception of independence if perception is widely felt to be a significant problem. Given the similarity in terms of role and operational independence between HIW and CSSIW it is difficult to envisage a case for providing statutory independence to one organisation, but not to the other. If both organisations were to be moved outside of government, then a merger between the two organisations should be actively considered. This would avoid creating barriers to joint working between the two organisations which do not currently exist and it would create an organisation of sufficient size to have a degree of resilience. It could also assist with communication of remit to the public since a single organisation would operate across health and social care. However, such a proposal would need to be carefully costed.

We would suggest, however, that this legislation would provide an opportunity to look beyond incremental change and undertake a more strategic consideration of the assurance landscape. For example, please see the additional comments in relation to the CHCs below.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?

We believe the strength of CHCs is in representing the patient voice and in their advocacy services. As mentioned earlier in this response, we believe CHCs should also be able to provide services for the patient who is receiving both health and social care services, for example from an integrated team or service and could potentially be extended further into social care.

Whilst there is merit in a lay function in relation to visiting and monitoring services, we are concerned that the CHC approach of blanket inspection programmes is not an effective use of CHC time and public money, as there are other organisations better placed to undertake inspections of services, which can and do include a lay input. We would also question the content of some of the current blanket visiting programmes which at times risk straying into clinical issues and judgements.

However, we value the local presence of CHC members and believe that through effective joint working, agreement on a complementary programme of CHC visits, and effective use of the issues raised through their advocacy service and local intelligence, there is scope for the two organisations to work effectively together.

For example, we have referred issues to CHCs which do not require clinical input to follow up. A CHC also referred an issue to us following one of their visits which required a clinical dimension to the follow-up. We see this as an effective use of both organisations' resources.

However, if there are to be structural changes to the landscape around external assurance the role played by CHCs could be part of the more strategic discussion referred to earlier.

If the option to create a statutorily independent integrated health and care inspectorate were to be progressed then it would continue to need to work closely with the CHCs, but this would be made more difficult by the remit of CHCs being limited to health. In this situation there may be some value in considering whether a single wider organisation incorporating the functions of health regulation and inspection, care regulation and inspection, and patient/ service user voice might be more effective in terms of joined-up working and its role might be more readily understandable to the public.

Chapter 7: Finance, functions and planning

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards? 34. 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?
Refer to response in 'Continuously engaging with citizens' above. Health boards and NHS trusts are required to engage in planning activities as a result of the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 so it would appear sensible to align planning duties, to avoid overlap and duplication, and maximise impact and outcomes for citizens.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
As the Williams Commission noted in 2014, the quality of leadership in public services is inconsistent. It would be helpful if an all Wales approach could be taken to develop the right leadership capability throughout Wales, as it is apparent that without the right leadership, governance structures are ineffective. From the governance work HIW has undertaken since 2013, key issues that we have found have tended to focus broadly on the following areas: • The clinical governance arrangements in place within organisations are not always conducive in enabling clear lines of sight from Board level to ward level • The weight of information that is considered at Quality and Safety meetings is such that it can impair the ability of the committee to

thoroughly scrutinise and challenge the information presented to it • Organisations are not always effective in dealing with concerns or complaints, and most significantly are not able to clearly demonstrate learning from issues when they occur. This includes the ability of organisations to respond to concerns that are raised by its own staff • Effective leadership, both of and within an organisation, is a required constituent to complement any governance structures that an organisation has in place.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed? 37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors? 38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation? 39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services? 40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
There should be a framework for health boards to follow as to the membership of their boards, but this framework should allow sufficient flexibility to ensure the organisation is fit for the local population it serves and the services within it. HIW's Governance Reviews have identified capacity issues in relation to Board members; specifically the work time allocated to independent Board members to enable them to fully engage with their roles and to provide appropriately informed levels of scrutiny and assurance. This should be considered within the framework. If there is something which currently prevents joint appointments then this should be rectified so that joint appointments are allowed. However, if the suggestion is that joint appointments are directed, this should fit in with the framework with flexibility described above.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed? 42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
HIW does not have a specific view on this, but would suggest that a full

evaluation of the current model should be undertaken before proposing wholesale change. This could build on the reviews that health boards have down on their own effectiveness.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity? 44. If so, what aspects of the role should be additionally set out in law? 45. How could potential conflicts of interest for the board secretary be managed?
Our work has highlighted issues with the role of board secretary as identified at paragraph 130 in the Green Paper. It is important that these issues are addressed, but further consideration is required as to whether this should be achieved through legislation.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees? 47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
This is a matter for Welsh Government. The current efficacy of advisory committees should be evaluated and action taken if required thereafter.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services? 50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
NHS Shared Services only provide for the NHS. Consideration should be given to what happens in integrated teams. For example, who is responsible for payroll? It is important that NWSSP structures do not prevent an integrated approach.

WGGP129 – Julia Ogiehor – Urology User Group Coalition
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Yes. The Welsh Government should require health boards, primary and independent health service providers, through Community Health Councils (CHCs), to fully consider patient choice as part of the local planning process. This needs to include consideration of product choice, so that patients are able to access products that are specific to their needs. For example, patients who suffer from continence problems often need very specific products, to effectively manage their needs and maintain their independence. These products may appear similar to those who don't use them, but have significant differences for patients. Inappropriate products can cause discomfort and increase in urinary tract infections (UTIs), putting patients at risk. Often, organisations look to make short-term cost savings, for example by introducing formularies to cut product provision. However, this can lead to greater future costs if inappropriate product provision leads to an increase in infections or reduced independence. When planning health services, organisations should focus on long-term decision making which focuses on the best interests of patients and considers the impact of decisions across the health service budget.

2. If so, what changes should be given priority?
Full consideration of patient choice when working with CHCs should be a priority, as should encouraging long-term, holistic planning rather than focusing on short-term cost savings.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Health boards should be required to raise awareness of the role of continence management in neurological and other long-term conditions. This should include providing training to healthcare professionals, as there is a general lack understanding of these areas. Those with neurological and long-term

conditions must feel that they can talk freely and openly with healthcare professionals about their conditions and that they are able to access the right support and advice to manage their conditions and enjoy a good quality of life. Legislation may not be the most appropriate way to achieve this change, but health boards must be encouraged and incentivised to improve the quality of services for these patients.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
The Urology User Group Coalition believes establishing permanent engagement mechanisms would increase patient involvement in decision making about services that have a direct impact on them, and allow those making decisions about healthcare provision to have a greater understanding of how service design and product availability impact on patient's quality of life. This will benefit the estimated 150,000 people living with continence issues in Wales.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
The Health and Care Standards framework requires NHS organisations to ensure continence care is appropriate and discreet, and that prompt assistance is provided as necessary, taking into account the specific needs and privacy of service users. The Welsh Government should make the framework a statutory requirement, to enable continence patients within Wales to manage their conditions independently. This will reduce the impact on A&E admissions as patients are better placed to make decisions on the type of services and products that are best for their needs, therefore reducing infections and reliance on the health service. A report published by the Unplanned Admissions Consensus Committee in November 2015 found that in 2013/14, the NHS spent £434 million treating 184,000 patients with unplanned admissions related to UTIs, or a cost of £2,361 per patient. It also highlighted that there was a lack of awareness amongst GPs of continence issues and were unable to tell the difference between products. There is potential long-term savings to be made through the provision of appropriate products and increase choice of products.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and

experience for citizens?
Yes. By consolidating the National Minimum Standards for Independent Healthcare Services in Wales with the Health and Care Standards framework, with a legal obligation on all health care organisations to comply with the standards set within the one document.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
We believe that a statutory duty of candour must address overall failings rather than just individual or team failings. The Welsh Government should also ensure that there is a clear and easy-to-access portal for patients to make incident reports.

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Yes. The Urology User Group Coalition believes the CHCs' duties should focus on representing the patient voice. This reduces the bureaucratic pressures CHCs currently face from their duties to monitor primary care services and propose service change. CHCs should also be encouraged, as part of its new focused role, to increase diversity of its memberships to include patients groups such as the Urology User Group Coalition, as was recommended in Professor Marcus Longley's 2012 report, *Moving Towards World Class? A Review of Community Health Councils in Wales.*

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Yes. There should be joint appointments between local authorities and the NHS to facilitate more joined up thinking within the health services in Wales.

WGGP130 – Matthew Kennedy – Macmillan Cancer Support Tref / Town – Bridgend

General comments

1. Introduction

1.1 Macmillan Cancer Support welcomes this opportunity to respond to Welsh Government's green paper on governance, quality and functions in the Welsh NHS. We believe that the discussion around governance in the NHS will create a strong base upon which to continue to improve outcomes and experience consistently for people affected by cancer in Wales.

1.2 In Wales, the cancer story is changing. Although more people are surviving, there are still too many people dying from cancer in Wales or not living well beyond their treatment. They may have long-term side effects such as fatigue, incontinence or lymphoedema.[33] We need a new ambitious approach to match the changing nature of cancer and its treatment, so that many more people survive and many more people live well with and beyond a cancer diagnosis.

1.3 In Wales, 19,000 (WCISU Feb 2015) people are diagnosed with cancer every year and more than 130,000 people are currently living with or beyond cancer, almost 4.5 percent of the population. By 2030 it is expected that 250,000, almost eight percent of the Welsh population, will have been affected by a cancer diagnosis and one in two of us will be affected by cancer at some point in our lives.

1.4 The good news is that survival rates are steadily improving and many people recover. On average 70 percent[34] of Welsh residents diagnosed with cancer can expect to survive at least one year. However, improving survival rates in Wales need to be considered in the context of even better survival rates in many other European countries.

1.5 We know the NHS is struggling now to meet current demand. A transformation in the way we treat and care for patients with and beyond cancer is needed if we are to close the gap between Wales and our European counterparts. This is the challenge we all face. We must change now to meet future demand, increase quality for patients and reduce instances of unacceptable variation.

1.6 Good governance is central to achieving this ambition. An effective system of governance is required within the NHS to deliver an often complex range of services to the public. People affected by cancer travel across organisational boundaries to receive services from a number of health boards.

[33] "Cured But at What Cost?" Macmillan Cancer Support (2013)
[34] Welsh Cancer Intelligence and Surveillance Unit Official Statistics 2012 data. Published 10 April 2014

It is therefore vital that good governance is the key-stone through which a seamless, consistent service is delivered to cancer patients across Wales.

1.7 In our response we have placed particular emphasis on the following topics covered in the Green Paper most relevant to the work of Macmillan Cancer Support:

- Meaningful engagement and use of people's views to inform service delivery and drive improvements.
- Consistent use of peer review across Health Boards and implementation of recommendations in a timely manner.
- NHS board governance which promotes transparency and accountability through its structures.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
We believe that engagement with patients and participation groups should make up a key mechanism through which health boards measure, reflect, and develop means to improve services. The views of patients, family members and carers are of prime importance in understanding people's experiences of individual services. One means of collecting this information to improve cancer care has been the introduction of a Wales Cancer Patient Experience Survey (CPES). The Wales Cancer Patient Experience Survey quantitative and qualitative data provides a rich and important source of evidence of patient experience during September 2012-March 2013. The survey demonstrated the value of engaging patients and we would encourage a broader exploration of how this can be done across the services. The CPES results provides a robust and comprehensive analysis of people's experiences of cancer care in Wales, with the survey capturing the views of 7,352 patients and achieving a completion response rate of 69%. The WCPES provides an important benchmark in relation to the patient experience and the extent to which Health Boards /Trust are meeting people's needs as set out in the Welsh Government (WG) Cancer Delivery Plan. It is important to acknowledge that the Wales CPES results in January 2014 revealed high levels of satisfaction with NHS cancer care in Wales, with 89% of patients rating their overall care as excellent or very good. This is a very clear indication that overall experience is a good one and provides a high baseline for further improvement.

Macmillan believes that across the NHS in Wales, patient experience should have the same importance as clinical care and patient safety in improving outcomes for people with cancer.

This needs to be repeated at appropriate intervals as a means to drive improvements within cancer services and beyond. In the future, we would further welcome the repetition of this important survey on a statutory basis.

2. If so, what changes should be given priority?

In considering NHS Wales's Planning framework for 2014/15 and 2015/16 Integrated Plans for Health Boards and Trusts, we believe that patient experience is a vital component which should drive improvement and be a regular asset available to Health Boards and Trusts both in informing service planning and ongoing service improvement.

Gathering the views of patients is listed among a raft of stakeholders within the planning framework a Health Board or Trust should seek to consult throughout its planning cycle. We believe that the skills and expertise required to engage patients in a meaningful way and capture experience through a variety of methods should merit its own focus.

Of the key elements detailed in the assessment and support of the Integrated 3 year plans maturity matrix, element 4 seeks to measure "dynamic and engaged planning; reflecting dynamic and engaged approach to planning rather than annual event carried out by a corporate department". None of the measures associated with this element note the importance of capturing patient experience on a regular basis.

We would seek to see a strengthened emphasis in utilising patient experience to inform the planning process. In addition to recognising key sources of patient experience, like Macmillan's Wales Cancer Patient Experience survey which could meaningfully support a Health Board or Trust's ongoing engagement with patients in relation to cancer services.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?

The Health and Care Standards published in April 2015 are highlighted as representing the cornerstone of the overall quality assurance system in the NHS in Wales.

The purpose of the Health & Care Standards include the following:

- embrace the principles of co-production and prudent health care;
- offer a common language to describe what high quality, safe and reliable healthcare services look like;
- can be used by people of all ages to understand what high quality safe healthcare should be and what they should expect from a well-run service;
- enable a person-centred approach by focusing on outcomes for service users and driving care which places people at the centre of all that the

service does;

- enable people to contribute fully to their own health and wellbeing;

We welcome the emphasis in the standards towards ensuring care is person centred. The plan highlights this as:

Person centred care refers to a process that is people focused, promotes independence and autonomy, provides choice and control and is based on a collaborative team philosophy. It takes into account people's needs and views and builds relationships with family members. It recognises that care should be holistic and so include a spiritual, pastoral and religious dimension. The delivery of person centred care requires both safe and effective care and should result in a good experience for people.

This understanding of person centred care and its links with addressing a person's holistic needs resonates strongly with our work and the outcomes of the Wales Cancer Patient Experience Survey. We believe the adoption and implementation of these standards would support Health Boards and Trusts in meeting some of the "exemplar" measures as set out in the NHS Planning Framework. The results of the Wales Cancer Patient survey demonstrates strongly the positive outcomes and experiences for patients when person centred care is consistently delivered.

At present however Health Boards and Trusts are not obliged to meet these Health and Care standards. We believe that a strengthened mechanism for meeting these standards should be developed to ensure that person centred care, patient experience and holistic needs are all key drivers in understanding the success of a service.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Welsh Government recommended that a peer review model be introduced a peer review model in 2011 into cancer services to be carried out by Healthcare Inspectorate Wales, and supported by the cancer networks. Peer review was launched in Wales in 2012 and focuses on the measures required to improve both the quality and safety of cancer services within the revised structures of NHS Wales. The purpose of the Peer Review is to demonstrate and share good practice and support all services in Wales in achieving excellence. The work undertaken by Healthcare Inspectorate Wales (HIW), the Cancer Networks and the Palliative Care Implementation Board has moved away from central reporting towards strong self assessment along with the rigour of a peer review process. The approach has provided an opportunity to bring together local services, clinical experts, and independent external scrutiny to assess how local services are performing using the health service wide

framework of Doing well, doing better along with service specific quality standards and indicators. This collaborative approach extends to the development of the new peer review process itself. For example, Cancer NSAGs and Network Clinical leads have identified relevant performance measures and are identifying existing available data to inform the assessments.

The links between the peer review and the results of the Wales Cancer Patient Experience survey would ensure the information collected is used intelligently to drive continuous improvements through the peer review programme. We support the maturity matrix underpinning the approach which rightly identifies areas for improvement. However, we believe that the mechanisms which ensure recommendations are implemented need to be strengthened considerably. We also believe there should also be external challenge from beyond Wales and that action plans and implementation of the recommendations should be strengthened to ensure improvement in services where it is needed is achieved.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?

We recognise that all Local Health Boards in Wales have both a commitment in policy to undertaking clinical peer supervision. We understand however that in practice, implementing this policy consistently and at the desired intensity across Wales has not been achieved.

The challenges to ensuring clinical supervision can be completed in a timely way relies heavily on two key factors, namely:

- That a sufficient amount of staff across an appropriate mix of services have been trained in facilitating the peer review process.
- Capacity exists within teams to allow the time for clinical supervision to take place without negatively impacting on the service a team is responsible for delivering.

Therefore, there is a need to develop a critical mass of professionals who have been trained to conduct clinical supervision, across teams and disciplines.

We believe clinical supervision continues to be of great value to professionals, offering a confidential environment to reflect, identify both poor and good practice and develop on the basis of the review's findings.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process

of referral in such an arrangement?
We welcome the exploration of a duty of candour as an option to increase transparency, openness and accountability in the Welsh NHS and better understand its merits and drawbacks going forward.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
One area, we believe greater legislation or guidance could improve transparency on performance is that of Individual Patient Funding Request (IPFR) decisions. Health Boards should however be required to report up to date data on a regular basis. The data should report the number of requests, approvals and rejections by Health Boards and specify information on: - Indication - Condition (e.g. cancer) - Type of condition (e.g. bowel cancer) More information on the IPFR process should be made available so that the public can be better informed and begin to develop more confidence in the process. Better information for the public is also vital to ensure the effectiveness of the government's policies, and their implementation by Health Boards, can be closely scrutinised. The current lack of transparency in reporting data is unacceptable. We are disappointed that the option of creating an all-Wales IPFR panel was not implemented as we believe this is a potential mechanism to reduce variability and inconsistency in decision making across Wales.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
One of the main barriers to sharing patient information is IT. We know that a person's cancer treatment can span services across primary and secondary care and a number of health boards, and is rarely confined to one. This means that where IT systems do not link effectively that there is a considerable barrier to sharing patient information quickly and effectively and therefore affecting the clinical management of the patients, the quality and timeliness of care provided can suffer.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?

Sharing information between healthcare bodies
We recognise the importance that healthcare organisations are able to quickly, effectively and safely share information to better manage a person's care. In the context of cancer services, this facilitates the potential for a quicker diagnosis, a more seamless service as people transition through their treatment and a more positive overall experience for the individual.

Sharing information with the public
We believe that the challenge around sharing information should not be one solely framed around the sharing of information between different aspects of the healthcare service.

"Sharing information to provide a better service" should be considered in the context of the offer of information to patients; about their cancer, treatment and living well by maintaining their health and wellbeing.

In our "Cancer: Time to Choose 2016" campaign, we have called on the next Welsh Government to ensure that each person diagnosed with cancer receives timely information and support to help them understand their cancer and make informed decisions about their treatment and care.

This will help to deliver improved patient safety, reduce risk and support better self management. To achieve this, improvements in a number of key areas are needed, including:

- Ensuring people regardless of where they live in Wales, or the nature of their condition, have access to high quality information both during and beyond treatment in a format which meets their needs
- Supporting people to easily identify high quality information and drive improvements in quality
- Ensuring the effective use of available resources by clarifying the role of services and integrating information within the care pathways – particularly in relation to support following hospital treatment
- Promoting a shift from healthcare professionals being an information provider to an information enabler, supporting people to access the information and support they need to make decisions and find their own solutions

All of these elements are needed to ensure both outcomes and experience of people affected by cancer in Wales are developed consistently and drive improvements in services.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?

Macmillan fully supports the principle of people being able to make informed decisions about their health, medical treatment and personal data. We want people to continue be able to express their preferences around data sharing.

Improving the public's understanding of how and why health and care data is used is essential. It is also vital that people are made aware of the

opportunities they may have to register a preference for how their data is shared or used, and that they are supported in reaching an informed decision. This should include a clear statement of the benefits and risks of data sharing, and what the opportunity costs are of not sharing data, using tangible examples.

Macmillan is conducting research to further explore people's preference in both the sharing of anonymised and identifiable data in relation to non direct patient care. The findings of this research will be available in the near future.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
Macmillan Cancer Support recently responded to HIWs draft strategic plan 2015-18. Although not linked to the legislative framework, we feel the points raised continue to be important in considering improvements to the way in which HIW carries out its role. In summary, the points raised in our response were as follows: • Welcomed the additional areas for review outside of HIWs regular programme of inspection, including "Treating people in the right setting and preventing unnecessary admissions" and "Discharge Arrangements" and in 2017-18 the focus on "Diagnostic services" and a review of "Palliative care". • We highlighted that there should also be a focus, or mention of, cancer peer review and its role in the ongoing improvement of services. • We highlighted that there should be a strong focus and recognition of the role of the third sector in delivering and supporting these services. • There should be a strengthened process for ensuring that recommendations are updated and implemented in a timely way.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
We would highlight that CHCs are not the only body or organisations representing patient voice. The third sector, including Macmillan Cancer Support have an important role to play in highlighting and bringing the views of patients to the NHS and its partners in order to shape and improve services.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?

The Wales CPES is a rich source of information and we would encourage its use by other organisations, such as CHCs to focus practice in areas that patients have identified as needing further attention to improve experience and outcomes.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
We believe that without greater accountability and transparency by Welsh Government in managing the performance of individual organisations in the NHS, Wales will continue to languish at the bottom of international comparators and our aspirations to provide cancer care that matches the best in Europe will not be realised. We believe strengthened national leadership and accountability is needed to accelerate the pace of change in terms of delivering agreed (or future) policy and improve existing governance arrangements for delivering services. We welcome the strengthened arrangements for a single cancer network in Wales. It is a step in the right direction of having clearer clinical structures spanning health boards/trusts which support better, more effective and timely cancer pathways, but there is still much more to do. The strategic direction set out in the Cancer Delivery Plan (CDP) was widely welcomed in 2012 but its operational implementation to date, has been limited. Although a small number of standards and targets were identified within the plan, monitoring against all of the objectives set out in it has been limited. In addition, there is still no comprehensive national plan which clearly describes how and when all of the aspirations in the CDP will be achieved. Furthermore, the consequences of non compliance e.g. against NICE guidance, cancer and peer review standards and other policy targets by individual NHS organisations have not been properly addressed (or seen to be addressed) due to lack of clarity about governance, reliance on self-reporting processes and absence of any real levers that drive action and change in and across individual organisations. There is insufficient rigour and grit in the current system to systematically reduce variation and tackle performance where it is laggard or unacceptable for cancer patients across Wales. The WG Cancer Delivery Plan (CDP) requires HBs to “publish regular and easy to understand information about the effectiveness of their cancer services” and “publish an annual report on cancer services for the public of Wales each year to demonstrate progress” and to “produce and publish a detailed local cancer delivery plan to identify, monitor and evaluate action needed by when and by whom...and publish these reports on their websites quarterly.”

Our analysis of Health Board annual reports and delivery plans has been that the implementation of these reporting commitments has only partially been met and that the quality of information about cancer services currently available to the public is often patchy, inconsistent and inadequate National scrutiny of individual NHS organisations in Wales rests with Welsh Government. We believe that a new national body should be created to address the existing national governance gap and publically strengthen Welsh Government's accountability for and management of individual organisations in NHS Wales.

We believe a new national body needs to be established. It should meet in public (as health boards and trusts are already required to do) to review and consider the performance, challenges, opportunities facing NHS Wales and to be responsible for setting ambitious plans for improving treatment and the quality of care provided. It should provide clear strategic direction for individual organisations and collective of organisations in NHS Wales and set out its expectations, targets and milestones they are expected to achieve. This new national body would help to improve transparency, accountability by providing a more visibly, open and strategic approach to governing the NHS in Wales than is currently the case. We believe this new body should fulfil the following purposes:

- Commission and receive international comparisons, evidence and research about NHS Wales's delivery of its strategy and the operational performance of individual organisations.
- Enable better collective leadership and strategic direction and coordinated action across Welsh Government and NHS Wales.
- Provide a focus for reinforcing standards of safety and quality – and proactively and openly addressing systemic issues and concerns early when they occur.
- Manage and improve the current escalation process for the management of individual (failing or potentially failing) organisations in a more open and transparent way dealing with issues at the earliest opportunity rather than when the situation has seriously deteriorated.
- Act as a catalyst for improving quality and experience of patients and their care across and between individual organisations promoting equity of care and patient experience.
- Making sure the views and experiences of patients and the wider public are systemically embedded throughout the NHS.
- Improve productivity and efficiency where national or networked arrangements would be best adopted or where a once for Wales approach needs to be implemented.
- Re-build public trust in the management, scrutiny and accountability of individual NHS organisations.
- Provide an enhanced steer on the integration of health and social services.

WGGP131 – Clive Morgan – Cardiff and Vale UHB Health and Care Professions Council
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
We are already guided by the principles contained in the Well-being of Future Generations (Wales) Act 2015 (WoFGA). We already have an Integrated Partnership Board and GP cluster plans in place. We will use WoFG Act fully when it comes into force on 1st April 2016 to progress change if it is slower than anticipated, or to deal with blockages. There is always a trade-off between willing collaboration and directive legislation and both approaches come with a set off different challenges. However pragmatically we feel that we need to optimise outputs of current collaborative frameworks and strengthen pace of change using the directive elements of the WoFG before further legislation is considered.

2. If so, what changes should be given priority?
There does appear to be a requirement for legislation for the provision of wigs in a way that provides best outcomes and choice for patients.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Consideration should be given to the appointment of key joint roles across Health and Social Care with a remit for change, removing unnecessary barriers and to ensure decision making is joined up around the needs of the people of Wales. It is important that all key public, private and third sector stakeholders have equitable influence within LHB/LA given the scale of change. Equal partnership working and advocacy for citizen / patient life time needs across the entire continuum of health and welling services. This will not only require national system level direction setting as established by the WoFGA but also functional or structural units within Wales with the legitimacy and authority to make the change happen.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service

change?
No we believe we should work with existing legislation to drive change to deliver outcomes that truly matter to people before introducing further complexity. Performance management focussed on the needs of the people of Wales in this highly complex environment should drive the appropriate pace of change. The greater use of PROMS and PREMS to manage performance will also support culture change. Performance management suggests that more performance targets don't incentivise clinicians or affect behaviour change.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
The Williams Commission states we should look at current mechanisms first. Therefore we need carefully consider what we already have in place in terms of stakeholder forums and the Health Professions Forum. If they are not delivering the required inputs to consistently inform LHB decision making then we should consider reconstituting them rather than invoking a new statutory requirement to deliver the required patient centred outcomes. New legislation will take time to be enacted and implemented and until we optimise existing systems the requirement for further legislation will not have been evidentially established. Therefore it would be helpful if the Williams commission report recommendations were implemented in totality. Focus could also be provided on the potential for strengthening the role of the LSBs in integrating services. There is also a danger that we could lose the richness of existing informal arrangements where we can approach hard to reach groups. Any local engagement framework must have the degree of sophistication required to address the needs of the patients it services and this may be better designed at a local level recognising the diversity of its population.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
We agree that there's too much duplication already which creates a massive burden of regulation, data collection and reporting requirements for the NHS. Again we need to carefully consider the roles of existing bodies. We already have a number of expert panels such as the Delivery Unit, 1000 lives + etc., the addition of another tier could prove counterproductive and increase complexity and delay in decision making. Consideration should be given to a review of existing bodies and whether an enabling framework to join up the work of these bodies would be helpful. We would need to build up evidence for change and to articulate the problem statement better to understand whether alternatives would be better than exiting systems. Delegated authority from WG to these bodies and clarity on referral routes and potential outcomes from a referral (i.e. level of authority of a body to make a decision or to institute change) would be helpful in reducing the burden of referrals to WG.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
We need to review current performance metrics which are very process driven / through-put driven rather than balancing quality metrics and patient centred outcome metrics which strongly align to prudent healthcare principles. What gets measured gets done, so let's measure the things that matter to the people of Wales by developing measurable health and wellbeing outcomes in partnership with them and aligning system level life pathways to support these outcomes. The WoFGA will support an integrated approach but this should also be strongly driven by a system level strategic enabling component of the Welsh IMTP process. Aligning public sector delivery plans to system level strategic goals. This should be done in partnership with the people of Wales, public, private and third sector bodies and WG.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
Ensure framework is integrated across Health And Social Care it is likely that the WoFGA will have a positive impact on this. Current differences create complexity and blockages for service improvement but the WoFGA will ensure that public bodies work better with people and communities and each other to take a more proactive and joined approach to delivering services which provide health and wellbeing outcomes that matter to the people of Wales.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
It is pointed that LHBs have a statutory duty to balance the books but no similar statutory duty to provide safe services to a minimum quality standard. This situation does question NHS priorities, and may not inspire public or professional confidence. However we feel on balance that no legislative measures are required. We do however need a greater emphasis on quality through existing mechanisms such as the IMTPs. We need to design joint quality performance measures for all public sector bodies developed in partnership with the people of Wales. Public bodies need greater mutual or peer accountability for delivering outcomes that people want and artificial budgetary, organisational or professional boundaries which compromise the delivery of these outcomes should be addressed sensibly by collaborative mutual agreement rather than legislation.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?

This would improve transparency, clarity and consistency. It would improve public confidence through a clearly understood individual accountability framework.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
We already have regulatory frameworks in place for professionally regulated professions, such as our staff groups which are regulated by the Health and Care Professions Council – a UK regulatory body. The requirement for the Clinical Executive Directors in Health Boards stipulates professional standards and personal code of proficiency and conduct. The registered individuals are accountable for their actions and professionalism at all times. This is hardwired into personal values and behaviours aligned to the duty to protect the safety and best interests of the public at all times. If these requirements were applied to other Board appointments then it would standardise practice and provides a greater level of assurance for the public that patient centred decision making is mandated for all Board members.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Quality must always be paramount in healthcare. Everything must be done to optimise quality outcomes using existing frameworks before legislation is considered. This links to corporate values and thinking and properly constructed quality balancing measures developed by the people of Wales will consistently drive planning decision making at a macro and macro level to deliver on those quality measures. If we get the quality metrics right then balanced operational and financial performance should follow.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Yes, it would be helpful if the new Health and Care Standards were equally applicable to social care settings and to third sector and private sector providers. Shared goals and a common language to articulate problems would drive closer collaboration on a patient centred pathway basis through joint ownership of standards. This would encourage system thinking where objectives could not be met by organisations managing their siloed piece of the pathway in isolation.

14. Could a common standards framework, which covers both the NHS and

the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes, for similar reasons outlined above. Patients don't compartmentalise their experience as it is on a continuum of needs. Very often interagency collaboration is required to deliver consistent patient focussed outcomes in the gaps between services. This is even more challenging where there are separate standards. Interconnectivity, or better still shared quality standards, across sectors is a basic requirement for high quality services which span multiple pathways. We need to emphasise what gives value to people and make the framework simple.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
We should consider building this requirement into a national system level commissioning framework. Perhaps a better integrated commissioning framework is key to unlocking desired change rather than legislation. We must commission 'across the gaps' in sectors and services to ensure that health and wellbeing services provided to the people of Wales are truly seamless. It is recommended that we use strategic budget setting to drive strategic level change and a transformational step change in patient centred outcome quality.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Already part of regulatory requirements for GMC, NMC, HCPC and GPhC. Again this should form part of quality balancing measures rather than legislation. Healthcare professionals who are registered on assured voluntary registers are supported as part of the Clinical Executive's professional portfolios i.e. Director of Therapies and Health Science, Nurse Director and Medical Director.

17. What arrangements should be put in place for self-employed health professional registrants?
Should be the same regardless of employment status. This is a public protection issue which applies to public, third and private sector equally and is of highest importance.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within

the NHS in Wales?
Yes, our patients deserve this.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Review current performance measures/mechanisms as majority already in public domain. As discussed previously patient centred service quality metrics are required to balance hard performance targets which by in large manage numbers and throughputs rather than individual patient needs. There should be greater emphasis on outcomes e.g. PROMS and PREMS.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Review current legislation to enable joint investigation and place requirement on integrated partnership boards to do so. Many have different burden of proof/standards which adds further complexity e.g. safeguarding adults. The Social Services and Well-being Act addresses strengthening safeguarding adults and puts on same fitting as child protection. Future iterations of “Putting Things Right” must continue to enable more timely engagement with patients encouraging face to face resolution earlier in process. This also supports duty of candour and public bodies must always ‘go honest and go early’.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
There are unnecessary system barriers which it is not always clear how to resolve, and not in the best interests of the public we serve. There are different Governance arrangements or interpretation of rules. There is still a lack of clarity on Caldicott rules and the implementation of these varies between organisations and sectors. We believe that current situation creates tension between protecting and sharing clinical data. However we strongly agree that when patients need data shared to deliver outcomes they want then sharing must always take primacy. The All Wales network for example prevents sending Patient identifiable information outside the network which can sometimes compromise patient care. It can also prohibit the use of technology to support patient care. Technology should build on the principles established in the second of Caldicott IG review and support and enable patient centred data sharing, not prohibit unless there are critical safety / governance reasons. We should be encouraging e-communication with patients and between professions. Our patients are often frustrated by our lack of ability to communicate with them

electronically. The new Welsh community information system should support better sharing of patient information, but this needs to extend to communication along the whole pathway and between organisations as well as with patients/clients themselves.

22. How can we consider breaking down any barriers?
Create more shared systems, design secure interconnectivity systems, review of firewalls and local governance arrangements. There could be a need for directives or advice and guidance to ensure standard interpretation of IG rules to aid design or to re-engineer existing systems. There needs to be better engagement with information users and data controllers. Shared governance frameworks are key and perhaps joint appointments at a regional or national level could standardise approaches. A national network of SIROs would be helpful to ensure consistent advice and interpretation of IG standards.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
R&D is an important health care activity which drives innovation and leads to improved outcomes, this should be supported. The collection and sharing of patient identifiable information for non-direct patient care could be required in certain circumstances, longitudinal cohort studies in Public Health when tracking patients over period of years provides important evidence on health determinants. We need to consider consent that remains contemporaneous and intellectual copyright. Informed consent needs to be carefully considered as we move toward genomic and personalised medicine as individuals can be identified by genotypic presentations. Would need wider public engagement on this issue as it has an impact outside healthcare and will be essential for the NHS in Wales to be at the leading edge of the Life Science 'Health for Wealth' national infrastructure.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
The current regulatory framework appears to be unnecessarily complicated. We will need to future proof legislation to ensure emerging models of care and new treatments are automatically subject to HIW review to provide the level of protection required by the public.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?

The evolving English model for regulation needs to be closely monitored. There is a danger that too many regulators may not deliver the desired effects. However there appears to be a strong argument for an independent inspection body with requisite vested authority that covers all aspects of healthcare provision and can target areas where evidence of poor care is found locally but may be replicated on a national level.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
We don't think there are any easy solutions. The most robust model would be a single inspectorate to ensure consistency and shared learning. Implementation of recommendations from HIW may be challenging where they don't have powers over Local Authority services. Independence is key but would need to review roles of other statutory regulatory bodies (HSE, HTA, MHRA, HFEA, NRW etc.) to ensure a consistent high quality approach and to avoid unnecessary duplication. There already appears to be overlap between the DU and HIW for example.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
It would be streamlined and provide services with a consistent investigation process, common standards and standard outputs. Ideally this would improve clarity, reduce uncertainty and differing interpretation of standards. It should also improve value for money.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Yes. Too much duplication with the HIW function. Creates an industry within Local Health Boards and delays service change. Could a Patient Advice and Liaison Services (PALS) model be considered to provide better advocacy and patient voice, rather than conflating inspection with representation functions?

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
Similar issues arise as outlined in 26. Inability to advocate for the Social Care element ultimately increases duplication and workload. Could present a conflicting report where there is currently a different system for LHBs. If patient engagement model changes to one of co-production/patient panels then this needs to be reflected in the role and responsibility of CHCs as this could create duplication and complexity into planning system. There will always be a significant role for the CHC or PALS in terms of patient advocacy but potentially a reduced role in inspections.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
LHBs and Trusts would need to have some way of income generating in order to repay any loan. This does not fit with WG policy re plurality of provider/private health income. There may be opportunities for LHBs to have the same powers as Trusts to establish joint ventures to form companies with a University partner for example. Whilst LHBs and Trust's should live within means rather than borrow to provide services which are not prudent or affordable, there could be opportunities to enable innovative model, with safeguards to enshrine NHS principles. This could significantly increase the risk of LHB insolvency though.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
Yes, but minimise bureaucracy, but ensure good financial governance.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes, so much of our core business is dependent on their services and vice versa for example WAST and patient flow, Velindre and Transforming Cancer services etc. LHB's cannot solve many of their existing performance issues unless a system level solution is developed in collaboration with Trusts.

34. 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 in order to provide better engagement opportunities with service users and consideration of unintended consequences.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
There would appear to be further opportunities to develop and strengthen integrated partnership boards. This would benefit from greater clarity with

regard to accountability and developed decision making powers and their impact on LHBs.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
The green paper affords an opportunity in relation to strengthening primary and community care and the subsequent opportunity to realign workforce and implement new roles. • The blend of expertise from the four professionally regulated Executive Director roles (Director of Therapies and Health Science, Director of Public Health, Director of Medicine, Director of Nursing) enables the Board to make timely decisions and explore new roles/unintended consequences with confidence. The strength of Executive clinical leadership serves to add diversity to the traditional skill set and provides greater opportunity to do things differently to improve prudent healthcare delivery. Future changes could strengthen need for this diversity particularly when seeking public endorsement. This arrangement of strong clinical Executive leadership hardwires multi-professional leadership in LHBs promoting the culture change required to foster multi professional team working at all levels within the UHB and partner organisations. It is recommended that Trusts should also have Director of Therapies and Health Science staff as these organisations would benefit from strengthened Executive leadership for the HCPC regulated staff e.g. healthcare scientists, therapists and paramedics. • Able to provide assurance to external scrutiny that all options have been considered. • Continues to build upon the need to transform health and social care with candour and transparency by ensuring that all professions have a voice which has equitable influence within the Board. • Structure has been emulated to next tier which enables Clinical Boards to provide assurance. Some of the Healthcare Science and Allied Health Professional assurance/regulatory mechanisms are complex and require a level of expertise at Board in order to challenge, they differ from medical and nursing regulation and affect all the other regulated health professions. • There appears to be no reason why we couldn't have some of the corporate roles shared across Executive Director portfolio as this already happens but there is a need to ensure the regulated roles are retained and equally valued. • Emphasis on leadership in the green paper and also William's commission, which remains important It is important to consider areas of expertise in co-production, integration across boundaries, promoting independence, self-efficacy and Health behaviour change. These are all areas that are core within AHP practice philosophy and mind-set and key functions of Directors of Therapies and health science who are accountable for Occupational Therapists, the only

profession that works in both health and social care.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
LHBs should retain professionally regulated Executive Director roles which cover majority of registered practitioners. The HCPC workforce comprises nearly all the health professions that are not doctors or nurses, comprising over 40 individual professional groups. The inclusion of this role in the Executive team has valued the contribution of all health professions and harassed the skills that are best placed to promote the integration agenda as therapists work in all elements of health and social care as well as education and the third sector. These roles also are ideally placed to lead the shift from hospital to community care. Healthcare scientists play a significant role in maintaining regulatory compliance, critical evaluation and introduction of novel, emergent and disruptive technologies. A case in point is molecular pathology and genomic analysis. This will be a game changer for health and well-being services and many existing pathways will be completely re-engineered or even removed as gene therapy becomes mainstreamed. These technologies will also drive leading edge translational medicine opportunities which will underpin the Life Science sector in Wales. It is essential that these professional groups have a strong voice at board level so that all available opportunities to drive transformational change are taken by LHBs. It also is recognised that roles like Chief operating Officers have evolved, most if not all of these already hold Executive positions. The size and complexity of the LHBs requires a strong and diverse Executive team, not a smaller one.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
There would appear to be risks for any representative function that it will be used to drive personal agendas. The role of independent members in providing that oversight needs to be fully developed and the time spent scrutinising LHB Board decisions should be ring-fenced.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
There is potential to reduce complexity and barriers to integration. However local appointments should remain in order to understand needs of local population in keeping with the principles established in WoFG Act. There is potential to subsume Director of Public Health into PHW but we think this

would be a retrograde step as it reduces influence, trust and engagement at a local level. Cardiff and Vale UHB has benefitted significantly in having this function at Board level as an integral part of the IMTP process and driving forward patient centred change.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Possibly consider addition of Chief Operating Officer role to Board to ensure interface with operational tier is hardwired into Board decision making.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
Velindre doesn't have a Director of Therapies and Healthscience even though it is a significant employee of these professions. Velindre is currently reliant upon advice from DoTHS in other organisations. Advice is not mandated as not requirement to act on this advice. There is a similar position for Public Health Wales employing large numbers of health care scientist, and WAST employing paramedics.

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
The role of the Independent member is time consuming and demanding. The Boards need this number of IMs to discharge the roles required and give the level of scrutiny expected. The IMs should not outnumber the Executives.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
Possibly, but this may not require law changes

45. How could potential conflicts of interest for the board secretary be managed?
Ensure scope is clearly laid out.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
The current advisory structures provide an opportunity to seek independent advice from the professional bodies, AHPs and Healthcare Scientists (HCS)

all provide advice through WTAC/WSAC The advisory mechanism assures independence from the LHBs and therefore differs from the DoTHS role and responsibilities. NSAGs aren't required to provide multidisciplinary advice and very often will use local networks which can't assure the most expert person has been engaged in providing evidence or is representative of the profession. SAGs can provide that assurance though they do not all have the same strength of voice.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
The key experts are often the four Clinical Executive Directors, their advice is readily available and doesn't require legislative change

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
This is well developed no changes recommended.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
Currently lack of clarity and enforceable accountability, this could be improved but may not need legislative change.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Must ensure value for money and responsive to customer needs, not sure that it is really in the public interest to expand the function to cover the entire public sector, would not be supportive of it developing a role for clinical service provision. Must not develop into a "quango".

WGGP132 – Jenny Williams – Conwy County Borough Council
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Preventative primary care is an essential component of an effective and efficient Health and Social Care System. The importance of integrated approaches cannot be stressed enough. It's not simply one person or one organisation's responsibility to promote early intervention. There is legislation in place identifying the increased need for a joined up seamless approach, however the focus of the Health system has been on acute provision for too long and the pressure of manging the day-to-day demand means supporting the agenda in a time of austerity is proving incredibly difficult. Initiatives have been established but often the finances are not able to follow and therefore it's tokenistic. The latest round of legislation identifies the need to work in collaboration and develop whole population assessments, however there is a strong belief that the legislation is focused on Social Care being the lead agency whereas reality is the first place someone goes to seek support is often their GP. It is paramount that the information obtained in primary care feeds into the population assessments but the disconnect between primary care and the health board in North Wales is too great. The health board's focus was initially one of a regional approach and this saw a significant erosion of community based facilities which led to disaffected primary care providers and communities. In the last 2 years there has been a Welsh Government drive on integration in respect of community services. The view from the local authority is that it is often pushing against a closed door, even with WG direction around the developments of statements of intent and the use of Intermediate Care funds. There is evidence to support a willingness to progress in respect of the development of strategic documents, but sadly evidence and history is now

directing that operational implementation (other than between case workers on an informal basis) is not forthcoming.

Implementation of existing and emerging legislation (SSWB Act, WB&FG Act, Public Health Bill etc.) should be sufficient without need for further legislative change or action. However, it is Ministerial responsibility from Welsh Government which should be driving this forward. A cultural shift in expectation is required, one which will require strong leadership. Legislation won't create leadership or develop that shift.

It is possible to conclude therefore that the facilitation of wholesale change may be best supported through revision of legislation, enforcing the collaboration in respect of meeting needs on a more formal footing. However, this is a significant move when ideally a change in attitude and culture would be best utilised to achieve the same outcome.

2. If so, what changes should be given priority?
Delegation of the function of delivering Community Resource Services for Older people and those with a Learning Disability to Local Authorities. Although we do not see additional legislation as the driver for change we do recognise that changes need to happen. For example the delegation of the function of delivering Community Resource services for Older People and those with a Learning Disability to Local Authorities. To deliver effectively, partnerships need to be based on an understanding of the equality of those within it. Playing to the strengths of the partners (as recommended above in regard to the delivery of community resources) would support this – the current attitude from Health may be perceived as arrogance. The size of the Health Boards and their footprint tends to lead to domination by the board, with Local Authorities feeling disregarded and tasked to undertake roles they are not designed to. This may reflect a lack of understanding by Health in regards to the purpose and definition of partnership.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Changes to GP contracts should be made in order to direct involvement with the LA as both lead commissioner and provider of the bulk of preventative lifestyle services (exercise by referral, Wellbeing activities, libraries etc.) as well as their role within the Community Resources Teams. Welsh Government should be leading in the changes to GP contracts, challenging improvements in local delivery and relationships with the Local Authority. Will Wales be seeking a return to Primary Care teams, bringing together services around practices and clusters (District Nurses, Community Psychiatric Nurses, Health Visitors, Social Workers etc.) or is this going to continue to be a model of integration led by Social Care, seeking to work with

clusters through clear and honest locality working? The vast majority of partners and agencies report to Welsh Government already, if the message which is pushed forward from there is more explicit regarding expectations for agencies to work together to plan to meet people's health and wellbeing needs then it will not require a legislative change.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Effective consultation and the principles of participation are not engrained within the operational thinking of the health board. The WG has legislated in respect of the need for citizen panel and it is fitting that that the Health Boards should utilise these as a credible way to consider and discuss the impact of change. It needs to utilise the SSWB Act to this effect. If there is a desire to see integrated provision it makes no sense to create a separate engagement mechanism. The Health Boards need to engage with their own staff – a significant proportion of the local community – to better understand what they are doing well and what they can improve upon. [An example in Local Government is the Improving Conwy process which engages all staff in key thematic debates and discussions to improve outcomes and services for residents]. The relationships required to engage citizens are local, it should not be an arm's length approach from which power is shifted back to the board.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
There is a need for this to be on a statutory footing as the involvement, input and priority that should be given to these panel needs to be made explicit to the Health Boards. A duty should be placed on the Health Boards accordingly. Each Health Board should be expected to have an engagement strategy and a statement of intent which demonstrates how it will change the culture and move away from its current issue focussed way of consulting to coproduction via the use of the panels. Current barriers are that systems are too fragmented internally and externally. There is hope that the Community Care Information System will move us forward over a period of time. However it needs to be recognised that significant investment is required. In addition the boards and trusts will need to evidence how they will

implement change as a result of listening to those engagement mechanisms. There is a clear need to link with the CHC.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Yes. There is a need to ensure those considering the challenges which will arise from differing opinion are scrutinised effectively. There could be a role and function for the use of democratically elected LA members with portfolio responsibility for Health and Social Care to participate in this process, supported by experts who are employed directly to be involved or whose time is requested to consider an issue. An example of how such a panel is developed might be modelled on the panels arranged by the NMC, Care Council or GMC where there is concern in respect of an individual professional's practice. Legislation in respect of these issues should again be captured in the SSWB Act as if the integration occurs then the plans should be coproduced and developed / designed, therefore all parties should be subject to the scrutiny. Yes we believe that the HIW inspectorate should be independent and would support joint working with CSSIW all be it recognising specialist skills where necessary. Access to expertise is essential, but there is a ministerial responsibility to undertake their role properly.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
No there is a need for everyone employed in delivering health care to own the agenda and this cannot be legislated for. Therefore legislation is another tool to ensure sign up and buy-in as the scale of the cultural change required is huge. Sadly the distance between front-line service delivery and Senior Health Board managers is too great and therefore ownership is not there at the highest level. Legislation will not ensure the Board's members lead by example and truly own the need for quality, making the change culture effective. No particular comments other than any budget setting and management should be transparent.

8. If so, how can we use our legislative powers to build on the existing duty of

quality to better fit with our integrated system?
As suggested the SS&WB Act and proposed changes to the Regulation and Inspection Bill should take account of the required changes in the Health system. No particular comments about size of boards but that they should have effective leadership in place and entirely accountable with the rigour of scrutiny applies in local government. There should be flexibility in membership to co-opt members according to the structures within the region and the local issues of priority. Scrutiny through effective supported CHC is vial, supported by Local Authority democratic processes.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Sufficient legislation is in place; the concern is more about ownership and accountability. The cultural difference that needs to take effect is one where governance and openness to challenge, and a willingness for external scrutiny in respect of all aspects of the Board's work is nurtured.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
The concept of Responsible Individuals would be a solid starting place. However there would be a need for clarity on the level of seniority that would hold the role. The introduction of standards of direct observation would also be of benefit and should be a requirement of all board and executive members. The benefits of the approach is understanding the impact of decision taken seeing care in practice, and the impact of that care on others. The opportunity to challenge but also see good practice in operation. It brings a sense of reality and ownership to the decisions being made as well as having the opportunity to hear and see first-hand. The responsible persons are the CEO/MD and the board should also be truly accountable. Need to link accountability and responsibility to the Minister and also to the civil service providing guidance and support.

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
As above this should apply to all Board and Executive members. Anyone who is making significant decisions that impact on whole population need to be exposed to this as a check on their accountability and ability to hold such significant positions and responsibilities.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
No; the issue is that legislating doesn't change these things, it's a significant cultural shift that is required.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Yes the same standards should apply across the public and independent sectors in terms of healthcare provision. NHS commissioned services provided via the independent sector should be considered as part of the provision of NHS services and therefore consistent standards and assessment across provision is fundamental. Clarity is required in respect of what constitutes good standards. Standards should be graded – not just pass/fail – as this is the only way to ensure continuous improvement. Achieving minimum standards are not enough.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes it would enable the public to have clarity on where services provided are of both quality and resilient, providing the opportunity to reflect on the practice equitably and compare like with like. This approach wold help stabilise some vulnerable aspects of the sector (OP EMI nursing) by giving those employed in the services a more equitable voice. In agreement a common standards framework would drive up quality and improve citizen outcome and experience. Citizens are not necessarily aware or actually bothered about who provides the service and the same quality standards should be expected regardless of the provider.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Understanding how others approach situations creates invaluable opportunities to learn. Evidence has demonstrated that in respect of individual practice reflection and observation of others is beneficial. However there is a need to be mindful that reflecting or critiquing can lead to defensiveness if not undertaken in a constructive way. Recent workshops held by the WAO sharing good practice was a good way of informing others of examples of work where outcomes for citizens had improved but the delivery of some of

the workshops left others feeling demoralised about their efforts. Accreditation and peer review fundamental to improve quality.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
There is a need for strong supervision and annual appraisals of practice. Supervision standards should be reflective of the codes of practice for that discipline and no registrant should be allowed to continue to practice without demonstrating at least an annual review of their development. Supervision allows you to be challenged about decisions you have taken, to safely explore the use of up to date ways of working and thinking as well as reflect on outcomes and how things could have been done differently. Concerns should be raised quicker where registrants have not undertaken their annual practice development – recent concerns in North Wales regarding midwifery provision http://www.bbc.co.uk/news/uk-wales-34631604 show that despite clear professional expectations these have not been undertaken.

17. What arrangements should be put in place for self-employed health professional registrants?
Each self-employed health professional should make arrangements for this to be in place. It needs to be a condition of continued registration. Statutory Services should make available officers to do this for a small fee. In doing this the workforce is seen as one and wider than the reducing statutory services.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes there is a need for ownership by board and executive members. Not objecting to the suggestion but if this has already been introduced in England following the Mid- Staffs enquiry the Members were keen to know whether this has been evaluated and whether it had made a difference.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Each health board should be asked to prepare a statement of improvements that is shared through the LA Scrutiny committees, published on their websites and issued to residents directly.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
The SSWBA should have legislated for this. There are too many complicated process in place at present preventing clarity of investigation of fact and real confusion for citizens. One organisation needs to take responsibility. If integration was a success this would be part of the conditions and terms of any formal arrangement. Felt complaint processes should be amalgamated particularly as services become more integrated. There was also agreement that the powers of the Ombudsman should be extended to reflect this. It was suggested that complaints should go to the CHC's to deal with by some but others were not in agreement as they suggested they were powerless to do anything about them.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
There are no genuine reasons or issues. A failure to share is often the result of fear of breach of confidentiality. There needs to be recognition as stated that a failure to share can have a far greater impact on someone's health and wellbeing.

22. How can we consider breaking down any barriers?
The development of the national information system will assist in this and considerable work will be required to address governance accountability and Data protection issues. A considerable challenge would be if once established there was a view that this needs to be accessible to all partners. If we are truly going to see integration work, raise quality and gain improvements then we need to understand the Independent and Third sectors as our extended limbs.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
There are some issues in respect of consent, however the planning of future services needs to be based on the real life situations of today.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
It is important that all health care settings, be they managed and provided directly by the NHS or by the independent sector, be open to the same degree of scrutiny and inspection. Citizens are often unaware of these differences and therefore left vulnerable. It is recognised that applying the same or an improved level of inspection to all providers would widen the scope and responsibility greatly, however there is a need to see all parties as equal in order to address issues and raise standards as previously identified.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
All regulatory bodies require a level of independence however it is identified that this is difficult given the statutory nature of the organisations involved.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
There does need to be a framework of inspection, greater transparency of inspections and more frequent joint inspections between all the organisations. If they retain independence then yes, registration detailing the expectation in respect of how they should be more aligned would be needed. An alternative model might be to suggest that the HIW retains responsibility for in-patient services (including those in the independent sector) and all those in the community transfer responsibility to CSSIW.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
It is unclear as to whether 1 organisation becomes too large and unwieldy losing the ability to have a proper dialogue with its providers. We believe that a combined inspectorate would need to look at the aspects of Estyn which also cross into the areas of health and social care provision. That is not to say that Estyn should necessarily be part of a combined inspectorate, simply that the interface around provision (for example residential school environments for children with learning disabilities, which also provide appropriate respite care for families). The same principles of engagement (with transparent framework) need to be

modelled by HIW, CSSIW and Estyn. If not, yes the organisations should merge as 1 organisation, but still operate as linear sections. Where crossover occurs this should reduce some of the existing difficulties that are apparent to providers.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice? 29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
The ability or influence of the CHC has been significantly diluted. Their voice and opinion is often lost in the decision making process. If true coproduction and proper integration is to occur then a single citizen engagement framework across statutory services (to include services provided by independent sector on our behalf) is the only way forward. An alternative approach would be to consider the division of care between what is described as inpatient provision and community based services. Seeking 1 common approach to engagement in respect of community services by widening the scope of the Citizen panel with CHC retaining responsibility for representing the voice of the public in respect of the in-patient provisions. The model of advocacy representation also requires significant improvement and the CHC could again continue to lead on aspects of this.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Yes due to the size of the Health Boards it is now imperative that they are able to access funds that become available to meet the needs of the population and encourage greater integrate working by removing some of the barriers. However, given the poor financial controls and attitude exercised by some of the health boards this should be done with caution and support. Legislation should link with the role of a fit and proper person, along with clear accountability and defined roles for those making the decisions as responsible individuals.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
No it is an outdated model.

32. 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?
Yes, there is a need to consider how all of the public monies are being spent and it's imperative that the public is able to independently scrutinise this. Legislation needs to be reflective of the changes to structures and there needs to be the ability to cross refer and make comparisons.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes, the planning requirements should be on an equal basis across health boards and NHS trusts.

34. 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, there needs to be urgent consideration to the duplication of responsibilities. The SS&WB act places clear responsibilities and reinforces the need for integration. However there is still a view from Health Boards that the Act is for Social Services and the expectation is for involvement as opposed to being jointly accountable for population needs assessments. It is clear that duplication exists and the opportunity to provide clarity would be welcomed.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Health boards need to be open to the same level of scrutiny in respect of this and should be subject to inspection to ensure that their arrangements are effective. A failure to do this robustly has led to a health board with poor arrangements continuing to operate in this manner with minimal accountability by senior staff. A repeat of this anywhere else in Wales would not be acceptable. There needs to be a true understanding of partnership working by the health board and in not a tokenistic approach that creates further confusion. Social Service are scrutinised in respect of this by both CSSIW and WAO the same level of scrutiny should apply to all statutory Health and Social Care

services.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
It is difficult to comment on this aspect; whilst it is extremely evident that this function has not worked it remains unclear as to why. The role of the stakeholder reference group requires revisiting and in particular its opportunity to act as a scrutiny committee providing quality assurance. It is felt that this could be placed on a stronger footing if it became a duty that elected members from the local authorities within the health board's footprint were actively involved in. The stakeholder reference group needs to have a clear sphere of influence in order to truly provide the required level of challenge.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
The joint appointment of positons (working with, within and across local authorities) in a changing world of integration would also be welcomed.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
The need for this is based on the existing difficulties in respect of good solid public engagement. There is a risk that the representation is tokenistic and not reflective of the true voice of the population. With the implementation of a framework on engagement there would be little benefit from this at this stage and particularly in an area where there is such concern and scrutiny on the board.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
The joint appointment of positions in a changing world of integration would also be welcomed.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
The proportion of representation from LA requires further consideration in the changing landscape.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
The Social Services and Wellbeing Act prescribes the new statutory partnership arrangements In accordance with part 9, this extends to health and should be regarded. In addition the requirement to establish area planning boards in accordance with the Wellbeing of Future Generations Act and therefore we feel there is sufficient law already in place.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
In addition to the response to 48. There should be clarity on the models of delivery to inform any shared service and a commitment to integration of social care and health at the outset.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Would need more detail as this would depend on the area for shared service.

WGGP133 – Dr Mair Parry – Royal College of Paediatrics and Child Health
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
RCPCH believes infants, children, young people and their families are not only beneficiaries of NHS care but also key stakeholders and, therefore, need to be involved in all areas of planning and service development. Taking patient experience into account should include the life course (infants, children, young people, and families) and include vulnerable groups, those with complex needs and disabilities, and seldom seen and heard groups. While permanent engagement mechanisms do provide continuity and enable members to gain expertise in often complex processes and factors influencing healthcare, structures can slow innovation and the design of new engagement mechanisms. A requirement to engage should be statutory, with examples of best practice, toolkits and scrutiny of its effectiveness, but the mechanism by which it is done should be left to the discretion of the services themselves. What would be effective for older people, for example, (e.g. focus group or survey) perhaps might not be effective for reaching a group of teenagers (e.g. textchat or drawing).

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
No, RCPCH Wales does not support the idea of referrals being made to a panel instead of Ministers. There is strong consensus among medical professionals and compelling evidence supporting the need to redesign services and concentrate specialist services into fewer centres. RCPCH has clearly set out its position on service reconfiguration and redesign: http://www.rcpch.ac.uk/system/files/protected/page/Reconfiguration%20Position%20Statement%20Final.pdf. RCPCH Wales recognises that, despite the strong evidence of the case for change, reconfiguration of services in Wales and the UK continue to meet

considerable opposition with protestors perceiving decisions being made for financial or political reasons. We are also particularly aware of very strongly held views in Wales about the importance of locality and retaining services in-county and in Wales. Patient transport is a frequent concern. Even where reconfiguration is clinically better and safer for patients there are examples of clinical staff in affected units also being outspoken against changes, which means the public, patients and staff are confused and anxious about whom to trust. In work that our Invited Reviews programme has conducted in north and south west Wales it is clear that an expert, independent, professional opinion with full engagement of the public and staff has helped reduce the 'politics' from decisions and the process to proceed. Indecision and uncertainty can be the greatest cause of anxiety and pose difficulties for healthcare recruitment in affected areas. However, communication between politicians, public, staff and Local Health Boards still remains a concern. RCPCH Wales would always recommend use of expert panels to help bring about service changes and we would recommend expert advice from outside Wales, through the medical royal colleges. However, RCPCH Wales does not believe Ministers should lose the final decision-making ability and accountability in referrals.

Chapter 2: Enabling Quality

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
RCPCH Wales has called for a Welsh strategic workforce strategy, led by the Welsh Government and involving key partners such as the Wales Deanery, medical royal colleges etc. However, this would not require legislation.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
There is a case for making more use of measurable standards and outcomes against which to judge the success of NHS services. The existing Welsh NHS standards (http://gov.wales/docs/phhs/consultation/141103frameworken.pdf) are universal and also difficult to measure. For paediatric and neonatal services RCPCH would expect any standards to reflect established RCPCH standards, such as: **Primary care and acute general paediatrics** • RCPCH's newly revised UK *Facing the Future: Standards for Acute General Paediatric Services* (www.rcpch.ac.uk/facingthefuture) which focus on consultant-delivered care and ensuring that paediatric services

are 24/7 with consultant presence at peak times, better supervision and support for trainees and senior review of patients. Workforce modelling which accompanies the standards shows that there needs to be a greater degree of consultant presence.

- RCPCH, RCN and RCGP's new UK *Facing the Future: Together for Child Health Standards* (www.rcpch.ac.uk/togetherforchildhealth) will ensure specialist child health expertise is available directly in primary care, where the needs of the child and their family are known. The standards aim to ensure there is high quality diagnosis and care early in the unscheduled care pathway and to reduce unnecessary attendances and admissions to hospital. Where children do need to be cared for in hospital, the standards aim to reduce the length of stay, enabling them to go home as safely and as quickly as appropriate (for example, through enhancing community children's nursing services).

Other specific settings

- *Standards for Children and Young People in Emergency Care Settings*, Intercollegiate 2012: Provides healthcare professionals, providers and service planners with **measurable and auditable standards of care applicable to all urgent and emergency care settings in the UK (**http://www.rcpch.ac.uk/sites/default/files/page/Intercollegiate%20Emegency%20Standards%202012%20FINAL%20WEB.pdf).
- *Short Stay Paediatric Assessment Units (SSPAUs): Advice for Commissioners and Providers*, RCPCH 2009: This report proposes that SSPAUs can improve the provision of safe emergency services for children and examines some possible models. http://www.rcpch.ac.uk/sites/default/files/asset_library/Policy%20and%20Standards/SSPAU.pdf
- *High Dependency Care for Children: Time to move on*, Consortium 2014: Contains a number of recommendations to improve delivery of safe, high-quality critical care outside of paediatric intensive care units. Children's health experts are calling for a new three-tier hierarchy system of critical care, enhanced staff training and a more consistent funding model to bridge the gap between critical care delivered to children in children's wards and high dependency units and that delivered in intensive care. http://www.rcpch.ac.uk/sites/default/files/page/HDC%20for%20web.pdf
- *Standards for Children's Surgery*, Children's Surgical Forum 2013: Key standards for the delivery of safe children's surgery. http://www.rcseng.ac.uk/publications/docs/standards-in-childrens-surgery
- *Healthcare of Children and Young People in Secure Settings*, Intercollegiate 2013: Designed to help plan, deliver and quality assure the provision of children and young people's health services in secure settings. These children and young people are some of the most vulnerable, often

suffering poor physical and mental health. http://www.rcpch.ac.uk/system/files/protected/page/Healthcare%20standards%20A4%20report%20pages%20english%20compressed%20FINAL.pdf

- *Workforce census*, RCPCH 2013 http://www.rcpch.ac.uk/census
- *Service standards for hospitals providing neonatal care*, British Association of Perinatal Medicine 2010 http://www.bapm.org/publications/documents/guidelines/BAPM_Standards_Final_Aug2010.pdf

Safeguarding Children and Young people: roles and competences for health care staff, Intercollegiate 2014 http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20%20(3)_0.pdf

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
As mentioned in response to question 13, the existing NHS standards framework are high level (universal to NHS services) and also difficult to measure objectively. If these are not supported by specific standards there is a risk clinicians will not feel generic standards are helpful to improve their practice or that they are not measurable. The risk is that monitoring universal standards could be seen as an administrative or management burden. Tailored standards are more sensitive, measurable and will better engage the enthusiasm of clinicians.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
It is important that healthcare professionals and teams keep up to date with new developments and seek external evaluation of their work. Too often this only happens where there is an incident or safety concern, or where services are being reconfigured. Some health economies, such as Guernsey, have arrangements for evaluation reviews every five years and this may be a model to consider to ensure Local Health Board teams remain up to date. Alongside Healthcare Inspectorate Wales' role as a 'third line' regulator, there should be a requirement for regular peer review using professional reviewers from another Local Health Board or, ideally, from elsewhere in the UK. Peer review is different from inspection as it is collaborative and can offer insights, examples and tools from other services. It is not punitive and includes reviewers who absolutely understand the specific challenges of delivering a service, share the values of the team, and 'speak the clinician's language' which sometimes non-clinical managers are perceived not to do so well. Being involved in peer review can also be a professional development activity for clinicians and help their learning.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
RCPCH supports the UK Academy of Medical Royal Colleges' view that it has serious reservations about the duty of candour (as defined in the Francis report) on individuals and organisations. RCPCH therefore welcomed the UK Government's decision only to propose the statutory duty on organisations and would not like to see a duty of candour on individual clinicians in the NHS in Wales. We believe it is right that the duty of candour for individual clinicians is a matter of professional regulatory responsibility rather than statutory duty. It would be sensible for the Welsh Government to co-ordinate its approach to a statutory duty of candour with other UK health departments to achieve a common approach. What RCPCH would like to see in the NHS in Wales (and across the UK) is a more open culture. Organisations must be transparent and clear about their obligations to report incidents and not seek to 'cover up' incidents. High quality leadership, good clinical engagement and professional responsibility are going to be far more effective at delivering and sustaining the sort of cultural change required. Clearly the organisational duty of candour will not be able to operate unless individual clinicians are regularly and openly reporting incidents. The same open culture is required to make individual and organisational reporting successful, so the two must be linked. It is important that the focus on the statutory duty does not divert attention of boards, trusts, and individual clinicians away from the incidents of low harm and near misses. The majority of incidents fall into the low or no harm category but provide an invaluable source of learning for organisations. Also, if not dealt with appropriately at an early stage, these incidents can escalate into complaints and claims.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
RCPCH strongly supports a greater role for Healthcare Inspectorate Wales in the inspection of children's health services (both acute and community services). Inspections should be tailored to the service type i.e. specifically include services for infants, children and young people. RCPCH has had contact with Healthcare Inspectorate Wales and would be happy to work closely with HIW to share intelligence and contribute to improvement in standards of care provided. HIW can make further use of existing, routinely collected information. IT systems should also be expanded

to capture baseline information, and inform benchmarking. RCPCH has developed a number of service standards (for example the Facing the Future series on acute general paediatric care and the Intercollegiate Standards for Children and Young People in Emergency Care Settings). They were developed specifically to provide measurable standards for inspection and improvement and RCPCH would like to see inspection teams make use of them to seek evidence of quality and safety.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Leadership skills are very important and form a core part of the curriculum for all paediatric trainees. It is important that sites are appropriately staffed so that clinicians have the time to be involved in training and initiatives such as leadership, advocacy and quality improvement. The Faculty of Medical Leadership and Management (https://www.fmlm.ac.uk/about-us) already provides a range of information and support to inspire excellence in medical leadership and drive continuous improvement in health and healthcare in the UK.

LHB size and membership

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Yes, the integration of public health into local authority functions has potential to benefit child health by improving preventative interventions, such as better town planning to help safe physical activity; and improved Personal and Social Education provision in education settings to support children and young people's health and wellbeing.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
RCPCH Wales recognises the need to reduce duplication in the clinical advice Welsh Government receives. RCPCH has consistently held the view that the Paediatric and Child Health National Specialist Advisory Group fulfils a useful role in bringing together multi-disciplinary representatives as a voice for child health in both strategic and specific matters. It has the ability to advise on both clinical and policy matters related to child health due to its range of members. RCPCH believes this is the model Welsh Ministers and NHS leaders should pursue with various multi-disciplinary groups although this would not require any extra legislation.

WGGP134 – Tony Rucinski – Board of Community Health Councils in Wales
Tref / Town – N/A

General comments

I write in response to the invitation to consult around the "Our Health Our Health Service" Green Paper as a relative new-comer, having taken up the post of CEO at the Board of Community Health Councils in July of this year.

I write in a personal capacity, expressing my own individual opinion. (I fully recognise and applaud the Board of CHCs decision to submit separately a combined response on behalf of the CHCs around Wales and I fully endorse that response). I am happy for this personal response to be made public.

Prior to joining the CHC Board, I was alerted to the "challenges" of the organisation in terms of perception around internal culture and external reputation - let alone its huge agenda to undertake the work ascribed to it.

Yet what I have found in reality, in a short few months, has amazed and impressed me. Yes, there are pockets of challenge - but having travelled around the country several times now, I have found a group of people (staff and members) infused with passion, dedicated to a cause and full of potential and desire to deliver meaningful change in helping to make our health services equal to the very best in the world.

However, when I speak to many senior people in Welsh public life (and I've spoken to lots of them recently), there also appears to be limited awareness both of what we are, what we do - and what our huge contribution can and will be. So let me take a moment to explain further in the context of the Green Paper's questions (28 and 29 regarding the CHCs) …

We exist to improve the patient experience and offer support if things go wrong.

We work primarily with patients, but also with practitioners and policymakers. We are independent from government and the health service. Members of the public as patient representatives, form our governing body and are the focus of our local activities.

These 276 independent volunteer members join us through a combination of the public appointments process, nominations from local authorities and nominations from umbrella third sector organisations. They are selected from local communities to form the seven local Community Health Councils that operate in the same localities as the seven local health Boards in Wales. The CHCs are supported by paid staff who report through a Chief Officer into the Chief Executive (me). Each local CHC elects a Chair, who, along with the Chief Executive, two independently appointed members,

and an independently appointed Chair, form the Board of CHCs in Wales. We are a statutory body - which means there are legal regulations in place to give us powers to do certain things in achieving our aims. These regulations were changed in April 2015 to give the Board increased powers to regulate, monitor and manage all of the work of the CHCs in Wales. This is quite a cultural leap from the 40 year history of autonomy and independence that the local CHCs have experienced.

Similar organisations that used to exist in the UK, have long since lost their standing - much to the chagrin of many who once advocated their demise, and to the arguable detriment of the health service in other parts of the UK. Ordinary local people expressing a lay persons view on local services is akin to the fundamental legal principle of the "man on the Clapham omnibus" and adds a deep patient and public-centric dimension to NHS evaluation, delivery and development.

How the CHCs achieve their aims:

1. Visiting, monitoring and Scrutiny - Regular visits to health services, scrutiny of local data, talking to the people using the service, and the people providing the care, to bring about both large scale change – and to influence lots of little changes that can make a big difference;

2. Consultations - Getting involved with health service managers and clinical staff at an early stage when they are planning significant change to local or national services, collecting and including patient opinion throughout the process.

3. Advocacy - Providing information and independent advocacy if things go wrong, and offering support through the health service complaints process as necessary;

4. Public Engagement - Proactively engaging more widely with patients, families, carers and people more generally across Wales, gathering views so that we can represent the public opinion to local health service providers and to policy makers.

Why CHCs are unique:

We are a public volunteer member led organisation. We are governed by ordinary people – members of the public appointed through various routes – but all on a voluntary basis, give oversight and direction to our organisation and its work.

Our visits are carried out by those ordinary people who join us as "members" because they want to help continually improve our health service.

Where we go and the questions we ask, or the things we look at, reflect the things that matter to ordinary local people, and are not driven by health service managers, clinical staff or government.

Our visits, while having a legal "inspection" remit, are more akin to conversations and take place with a view to co-producing the best patient experience and environment.

We differ greatly from organisations like Healthcare Inspectorate Wales (HIW) in that, while they may visit a ward once every, say, 3-5 years and inspect it against compliance with clinical guidelines or note taking procedures, we might visit that same ward 3 times every year. And when we visit, we are broadly asking a question akin to - would your Mother or loved one be happy here today? And as mentioned, often the staff are keen to talk to us in a way that they don't feel able to talk to others about what might improve the patient experience. Yes, we publish subsequent reports - but we will often deal with little things there and then - for example, if there isn't enough linen supplied, we might ring the Director of Nursing that night (because we know her/him) and linen will suddenly appear. Then, in a systematic way, we might ask the Health Board via our report why the Ward Sister isn't listened to when he or she asks for bedding - and explore whether this is happening in other Health Boards. Our reports once written are not left - but are pursued through to resolution via a committee structure that engages continually with the local Health Board. So we are fundamentally different but complementary to organisations such as HIW.

The Welsh Government is NOT therefore paying twice for inspections. This fact, along with our unique public volunteer led basis, is extremely important to fully appreciate and note when thinking about the wider inspection landscape that may well merit combining resources in other areas.

Because our 276 members can visit so often, we can build up good relationships and a rich sense of the patient experience. People feel that they can talk to us in a way that they sometimes feel they can't talk to the staff giving them care.

Clinical staff trust us and often use us as a means of highlighting patient experience issues that they can't get highlighted in other ways.

We cover the whole of Wales and are able to feedback on areas of concern in any place, at any time – and we have the agility to act at very short notice if necessary.

This capacity does not exist elsewhere.

Developing CHCs effectiveness and impact.

The CHCs have of course been the subject of several recent national reports – the most comprehensive being the Longley Review, and the most recent being the Welsh Government's Our Health, Our Health Service Green Paper.

In recognition of the need to change the way the CHCs work, the regulations governing their operation were amended in April 2015 so as to strengthen the

Board's role in setting standards, monitoring and managing all activity of the CHCs members and staff.

The newly established post of CEO was filled in July and the Board agreed that month to pursue a change process based on five principles captured by the acronym VOICE and explained briefly here as:

Vision - establishing ourselves as the "go-to" place for patients, practitioners and policy makers seeking information and support from a health service user's perspective. We will be pace-setters as is necessary to delivering an NHS equal to the best in the world. This may require a change in our operating name to something more obviously indicative of what we do;

Objectivity - we will use consistent, best practice, quality assured and fully documented methodologies in all that we do. We will be objective in our representation, reaching a broad cross-section of society and be representative of the wider patient voice in Wales;

Impact - we will differentiate what we do from what others do and demonstrate explicitly and comprehensively its worth and value add - starting with clear objectives driven by our purpose, demonstrating the scale and scope of our activity, measuring and continually improving quality - and highlighting the "so what", or the difference we have made to peoples' lives. We will use social media and real patient voices;

Collaboration - we will manage ourselves in a collaborative fashion with national leads for each of our core functions, and we will strive to fulfil our unique contribution to Wales and the NHS in the context of the whole range of partners working in the same area;

Engagement - through pro-active research publication, thought leadership and escalating our member and patient focused issues, we will set the national agenda and engage with a wide range of the public so as to lead developments from the patient perspective.

Planning what we do
We will develop annual plans that identify work which will take place on a locally driven needs basis, as well as agreeing at the Board the work that we will address together on a national level. Recognising that developments emerge from our advocacy service as well as from other local and national issues, we will allow spare capacity to respond in a nimble and agile way while having other work ready to make use of this resource if necessary.

What needs to change from the legal perspective (in my personal opinion)?

Peoples lives and problems don't tend to fall neatly into discrete government budget headings. Health problems very often cross over into social care problems. However, we have to inform patients and the public who use our advocacy services that we are unable to help in those areas. If we are asked

who they should turn to, we are unable to point to a direct social care equivalent to ourselves.

For the benefit of patients and the public, our remit should therefore allow us to pursue each of our 4 activity areas in accordance with a patient or care user's needs - even if this crosses the boundary into social care issues. Members of the public, patients, NHS staff, other agencies - and other Commissioners have indicated their support on this point.

It is my view that formal engagement standards should be developed for local health boards and Trusts to adopt as part of their medium term planning obligations, and that the development of and compliance with these standards should be driven from the patient perspective and potentially led by the CHC.

When we are involved in change consultations, we currently have an ability to refer to the Minister if we feel that consultation process is not followed correctly. In my opinion, this is a fundamental expression of the seriousness that the Welsh Government attaches to the voice of patients and the public in Wales. However, it is my view that this should rarely if ever be used, as to do so might arguably indicate a larger failure in wider cross-sector communication and influence. It is accepted that the nature of the relationship between a CHC and a Health Board needs to be one of "critical friend" - not too close, not too distant. But that type or relationship requires high degrees of emotional intelligence and trust by all parties - something which goes beyond legislation and into requirement of leaders with appropriate behaviours. None the less, it is my opinion that this facility of referral should remain.

In certain situations of referral to the Minister, we are obliged to submit alternative costed service change plans. It is my view that this requirement is wholly inconsistent with our nature as a lay organisation - and that the obligation should be removed and replaced possibly by the independent committee referred to.

Our Membership (and therefore capacity to work) currently stands at about a 30% vacancy level. This is because it is sometimes difficult to recruit via the public appointments process and it is sometimes difficult to obtain willing and active participants via the Local Authority nomination process. It is my belief that the membership (and Governance) model should be fundamentally reviewed with a view to allowing a more nimble and agile member recruitment process that may also be more appealing to the broadest possible demographic. A process should be developed that enables the Board to highlight additional specific skills required when recruiting to the Board - something not currently embedded in either the public appointments process or member Chair appointments. The Board may also merit from being able to co-opt additional individuals from other agencies as needs arise.

Payment of a Chair is a subject often returned to within the organisation. On the one hand, many large national charitable bodies are governed by volunteer members who give of their free time and huge skill base. However,

the Health Service model allows for paid Chairs to be in place, recognising the need to get the very best people in place and that those people may not always have the financial capacity to simply give extensively of their time. It is also arguable that not paying the CHC Chair position indicates a lesser relevance or worth from the perspective of the NHS and Government. I am sure that the latter is NOT the case - but I none the less feel that the subject merits a formal review.

I have been asked directly on occasions whether I feel we need Chief Officers going forward. My response has been that with a matrix management approach of national functional leads, there will always be a need for local staff management - and a single senior point of contact for the local Health Board and members requiring support. I am not overly concerned about the name of the role - but its mentioning (together with Deputy Chief Officer) in the legislation does somewhat appear inconsistent with the existence of many other post holders in the staffing structure who are also fundamental to the success of the organisation but who's job titles are not explicitly referred to.

Aside from the specific subject of CHCs, my personal comments around how the Health Service should be developed that this consultation may have an impact upon include:

The need to integrate pathways (not necessarily complete organisations) around health and social care;
The need to oblige health boards to focus on outcomes based around clinical need above blunt targets such as initial referral to treatment times (RTTs) when allocating resources;
A national and patient driven approach for triage in primary care;
A mechanism and incentive for health boards to identify good practice, analyse it - and roll it out within other health boards;
NWIS (whom i respect highly as an organisation) should be resourced and obliged to meet nationally agreed targets around delivery of certain key underpinning outcomes such as a secure electronic patient record;
So long as appropriately anonymised I am excited about the potential of a large scale national database of certain aspects of medical related information being made available for research into better treatments and greater equality of care and life outcomes across social and geographical boundaries in Wales.

Response to specific questions

No response to specific questions.

WGGP135 – Anonymous
Tref / Town – Anonymous
Sefydliad / Organisation – Anonymous

General comments

Wishes for response to be kept anonymous.

WGGP136 – Cristina Sarb – Nursing and Midwifery Council
Tref / Town – N/A

General comments

Introduction

1 The Nursing and Midwifery Council (NMC) is the professional regulator for nurses and midwives in the UK. We exist to protect the public. We do this by holding and controlling access to the register of qualified nurses and midwives and setting standards of education, training, conduct and performance for nurses and midwives. If an allegation is made that a registered nurse or midwife is not fit to practise, we also have a duty to investigate that allegation and, where necessary, take action to protect the public.

2 We welcome the opportunity to respond to the Welsh Government Green Paper Our Health, Our Health Service. Given the remit of the NMC, not all questions are for us to provide a view on. We have provided a response from our perspective as a professional regulator for nursing and midwifery, setting out where the proposals in the Green Paper have the potential to link across to our work.

Responsible person / fit and proper persons test

3 The Green Paper seeks views on setting out in legislation the role of 'responsible person' or legislating for a 'fit and proper persons' test. Within England, we have experienced the introduction of a new registration requirement covering the fitness of directors by the Care Quality Commission (CQC) as a way to strengthen the system of accountability for standards of care at a senior level. This applies to directors who may also be registered healthcare professionals, such as Directors of Nursing who may be on our register.

4 It will be essential to ensure that any proposals to introduce a corresponding test within the Welsh context are complementary and consistent with the regulatory process of professional regulators such as the NMC. Consideration ought to be given to how the criteria for a 'fit and proper persons' test align with professional codes, such as the NMC Code which sets out the professional standards and behaviour expected of all registered nurses and midwives.

5 If a similar model was to be taken forward within Wales, an important aspect relates to the cross-referral of concerns. On the one hand, in places where the 'fit and proper' test has already been implemented, whether an individual has been erased, removed or struck off a register maintained by a professional regulator has been deemed as a relevant factor in determining whether they meet the fit and proper test requirements. On the other hand, if a lack of fitness is found in relation to the test, it is important to ensure that processes are in place for referrals to be made to other agencies as appropriate. A

process will need to be established to inform professional regulators of concerns/findings relating to a person's fitness.

6 There is a significant amount of important detail not covered in the Green Paper that will have an impact on how a fit and proper test would work in practice. We would be keen for any lessons from the operation in other parts of the UK to be considered as part of further developing these proposals, with a particular emphasis on unintended consequences.

Clinical supervision

7 The Green Paper makes reference to various models of clinical supervision usedby health professionals in Wales, including statutory supervision of midwives. One of the questions posed in the consultation is whether a legislative approach is needed to ensure health professionals have the opportunity to have clinical peer supervision.

8 In the case of midwifery, the current framework provides for a model of supervision that encompasses regulatory activity (investigation and sanction) and the more supportive, developmental aspects more commonly associated with supervision. A number of independent reports and reviews3 have called into question the additional layer of regulation currently in place for midwives and recommended that midwifery supervision and regulation should be separated. This has further been supported by incidents of care failures which have demonstrated that the current arrangements are not appropriate for public protection. The Department of Health in England has committed to bringing forward legislative change to remove the additional tier of regulation and also take supervision out of our regulatory legislation. The effect of these changes will be to give the NMC direct control of regulatory decisions about midwives.

9 The Green Paper notes that 'following cessation of the statutory supervision of midwives there is a strong case to be made for some form of clinical/peer supervision to be continued for this professional group'. We retain a keen interest in the future model of non-statutory supervision, not least in the context of revalidation. We have been engaging in discussions hosted by the Department of Health and including the four UK Chief Nursing Officers (CNOs) on the future arrangements outside a statutory framework for the important aspects of supervision.

10 Our Council has recently approved the introduction of revalidation for nurses and midwives from 2016, with strong support from leaders of the health sector in Wales. This will involve registrants demonstrating their continuing fitness to practise. The revalidation requirements emphasise the importance of reflective practice and will provide an opportunity for discussion with peers about their practice. Nurses and midwives will have to show evidence of a minimum of five written reflections as evidence of the learning achieved from their practice, continued professional development or feedback. These reflections must then be discussed with another NMC registrant.

11 Our view has been and continues to be that clinical supervision represents an important element of clinical governance. With the end of the current statutory supervision for midwives, it will be for system regulators, employers and the sector to ensure that there are appropriate clinical governance arrangements, including clinical supervision.

Duty of candour

12 The Green Paper gives consideration to whether a statutory duty of candour should be introduced within the NHS in Wales. We firmly believe that healthcare professionals should be bound by a duty of candour in their practice. Following the events at Mid Staffordshire NHS Foundation Trust in England, we have worked hard to improve this element of how we regulate nurses and midwives.

13 All nurses and midwives in the UK are bound by standards set out in our Code, which includes a specific section on the duty of candour for nurses and midwives.

We have also issued joint guidance with the General Medical Council (GMC) on the professional duty of candour.

14 In summary, the Code requires nurses and midwives to recognise and work within the limits of their own competence, be open and candid with service users about all aspects of care and treatment including when mistakes or harm have taken place. If a nurse or midwife believes there is a risk to patient safety or public protection, they have a duty to raise concerns; this may include through the local healthcare setting's management, whistleblowing to the appropriate prescribed person, making a referral to a professional regulator or raising a concern with a system regulator.

15 Our joint guidance makes clear that when things go wrong, a nurse or midwife should inform the patient (or an appropriate other person such as a carer or family member as the case may be), apologise, offer an appropriate remedy to put matters right and fully explain the short and long term impacts of what has happened. In addition, professionals must be open and honest with colleagues, employers and relevant organisations on such matters and raise concerns where appropriate.

16 Each of the four UK governments has considered ways to implement the organisational duty of candour, with some prescribing it into law. As we have previously stated, we believe that an organisational duty of candour can support and complement our existing regulatory requirements in terms of the professional duty that nurses and midwives have in relation to candour, openness and honesty.

Health Inspectorate Wales (HIW) reform

17 We do not have a position regarding the proposal for the Care and Social Services Inspectorate Wales (CSSIW) to merge with HIW to become one single organisation. We have established a good working relationship with HIW and are in the process of agreeing a formal agreement for collaborating,

sharing intelligence and exchanging information. HIW also acts as the host organisation for the Local Supervising Authority for midwives in Wales, the legal basis for which will be removed once the changes to midwifery regulation take effect.

Response to specific questions

No response to specific questions.

WGGP137 – Dr Alan Rees and Dr Andrew Goddard – Royal College of Physicians
Tref / Town – N/A

General comments

Introduction

RCP believes that:

- legislation is an essential tool for government but it must be proportionate and evidence based. It is not a panacea for driving up standards or improving quality;
- improvements to quality, efficiency and outcomes are often best achieved through a change of practice within an environment where professionals feel supported, empowered to do things in a different way; able to take risks and where there is a clear focus on raising standards;
- clinicians must be at the heart of the decisions and actions that concern service changes, improvement initiatives and the handling of complaints.
- trainees have a good understanding of the day to day operation of a hospital and they are a valuable resource for improvement and solving problems
- the RCP is well placed to provide direct high quality clinical advice to government. The dedicated office in Wales is a valuable resource that policymakers and stakeholders can drawn upon when seeking expert clinical advice and support in order to achieve higher standards and health service reform.

Summary of our response

RCP supports

- a common standards framework which covers the NHS and the independent sector.;
- the use of clinical peer supervision is a valuable tool for improvement and for driving up standards and therefore should be extended to other health professional registrants;
- the introduction of a statutory duty of candour for NHS and social care providers within the NHS in Wales;
- a statutory provision to create joint appointments between local government and the NHS in Wales for directors of public health;
- a reduction in the current number of expert panels and specialist advisory groups in favour of direct engagement with the RCP to gather evidence and expert clinical advice;
- greater independence for the Healthcare Inspectorate Wales (HIW.)

RCP does not support

- the merger of the Healthcare Inspectorate Wales (HIW) with the Care and Social Services Inspectorate Wales (CSSIW) at this point in time.

Our response

A common standards framework which covers the NHS and the independent sector

It is not acceptable for patients to receive a different standard of care simply because of the different legal status of the provider. We are aware of the difficulties that arise when providing consistent mental health services and we would be supportive of ensuring within legislation that the NHS is legally required to meet agreed standards as set out in agreed quality frameworks and also that there should not be a difference between the appropriate regulations set for independent providers and the NHS.

The use of clinical peer supervision is a valuable tool for improvement and for driving up common standards which should be extended to health professional registrants

Clinicians strive for the best possible care for their patients. Ongoing clinical support, mentoring and tuition are fundamental to ensuring high quality clinical practice and the continued development of doctors for the future. Clinicians empower others and also value the act of passing on their knowledge, expertise and experience through clinical supervision to junior doctors and students. Thus peer supervision a core element of how medicine and doctors develop; we believe that it should be extended to all health professional registrants. The RCP has valuable experience in processes and systems to embed peer supervision within day to day practice and career progression and would be happy to work with others to share practice an experience.

The introduction of a statutory duty of candour within the NHS in Wales

Doctors already have a duty to raise concerns, as set out in the General Medical Council (GMC) document, Good Medical Practice set within their contract. The introduction of a statutory duty of candour for health and care providers is an additional important step towards ensuring that an open, honest and transparent culture exists within the NHS in Wales and one we would fully support. It also brings Wales into line with England in this regard.

A reduction in the current number of expert panels and specialist advisory groups in favour of direct engagement with the RCP to gather evidence and expert clinical advice

The current advisory landscape is cluttered and it duplicates scarce resources. The RCP supports a move towards a streamlined advisory

structure and we would prefer if the Welsh Government and the NHS Wales approached the royal colleges directly for advice. The RCP is able to provide high quality advice on issues affecting over 30 medical specialities and can call upon the views of approximately 1,100 clinicians in Wales.

The RCP has a dedicated office in Wales which has the advantage of accessing resources, clinical expertise from specialist working groups across the UK, while retaining the ability to set this advice and develop recommendations in a devolved context. We continue to develop all Wales working groups and specialist forums to address the unique issues affecting the NHS in Wales, whilst our advisory structure ensures participation from all parts of Wales and its hospitals.

A statutory provision for joint appointments between local government and the NHS in Wales for directors of public health

RCP members consider the practice of medicine in is broadest sense – from the prevention of ill health to diagnosis, treatment, recovery and self-care. We have a strong focus on reducing inequalities and improving public health in all of our work and policy development. We consider that the approach taken to tackle long standing, preventable health problems such as obesity and alcohol misuse, could be more effective if our respective resources are used in a more coordinated way. Local government reform creates uncertainty for partnership working between local councils and the NHS in Wales however when the final decision on the reconfiguration of local government is determined, it would be logical to implement this statutory provision within a similar time frame.

An independent Healthcare Inspectorate Wales (HIW)

We believe that robust and effective inspection and external review is an essential element of a system designed to improve care, drive up standards and provide public assurance that care is safe and effective. There is a compelling argument that for any inspectorate to be effective it needs to <u>be perceived</u> to be independent of governments' influence and intervention whilst also having the necessary resources and expertise to undertake its remit and meet expectations.

We are keen to support and work with the HIW so that it can become fully recognised as an effective external regulator for the NHS, valued by our clinicians, and routinely draws upon the wide range of data and information from the royal colleges and their respective expertise. The RCP has a range of quality improvement resources to offer spanning national clinical audits, accreditation schemes, hospital health checks and clinical consultancy services. Whilst the quality of clinical data may vary across the NHS, Healthcare Inspectorate Wales could make better use of the high quality data available within the RCP national databases and audits which record data,

patient experience and performance on the care received by patients across a range of different conditions.

If the HIW and CSSIW were to merge there is the potential for HIW to divert its focus away from its own necessary development. We recognise the value of an integrated approach to inspection across the health and social care landscape that perhaps the creation of a merged body may provide, but we believe there are risks pursuing this path at this time.

Response to specific questions

No response to specific questions.

WGGP138 – Andy Pike – Royal British Legion
Tref / Town – N/A

General comments

1.0 About us

1.1 The Royal British Legion was created as a unifying force for the military charity sector at the end of WWI, and still remains one of the UK's largest membership organisations. We are the largest welfare provider in the Armed Forces charity sector, providing financial, social and emotional support, information, advice, advocacy and comradeship to hundreds of thousands of Service personnel, veterans and their dependants every year. In 2014, we responded to over 450,000 requests for help – more than ever before – and spent £1.4m every week on welfare support. For further information, please visit www.britishlegion.org.uk

1.2 The Legion is grateful for the opportunity to respond to the Welsh Government's Green Paper, *Our Health, Our Health Service* and welcomes the good work already done by the Welsh Government on identifying the need for specific support targeted at the Armed Forces community in Wales. This includes the referral pathway for serving personnel, which should be maintained through any revision of NHS healthcare provision in Wales. We would like to take this opportunity to feed in some overarching comments to the strategic approach the Welsh Government is taking to delivering health services and ensure that the needs of the (ex-)Service community are met.

2.0 The Size and health needs of the (ex-)Service community in Wales[35]

2.1 In 2014 we estimated that the adult ex-service community in Wales comprised approximately 310,000 people, making up approximately 12 percent of the adult population of Wales. This community frequently interacts with the National Health Service in Wales for both primary and secondary care, and whilst in many areas health issues are broadly comparable with the general population, there are some notable differences that should inform the Welsh Government's approach in the Green Paper and beyond:

- Half of the ex-Service community have some long-term illness or disability, most often a physical condition. Prevalence of many conditions has increased in the last decade because of the ageing population (46% are now aged 75+, compared with 28% in 2005), especially musculoskeletal conditions, cardiovascular and respiratory problems, and sensory problems.

[35] Royal British Legion, *A UK Household Survey of the ex-Service Community*, 2014

- Working age members of the ex-Service community are more likely than the general population to report having musculoskeletal problems, hearing difficulties or depression, or some condition that limits their activity.

- Reported mental health problems have doubled since 2005. Only one in twenty have sought help for mental health problems. Even among those reporting psychological problems, only 16% have accessed help.

- One in five veterans with a long-term illness attributes it to military Service; particularly musculoskeletal problems, hearing problems and mental illness. Over half of veterans aged 25-44 with a long-term illness attribute it to their Service.

3.0 'Asking the question'

3.1 Routine and effective data collection is fundamental to both ensuring that GPs are able to meet veterans' needs and to veterans engaging in the positive commitments towards patient involvement in the Green Paper. The current Read code/SNoMed CT Code "Served in Armed Forces" is in place, yet anecdotal evidence suggests that it isn't always being routinely and uniformly used to identify veterans accessing health care. As a minimum we would expect the presentation of an Fmed 133 form to automatically result in the allocation of the Read code, as outlined in the Package of Support, however this alone will not guarantee universal coverage. Without this code being used across the board, we don't believe the NHS in Wales, or local authority partners, will be able to effectively deliver services for the Armed Forces community or ensure that the most appropriate frameworks and procedures are used.

3.2 Progress in this area has been welcome but more work is needed. The Legion believes it is the duty of all statutory bodies and those delivering statutory services to 'ask the question' and ensure veterans are identified and therefore receive the services to which they are entitled. The Welsh Government should take the opportunity of the context of this review of the delivery of Health Service in Wales to introduce a standardised question for public bodies to ask in order to improve identification of members of the armed forces community and in turn, improve signposting and awareness. This would also be beneficial in creating holistic care pathways that bridge statutory services and avoid veterans "slipping through the cracks".

3.3 The Legion has been pleased to note other welcome improvements to the health landscape in Wales for members of the serving and ex-Service community. The appointment of Local Health Board (LHB) Armed Forces Champions and the establishment of LHB Armed Forces Forums across Wales is a very positive step in highlighting the health needs of the Armed Forces community and must be utilised as a vehicle for ensuring the principles of the Armed Forces Covenant are delivered at a local level. However again, these champions must be equipped with data through the

effective use of a standardised question on the size of their local Service community in order to make informed interventions.

3.4 We also continue to be pleased with the emphasis that the Welsh Government places on ensuring that, where veteran status is formally collected, a patient, where appropriate, can access priority treatment. The current *Package of Support for the Armed Forces Community* states that, "Health bodies and their staff are being reminded of their obligation to offer priority treatment and care for veterans whose health problems result from their service. This policy is outlined in Welsh Health Circular 051, which was published in 2008 and distributed to all relevant individuals and health bodies across Wales."[36] We hope to see this commitment to the principle of priority treatment continue to feature in the latest version of the *Package of Support* as it has done in previous years. It is vital however that awareness of this important document amongst service providers is increased via promotion and training.

3.5 It is vital therefore that existing commitments produce tangible outcomes and further steps are taken to ensure that any commitments are underpinned with comprehensive recording of Veteran status. Legion research has found that awareness of priority treatment amongst veterans and GPs appears to be very low. In response to a 2009 survey of 500 GPs across England and Wales, 81 per cent of respondents said they knew not very much or nothing at all about priority treatment. Although this may be improving, it is still a significant problem and more should be done to educate GPs and other medical professionals about military health needs once Service history is identified.

4.0 Understanding the needs of the Armed Forces community

4.1 As outlined above, Legion surveys of GPs reveal a worryingly low awareness of the Service community's requirements. Alongside the principle of special treatment, the majority of Veterans should as a minimum be able to expect that service providers are aware of the principles of the Covenant and have a level of understanding of armed forces issues. The Welsh Government must do all it can to ensure that the revised Health Service outlined in the Green Paper is underpinned by practitioners able to recognise the specific needs of the Armed Forces community and therefore offer them the most appropriate and sometimes specialised treatment.

4.2 This is not to say that service providers must necessarily be veterans themselves or have experience in Armed Forces communities; many service providers have a non-Armed Forces background and deliver an excellent and effective service. What is vital is an understanding and empathy for Armed Forces patients and service users.

[36] Welsh Government, *Welsh Government Package of Support for the Armed Forces Community in Wales*, 2011

4.3 All local authorities and Local Health Boards have signed Armed Forces Community Covenants and made a commitment to service delivery for this significant cohort of the population. Ensuring staff have training on veteran specific issues available to them should be embedded in Community Covenant activity. The e-learning module designed to train GPs and NHS staff on management of veterans with PTSD was a welcome innovation in this regard.

5.0 Patients rights and self-advocacy

5.1 The Legion would finally like to take this opportunity to highlight comments in relation the Welsh Government's welcome initiatives towards the empowerment of patients to be effective self advocates. In 2015, NHS England updated their NHS constitution to reflect the commitments set out in the Armed Forces Covenant. One of seven guiding principles of the new constitution now states:

"4. The patient will be at the heart of everything the NHS does. It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. ***As part of this, the NHS will ensure that in line with the Armed Forces Covenant, those in the armed forces, reservists, their families and veterans are not disadvantaged in accessing health services in the area they reside. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.*** *The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services*."[37]

5.2 The accompanying handbook outlines what NHS England will, in practical terms, provide to patients. Not only is the principle of no-disadvantage now enshrined in NHS England, the handbook makes reference to the special treatment that the (ex-)Service community may be entitled to:

"As part of this principle and in line with the Armed Forces Covenant, the NHS will ensure that members of the Armed Forces Community (including those serving, reservists, their families and veterans) are supported, treated equally and receive the same standard of, and access to healthcare as any other UK citizen in the area they live. For those with concerns about their mental health who may not present for some time after leaving Service, they should be able to access services with health professionals who have an understanding of Armed Forces culture.

Veterans who have lost a limb as a result of their service will be able to access prostheses that reflect their clinical need. Veterans receive their healthcare from the NHS and are encouraged to identify themselves to their GP as member of the Armed Forces Community. For families of

[37] NHS England, *The NHS Constitution and accompanying handbook*, 2015

serving personnel moving around the country, any time taken on an NHS treatment waiting list will be taken to account in their new location. For further information on what you can expect if in the Armed Forces Community see Section C.2 Scope of the Covenant, Healthcare"

5.3 These documents have brought much-needed clarity to veterans themselves on what they can expect when accessing NHS services in England. The Welsh Government has taken steps, via the Package of Support, to ensure veterans in Wales have access to similar levels of information regarding service entitlement and provision. This document must become more of a focal point for veterans, practitioners, the MOD and local partners, through greater awareness and promotion.

Our Health, Our Health Service takes steps towards empowering patients through open and honest decision making and sharing their own data with them, however without a clear understanding of what this entitles them to, a truly health-literate population cannot be achieved. The Legion recommends that the Welsh Government takes proactive steps, via the Package of Support and via local partners, to explain what veterans are entitled to when accessing health services, thereby ensuring that patients are fully empowered in any decision making over their own health and treatment.

Response to specific questions

No response to specific questions.

WGGP139 – Cathrin Manning – British Red Cross
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The British Red Cross fully supports the motivation to promote better health and wellbeing for the people of Wales. In light of the legislative duties and requirements under the Social Services and Wellbeing (Wales) Act 2014, the Wellbeing of Future Generation (Wales) Act 2015, and the driving principles underpinning health and social care, this should be reflected within health legislation to ensure unified purpose across health and social care to enable stronger collaboration and a consistent focus on prevention.

2. If so, what changes should be given priority?
The Red Cross believes that health legislation needs to be aligned to social care legislation to ensure a shared commitment and purpose to improving the health and wellbeing of individuals.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
In Wales, it is well known and celebrated that statutory agencies regularly work closely with third sector organisations. However, short-term funding, often offered on a yearly basis, to third sector organisations results in instability of service provision, inefficiency and waste in terms of recruiting and training staff and volunteers for short periods and, importantly, an inability to measure outcomes over adequate time to inform planning. The Red Cross urge that legislation should be strengthened to require longer term commissioning of services which would provide efficiencies for the NHS and more consistent, effective and quality services for the public by retaining expertise and experience, and reducing development time as services are forced to start-stop-start due to bursts of short-term funding.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement

mechanisms, such as patient panels or participation groups?
We welcome the intention of the Social Services and Wellbeing (Wales) Act 2014 to strengthen the voice of service users and carers and we believe that people should have equal opportunity to engage with health services in Wales. We agree that permanent engagement mechanisms could support this but would further suggest that these mechanisms existing for social services and health services also need to easily enable the public to engage with integrated services. We would also encourage the use of simplified, consistent and shared language and terminology between NHS and local authorities to improve the ability of citizens to understand and engage across health and social care.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
We support the proposal of a national expert panel independent of government but require clarity over whether the panel would have the powers to act on its decisions or if it would then need to refer to Ministers. If the latter, we would question how effective this would be.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section? 8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
The quality of services is paramount. Legislative measures are essential in order to ensure consistency in quality and to provide a basis from which services can continue to improve. Legislative measures should be aligned where appropriate with those under the Social Services and Wellbeing (Wales) Act 2014 to create a synergy and shared outcomes for collaboration and integration. It is imperative that all staff are made aware of those standards and understand what they mean in practice through continued training and clear leadership. It is also important that strong focus should be given to sharing good practice and celebrating excellence in quality rather that purely adopting a punitive approach.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
The Red Cross welcomes the concept of the “responsible individual” which is also reflected in the Regulation and Inspection of Social Care (Wales) Bill. We feel that adopting the concept of a “responsible individual” for both health and social services would create clearer lines of accountability across services.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
We support the proposal of legislating for a “fit and proper persons” test and feel it should apply to director level roles. This would help to provide the public with the assurance that directors have the qualifications, attitude and character to undertake their roles effectively.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Yes, the Red Cross believes that there should be a legal requirement for all healthcare providers to comply with the same set of standards to ensure quality and provide assurance to the public.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
We agree that a common framework could better deliver a focus on improving outcomes and experience for citizens. Citizens should be able to expect and have the confidence that services, whether NHS or independent, are required to meet the same standards.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
The Red Cross would welcome a statutory duty of candour to support openness and honesty. A duty of candour would empower citizens to challenge where openness and honesty are not exercised. A duty of candour would need to be embedded into the culture and training of the workforce, to be encouraged and rewarded, not feared.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
The Red Cross feel the complaints process needs to enable individuals to direct their complaint, in the case of an integrated service, to one point of contact able to pursue the investigation on behalf of the citizen across both health and social care services.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Our experience working with and talking to healthcare bodies has highlighted several issues which prevent the sharing of patient information. These include different IT systems, IT competence, incompatible data, lack of trust and lack of understanding of information governance.

22. How can we consider breaking down any barriers?
The Red Cross suggests that: ➢ IT systems need to be streamlined. ➢ Data needs to be coded and recorded consistently. ➢ Additional and on-going training is needed in IT and information governance. A shared/unified purpose across services is developed.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
We believe that patient consent must be sought before data is shared for this purpose and the patient must fully understand what information will be shared, how and what for.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
We agree with the issues identified in the Green paper. We feel that there is a need for greater independence of HIW to increase confidence in its functions and effectiveness.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
In light of increasing integration between health and social care, full independence for HIW would create an imbalance of independence between HIW and CSSIW. This could cause challenges in the inspection and regulation of integrated services.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
We believe a single inspectorate could improve citizen engagement and reduce confusion over which inspectorate is responsible for which service, and in particular with regard to integrated services.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
We believe that, if CHCs' activities are refocused on representing the patient voice and on providing advocacy services, regulators will need to be required to carry out inspections on behalf of CHCs where complaints are raised to ensure issues are effectively dealt with.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
We would support CHCs adopting a broader remit to reflect a more integrated system, perhaps, by extending membership to include representatives with a social care and well-being portfolio. We would also propose that the term Community Health Council does not reflect a more integrated approach.

Chapter 7: Finance, functions and planning

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
We support this proposal.

34. 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?
We support this proposal.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public

services?
We would welcome joint appointments to support integrated working across NHS and local authorities.

WGGP140 – Rhiannon Hedge – Mind Cymru
Tref / Town – Cardiff

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
We welcome the Green Paper's acknowledgement of the importance of access to services in Welsh as core criterion of quality care, but feel this needs stronger consideration. While a commitment to improving the NHS workforce capacity to deliver services through the medium of Welsh is covered in many strategies, including Together for Mental Health, we are seeing little evidence of improvement. This is a significant development need for the Welsh NHS and one that directly impacts on patient safety in many case, such as people with dementia. Throughout mental health services this is a key issue, including through the delivery of psychological therapies. There is a wealth of evidence that people struggle to express their emotional state through a second language, and this results in a diminished quality of care and poorer outcomes. We would welcome moves to ensure health boards are taking steps to address the staffing shortfall in Welsh speakers, such as actively targeting Welsh speakers through recruitment processes and reporting in a transparent way on the outcomes of their efforts. We welcome the focus on meeting mental health and wellbeing needs closer to home and preventing people from being admitted to hospital unnecessarily. To achieve this aim health boards across Wales must be delivering community mental health services to a common standard, including 24/7 crisis care and investment in innovative, alternative places of safety for those in crisis who do not require a long-term hospital stay.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change? 5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Continuous engagement is core to the principles of co-production and prudent healthcare. Strengthening the patient voice in service delivery is crucial, as is

ensuring the ‘citizen’ voice is heard through the planning of services and assessment of population needs. Third sector partners in delivering services in the local community should also have a role in permanent engagement mechanisms, and their role in supporting the voice of those in ‘at-risk’ groups should be recognised.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section? 8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system? 9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
In some recent cases, inadequate staffing levels and a negative working environment have been a barrier to quality in mental health services and this must be addressed if the principles of dignity and respect are to be delivered on. Issues effecting the working environment often revolve around a lack of learning and development, training, supervision, celebration of good work and reflective practice. Consistency between health boards regarding their individual policies on restrictive physical interventions within mental health services should be addressed; currently health boards widely differ on their guidelines and usage of forms of restraint within these services. The Welsh Government’s framework on restrictive physical interventions from 2005 is not fully being followed, including the framework’s stance that face-down restraint should never be used.

Chapter 3: Quality in Practice

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how? 17. What arrangements should be put in place for self-employed health professional registrants?
As we have highlighted in previous answers, issues around staff support and development are a common denominator in cases of poor care across Wales. Health settings must become good workplaces in order to deliver good care, and improving workforce support is vital in driving up quality of care and delivery on the principles of dignity and respect. Reflective practice should be a key part of this.

Chapter 7: Finance, functions and planning

Planning

34. 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?
Mind welcomes the proposed use of wellbeing indicators such as the Warwick-Edinburgh mental wellbeing scale under the Well-being of Future Generations (Wales) Act to assess the mental wellbeing of the population. The planning of preventative services for those with care and support needs under the Social Services and Well-being (Wales) Act also have the potential to improve health outcomes if delivered successfully. Mind believes a joined-up approach to planning and assessment must include close alignment with both pieces of legislation. Integrated planning must however remain a strong focus moving forward. Joint needs assessments should always cover: • Levels of risk factors for mental health problems and poor wellbeing (including in higher risk groups) • Levels of protective factors for mental wellbeing • Numbers of people at higher risk of poor wellbeing and/or mental health problems • Levels and variability of mental wellbeing across the local population • Levels of, and numbers of, people with mental health problems (including those from higher risk groups)

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
To effectively deliver on the principle of parity of esteem between mental and physical health, we believe it is vital to maintain the role of a director covering mental health services as a statutory executive member of a health board. While many directors that make up the membership of the boards should and do consider mental health within their remit and the delivery of their services, we feel the protection of a specific mental health focused directorate on a board's executive is key to ensuring this is a priority for each area. We support the Williams Commission recommendation that at least one local authority director of social services should be appointed to support the

integration of services with local authorities in the health board area.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Transparency and openness on public health spend should be far greater, and Local Government reform is a potential vehicle for this change which should be explored. Whether public health is devolved to local authorities or remains with health boards or is a shared responsibility, there should be a move to collect and publish full breakdowns of spend on public health interventions, including those relating to mental health. An audit on public health spending in each health board area should underpin any proposed changes to delivery of this area. With LHBs and local authorities being required to work collaboratively moving towards integrated health and social care, and where budgets are pooled for mental health across health and social care, serious consideration should be given to the recently reviewed ring-fence on mental health spending within health boards and how closer integration relates to the ring-fence.

WGGP141 – David Rowland – General Optical Council
Tref / Town – N/A

General comments

The General Optical Council (GOC) welcomes the opportunity to respond to the Welsh Government's Green Paper: Our Health, Our Health Service.

We agree that it is important to promote discussion on how to improve the quality and governance of the NHS in Wales. As the regulator for the optical professions in the UK, our role is to protect and promote the health and safety of the public. Over recent years, there have been several high profile healthcare reviews following failings in the quality and standards of care provided by healthcare professionals – most notably the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* by Sir Robert Francis and, in relation to Wales, the report by Ann Clwyd MP and Professor Tricia Hart - *Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture.* We recognise that we must continuously assess the process we have in place to protect the public and demonstrate that we have taken learning from past failings in the system to improve the quality of care provided by our registrants.

About the GOC

We currently register around 28,000 optometrists, dispensing opticians, student opticians and optical businesses. We have four core functions:

- setting standards for optical education and training, performance and conduct;
- approving qualifications leading to registration;
- maintaining a register of individuals who are qualified and fit to practise, train or carry on business as optometrists and dispensing opticians; and
- investigating and acting where registrants' fitness to practise, train or carry on business is impaired.

Chapter 1: The Changing Shape of Health Services: Promoting health and Wellbeing

We welcome the overarching principles underpinning the primary care plan in Chapter 1 (Promoting Health and Wellbeing) of the Green Paper – for example, a focus on prevention, early intervention and delivering co-ordinated care in a community setting. As stated in the Green Paper, primary care services, such as optometry, dentistry and pharmacy, have a key role to play alongside general practice in helping to meet the health and wellbeing needs of local communities.

Over recent years we have seen optometrists and dispensing opticians expand their skills and work alongside other healthcare professionals to deliver more integrated care in the community. Optometrists with the appropriate training can play valuable role in the identification and management of chronic and acute disease alongside ophthalmologists. With the appropriate training and with appropriate clinical governance arrangements in place, optometrists could also be the first port of call for non-sight-threatening eye complaints rather than GPs. Dispensing opticians, with the appropriate training, can assess and manage the needs of patients with low vision in a community setting. Referrals to GPs or ophthalmology departments are only made when necessary. These developments can help to ease the pressure on more overstretched areas such as general practice and hospital eye services.

We recognise that significant progress has been made in this respect due to the success of the Welsh Eye Care Scheme which has helped to reduce referrals to secondary care as it allows accredited optometrists to provide more enhanced services to patients in the community.

In terms of public health, the optical profession can also play a role in working with other healthcare professionals to help tackle issues such as smoking and obesity. Eye health is linked, for example, to smoking and diabetes so patients visiting an optometrist could be directed to smoking cessation services or given information on the links between diabetes and eye health (including conditions such as diabetic retinopathy).

Chapter 3: Quality in Practice: Meeting common standards

In relation to Chapter 3 in the Green Paper about the need for healthcare professionals to meet common standards, part of our statutory duty as the regulator is to set standards of practice for optometrists and dispensing opticians. Our standards of practice define the standards of behaviour and performance we expect of all our registrants.

In July 2015 we agreed a new set of standards following a wide ranging consultation with our stakeholders. Our new standards reflect learning from, for example the Francis Inquiry, and more clearly outline the expectations we have of our registrants by providing a more comprehensive and robust framework.

When developing our new standards we reviewed and learnt from the approaches of the other regulators. We wanted to identify areas where patients have common expectations of all healthcare professionals and reflect this by aligning our standards as far as possible. Our new standards are now consistent with the standards of the other regulated professions in the UK. We

agree that it is important to consider aligning standards and sharing good practice, however as the Green Paper states, currently professional standards for the regulated professions are underpinned by different legislative frameworks.

Chapter 3: Quality in Practice: Clinical Supervision

We agree that it is important for healthcare professionals to undertake clinical or peer supervision/review as part of the revalidation process. In relation to our registrants, our enhanced continuing education and training (CET) scheme is a statutory requirement for all our fully qualified optometrists and dispensing opticians. Our CET scheme ensures that all registrants maintain their skills and knowledge and remain fit to practise.

As part of the CET scheme optometrists and contact lens opticians are required to undertake peer review or a peer discussion event. This gives registrants the opportunity to discuss and learn from challenges or issues they have faced while working with patients and help identify good practice. We agree that peer review is important in helping to drive improvements and raise standards across the profession and would be happy to provide any additional information on our model of revalidation.

Chapter 4: Openness and honesty in all that we do

We agree that it is important to move towards embedding a culture of openness and honesty in the NHS and the wider health care sector. One of the main changes we made to our standards was to introduce an explicit duty on registrants to be candid when they have identified that things have gone wrong which has resulted in harm to a patient.

In relation to introducing a statutory duty of candour within the NHS in Wales, we responded to the Welsh Government's consultation in January 2015 on revising the Health and Care Standards for Wales. In our response we noted that there was no reference to duty of candour and suggested that this could be included in Domain 2: Safe Care.

We support exploring options for enhancing openness, transparency and candour in the NHS in Wales. We think it is important to apply a consistent approach to learning from the Francis Inquiry, so that NHS patients can expect the same standard of care wherever this is accessed in the UK. Whilst it is important that individual members of staff be accountable in terms of candour, there should also be an obligation on their employer to adhere to the same principles.

Implementation of the GOC's new standards of practice

Our new standards of practice come into effect from 1 April 2016 (replacing the current Code of Conduct). As part of the annual retention process (whereby registrants renew their GOC registration), registrants will have to declare that they have read and will abide by the new standards. Furthermore, under the GOC's CET scheme, all registrants will have to demonstrate that they have engaged with the new standards as part of the 2016-18 CET cycle.

Our new standards are available on our website: https://www.optical.org/en/Standards/Standards_for_optometrists_dispensing_opticians.cfm

We are currently drafting supplementary guidance to assist registrants on how to comply with some of the standards, including, duty of candour. We will be consulting stakeholders in 2016 and would welcome your views.

Response to specific questions

No response to specific questions.

WGGP142 – John Palmer– Directors of Primary Care, Community and Mental Health Network
Tref / Town – N/A

General comments

We welcome the chance to make this response. Ours is not a comprehensive response, but reflects our recent discussions on the need for some particular changes in the NHS Wales system, that might be achieved through appropriate legislative and other complementary measures.

Permanent engagement mechanisms/patient participation

We feel that there is a good case to be made for compelling the creation of patient participation groups at the local level given their current numbers, though we note that this would probably require both legislative and contractual elements for any measure to be successful. In general terms, especially for more remote or isolated communities, patient participation groups can provide an important holding space for practices and patients to share concerns and ambitions – and provide mutual support.

Strengthening local collaboration in planning / Strengthening legislation to ensure agencies work together

- We feel that further legislative changes are not likely to add value. Our sense is that the Public Service Boards should be given the opportunity to bed in and drive collaboration with a grip on both outcomes (visible commitments to change) and outputs (pooled budgets, terms and conditions, information sharing).
- We felt strongly that the role of primary care in this collaborative environment should be carefully considered. If the natural endpoint of the current contract is federated clusters with commissioning powers, then it will be important for these emerging bodies to be accounted for.
- We felt that cross-sectoral working might well be strengthened by adoption of some shared performance arrangements. The emerging KPIs for primary care, would be greatly strengthened if they were complemented by social care data and if any performance architecture was whole system, with incentives for collaboration rather than competition.

Meeting common standards

We feel very strongly that a single set of common standards across the NHS and independent sector would have a strong impact. However, if Public Service Boards are to be successful and different to their predecessor arrangement, we also felt that a broader set of common standards across public services would be necessary. It will be important for there to be a clear

line of sight for all reporting arrangements; and a strong joined up narrative if such endeavours are to be successful.

Being open about performance

We feel that it was unlikely that legislation would add a great deal to the openness of performance. We do however feel that the public publishing of the 22 KPIs for primary care in Wales, in an accessible dashboard will be an interesting natural experiment in the early part of next year. We would also support local measures to promote reflective practice in both primary and secondary care spaces – such as Schwartz and Balint rounds.

Sharing information

This is an area that the Directors are taking a very strong interest. We feel that there are too many initiatives running to collect and manage data in the various parts of the Health system and that we ought to adopt a very strong national drive to create a single, integrated patient record. Notably Catalonia have the HC3 project that:

- is a platform for the exchange of information.
- is a tool for consultation for medical staff that allows them to access information on patients, independently of their geographical location and their care level.
- provides information to improve the decision-making process related to diagnosis and treatment.
- improves coordination between the different levels of care such as, for example and especially, between primary care and specialist care.
- allows access to and visualisation of radiological images so that they can be shared between different centres.
- contributes to reducing errors and the duplication of unnecessary diagnostic tests.
- It adopts a leading interoperability model in Spain (for example, for the digital medical record project for the National Health System and in the international sphere (the international project EPSOS, Smart Open Services for European Patients), which will facilitate health care provided to users when outside of Catalonia.

We also note (New Zealand) Canterbury's Shared Care Record Review, which is a summary care record that might be a less heavy alternative. Any national construct to support an approach of this type would be welcome. The case for a single citizen record across public services is a fortiori, but that may be a step too far at this stage.

On research, there is ample evidence that UK and more particularly Welsh research is held back by low levels of consenting. Demark and to a lesser

extent Finland and Sweden benefit from high levels of prospective consent that allow for research that exploits significant data linkage between biological, health and science data (we note that in areas where we do have some outstanding research like CAMHS, our researchers struggle to enter international studies because of the disparity in consenting levels). Any national measures that could drive us towards higher levels of consent would be extremely valuable. If even one Health Board population could achieve universal consent in pursuit of research to achieve population health, then that would be utterly transformational for NHS research.

Inspection and regulation

We would support a more integrated approach to inspection. Primary and Community care are episodically accounted for by the various inspectorates and there tends to be less focus and inspectorate capability in these areas than acute specialties. HIW has piloted GP inspection in 2015/16, but this is yet to mature into a significant offering. Mental Health tends to have a much clearer focus, but there are times when HIW, WAO and Delivery Unit activities can feel duplicative. Other 'softer' improvement techniques such as peer review will also need to be factored in, particularly where new ways of working are being explored.

Representing patients and the public

We feel strongly that the CHCs are an important part of NHS Wales' integrated model and that a strengthened role in advocacy would be important. However, Health Boards have an important and direct duty to engage and consult with patients – so the CHC role in representing voice should be considered carefully. The active role that local Councillors already play in representing communities should also be taken into account here.

Borrowing powers

The prospect of European Social Investment Bank funding has very rapidly stimulated thinking on Primary, Community and Mental Health Estate – following a period when these elements of estate have not been strongly articulated in IMTPs. Given the degree of latent enthusiasm for potential development in these areas; and the ongoing likelihood of severe capital constraint in the public service, then the potential for alternative routes to funding would be welcomed. There is obviously a level of prudency required if powers were to be made available, but there is also much learning available from local government's own prudential borrowing model.

Planning

We feel that a statutory planning duty for Trusts would be welcomed – on the basis that it would create a stronger drive for alignment between Trusts and Health Boards. We are currently working hard as a group to ensure that Trusts work in support of the planning assumptions in each Health Board IMTP; and anything that could reinforce that approach would be welcome.

LHB size and membership

Unsurprisingly there is a general consensus that the Director PCMH is an important role and should not be considered as discretionary, especially at the moment when signal commitments have been made to develop Clusters further (to federate and commission), lever new funding into primary care and mental health and to use these and other elements to achieve a permanent rebalancing of the healthcare system towards out of hospital services. If Government thinking remains that prudent healthcare and the development of the social model of care are key priorities; and complex multi morbidity and hence increasing incidence and prevalence of mental health conditions are becoming the key challenges of the next twenty years in healthcare; then it seems critically important to maintain this role as a check, balance and enabler.

Advisory structure

We have spent a good deal of time over the last six months, carefully drawing together the very wide range of resources – professional, clinical and managerial – to try and achieve some alignment towards the all Wales Primary Care Plan. There remains a wide array of advisory committees that have varying degrees of representation and expertise. Proposals for developing a more streamlined model would be very welcome indeed.

Response to specific questions

No response to specific questions.

WGGP143 – Natalie Vanderlinden – Therapies and Health Sciences, Hywel Dda Health Board
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Both the Social Services and Well-Being Act (2014) as well as Well-being of Future Generations Act (2015) are legislative frameworks which have been introduced very recently. Both Acts are designed to strengthen local collaboration in planning and meeting the needs of people. However, there has been insufficient time to evaluate the implementation and embedding of both Acts, to inform the decision whether further changes to the legislative framework are required. What is the evidence base behind the proposal to use the law to strengthen local collaboration and integration? Are we clear on to what extent current legislation has enhanced or hindered collaboration and integration within a multiagency context? The law can be a blunt tool, and result in unintended consequences which may hinder rather than facilitate its original intend. Following the implementation and embedding of the 2 Acts, it may be opportune to evaluate the effectiveness of other relevant legislation in achieving the intention of both Acts and consider the streamlining of legislation, rather than adding to its complexity. There is a need for greater focus on aligning responsibility between NHS and Social Services and Wellbeing Act. Reciprocal responsibilities require to be described reliably with shared, common performance measurement. There is a continued risk that the detail of implementing one piece of legislation will compromise the ability to comply with another due to shifting financial responsibilities.

2. If so, what changes should be given priority?
Consideration should be given to establish a hierarchy of interventions which would be used when a 'partner organisation' is not collaborating; e.g. supporting, encouraging, directing, mediating, arbitrating, sanctioning.

Establishment of a collective responsibility for a single needs assessment with all parties bringing their data and expertise. Improved informatics and analysis capacity within the public sector is pivotal to this as it would provide real, powerful data and subsequently reduce waste within the system. The concept of pooled budgets should be supported by a common performance framework for those services. The ability to develop regulations and explanatory memorandum allows this type of detail to be added to primary legislation already in place.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The existing governance structures within NHS Wales are complicated and not easily understood. However, the goodwill of individuals will often circumvent these complexities. Whilst changes in legislation will outline the process for undertaking local collaboration, a paradigm shift to achieving consistent local collaboration won't automatically occur and progress and development will be dependant on leadership behaviours, local agendas and financial priorities. There is a risk that the introduction of further legislation may only serve to make the position more complicated and complex. The Green Paper provides the opportunity to review, remodel and, where applicable, rationalise existing models and structures. This should take place before any further legislation is considered. Coproduction is a challenging concept to apply reliably and in a meaningful way. Whilst legislation may not be necessary it would give a positive message if e.g. 1000 Lives and Social Services Improvement Agency worked together to develop a common standards framework to support the approach.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Clinical staff continue to advocate for service users without reliably providing the opportunity for informed discussion regarding clinical management. Similarly the NHS is not reliably open with the public regarding the challenges operating services with e.g. adequate medical staffing. Expectations regarding the nature of information exchanged could be made more robust through legislation.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement

mechanisms, such as patient panels or participation groups?
Whilst reliable engagement mechanisms are required, a rigid statutory framework can lead to a “ticked box” approach to consultation. Description of clear standards and expectations may be a more effective approach. If there is an expectation of strengthening partnership working with other agencies the engagement mechanisms should be common (local authority already has systems of user consultation that could be considered as joint forums)

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
There is a need to be clear regarding the added benefits of such a panel.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Legislation is one effective tool – It is debatable whether it is the most effective tool. Legislation will mean statutory accountability and also that the quality standards will be prioritised. If legislation is introduced, it should make quality the focus for the integrated systems rather than, as is now, other measures such as finance. Legislative measures merely outline the process and therefore to ensure continuous improvement in quality a shared performance management framework would need to be introduced to monitor specific key performance indicators across different geographical boundaries. The framework would need to encompass specific measures to enable monitoring and evaluation of “real time” performance indicators through a dashboard. This approach would provide valuable business intelligence. This would be heavily dependent on sophisticated IT structures which were interoperable across NHS and social services. We recognise that in the NHS quality is paramount and there is an escalation and intervention framework now in place across NHS Wales. However, there is an imbalance between the financial and quality duty, with the former more easily defined and measured that need to be addressed in any changed approach. Legislation is a blunt tool. Unless it is well crafted it leads to ambiguity that requires case law to settle. Legislation does not provide “black and white” direction or answers. It is questionable whether legislation is a solution particularly with concepts such as quality.

It is of concern that we may need further legislation when Health Boards are already working through and struggling to implement current legislation.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
In considering service change there is currently no requirement to complete a quality impact assessment, whereas there is for finance; equality; health needs etc. assessments are required. In the existing economic climate, the reality of the situation is that there is a balancing act to be achieved in considering financial pressures with maintaining quality of service provision. Therefore the gap that needs addressing is making "quality" count and matter. The Health and Care Standards were introduced to focus on quality and improving patient care, however there are no tangible repercussions if you do not meet all of the Healthcare Standards, however there are significant consequences if financial targets are not met. Dichotomy between "quality" and "safety", too much focus on quality in isolation. Need to factor in the safety element especially in light of the Mid Staffs review and the Andrews report. Not just NHS priorities but this should be joint H&SC priorities. The Social Services and Well-being (Wales) Act provides legislation on a citizen centred approach and how this can be achieved through partnership and integration. Before further legislation is required a review of the impact of this Act should be undertaken to ensure that it has facilitated a citizen focused integrated delivery of care and that the citizen's are satisfied with this within the coproduction agreements and maintaining prudent health and care. 'The Prudent Citizen'.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
We need to be clear what we mean by quality, especially in an integrated health and social care environment. In considering service change there is currently no requirement to complete a quality impact assessment, whereas there is for finance; equality; health needs etc. The views of the experts and the public are much different on this and the need to engage with people on this was stressed in Trusted to Care. Any legislation should focus on integrated standards as this would facilitate and enable quality to be at the forefront of decisions and joint decisions of health and local authority organisations. It may be more appropriate to consider how we could establish safe standards that could ensure consistency across the system and would have the same monitoring and audit arrangements that apply to the financial systems and the

Annual Quality Statements would then have primacy and would be resourced accordingly. Under the Social Services & Wellbeing Act there is an element that health services have a duty to participate in relation to the standards for Social Services.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
Given the issues above regarding quality it is difficult to see how such an individual could be responsible or accountable. Accountability lines within the NHS Wales at Health Board/Trust level are already clear.

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
Following the aftermath of recent failings in managing quality and care standards within the NHS the principle of the introduction of a "fit and proper persons" test is supported. However, this should not distract from the primary responsibility of the employer to check that their Board members are competent in discharging their roles and responsibilities effectively and that they behave in a fit and proper manner and continue to do so for the tenure of their employment. Advantage – it will provide assurance to Welsh Government and also to the Health Board Some questions to consider: 1. How will the test apply to those Directors who occupy a professional as well as corporate role (concern regarding dual regulation)? 2. How will the test differentiate between those who are clearly the decision makers versus the responsibility of a Board? Disadvantage (dominant position) – it would potentially create another layer of bureaucracy to regulate health practitioners. This will include an industry setting standards and also time out of practice in order to be evaluated against these standards. This will be in addition to regulation that is already in place by the appropriate health regulators e.g. NMC, GMC, HCPC. It will also be in addition to other systems in place in the workplace e.g. capability policy.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
The term integrated planning refers to the integration of the systems within the NHS, whereas the Health, Social Services and Well-Being Act and Well Being of Future Generations Act are aimed at broader service integration and quality (however defined) needs to be seen in this context.

It would be helpful if this was set in the context of an over arching health and social care plan for Wales. Many of the quality targets set down by Welsh Government are related to accessing services and it is the core Tier 1 targets on which health organisations are held to account. If quality is to be promoted as indicated this needs to be the core requirement within the planning framework and guidance. This will then lead to a full focus on quality throughout the system. As Health Boards improve the quality of their plans, the promotion of quality will develop and be much stronger. The danger of trying to legislate for this would be to impose further complexity onto an already complex process and the subsequent risk of reducing the quality of the plans. Rather the main requirement in a cultural change in mindset and legislation is not the answer. Therefore we do not believe that legislation is needed to further strengthen the NHS Planning framework.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
This should be viewed in light of the section on quality. As indicated there may be merit in setting safety standards that can be easily monitored. Again the standards apply to the NHS and it would be helpful to have an integrated set of standards across Health and Social Care. This is particularly important given the changes in legislation such as Social Services and Well Being Act. The standards are mainly provider led and as integrated organisations it is important that these reflect all the accountabilities of Health Boards/Trusts. The Health and Care Standards have just been refreshed and these need time to be embedded and to be reviewed.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
It is important to ensure development of such systems provide assurance to the public. Peer Review is an important process and whilst there have been examples of how this has been used across the service, it is time consuming and important that it is seen as an integral part of a role/s and not an add on. There are already a number of national bodies that provide accreditation and

these need to be utilised fully to avoid the risk of duplication. There would be a need for consistency of approach which would be agreed by the Health Board. Whilst this would have much benefit across the whole system, this is a decision that could be taken at a local level and does not require any changes to the legislation framework. Mandatory accreditation across the sector would require the appropriate resource to support the cost of the accreditation process. Thought needs to be given as to the escalation of services that are unable to meet accreditation such as endoscopy across Wales as the current infrastructure is not to the accreditation standards. Would patients have to travel outside of Wales to access an accredited service until infrastructure is up to accreditation?.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Support the principles that this should be implemented as an integral part of health professional practice. Do not support the suggestion that this should require legislative changes as this would create more of a burden on organisations and individuals and this needs to be linked to the introduction of revalidation for nurses, and other professions to follow. There would be significant resource impact if this were to be legislated and this would require additional funding to Health Boards to ensure appropriate resources are allocated to undertake the role of clinical supervision. Good clinical supervision does improve services but legislation would not ensure the quality of the supervision just that supervision activities have taken place.

17. What arrangements should be put in place for self-employed health professional registrants?
The NHS could offer mutual supervision cover with private practitioners (i.e. cross sector supervision or peer review arrangements).

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
We are broadly supportive of the introduction of a statutory duty of candour in the aftermath of the failing at Mid Staffordshire NHS Foundation Trust. The Francis Inquiry Report made 290 recommendations including: o Openness, transparency and candour throughout the healthcare

system (including a statutory duty of candour), fundamental standards for healthcare providers

- Improved support for compassionate caring and committed care and stronger healthcare leadership

Candour is defined in Robert Francis' report as: 'the volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made'.

'Prompt apologies and explanations, with a reassurance they will not reoccur, may prevent a claim being brought at all'.

Mr Francis' recommendation 181 provides that there should be a statutory obligation of candour on healthcare providers, registered medical practitioners, nurses and other registered health professionals where there is a belief or suspicion that any treatment or care provided to a patient by or on behalf of their employing healthcare provider has caused death or serious injury.

Provision of information should not itself be evidence or an admission of civil or criminal liability, but not disclosing the information should entitle the patient to a remedy.

Candour (and its close allies openness and transparency) permeates throughout Mr Francis' report. Out of his 290 recommendations, several are drafted with those themes in mind. It is difficult to dispute that these are laudable recommendations.

Promptly identifying negligence and providing redress for the patient and their family should be encouraged. Doing so quickly and efficiently will reduce expenditure on legal costs and should provide a better experience for the patient and their family.

It is likely that Health Boards/Trusts will be required to draft candour and disclosure policies to ensure all staff are clear about what their obligations should be in order for them to avoid liabilities arising.

While criminal sanctions may arise for senior individuals, Trusts may also be held vicariously liable for the actions of their employees. However, there are other forms of redress and remedies that already exist for potential claimants and which may be more easily proved in a civil claim. Training on such policies may also be required.

Professional groups already hold this duty. If Boards could be held accountable for its emphasis and delivery this is more powerful. Legislation implies NHS Bodies do not want to be open and transparent Putting Things Right and redress already require this and needs to be implemented fully.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
The three year planning cycle process – Health boards need to be able to start from a level playing field and not constantly trying to play catch up against historical deficits. This mechanism allows internal 'invest to save' but some investment is very difficult to map out a specific financial saving. It is inevitable that some 'pump priming' will be required to develop service changes.

Planning

34. 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?
Alignment of all relevant Acts, which result in more streamlined, less complex government structures which support the principles of a one system approach across Health and Social Services would be welcome.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
With the need to deliver across Health & Social Care and pressures in one area impacting on the other, combined with the need find the solution to this challenge, we need to work as an integrated system. LHB's working co-terminus with Local authorities to deliver on aligned strategy from WG would support delivery of services to better meet the needs of the population.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Effective decision making is a combination of speed and quality. And whilst an argument can be made that reducing the size of Health Board membership will improve the speed of decision making, priority setting and providing scrutiny, evidence shows that the quality of these 3 activities is highly dependent on the diversity of the board membership. Therefore, when considering limiting the number of board members to increase speed, careful consideration is required to ensure that this is not at the expense of quality.

Considering the challenges ahead for the NHS, and also for its partner organisations, a more diverse and different board membership is required, representing the future direction of both Health and Social Care.

When considering the Board membership it is necessary to consider the breadth of portfolios required by health organisations to deliver against the current policy drivers. Board membership needs to give adequate Board level resource to allow robust fulfilment of each portfolio item and ensure Board members can fulfil their obligations and accountabilities. This includes ensuring appropriate skills base on Boards, particularly to cover complex professional issues across the entirety of Health Professions, and to ensure there is a strong, clinically focused cohort of Board members. The Board should be able to vary the regulations and to decide the executive structure that is needed rather than being prescribed by regulations.

Of note is the large number of independent members, scrutiny is vital – however the number required could be considered (in the light of evidence base re effective decision making); whilst recognising of the importance of bringing relevant knowledge, experience and specific skills to complement and challenge at Board level.

The inclusion of a representative of Social Services may support integration.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
It is felt that total discretion should not be supported. There needs to remain core 'legislative' responsibilities, supporting clear accountability. This is also vital for succession planning, i.e. development of future Board members. Outside of this some flexibility may be required to align portfolios to best suit skills and experience and deliver on the required agenda. Of particular importance is the need to ensure the Board continues to have clinical balance and therefore the number of clinical executive directors should always be more than the number of non clinical directors. The NHS in Wales is challenged with shifting away from a traditional medical/hospital model of approach. AHP's bring the perspective of the 'person', promoting a person centred and empowering co-production approach, very often within away from the hospital setting. This brings challenge to thinking and will drive the modernisation agenda required. There is still much more these roles can offer in engaging and giving voice to the innovations and solutions sitting across these services in Wales which already have effective multi-disciplinary and multi-agency partnerships in place. The therapies and health sciences professions are intrinsic to providing the solution to the challenges NHS Wales is tasked with and visible leadership at executive level is crucial to this.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
With respect to overall size of Health Boards (refer to Q2 response). Yes - LA and Social Services representation would better represent the needs of the population and support integration. Election of community representation is something that should be explored to ensure transparency and maintain a 'grass routes' level of understanding, supporting effective communication and management of expectations.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
In 2014 the WG undertook a review of the statutory structures in Wales. WG aimed to develop a more efficient and effective advisory structure for both NHS Wales and the Welsh Government. The review recommended the establishment of single Joint Professional Council to replace the following groups: National Joint Professional Advisory Committee; 7 Statutory Advisory Committees and 24 National Specialist Advisory Groups. Clarity is required with regards to the status of the recommendation and any progress made to date. It is important that the Minister seeks and listens to advice and that the advice available is robust, inclusive, balanced and transparent. The statutory status of the advisory committees ensures this. The statutory status of the advisory committees also ensures that professions which are 'smaller' such as the therapies and health science have a voice and have an equal opportunity to influence as the medical and nursing professions. There are examples of non- statutory national advisory groups not being inclusive of all relevant professions, and therefore the advice not being robust, inclusive and balanced. There is concern that lobbying by any 'lobbying groups,' whether professional bodies or specific condition groups, can create a bias on how to organise/structure/prioritise services. Due consideration needs to be given to safeguard against this. This includes self nominated individuals, who are referred to as 'experts'.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
One of prudent healthcare's principles is that of co-production with the end-

user, whether the patient and/or the carer. Whilst it is important that policy and service delivery is based upon expert professional advice, it is only one element of the whole. Therefore, this question does not support the co-production, and therefore the prudent healthcare agenda.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Both the Social Services and Well-Being Act (2014) as well as Well-being of Future Generations Act (2015) have been introduced very recently. However, there has been the insufficient passing of time to evaluate the implementation and embedding of both Acts, to inform the decision whether further changes to the legislative framework are required.

Hosted and Joint services

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Not all aspects of Shared Services are working well and the impact on service users is not always understood. It is important that prior to extending the remit of Shared Services a review is undertaken to understand the current impact as well as anticipated impact on service users; for e.g. responsiveness, timeliness, etc.

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General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
For over 25 years since the implementation of the NHS and Community Act (1990) there has been a focus from both policy and legislation that collaborative / integrated planning and service delivery is identified as an informed method to achieve holistic outcomes to meet people's needs. Historically, Health and Social Care organisations approach appears to be more on developing services / service models through combined inputs that are not necessarily outcome focussed as opposed to achieving integrated outcomes to meet local needs? There needs to be clarity as to the purpose and expected outcomes for collaborative planning and subsequent delivery of services before changing legislation. It is difficult to legislate for effective collaboration. However it may make sense to have an equitable legislative status for both health and social care. It is more challenging to align priorities whilst social care has a 'duty' and health boards only have to 'have regard'. That said, changes to legislation alone will not provide sufficient leverage for positive change to culture and practice. Clear mechanisms for monitoring and support will need to be provided in tandem if there is to be meaningful implementation. Rewarding collaboration may be more beneficial than legislation, however consideration must be given that not all services (not just specialist services) can safely and effectively continue to be delivered locally close to home. Regular consideration of the sustainability of service provision must occur.

2. If so, what changes should be given priority?
A priority change would be compulsory planning meetings that hopefully will lead to a culture of collaboration going forward this may require a legal framework for accountability purposes

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
There should be joint accountability for the delivery of people's health and wellbeing needs.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Probably not; in this case legislation would be a blunt tool and it is more a question of building skills and confidence.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
There is definite value in statutory requirement for co-production/engagement mechanisms. However, requirement for only one means of engagement i.e. patient panels risks organisations limiting their engagement to that one method. Expert patient panels, whilst valuable, tend to be occupied by a particular section of society – often of a particular age, social class or those with particularly strong views relating to one aspect of health and consequently have the potential to exclude the views of the wider population. Co-production and engagement requires a range of approaches from 'expert' panels to use of online questionnaires and social media. The challenge for health boards is in posing the questions and seeking input in ways that are palatable to all sections of society. If such statutory panels were to be established there would need to be detailed guidance to ensure that members are truly representative of the local community. Experience has demonstrated that there are risks that self-selecting members/volunteers can become semi-professional. Alternative mechanisms can include statutory engagement with a range of existing forums e.g. over-50s, carers etc. Health Boards should be encouraged to utilise a variety of methods to engage with the widest spectrum of users. Some 21st Century engagement is required and lessons can be learnt from some industry leaders who engage regularly with their customers Virtual and electronic forums can and should be considered as part of this.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
The idea of national expert panel for referrals seems sensible. Decisions should be based on an objective assessment of need and separated from politics. Such panels will need to have credibility in those areas of need in order to gain public confidence. The appointment process will need to be carefully crafted in order to ensure that independence is enshrined. This could be achieved without a need to reform the law.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
No; current legislative measures should be sufficient. Legislative measures are not necessarily the most effective tool. Better engagement and co-production (if truly implemented) should drive the quality agenda. It should be noted that quality can be interpreted in different ways. Maybe there is a need to consider whether the current standards of care are sufficient for purpose?

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
There is currently no clear integrated system.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
It is difficult to legislate for quality a rewards system would be better so that people are incentivised by quality, good quality doesn't cost, poor quality costs dearly.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
There would be advantages re the clarification of accountability, but the scale of implementation is logistically huge compared with social care establishments/services. In addition, there are arguably too many variables outside of the 'responsible individual's' control to make that accountability realistic. The advantage would be accountability and responsibility, the disadvantage is that a failure to take appropriate action when things are not going well undermines the concept, there has to be a willingness to address adverse consequences. This is easy to talk about and hard to do, but would be critically important in this situation.

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
This could get very tricky as who would be the judge of fit and proper? Judging individuals to be fit and proper will always draw accusations that they may not be.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Yes it would help focus on Quality and Safety in the delivery of services and the focus needs to be on outcomes and not process alone. This should be intrinsic to the planning process and would be of benefit. There would be a difficulty in defining quality to ensure that it encompassed the full spectrum of safety, effectiveness, sustainability and efficiency that apply to the provision of quality services.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Yes. The current healthcare standards are so broad and open to interpretation that it would be difficult to determine if a particular ward, for example, was delivering a quality service. The health board quality self-reported evidence relating to each particular standard focuses on compliance rather than detail of areas for improvement. Using 'Tawel Fan' as an example, as this paper does, would the healthcare standards enable an organisation to determine if it had the issues of poor quality, leadership and culture that existed on that particular ward? What might be better is nationally agreed standards for particular areas and a national framework for assuring against those standards. Using Tawel Fan as an example, one might ask 'what does good look like in older person mental health in-patient wards (as a set of mental health specific standards)?' and evaluate a service against more specific and mandated standards that are common to all of Wales. This approach would equally benefit other service areas e.g. A&E, Surgery etc.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
If it's a framework that more specific sub-sets of standards could feed into then yes, that could be useful; if it's to design a set of standards across the NHS and independent sector (such as the current broad brush health care standards) then it is unlikely to have the desired impact or focus. The requirements for both NHS and Independent sector should be consistent and patient focussed This could be a useful lever but needs to be accompanied by a change in attitude to working in partnership with the independent sector if it is to be effective.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Accreditation and peer review have a definite value but Wales is a small country with close professional relationships within specialities – this risks peer review having limitations in terms of critical challenge. There is definitely a place for a combined independent and peer review process. Whilst peer review is embedded in medical culture, experience suggests that significant ground work would be required to spread the practice in a meaningful way across health care.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Legislation seems a heavy handed approach. Time and access to appropriate clinical peer supervision could simply be enshrined in contractual arrangements. There are risks in requiring employers to ensure access to supervision as this does not necessarily mean that there will be quality supervision with the desired degree of professional challenge. Having clinical peer supervision while important cannot be effectively legislated for the quality of supervision will be dependent on the quality and skill of those providing supervision, protected supervision time with a less able supervisor will not benefit staff.

17. What arrangements should be put in place for self-employed health professional registrants?
Self-employed registrants would need to adhere to the professional body requirements and where required have arrangements in place for supervision to occur. This could be achieved by linking in with other organisations and utilising there resources /systems arrangements and it may include a fee. It may also be achieved through agreement with professional bodies where a charge could be made through the professional registration fee.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes. There is an issue with current NHS complaints investigation, in that investigations are usually undertaken by service leads or clinicians from within the specialities that are being complained about. Whilst there may not be a deliberate attempt to align with one position, it has to be questioned whether there is enough objectivity and patient perspective being applied. This would support current Putting Things Right requirements and expand openness and transparency to an organisational level. However there does need to be greater clarity regarding the outcomes of non-compliance if this is to 'have teeth'.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
The national agreement of key outcome data by speciality and imposition of A legislative requirement on Health Boards to publish service / consultant / clinician specific outcome data could drive this. A statutory duty of candour would lead to this.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
There are definite advantages to implementing a standard process and equitable outcomes as Wales seeks to move to a more integrated approach to health and social care delivery. For example, in integrated community teams at present, there have been incidents where the sanctions on staff have been perceived to be inequitable and dependent upon on their employer's individual policy. This causes friction within the teams and is counter-productive to the further development of partnership working. There is a value in the joint methodology already in existence for Child Practice Reviews, as an example. This approach sits within a legislative context that could usefully be applied to concerns. Primarily, the focus of investigation should be around the patients experience and not hindered by service boundaries. It will also support joint working/ input to enable improvement.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
There are several issues that prevent healthcare bodies from sharing patient information including: - Understanding of Caldicott - Concern over breaching confidentiality - Data protection - Organisation interpretations of what can be shared - Over complicated process to achieve the required outcome - Confusion over the exact detail of the law as to what data can be legitimately shared. Safe sharing portals are inconsistent and often time consuming and difficult to set up.

22. How can we consider breaking down any barriers?
If we are serious about co-production then there is an argument for citizens owning their own key information and sharing it directly with whom they choose. (E.g. as is currently the case with patient–held maternity records.) There are existing examples where collaborative records are kept in patient's own homes where they are receiving integrated services/joint packages e.g. the 'Big Orange Folder' model. Where further or more detailed/sensitive information sharing is required, or the citizen is unable to make those choices/decisions, then the solutions need to be simple. E.g. the use of secure e-mail, an 'opt-out' conversation with the individual ('who do you not want us to share this information with') and access to plain English advice if the practitioner has any concerns regarding the information they want to share. There is a need to have clear and consistent consent processes. It may be helpful to put some working examples and exclusions into Caldicott guidance.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
This question needs a fuller paper with further detail to answer fully. Some issues: • Consent • Governance arrangements of research body (?drug companies) • Public confidence • Security • Onward transfer (?selling) of information • Impact on life insurance etc.

- The guarding of information not necessarily the provision of it.

This would require much broader public debate.

If we are really serious about co-production, with citizens as equal partners, then explicit consent must be gained for the use of patient identifiable information for any purpose other than direct care.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
This is not necessarily about a change in legislation but more of a clearer understanding of structure, process and outcomes to further ensure effective practice.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
Statutory independence would need to be equitable across health and social care. This would however raise the question of accountability; 'who regulates the regulators?'

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
The current concordat arrangements have proved ineffectual in terms of agile responses to modernisation and integration. If there are to be common standards, then it makes sense to have a common inspectorate, with the appropriate expertise to assess implementation in all the various settings (establishments and community). That said, as both inspectorates currently work in different cultures and with different methodology, change would require sustained commitment and a long-term commitment to implementation.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
There is little evidence to support that inspection drives quality, so this may be a red herring. Regulation and enforcement needs to go hand in hand with effective performance management and service improvement if there is to be any impact on citizen experience/confidence in the system'.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Yes. Definitely , they offer the independence and support patients are looking for CHCs are an underutilised potential force for change and patient engagement, CHCs should be formally represented on Trust Boards and intrinsic to the development of the Local Development Plans (LDP).

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
Any new CHC model should align with the health and social care GP cluster/NCN model and should reflect a patient focussed integrated model.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Currently Health Boards have not shown the planning delivery or financial maturity to support them being allowed to borrow. This could present as a significant financial risk to the NHS in Wales. In the future borrowing may be appropriate for high performing organisations. Successful consecutive delivery of a number of years of a LDP might be a mechanism to facilitate this in the future.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
Yes, but could be strengthened to include where money has not been used effectively and highlight either failures or successes related to invest to save.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes, this is important given the functions served by the Trusts, i.e. Ambulance, Velindre, both of which have all Wales roles and where effective integrated planning is essential to the delivery of high quality services to patients across Wales.

34. 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. Planning for sustainability should be made a legal requirement and reflect the health and social needs of the population. As it stands, risks for planning and service delivery are not always jointly owned and consequently where individual organisations have independently made planning decisions there is the potential that such decision making could have a negative effect for citizens. There has to be whole systems thinking.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Legislation could be a lever but also a barrier. Quality leadership and governance is not just about legislation it's about ongoing commitment and development.

<u>LHB size and membership</u>

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Health Boards are accountable for the planning and delivery of services that meet the needs of their local population. Health Boards have many challenges in achieving this objective as a consequence of : -The Health Board size -Demand and capacity challenges -Providing equitable services across rural, urban, valley communities -Variable planning and commissioning of services -Health Boards focus seemingly towards secondary care. -Limited evidence in the development of community focussed models / integrated models of care (Health & Social). - Managing the balance in effectively achieving access to services, meeting finance targets and providing quality services that are safe Noting the above points, there needs to be a review of the functions at Board Level to ensure there is appropriate leadership, accountability and scrutiny for the presenting challenges. Along with the statutory functions, consideration needs to be given to Boards having members that represent – Quality and patient safety (in the title). Primary and Community Care

Integration. Health and Social Care The patients voice The carer's voice.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
The size and scope of services does differ between health boards as such it could be appropriate for specific nuances to be reflected within the establishment of the executive function. However there also needs to be certain statutory functions to ensure standardisation of practice i.e. quality and patient safety, finance, There needs to be learning from the past. There were previous concerns about a lack of focus on mental health services and there was a subsequent Welsh Government directive that: - Deputy Chairs in Health Boards be made accountable leads for mental health. – Health Boards had an Executive Director for Primary, Community and Mental Health

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
In conjunction with an enhanced role for CHCs these individuals could have a strong role to play in ensuring local accountability.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
No joint appoints should not be a statutory provision however the requirement to work in tandem between Health and Social Care should be.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
There should be service innovation and development role on the Board.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
This is a duplicate question answer as above number 36 same applies Trust or Board.

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
See point number 36 Joint appointments across health and local authority at board level could support integrated delivery of services. A Board Member should have Quality and Safety in their title.

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
Yes.

44. If so, what aspects of the role should be additionally set out in law?
Accountability of the role.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Requires further consideration and assessment This could change the nature of 'advisory' and lead to longer discussions seeking evidence based research answers where often only advice is required and is immensely useful.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
The most important fact is that there needs to be a workforce that has the right numbers and skills that reflect local needs. Service models need to be evidence based and fit for purpose. To achieve this should be good practice and usual practice in and across agencies.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
There is definite room for further clarity on the role, function and governance arrangements for hosted services and for how they both link to each other and to their host and for this to be explicit to stakeholders and the wider public.

The appropriate placement of services to be supported to deliver their function is central to effective management of the health and social care function. Care needs to be made that sector specific functions that require detailed understanding of the operation and performance of that sector need to be maintained with the sector to enable effective delivery of duties.

Clearer demarcation of roles and responsibilities of different organisations may be necessary. However opportunities should be taken to link work between organisations and ensure that the different arms of performance management and improvement can seamlessly link to support Welsh Government and organisations respond to performance issues.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
Having greater joint working in areas of common practice such as purchasing, recruitment and even capital and estates management would be beneficial to the public sector however care would need to be exercised to ensure that levels of existing performance were at the minimum, maintained if not improved upon.

WGGP145 – Simon Emery – Academy of Medical Royal Colleges-Wales
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Not clear how the current law inhibits local collaboration

2. If so, what changes should be given priority?
Duty of prevention of health harm Duty of enhanced health. Responsibility of all Gov depts.. every action/recommendation of gov should include an assessment of health impact.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Use the language of ownership-the public own the health service and the owners should get what they need.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
The public owners should determine how their voice is heard- Gov may assume they are the voice of the public in which case legislation might help. More engagement is needed-greater use of and completion by the public of satisfaction feedback after every contact with the service.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
No --the minister must be accessible but internally may sort out how to respond an as the individual cannot.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Professional duty—strengthen annual appraisal—are you doing the right thing well?

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Very difficult because quality is variable and the level chosen is a fine balance between cost and effect. So quality within the available resource is OK only if the public agree the resource limit. Legislation may drive ever higher quality that is unaffordable. Must not encourage excellence to be the enemy of good. The trend should be towards excellence at ever lower cost.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
Does this already exist- CEO, Chairman of the board?

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Not sure- planning is often poor and sometimes directly against medical advice. Who are accountable for bad planning decisions? Often huge waste of money and time. Royal colleges should be consulted more often during contentious reconfiguration of services in order to risk assess the impact upon agreed standards of care.

Chapter 3: Quality in Practice

Meeting common standards

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Standards are rarely absolute- vary depending upon practical constraints and relative risk of harm. The important issue is to recognise the variance and pragmatism-take overt corporate risk.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?

Peer review can be cumbersome-(regulatory) or light touch- (mentoring). Skilled peer review can be very cost effective. Different models exist but the principle is excellent and should be actively encouraged.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Employers should ensure that time and facilities are provided. They should be legally required to report arrangements to cover all groups of pts their organisation cares for.

17. What arrangements should be put in place for self-employed health professional registrants?
Whoever employs them should clarify. Doctors are sorted by appraisal system all others will need to move towards similar arrangements. Prospective audit of work done against agreed standards and including outcomes should be expected.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Doctors must follow the GMC guidance. Full and immediate candour is easy to expect but not always easy to comply with; as not always in a patients best interest. Under these circumstances a ethical arbitration is required and structures to provide this are needed.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Consider no fault compensation. Use Datix “lite” to pick up low level concerns.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Introduce targets for 1st MEANINGFUL response.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Organisational-defensive attitudes-fear of benchmarking Clarity of anonymity to protect identification of individuals

22. How can we consider breaking down any barriers?
Ensure that there is independent ethical overview. Move to an assumption of sharing—need strong reasons not to share.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Very important that there are systems in place to pool data and identify individuals-eg when implants are used in surgery that are subsequently found to be defective. Treat NHS and social care Wales as one entity-with on organisational data boundaries. Break the artificial divide between research and audit data.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
Wales is a small country-one inspectorate with specialised subsections

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
Integrated services are the aim so why prevaricate?

Representing patients and the public

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
May need legislation to visit social care institutions The name CHC is confusing. Patient satisfaction survey data and pt comment generally upon all aspects of NHS is unacceptably low. The CHC might be required to improve routine feedback and public engagement.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
the current boundaries appear to inhibit patient choice and essential reconfiguration. The centre needs to be strengthened by reducing health board autonomy. National IT strategy and service planning and contracts are required. The north south divide needs to addressed or accept long term formal northern relationship with Merseyside. Time to build better transport links (north south western and central motorways) as part of Nation building- meanwhile create excellent IT infrastructure.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Already widely consulted upon.

WGGP146 – Barbara Trahar, Chair – Neath Port Talbot Older Persons Council
Tref / Town – Port Talbot

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Yes

2. If so, what changes should be given priority?
Support for existing and new community groups

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Yes, make it an obligation.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Yes.

Chapter 2: Enabling Quality

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Yes.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Yes. Not sure how it could be strengthened but should be.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
Independence and autonomy is the key for CHCs for them to retain and improve accountability to the public/patients. The structure of the CHCs should be carefully considered. It should not be more centralised, as this could result in the smaller more localised issues being missed or not receiving priority. The CHCs should not stand back from 'inspections' but they should not be called this as it tends to formalise them they should be called 'monitoring visits' and be made announced. Giving them a specific role rather than the 'inspection bodies'.

WGGP147 – Paul Egan – Llandough Community Council
Tref / Town – Llandough

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Yes

2. If so, what changes should be given priority?
A statutory requirement should be introduced to require that a plan for all patients is prepared before they leave hospital. A copy should be given to the patient and/or their primary carer.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Stronger relationships should be developed between health and social services personnel to ensure that they are fully joined up thereby providing maximum benefit to patients.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
The Council would support the creation of patient panels or participation groups and consideration should be given to introducing something akin to the 'mystery shopper' methodology used in the retail sector and engagement of volunteers to undertake patient surveys.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
YES

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Legislation is not a panacea and instead greater investment should be made in leadership development and management training supported by an effective performance management system.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?

17. What arrangements should be put in place for self-employed health professional registrants?

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Most certainly YES

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
There should be a standards complaints procedure applying throughout the NHS and Social Services.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
An all Wales IT platform with a common information system is vital managed by a Central IT Bureau.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
There is an overriding need for a single Social Services and Health Service Inspectorate with the focus on the client and not the specialism.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
YES and extend the power so that it is similar to that available to the Older Persons Commissioner for Wales.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
NO – Boards may end up in considerable debt.

WGGP148 – Alyson Davies – Therapies and Health Sciences, Cwm Taf University Health Board
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The strong focus on health promotion and co-production within the paper is very welcome' however to maximise opportunities there should be a sharper focus on health promotion and early intervention for children, to avoid missing a significant opportunity. Collaborative planning should have to demonstrate how proposals enable health and wellbeing for all age groups. **Wigs** Following a task and finish group to develop an equitable solution across Wales to delivering NHS Wigs the main findings were: To deliver a solution that patients are happy with would require a change in primary legislation to allow Health Boards to implement a voucher or equivalent in the provision of Wig services. The NHS Quality, Governance and Functions legislation in the new Assembly term would seem the obvious mechanism to address the legal issues surrounding wig provision. Therefore it is felt that this would provide the most effective solution to continuing the service the patients are happy with, make it equitable across Wales and provide a completed policy for Shared Services tendering solution.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The Social Services and Wellbeing (Wales) Act 2014 will be a good enabler which could be strengthened by a clear expectation and requirement that IMTP plans demonstrate collaboration with partners to achieve truly integrated local planning to meet the health, social care and wellbeing needs of the population, evidenced by use of Section 33 Agreements etc.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for

health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Yes.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Yes.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Not legislative measures alone but the cultural change underpinning this ethos is also critical.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Yes

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Yes.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes it could and this approach is to be welcomed as it would provide a level of expectation, consistency and assurance for the public. Needs to also include more emphasis on all age groups and not bias towards adults.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Evaluation would need to be undertaken by experts with a knowledge of local issues.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Clinical supervision is a core component of clinical practice for therapy services but again there is no standardised model in place. There is merit in mandating and evidencing this as part of a professional's continuing professional development record to support ongoing validation/registration: it should be recognised that all registered healthcare professionals should have protected time for quality supervision within their job plan.

17. What arrangements should be put in place for self-employed health professional registrants?
Self- employed should be required by law to show they have taken supervision from an appropriately qualified , registered -and relevant to their practise -peer

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
There should be one unified process for both H&SC which could also include Education departments within Local Authorities.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
It is often not a lack of will, nor governance processes but Information systems that hinder. For example, both health and social care have confidential and secure email accounts within their system but are unable to email into those accounts from their respective systems.

22. How can we consider breaking down any barriers?

CCIS should go some way to addressing these challenges but could also include interfacing with Education department systems within Local Authorities.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
In principle this could be beneficial but this should be subject to rigorous consent procedures.

Chapter 7: Finance, functions and planning

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
It is important to retain a collaborative and engaging leadership style at the Board and the DoTH role is an example where one role, representing more than 60 professions across the Therapy and Healthcare Sciences can provide leadership and represent diverse professional practice covering preventative, diagnostic and therapeutic services as well as maintaining the standards of regulated and non-regulated professions covering the third largest group of professional staff in the NHS. They ensure a synergistic work environment, where multidisciplinary groups are encouraged to work together innovatively toward the implementation of effective service delivery.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
NHS Boards should not be large and cumbersome, but must be large enough to provide the balance of skills and experience that is appropriate for the organisation. Evidence from Mid Staffs etc has suggested that Executive Boards need to engage staff with a compelling vision that inspires them to work towards a common goal (Stewart 2014). The future workforce are going to have to be more flexible and adaptable working easily across health sectors e.g. primary, community, secondary tertiary and also other sectors such as social care and third sector. Promoting strategic decision-making is an integral part of the board's role in

formulating strategy and clinical leadership is necessary for the delivery of excellent outcomes for patients and populations. The skills and knowledge that the DoTHS bring to the Executive role through collaborative clinical leadership is essential in understanding the different professional cultures, facilitating integration and interdependency among the multiple stakeholders so that working practices can achieve outcomes that are greater than the sum of individual efforts.
Supporting the change in culture needed through prudent healthcare. The culture of the NHS is changing to promote a much more socially directed model of care that is integrated and also able to easily cross sector and cultural boundaries and the success of reablement services is testament to this. The contribution of Therapists and Healthcare Scientists is going to be key in realising and enacting this vision. Staff, working to the top end of their competences, has increasingly been taking on clinical practice previously carried out by medical trained staff and Boards need to be clear about accountability for maintaining standards of care. The DoTHS provides the assurance that the systems of control are robust and reliable for the multiple professions that make up the Therapists and Healthcare Scientists that cannot be readily provided by either a doctor or nurse as the registration and professional practice requirements are quite different.

Fostering a strong and healthy organisational culture: Boards are leading NHS organisations in an enormously demanding environment. Evidence supports the critical role that the Board plays in shaping and exemplifying an organisational culture that is open, accountable and compassionate, puts patients first and hears, supports and nurtures all staff (NHS Leadership 2013). It is important for Boards to develop a good understanding of the current values, behaviours and attitudes operating within the organisation, and to work with the staff to shape the desired values, behaviours and attitudes. The importance of Board visibility in the organisation has long been recognised, a more interactive process allows board members, staff and users to shape organisational values and culture through direct engagement. The Executive DoTHS role brings a clinical mindset to the Board that is creative, analytical and holistic. The need for the role to be a member of the HCPC regulated professions provide credibility with Therapists and Healthcare Scientists, having previously held clinical roles provides integrity and ability in interpreting the complexity that surrounds the diverse professions to support the development of the organisational shared vision and provide an authentic professional view of the Therapies and Health Scientists to the Board.

Encouraging innovation: Creating an organizational climate where others apply innovative thinking to solve problems and develop new services facilitates a culture of innovation.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
It is vital that the Board to continue with role and function of DoTHS to ensure

these professions have a voice.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
A statutory provision for joint appointment would be a useful provision to ensure consistent and meaningful collaboration and integration across organisations.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Opportunity exists to streamline current advisory structures but it is essential a diverse and adequate representation of all professions is included.

WGGP149 – David Hill– Action 50 Plus – Monmouth
Monnow Vale Service Users Focus Group
Tref / Town – Monmouth

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Yes, particularly in more rural communities.

2. If so, what changes should be given priority?
Health is like a continuous process industry it needs to operate fully 24 hours a day 7 days a week and maintain quality of, and accessability to, healthcare at all times.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Monmouth has a very integrated system of healthcare based around the Monnow Vale Health and Social Care Centre Hospital. This provides a good service in helping prevent people having to go into hospital and coordinating with hospitals on patient discharge and looking after them when they are discharged. There is a very low Delayed Transfer of Care rate and patient comments are normally very favourable. At the other end of the scale with paramedic assistance the sharp end of A&E works pretty well most of the time. There are incidents of poor ambulance response times which could do with improving. Rural areas like Monmouth have a problem in the middle between these two extremes. GP surgeries are in general not open at weekends or outside normal working hours. There is a limit to what pharmacies can do and they are not open at all times. The Minor Injury Unit in Monmouth was closed completely. Others have been closed or only operate day hours and not at weekends. Such Units like Monmouth were supported by GP's in the past but the GP contracts were changed some years ago and this enabled them to withdraw out of normal hours services to Minor Injury Units. This has led to a situation where people who have problems however minor finish up going to A&E as this is their only option. Andrew Goodall recently said 80% of people in A&E shouldn't need to be there. What is needed in Monmouth and I am sure other places is a 'Clinic Room' where minor ailments and minor injuries can be dealt with out of normal hours

without the need to travel to larger hospitals often at times when there is no public transport. This would help to keep people out of A&E. You won't get A&E right until you get primary care right. GP's should have a role in supporting the nurses if necessary but I think it could also help to relieve the pressure on GP's a bit. It is difficult now to get a GP appointment in less than two to three weeks. Such a Clinic Room should be situated at Monnow Vale and operated by suitably qualified nurses who get ENP training but can also work on the ward in Monnow Vale which would probably be the cheapest way to do it and also help with the number of available nurses. I think that these nurses should be rotated at a suitable frequency through A& E Departments to keep up their skills and I think this could be a benefit to A& E if they built up a pool of such nurses at local Clinic Rooms or Minor Injuries Units and hospitals as it would increase the number of ENP trained nurses.

Continuously engaging with citizens

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Yes but I think you need to carefully consider whether we need all the current bodies that there are and you need to make them independent enough to be effective enough according to their role.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Integration needs sharing of information. I think logically most people would expect if they were taken ill or had an accident that the people treating them had access to information about their medical history, drugs they are allergic to, medicines they are taking, are they diabetic or other things that might affect their treatment.

22. How can we consider breaking down any barriers?
Clear safeguards on use of information and talking to people

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Only with their agreement or if deceased that of their family

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
I would think that continuing integration of Services needs Integration of the Inspectorates but it would need to be constituted in a manner properly representative of the functions of both HIW and CSSIW

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The CHC needs to be more independent of the Local Health Boards and able to follow up its recommendations following inspections and act more effectively on complaints.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
Could be a licence to increase their current debt levels. Who is going to bail them out? On the other hand it might enable modernisation or improved equipment that is highly desirable. Needs careful control so it doesn't get out of hand.

WGGP150 – Katrina Hurowski – Bridgend People First
Tref / Town – N/A

General comments

Introduction

During September and October of this year, 55 people with learning disabilities in Bridgend took part in a Welsh Government consultation about the Health Service in Wales. Different methods were used with different groups and individuals dependent on the best way for particular people to participate. This included a questionnaire for individuals to fill in themselves; a presentation followed by group work to answer set questions; and use of the Welsh Government's own easy read document with set questions. Everybody's comments and views, with in some cases direct quotes, have been merged into this report.

Summary

- People with learning disabilities use a huge range of health services and are therefore in a good position to comment on the way the health service in Wales is organised. Interestingly, the only services used are face-to-face and no-one has used (or remembers using) NHS Direct or Primecare out of hours services.

- People with learning disabilities feel that if all professionals used tools such as the Traffic Light System and Health Pathway, this would make sure they are all working from the same value base. They also feel it is essential that professionals work well together in order to provide good quality care, and that effective teamwork depends on good communication skills, respect for patients and colleagues, and a holistic approach to care. People also feel that learning disability and autism awareness training is essential for all professionals.

- One thing nobody wants or likes is a hierarchy of professionals where some people are seen as more important or given more power, as this can be reflected in the way they treat patients.

- People believe that patients and professionals should have an equal say about changes to the health service: patients are experts when it comes to their own bodies, but professionals are experts in terms of treatment.

- Quality care not only depends on good communication skills but also respect for confidentiality; patience; giving people accessible information; being treated with respect and dignity; making it easy for people to complain; and ensuring people understand treatment and medication options. Most importantly, people feel good quality care should be available to everyone, regardless of their status or disability.

- Public and private medical care should adhere to set standards. Patients should be encouraged to feedback with a scoring system that is publicly available. Information sharing about what works well should always be shared between professionals.

- Health professionals should always be open and honest about things that go wrong, if they want patients to trust them.

- People are absolutely fine about professionals sharing information about them, providing it is to their benefit.

- People want independent advocates to help them to speak up, and to help them to complain when things go wrong. Nobody knew about the role of the Community Health Council.

- People all felt that charitable organisations should have an equal say to statutory organisations in saying how health services should be run.

- A wide range of health professionals, as well as patients, should be listened to in order to identify the changes that would improve the health service.

Response to specific questions

What services do you use to make sure you have good health?			
GP	Doctor	Nurse	Optician
Chiropodist	Psychiatry	MRI scanner	Psychology
Phlebotomist	Surgeon	Radiographer	Physiotherapist
Eye Clinic	Depo Clinic	Podiatrist	
Dietician	Paramedic		
Social Services	Occupational Therapist	Contraception	Dental Hygienist
Dentist (hospital and community)	Speech and Language Therapist	Wheelchair services (Rookwood Hospital)	
No-one knew about NHS Direct or Primecare Out of Hours Services			

Working together to give good care

How do you think we could get people to work together better?
Listen to patients.

Good communication between professionals at all levels. Value the expertise and opinions of professional colleagues. Keep records up-to-date for any professionals that need to check them. Keep email and other contact details up to date for all professionals. Good teamwork and good cooperation between professionals. Listen to others and make an effort to understand what their jobs are. Trust each other's practice. Just get along with each other! Give everybody information and training sessions about each other's departments and what they do. Respect each other and treat each other as equals. View the 'whole' person, not just the bits that you are treating. All professionals should have learning disability and autism awareness training. Use the Health Pathway for People with Learning Disabilities. Promote the Traffic Light System. Make sure that where a person is likely to need a range of services they talk to each other (e.g. GP, Diabetic clinic, Eye Clinic). No bullying tactics - A boss who is properly in charge does not bully staff but really knows his/her job. There should be equality between and within professions: no hierarchy, doctors should be as equal as a cleaner or paramedic.

Making changes to health services

The report said that local people should be asked to say what they think about changes. It also said that some changes might need to be looked at by experts. What do you think?
Professionals and patients should have an equal say about changes. ***"We are the experts about our own bodies, but the professionals know the treatment we need."*** Both should have a say – we can learn from each other. People who are ill are on the receiving end of the service so they know what needs changing. ***"Professionals should have their say as well, as they know different things to us about the running of the hospital or clinic."*** Must not forget that Doctors and Nurses are sometimes patients too!

Good quality care

How do you think we could make good care happen all the time?
Listen to the patient at all times.

Treat people with respect and dignity.
Treat people equally without being patronizing.
Respect confidentiality.
Make it easy to complain when things go wrong.

"We should complain – it should be easy for us to say what we think."

Managers should make sure professionals are competent and that they listen to complaints.
Doctors should be polite, speak clearly and to the point.

"Be helpful, patient, and ask me; do not tell me what I want."

Give advice but don't tell us what to do.
Make sure professionals are properly trained and kept up to date with their training.
Be on time. Some people with high anxiety levels, especially those on the autistic spectrum, find waiting difficult.
Be patient; don't rush people.
Check the patient understands what is said (use simple language).
Make sure all staff understand autism and learning disability.
Make sure the patient knows how their medication works – discuss it with them, don't just assume and decide for the person.

"Explain things, especially anything to do with medication. Explain medication to ME!"

Give people the correct information in ways they can understand (pictures, easy read etc.).

"Patience with patients!"

Give people time: some people can only move about slowly, and some people need time to understand what is happening about their health or treatment.
Be gentle – like when people have to have blood taken.
Try harder to understand what people are saying, what they need or how they are feeling.
Speak to people in private, not in front of other people.
Don't make people feel they are wasting your time.

"Try to make sure I understand things – check this out, I might tell you I understand because I think I do, but I haven't fully understood what you have told me."

Don't be rude or embarrass people.

"If you need to tell me to lose weight, don't make me feel bad about it or

that I am costing the NHS a lot of money – tell me more about how being heavier is damaging my health."

Encourage patients to always report low standards.

"It is not fair if where I live says what treatment I get."

No postcode lottery, the best treatment should be available to everyone.

High Standards

We might want to set standards for those people too. Doctors talking to other doctors about the way they do their work can also help to improve standards. Making a new law might help this happen. What do you think?

All organisations should strive to provide the highest quality of care. Experts should work together to provide the best care possible.
Everybody should expect high standards, whether the service is public or private medical care.
Doctors should communicate useful information and learn from each other.
Have a system similar to the hygiene standards in cafes. Use a scoring system of 1-5 and display it on doors so the public knows how good previous patients have found the service.

"Make sure we know we can complain if we are unhappy with our treatment or the way we have been spoken to."

Share information about what works well – e.g. treatments.

"Every health service should have high standards."

Doctors should always share good practice.

Telling the truth

We want the NHS in Wales to be honest and tell people if something goes wrong. We also want the NHS to tell the public about whether services are doing well, or not so well. If people are unhappy then it should be easy for them to say so, even if their complaint is about more than one service.
Making a new law might help this happen. What do you think?

It is important to know the truth about what is going on in the NHS.
We should be able to make complaints easily if necessary.

"It should be easy for you to make a complaint if you are unhappy."

Be truthful.
Make complaints process easier and make relevant information clear.

Health services should be honest with us. ***"If you are honest, we are more likely to trust you. When things are hidden we might get suspicious and untrusting. We will be fearful if we know there are cover ups."*** People should always tell the truth even when it is bad. They should say what they could do to make things better. People do not know who to complain to. We should always be told when something has gone wrong with our hospital treatment. When something has gone wrong, professionals should use lots of different ways to tell people: o Face to face o Email o Letter o Phone call o Web cam Use all technology

Sharing information

We want information to be shared if it will improve things for patients. What do you think?
Sharing is okay as long as information is kept confidential. Ask for permission first, unless it's an emergency. Keep information correctly stored. ***"It is okay to share information if it helps me get better – as long as you tell the right person and not everyone."*** Share and use information if it will help other professionals do a better job. Confidentiality – only authorized people should be allowed access. ***"If it makes my life better, it is okay."*** Okay, but only on a 'need to know' basis ***"Help me get an advocate to speak up for me!"***

Checking how things are going

We want to know if HIW could do its job better. This could mean making some changes to the way it is set up. It might be helpful for HIW and CSSIW to join up because this might make services even better. What do you think?
People had evenly mixed views about merging HIW and CSSIW into one inspectorate.

Making sure people have a say

It is important for people to have a say in the way the NHS is run. Making a new law might help this happen. What do you think?
People are unaware of the Community Health Council. Most people said they would ask staff to help them write a letter of complaint if they were not happy about something. Everyone said they would like an independent advocate to support them to have a voice.

Good Leaders

It is important for all of us that the NHS is run properly… making a law might make this happen. What do you think?
Organisations such as social services, and voluntary organisations (charities) should have a say in how health services are run. It is important that Advocacy organisations (such as People First) have a say in how things are run. People First can remind people that it is their right to speak up about how they feel.

Listening to NHS staff and experts

The Welsh Government asks many people to help with making laws, making changes and deciding things. It might be helpful to change the way this is done. Making a new law might help this happen. What do you think?
Everybody (doctors, nurses, health care workers, patients) should be asked what changes they would like to see. There should be different ways to find out what changes people want - groups and individuals should be asked.

WGGP151 – John Hill-Tout
Tref / Town – Pontyclun
Sefydliad / Organisation – Cwm Taf Local Health Board (Independent Member)

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
The Welsh Healthcare system is based on the philosophy of Integrated Healthcare organisations planning and delivering care to their populations. It is not based on Provider competition as in England. Therefore we should review current legislation to ensure that this is clearly embedded. For example in Wales there are still 3 NHS trusts operating in a legal framework which promotes competition and independence of provider organisations. We need to consider integrating those organisations into the LHBs, as is the case for WHSSC and Shared Services etc. This would strengthen collaboration and planning. In relation to local collaboration between Health and Social Care , I would not support legislation, being of the view that if the planned reorganisation of Local Authorities results in coterminous boundaries with the LHBs, this will achieve the full benefits of collaboration.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
I do not support the need for legislation . The obligation to engage and consult is clear and LHBs are fully aware of their responsibilities in this area. There are two areas which need to be examined. The first is the need to have a clear view of the response in scenarios where there has been excellent public engagement , and yet the public still remain resistant to change in their local communities. This is often characterised by support from Local politicians who may have supported the principle of such changes in the Assembly, but are resistant when it effects their own area. How do we as a country want to deal with such issues? Do we want to press on, despite the resistance, if the policy and engagement is good, or do we draw back? This must be addressed. The second area is the competence at local level do manage effective engagement. I believe that problems have resulted from poor execution rather than poor legislation.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
I think this is unnecessary. We already have Community Health Councils, Stakeholder Committees and Professional Advisory Committees.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
I do support this proposal on the basis that the panel would have two roles. Firstly to ensure that the engagement and consultation process had been fair and just. Secondly to make the final decision on service change where there is disagreement locally. Also there must be no subsequent appeal to or involvement of Ministers, otherwise the Panel would have no purpose.

Chapter 2: Enabling Quality

Quality and co-operation

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
This is unnecessary and would leave room for confusion and mixed accountabilities. The Chief Executive is the Accountable Officer and is responsible for all aspects of LHB delivery. This works effectively, is well established, and is well understood.

Chapter 3: Quality in Practice

Meeting common standards

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
I would support a common set of standards.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
We see in England that failures by organisations to meet standards, has met with a robust response which has even resulted in organisations being merged or dissolved. In Wales we have Special Measures, but I believe that we need to reflect

further on how to respond to a continual failure to reach accredited standards and peer benchmarks.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes I would support this. The English NHS had done this and we should follow suit in Wales.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
I think we should explore how other Health systems have dealt with this. It is a complex area and we need to adopt best practice. As an independent member, I scrutinise performance in my LHB on a monthly basis and the Performance Dashboard is a public document readily available so that the organisation's performance is transparent to all. I would advise that we do not need legislation, but we do need examples of how that information can be made readily available in a simplified form and how to advise the public if they are dissatisfied.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
This is not my area of expertise but I would suggest that the main problems lie in technology. We do not have a system capable of transferring information between health professionals where they work in different organisations, even though patients interface with a whole range of different bodies.

22. How can we consider breaking down any barriers?
As a beginning we should stipulate at national level what information we expect will be shared and in what time frame.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
I wholly support this in the context of research. This is essential and presumably can be anonymised.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
Before considering the need for legislative change we need to consider the following issues. Firstly I am not convinced that we have the appropriate skills and talent in Wales to fulfil the HIW role effectively. Does Wales as a small country have the depth of talent to operate its own Inspectorate effectively? Or should it ask the English service to provide that role? Secondly I believe there is much duplication between the agencies.. There seems to be a good deal of crossover between the inspectorate roles of HIW, the WAO, and the Delivery and Support unit. This leads to confusion of purpose and accountability. Thirdly there must be more clarity about the consequences of good and poor inspectorate assessments, linked to a clear Performance system. WG needs to clearly articulate the consequences and benefits of the assessment. If after considering these points, it is decided to consider legislative change, it must be clear that HIW is totally independent of Government.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
Clarity of accountability and ease of understanding.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
I believe that the role of CHCs has always been to represent the patient voice. It is important that it continues to represent the Patients and Public voice, particularly on matters of proposed service change, and continues to be the advocate of individual patients when requested. There should be no reduction in the CHC role. Other models, particularly those in England , have been less effective.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
I believe that the model remains fit for purpose.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
No . Borrowing powers are a feature of a mature financial environment. The recent track record in Wales is that many organisations have failed consistently to break even financially without support at year end from WG. Borrowing powers would be too high a risk. If they are to be considered they must form part of a Performance Regime in which such powers are an accompaniment to good performance. I am concerned about the absence of a Primary Care Fund for the development of primary care premises which in many instances are in poor condition. This may be an exception in that it may be appropriate to devise a funding system with some borrowing powers, jointly between LHBs and GPs, to produce an improved primary care estate.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes if they continue to exist.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Before considering legislation, the current processes need to be strengthened. For example the role of the Health and Social Care Department of WG needs clarifying. Its role is to provide management and oversight of the Heath system in Wales. It is the "System Manager". Yet there are instances where it does not intervene when it should, for example in dealing with organisations failing to cooperate in the delivery of agreed policy, and where it does intervene when it should not, for example in promoting initiatives outside the approved Three Year Planning cycle. WG,s role in dealing with governance issues across the system must be better defined and implemented. To achieve this there may be a case for dividing the Health and Social Care department in two distinct roles--The policy role in support of the Ministers, and the oversight of the NHS role. I presume that this would not require legislation.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
I believe that the current structure does fulfil these objectives. It is important not to confuse structural issues with issues of competence particularly of Independent members. Whoever is appointed as an Independent Member must be competent to fulfil the role – The Minister must be assured of this before considering structural reform. Independent Members must be able to bring sound experience and independent judgement to the Board.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Yes.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
We must first be clear about what we want Independent Members to do. The role is to bring independent judgement and experience to contribute to decision-making which is in the best interests of the local population, and to scrutinise the organisation effectively. Independent Members do not represent the Community but they do reflect the community. I am concerned that elected community representatives may be constrained to act always in response to local opinion, and may not feel able to exert independent judgement.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
I believe that this should be a discretionary issue, with the powers available to the Bodies, to be used if appropriate to their circumstances.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
I am of the view that Trusts should be abolished as inappropriate for the Welsh Healthcare system, and their responsibilities taken on by Health Boards.

Board secretary role

45. How could potential conflicts of interest for the board secretary be managed?
By reference to a panel of Independent Members.

WGGP152 – Tina Donovan and Wendy James – Learning Disability Advisor Group Sub Group
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
What would be different now to previous legislation as we have no pooled budgets no formal partnership arrangements? Current CHC Framework especially in relation to people with learning disabilities who would be assessed as having a primary health need would be the responsibility of health rather than joint packages. Locally there appears to be pressure from LA's to reassess and move funding responsibility via the CHC Framework. The term duty under the new act doesn't clearly demand a mandate to provide or arrange preventative services.

2. If so, what changes should be given priority?
Funding issues still a problem there are some local agreements rather than formal agreements. Funding arrangements can jeopardise future care needs.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
More clearer manadate.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
Focusing equally on quality of care and not just finance.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
We agree there should be a statutory basis We support the idea to prevent delays in decision making waiting for

ministerial decisions, but patient panels and participation groups need clear direction and management.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Agree it will cut down on bureaucracy and expedite decision making for the patient.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Not in isolation it needs to balance with a softer approach too.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
National Minimum Standards across all settings backed up by legislation would provide consistency.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
Advantages are there is clarity of role with clear direction and provides consistency. Disadvantages can rely on just a few individuals if there is not a committed Quality Assurance Team, and needs to be supported by clear governance structure.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Who would the fit person be accountable to? What is the role of the Chief Executive?

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare

standards for use in the NHS are set?
Yes to make sure they are applicable in all sectors so that we are not setting different standards for different sectors across wales

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
Yes.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Commission against minimum standards that are person centred led and policy driven Peer reviews across all sectors

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Standards should be in place for all health workers not just professionals and there should be minimum standards on regular reviews and clinical supervision. Whatever is built into the budget is soaked up in mandatory training not in specialist training or clinical supervision

17. What arrangements should be put in place for self-employed health professional registrants?
Standards should be the same.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
IMTP's to be more user friendly for the general public, showing how LHB's are measured against their plan, and if actions haven't been met reasons should be noted and what actions have been taken?

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
More transparency and true collaboration between both parties.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
Difficulties in getting true, accurate data across the care sector and an unwillingness to co-operate and share information.

22. How can we consider breaking down any barriers?
As Above. Surely IT Systems are now sophisticated enough to allow access between medical/professionals so relevant information can be accessed in an expedient way.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
Consent at the point of contact, ask permission record it etc.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
Yes workload of Inspectors and skills and expertise.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
A single inspectorate with clear specifications and areas of inspection. Working towards a minimum standard that NHS Trusts and LHB's are all committed too.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?

As above for a single inspectorate this will create some standardisation across services and clear direction. Disadvantages without additional resources, expertise, and clear frameworks. Inspections will remain diluted and fragmented.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
Yes, particularly in relation to advocacy and providing support to patients who may wish to raise a concern. Practical help to enable them to do so.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
Flexibility across boundaries.

Chapter 7: Finance, functions and planning

Summarised accounts

32. 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?
Yes.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Need to protect specialism's such as learning disability

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
agree

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health)

between local authorities and the NHS in the new arrangements for public services?
Definitely, need much more joined up working.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Yes.

WGGP153 – Karen Maddock-Jones
Tref / Town – Swansea
Sefydliad / Organisation – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority? 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Yes. I am currently a patient at Morriston Hospital following a car knocking me off my bike. As I live in a 3 storey property with large numbers of steps to access the living areas, it will be some considerable time before I can go back home. I am able to go home to my partner's house however, once we can get a care package put in place. The stumbling block appears to be, that his property is in Powys rather than in Swansea, and the difficulty in getting Powys and Swansea to talk to each other, and keeping us informed of what is happening. For example, a lady from Powys, was due to visit me this morning to discuss the home care arrangements that will be required. To ensure that I was clear about what will be required etc., I requested my partner attend the meeting, which entailed him taking several hours off work. An hour after the Powys lady had been due to turn up, there was still no sign of her. We therefore phoned her, to be told that she had cancelled the meeting, and had Asked someone to tell me. But nobody had. It appears that my case is now being handled by a different part of POWYS social services, and we now need to wait for them to contact us! Changes should therefore be made to ensure better cross boundary/authority working, and to ensure that patients and their representatives are kept fully informed of the processes taking place regarding their care, and any changes that are made to appointments etc., to ensure that family members, who are likely to be already stretched by having loved ones in hospital and the additional time burden this adds, are not further inconvenienced by attending hospital for cancelled appointments.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
See response to Q5 and 6 below

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Yes.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Yes I support the establishment of a national expert panel rather than referrals to Ministers. Such panels should comprise of expert practitioners, rather than bureaucrats from middle and upper management.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section? 8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system? 9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
From the text it appears that there are already legal obligations in place, such as the duty of quality. However from my experience the last 3 weeks, it is not clear how this duty is implemented in some parts of Morriston hospital. Therefore it is pointless having legislative obligations and duties if they are not implemented and those areas that fail to comply with such duties are not made to improve. Quality is not about the cheapest service/food you can buy. But that appears to be the ethos that operates in the catering department at Morriston. Since admission, although, I have repeatedly stated that I am lactose intolerant, there appears to be a problem with the kitchen being able to provide a varied, nutritious diet that is lactose free and enables a speedy recovery. It seems to be acceptable to provide a beef related dinner 5 days on the trot, ham salad for 3 successive meals, and the cheapest form of sausage and chips 3times in 7 days. When I spoke to the catering manager, he agreed that that was not acceptable. After speaking to him, the quality and variety of food did improve slightly for a day or two, but has since returned to being sent the same meal repeatedly, and not providing what has been ordered at breakfast (although I have been advised to order meals at that time). I appreciate that it is a difficult job to cater for such a vast number of likes and dislikes and dietary requirements, but given the cost of food, and to ensure that what is prepared is not simply binned thereby throwing money away, surely a bit more care and thought could be put into menus and the amount of

time food, particularly vegetables are cooked for.
This should not require legislation, but common sense and a good understanding of food, diet and nutrition.

Furthermore, staff serving food should be trained in food intolerances so that they understand what they are serving and what the consequences can be of serving the wrong foods to patients. I am fortunate in that I've been able to tell staff when I am continually offered milky products that I do not want them due to the intolerance.

However, there is an elderly lady in the bed next to me that has early dementia, and doesn't know what she wants or likes half of the time. If she had an intolerance and was not carefully monitored regarding what she ate and drunk, she could end up with upset stomach and nausea, which might appear as though her medication for pain relief was having side effects. This could result in additional costs to the NHS budget in trying to resolve the problem, and an extended hospital stay.
Prevention through better training and understanding, is far more appropriate, than suffering to patients and their extended hospitalisation.

With regard to the duty of quality, quality care can only be provided with adequate staff resources. Although, the standard of medical and nursing care I have experienced since being in Morriston has been excellent, there are frequently times when staff resources are stretched so thinly, that patients are left a considerable time waiting for assistance to go to the toilet or to return to bed, or insufficient thought is provided by care when serving food etc as to the ability of the patient to serve themselves/ cut up food etc. Frequently, this is distressing for patients, particularly when they are in considerable pain and left cramped over a toilet, or have to trouble staff to assist with cutting up of food.
Quality care must therefore ensure satisfactory staffing levels and expertise to provide the proper care and assistance that patients need to ensure a speedy and dignified recovery.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
To enable a response to this question, a definition of what WG consider a 'responsible individual' to be should be provided.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
If there is existing legislation in place, consideration should be given to enforcing that properly, before considering further legislation. If existing legislation cannot be implemented and enforced properly, consideration

should be given to repealing / amending the existing before introducing new legislation.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
YES, a common framework should be established that covers both the NHS and the independent sector, to ensure that consistent healthcare standards are delivered across both sectors.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
A standards framework across both the NHS and independent sector, if monitored, implemented, and enforced properly should provide a focus on improving outcomes and services/experiences for patients across all sectors of care.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Accreditation, is undertaken at a specific point in time. Unless it is monitored, and reviewed frequently, standards can slip once accreditation is achieved, resulting in poorer service quality. Regular monitoring and review is therefore required to ensure that accreditation results in better service quality.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
There should be a compulsory requirement for all health professional registrants to have clinical peer supervision/ undertake continuing professional development, to ensure they are up to date with new developments/ practices in their field, and that they refresh existing knowledge and practice.

17. What arrangements should be put in place for self-employed health professional registrants?
The same requirements should be put in place for self-employed registrants to ensure that they also keep up to date with new developments and practices. This could be monitored and enforced through their professional bodies.

Clarification is required on what is meant by health professional registrant. Does the term also include auxillary nurses/carers? If not, there should be a requirement, for such staff to also undertake continual professional development.

Chapter 7: Finance, functions and planning

Planning

34. 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?
See response to Q1.

WGGP154 – Penny Gripper
Tref / Town – N/A
Sefydliad / Organisation – National Forum of Mental Health Service Users and carers

General comments

(Parts but not all of this response are made on behalf of the National Forum for service users and carers in mental health – these parts will be identified in the text)

Appendix 1 – Mental Health Service Charter - draft

Dignity Pledge
We (named service provider) recognise the importance of the emotional and psychological dignity of the people we serve and pledge to ensure that care, treatment, and support reflect the following principles of dignity

Each person is equally valued

- Staff treat the people they serve as equal in value to themselves and their colleagues
- Staff treat the people they serve as equal in value to each other, impartially and with no preferential treatment given on the basis of any personal characteristics
- Staff recognise the worth and potential of individuals as human beings with the capacity for both pain and well-being

The people we serve said:-

"dignity is when my opinions are considered to be as informed and as valuable as professional opinions"

"I am the expert in my inner world and experience and I would like professionals to understand that"

Mental Health Service Charter

Introduction

It is proposed that a document be developed as a set of standards, for voluntary adoption by mental health services. This would be voluntary in order to avoid the legal interpretation debates which complicate the enforcement of standards.

The idea would be to have a set of simple straight forward standards which must be met by adopting organisations, unless they can prove without doubt

that it was impossible to do so. Failure to meet standards in any case could lead to the loss of the Charter status, unless the situation is put right quickly.

This would allow those served to know what to expect and facilitate a quick and simple response if the service they receive is not meeting any of the standards.

This would not be an alternative to a complaints process. It will not involve investigations, blame or debates about who said what. It will be about improving service experience by setting achievable standards.

These standards can be developed and reviewed over time.

In addition there could be a set of standards, like Investors in people, to ensure that systems and processes are in place to maximise the quality of experience and co-production, of those served by the organisation holding the standard. These could be more aspirational, and complex, and perhaps at different levels eg bronze, silver, gold, and platinum??

With the latter there would need to be an accreditation process through which the service would be audited, and any actions needed to meet the standards would be highlighted. Once all the standards have been evidenced as met, the Charter level would be awarded.

Organisations wanting to adopt the standard would be charged to cover the administration and audit costs of the Charter.

Ideally the process of developing the Charter will involve robust engagement and co-production processes, to ensure that it reflects the most important issues for those served by the NHS or other mental health organisations, whilst being practical and achievable for staff and organisations.

The ambition would be for the Charter to be administered and verified by a social enterprise employing people served by mental health services.

Relationship to the 'Dignity Pledge'

The concept of the charter is designed to go alongside the 'dignity pledge'. All Chartered organisations would be expected to sign up to the dignity pledge. (see appendix 1)

<u>Proposal</u>

This charter outlines the legal rights of the people served by the mental health services. These must be carried out whether or not the whole charter is adopted by the organisation.

In addition it contains commitments and standards that the adopting organisation agrees to meet unless doing so is impossible, in which

case the organisation will agree to provide evidence of these circumstances to the charter verifiers, to make their case for non-compliance.

Adopting the charter is voluntary. However it demonstrates organisational commitment to the cultural changes within Welsh Government policies with respect to co-production of services with the people served; who have as much choice and control of services as possible; where the staff start with the assumption that the people they serve are the best placed to determine what is in their own best interest; independence and self-management are maximised; the service provided is holistic and recovery focused; evidence based and flexible to adapt to the individual needs of each person served; and is citizen directed, rather than service led.

Because this Charter is a mark of quality, processes must be in place to address instances where those served feel that the standards are not being met in their care, to ensure that problems are quickly resolved. There will also be a route for those served to take concerns directly through the verifying organisation. Charter holding organisations will be expected to respond quickly to the verifying organisation, giving the actions they will take to improve the individual's care. Concerns about the implementation of the charter will be resolved through a mediation and conflict management process, and not through investigation to apportion blame. This allows the possibility of win-win solutions, and avoids the negative consequences of blame with respect to staff distress, and promotes openness to resolve problems. Any exploration will be purely aimed at learning. The objective is to encourage and promote creative problem solving and learning from experience.

Organisations will be expected to provide plans to meet the Charter requirements and evidence of how well they are putting the actions into place, to support on-going permission to use the Charter as a mark of quality. Such performance information will include information about complaints, or concerns about whether the charter is being fully applied.

Rights

Some actions are already legally required. However, within the Charter a mechanism is provided to ensure the delivery of legal rights without resort to the law, and all the distress and expense that legal action entails.

The rights below in black are drawn from the NHS constitution from England, a few others relating to Welsh legislation will also be needed. This list is not complete, and would require legal advice to ensure all legal rights are included.

There are also rights which reflect many sets of professional regulatory codes of ethics and practice.

The rights written in red are additions to the NHS constitution, reflecting the Welsh context and designed to improve the experience of services.

Titles, additional commitments or actions are in blue

Access to health services:

You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.

You have the right to access NHS services. You will not be refused access on unreasonable grounds. (define reasonable as what would be considered fair and ethical by an 'average' member of the public)

You have the right to an assessment at some level, by the GP, the Local Primary Care Mental Health Support Service, the Crisis and Home Treatment Team, the Community Mental Health Team, Police Triage, or Mental Health Act Assessment.

You have a right to a social care assessment

You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.

(To fit in with the Social Care and Well-being Act 'needs' to be defined as what is needed to fulfil your well-being goals, on the basis of the 'can and can only' test where the individual can only fulfil goals with the support of services)

We commit to starting from the position that you are the best placed to decide what is in your own best interests. If there is any doubt, we agree to provide your preferred treatment and only to discuss changing the approach if we find it is not helping.

You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

You have a right to receive services in Welsh if you choose.

Quality of care and environment:

You have the right to be treated with a professional standard of care, by appropriately qualified, registered and experienced staff, in a properly
approved or registered organisation that meets required levels of safety and quality.

Individual responsibility for our own professional practice, always takes precedence over team loyalty. Whilst mutual support and respect is essential between members of a team, our primary individual duty is to those we serve.

You have a right to unbiased care provided by people who make their own individual relationship with you based on face to face contact, uncontaminated by the opinions of others.

We commit to using case numbers, and not names when discussing your care in any group of staff, where some present have not yet met you.

We commit to ensuring that staff involved in your care, get to know you, *before* looking at your notes

We commit to ensuring that all independent second opinions, reviews, or re-formulations, occur with your permission (or with permission through your advocate if you lack capacity); are based on face to face assessment of you; and are not based on discussion with people already involved in your care, either verbally or through your notes.

We commit to ensuring that the opinion of one practitioner on your suitability for psychological treatments, does not preclude new assessments and other opportunities for psychological treatments, in recognition of the fact that how you respond to therapy, how much you are able to disclose or examine, is very much a consequence of the quality of your relationship with the therapist.

You have the right to be cared for in a clean, safe, secure, and suitable environment, where you will not be overheard.

You have the right, when in hospital, or residential care, to receive suitable and nutritious food and hydration to sustain good health and wellbeing.

You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.

Nationally approved treatments, drugs and programmes:

You have the right to drugs and treatments that have been recommended by NICE1 for use in the NHS, which are evidence based for your condition.

You have the right to a formulation/diagnostic assessment, which is arrived at with your full involvement, makes sense to you, and which clarifies which treatments are evidenced and/or Nationally approved as suitable for your care

You have the right to have NHS mental health care irrespective of whether you agree with the formulation or diagnosis made by staff

You have the right to a second opinion if you feel a decision in your care is wrong or unfair

We commit to ensuring that decisions about whether you can have a second

opinion, are not made by staff currently, or previously involved in your care

You have the right to expect local decisions on funding of other drugs and treatments to be made rationally and ethically, following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.

1 NICE (the National Institute for Health and Care Excellence) is an independent organisation producing guidance on drugs and treatments. 'Recommended for use by NICE' refers to a type of NICE recommendation set out in legislation. The relevant health body is obliged to fund specified NICE recommendations from a date no longer than three months from the publication of the recommendation unless, in certain limited circumstances, a longer period is specified.

Respect, consent and confidentiality:

You have the right to be treated with dignity and respect, in accordance with your human rights.

We commit to training all staff to understand dignity and human rights, including UN conventions, and principles, for children, older people and people with disabilities.

You have the right to be protected from abuse and neglect, and care and treatment that is degrading.

You have the right to freedom from threats used to pressurise you to accept a diagnosis/formulation or a particular kind of treatment, such as a threat to deny you further services if you don't agree to, and comply with, professional opinions

We commit to training all staff in definitions of abuse, and how to recognise the signs of abuse in the people they serve, and also in up to date safe-guarding practice.

You have the right to the protection of your reputation, good character, and worth.

You have the right to have your contact with services audio recorded

We commit to co-producing a public facing policy to prevent and deal with the abuse of the people we serve by professionals and other staff

You have the right to have your questions answered in full, in the detail appropriate
to your ability

We commit to training staff and developing processes to increase the

transparency and openness of decision-making and an audit trail of how and why decisions are made, and who made them. All meetings about your care will be fully minuted and/or audio-recorded.

You have the right to honesty and transparency regarding all discussions and written material used in your care

We commit to changing the culture to stop staff withholding information or opinions from the people we serve

We commit to ensuring that notes on documents saying that the person we are serving must not be told about what is contained in the document, are treated as unacceptable practice. If staff can't say it to someone's face, then it must not be said, or recorded

You have the right to accept or refuse treatment that is offered to you, and not to be given any physical or psychological examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf. 2

(NB, consent must be freely given. Refusing a treatment option must result in something else being offered, and at the very least on-going support to alleviate suffering and prevent deterioration)

We commit to ensuring that you are happy to sign your care and treatment plan, except in situations where this is impossible, on the basis that any unsigned plan must be replaced by a signed plan as soon as this is possible.

You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.

You have the right of access to your own health records and to have any factual inaccuracies corrected.

You have the right to have all opinions on your notes identified as opinions, and if an opinion is recorded, the facts upon which the opinion was based, are itemised, so that the opinion can be challenged if the facts given are wrong.

We commit to training all staff in how to identify and correct errors on records, including changing facts, and annotating opinions to reflect new information. All information on records will be presumed to be a fact unless specifically identified as an opinion.

You have a right to add comments to your notes, about opinions.

You have the right to bring external witnesses to consultations or meetings to give testimony regarding your character and presentation in the community, and to have their testimony kept on your notes and used to inform decisions about your diagnosis and care. (testimony of witnesses at meetings or consultations, where the record does not reflect your/their memory of the situation must also be placed

on your record if you request it to be)

We commit to ensuring that clinical descriptions of your problems are based on evidence additional to and beyond your behaviour when you access our service. We recognise that behaviour when seeking mental health care may not be representative of how you behave in other situations.

You have the right to be described in your records in respectful, non-judgemental, non-blaming, non-accusatory, non-derogatory, terms without any assumptions, interpretations, or implications regarding your motives, intentions, emotions or thoughts, included, if they have not first been discussed and checked with you.

(Opinions on records cannot be changed, but you have a right to a fair trial when accusations are made, on the basis that you are innocent unless proven guilty. In the circumstances it is critically important that no non-clinical, potentially insulting, or abusive statements are made in clinical notes.)

We commit to beginning from the position of assuming the people we serve are innocent of any negative intention, motive, or character traits.

We commit to training and supporting staff to have difficult discussions with the people they serve about their true opinions, to ensure that all individuals we serve have the opportunity to explain, clarify, or provide other evidence on the subject, in a spirit of openness by staff to the possibility of changing opinions as a result of such dialogue and evidence.

You have the right to expect that what you are told will be recorded on your notes, including any diagnostic opinions, explanations, or treatment offers

We commit to training staff in respectful, impartial and complete note taking, and to auditing notes on a regular basis to make sure that staff are meeting the required standards. (see record keeping standards – appendix 2)

You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.

You have the right to decide who sees or touches your body, and who hears or reads about your most intimate and sensitive experiences.

You have the right to exclude individuals from involvement in your care, and to ask for and receive a change in staff involved in your care

You have a right to treatment and care by people who do not work alongside your close family or friends, and in a facility where your close family or friends do not work, without any negative consequences to the quality of your care.

We commit to ensuring that staff relationships with the people we serve are positive, affirming and supportive, by discouraging staff from working with people they don’t like or respect.

We commit to providing all staff with training in recognising relationship breakdown with their clients and in how to repair relationships, and resolve conflicts.

We commit to following the wishes of clients to exclude individual staff members from their care. We also commit to providing alternative staff when those we serve ask for a change of any member of staff involved in their care.

You have the right to be informed about how your information is used.

You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons including the legal basis.

2 If you are detained in hospital or on supervised community
treatment under the Mental Health Act 1983 different rules may apply to treatment for your mental disorder. These rules will be explained to you at the time. They may mean that you can be given treatment for your mental disorder even though you do not consent.

Informed choice:

You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the Mental Health Charter.

Involvement in your healthcare and in the NHS:

You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.

We commit to eradicating the practice of making decisions ‘by proxy’ in staff meetings and discussions where the individual being discussed is not present, or represented

You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.

You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

(See standards for co-production and involvement, Appendix 3)

Complaint and redress:

You have the right to complain at any time, without that complaint negatively affecting your care

You have the right to have any complaint you make about NHS services properly investigated.

You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.

You have the right to have the complaint investigated without staff involved in your care being informed, unless you agree that any individual staff member or members should be involved.

You have the right to have all information about your complaint kept off your clinical files so that it cannot affect decisions about your diagnosis or care.

You have the right to be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.

You have the right to know what actions will be taken as a result of you complaint

You have the right to take your complaint to the Public Services Ombudsman for Wales, or if it is about an individual professional, to their professional regulatory body, if you are not satisfied with the way your complaint has been dealt with by the NHS.

You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.

You have the right to compensation where you have been harmed by negligent treatment.

We commit to training all staff in the rights of those we serve, under the complaints process, and to auditing all complaints to ensure that the process is consistent with these rights

We commit to a process of mediation and problem solving as an alternative to a formal process, but with the same protective rights for those we serve.

We commit to monitoring staff who have been the subject of a complaint, if they remain involved in the person's care, to ensure that this does not

contaminate their practice, that it does not affect diagnosis or treatment options, or affect the practice of other staff involved in the person's care.

We commit to giving those we serve the option to exclude people involved in any complaint about their care, from any future involvement in their care.

Appendix 2 (draft – to draft Mental Health Service Charter)

Record keeping standards for mental health services

Definitions

Facts –

- Information provided by the people served by mental health services about their life history, relationships outside the health service, experiences, thoughts, feelings, beliefs, values, moods, preferences, abilities, difficulties, explanations, self-knowledge, stable character traits, and preferences are all facts
- Assessment test results and questionnaire responses made by the service user are facts
- The conclusions of face to face verbal assessments are only facts if the conclusions drawn are agreed with the person being assessed.
- Witness statements from family and friends of the service user are facts, however what is said may be an opinion. The possibility of malice must be considered, when basing an opinion on a witness statement.
- Observations of behaviour are facts, but the reason for the behaviour can be a fact (if based on the service user's report) or an opinion (if based on staff supposition).

Opinion

- Opinions are identified as opinions in the notes. Anything not identified as an opinion can be treated as a fact and changed.

Standards

1) Accuracy

- The date and time of the appointment or meeting and the date and time of the entry are both recorded – as this gives an indication of the chances of error, inaccuracy or incompleteness
- Facts recorded on file are first checked with the service user
- Audio/video records can also be kept when available

2) Opinions

- if an opinion is recorded, the facts upon which the opinion is based are itemised
- In the absence of facts, any diagnostic hypothesis is identified as a hypothesis, and a list of other possible diagnoses is also given

3) Third party information

- Third party letters are checked with the service user for accuracy, and the possibility of malicious intent is considered. Letters from third parties are only placed on the file if they are accurate and non-malicious, or if the records owner want them to be.

4) Contents of clinical records

- Language used in clinical records is impartial, and non-judgemental.
- Accusations are not made in clinical records without impartial, high quality evidence, such as audio or video recordings. Eg. never say that someone has been verbally or physically aggressive without impartial evidence such as audio or video recording, or impartial witness evidence from people who are not NHS employees. The owners of notes have the same rights to be considered innocent unless proven guilty as those working for the service.
- Observations are recorded without using language that implies reasons or motives for behaviour. Eg, use the word 'said' instead of 'claims', use the words 'said they were suicidal', instead of 'threatened suicide', use the words 'agitated, animated or loud' instead of 'hostile or aggressive', etc.

- Letters written by someone we serve, are only put on their file if they are not complaints. The individual will be asked if the letter is raising a concern. The letter will only be put on the file if it is not raising a concern.
    - Any information relating to complaints is kept by the "Putting Things Right" department, where it cannot be accessed by clinicians involved in the person's care
    - Where a request to see or access notes is linked to a complaint, the decision to grant access to the notes is not made by a clinician currently involved in the service user's care

- Information about activities of the people we serve, which occur outside the confines of their clinical care; which are legitimate; and which have no relevance to their care, will not be kept in their clinical notes.
- All observations about thoughts and feelings from face to face assessments are first agreed with the person being assessed before being recorded in writing and placed on their notes.
- Scanned copies of all questionnaires, and results of all tests are retained on the file
- All offers of service made to the person being served are recorded in their notes
- Everything the person being served is told by staff, is recorded
- All meetings between staff about someone we serve are recorded – itemising who said what – for audit purposes, and to facilitate any investigations that may be required in the event of a critical incident or a complaint

5) Staff must be trained,

- to identify and correct errors in notes as required by current legislation and government guidance
    - how to change facts
    - how to annotate opinions
    - how to add in patient views

- to know about people's rights (see below)

6) The rights of the people we serve regarding their records

- The people we serve have the right to have mistaken facts on their notes corrected by staff
- The people we serve have the right to view their records
    - The people we serve can view their records with a clinical staff member present, free of charge
    - The people we serve can make a request for a copy of their notes for a fee
    - Access to notes can only be refused in exceptional circumstances where there is a risk of serious harm to the service user or others. However, a service user can appeal against any such decision, when a high quality of evidence will be required to prove that harm would be done.
    - Access to notes must be agreed within the statutory time scale
    - Service users can see third party letters kept on their notes, where it is reasonable to believe that the letter was written with the service user's knowledge. (e.g. a letter on their behalf from an advocate, or a witness statement about what happened in a meeting)
    - Service users can make a Data Protection Act 'section 10 request' to remove material from their notes on the basis that it is causing distress.

7) Improving the quality of records
If someone we serve makes a comment on their notes, including sending in a letter to explain or add information to the notes, the staff will acknowledge the comment and discuss it with the individual at their next appointment before agreeing and recording the difference made by the comment, and how it will affect diagnosis and/or care.

Appendix 3 to mental health service charter- draft

Draft standards for co-production, engagement and involvement

Not yet developed

Plan to look at good practice examples, and develop standards based on them.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
At present there are significant gaps in service between primary and other

levels of care, particularly in mental health. There is a need for longer term services in primary care to help prevent the deterioration of mental health for those with long term problems, and to provide intermediate care for people who need more than the short term interventions currently available, but not as much as secondary services. It would really help to have OTs and CPNs based in GP practices

There needs to be a legal requirement to have joint funding from health and social care to deliver better, more widely accessible information and resources on healthy life styles, to the public, and also to fund support for those who need it most, to access services which will help them to develop and sustain a healthy lifestyle.

There needs to be legislation to create a duty on all public services to create accessible and affordable opportunities for healthy lifestyles.

For 'people in need' (as defined by the social care and well-being act) there needs to be legislation to require health and social care to jointly fund leisure, sport and nutritional coaching for those who are only on benefits, or on a low income (excluding savings), to create parity over the whole of Wales. In some areas of Wales exercise on prescription is free of charge, and can be extended on a long term basis for those who need it. In others it is expensive and short term.

There also needs to be a requirement for similar joint health and social care funding for 'learning on prescription', for at risk groups, so that local education courses are more available and don't have to deliver qualifications in order to be funded, and don't have to put time limits on access to courses for 'people in need' at risk of isolation and inactivity.

All health and social care staff need to be trained on where to direct people to find information and resources to help them live, healthier, more productive and more satisfying lives. Staff also need training to understand that a productive and satisfying life is not a luxury, but a legitimate need, and to take on the philosophy that the individual is best placed to judge and make decisions about their own health and welfare. A legal requirement for such training, as with training in first aid, or fire-safety or lifting and handling, is needed.

There also needs to be legislation in place to require all public services to provide paid positions for 'people in need' and their carers, for roles in co-production, service governance, staff training, recruitment, commissioning and tendering processes, complaints investigation, staff performance processes, research, quality assurance processes, and peer mentoring. (see Merseycare model)

In addition legislation needs to create a duty on public services to develop supported part-time/jobshare paid roles for people in need and their carers, and supported work experience opportunities which are long enough to enable people to build up their stamina, determined on a case by case basis.

(see Flintshire Social Services Social Enterprise model)

2. If so, what changes should be given priority?
Legal requirements for service user/patient, and family/carer involvement in high level decision making and governance in the health service, and in all boards and partnerships responsible for planning, strategy, evaluation, audit, monitoring, (Quality Assurance) staff training, staff recruitment, tender evaluation and commissioning, complaints and concerns investigation, in co-production, staff performance processes, research, and peer mentoring, with pay or other appropriate rewards. Legal requirement for secondary services (including mental health) to respond to all referrals, without exception, and to support the training and development of primary care staff to better support people in primary care by increasing their knowledge and services available. Legal requirements to offer more services at primary care level, to ensure no gap between services in secondary and primary care, eg long term support for people with mental health problems to maintain stability and prevent relapse, and access to OT to support healthy activity and return to work, supported if necessary.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Legal requirements for all partners to report on their attendance at and contribution towards the objectives of, all local partnership boards for healthcare groups eg mental health, older people, disabilities, children and young people. The approach for meeting well-being needs should be pursued in the health service as well. It is essential to close gaps in provision which lead to a crisis only service, at one end and a low intensity short term care service at the other with nothing in between to deal with supporting people to maintain health stability and prevent crisis. The OT service for mental health is located within the health service rather than in social services. As a result help is not available to help people with complex needs who are stable and not under secondary care, to return to work, or have meaningful activities which prevent isolation and relapse.

<u>Continuously engaging with citizens</u>

4. Are there ways in which the law could be reformed to shape service change?
The National Forum for Service users and Carers of Mental Health Services, are proposing a Mental Health Charter which would include standards of service user involvement, based on current best practice, and administered by service users and carers through a social enterprise. (also discussed later)

It would help if there were a legal requirement for services to adopt such externally developed and verified standards, even though the standards themselves would be better if they were not enshrined in law, so that they are easier to change, develop and administer.

It would be helpful if here were legal requirements to meet minimum standards for the involvement of people served by the NHS, through people who are frequent users of services

- Being present on all key bodies, locally, regionally and nationally.
- Being members of all decision-making structures, such as health boards and Trusts, committees, working groups, and partnership boards, including local service boards and Local Health Social Care and Well-being Partnerships
- Being involved in the development of job descriptions and person specifications for all roles in the NHS
- Being present on all short-listing and interviewing panels
- Being involved in developing criteria for tendering processes, shortlisting tenders and on panels deciding who gets the tender
- Being involved in decisions about promotion and career progression
- Being involved in the development of all service evaluation protocols and tools, and one to one evaluation research
- Analysing and reporting evaluation responses
- Carrying out audits of records, care plans, and outcomes (mental health)
- Being involved in designing and delivering all staff training relevant to direct working with those served by the NHS
- Providing peer mentoring and support (eg in mental health)
- Identifying research priorities
- Involvement in carrying out research
- Being on ethics committees
- Being involved in complaints investigations
- Being involved in staff performance management (disciplinary panels)
- Being involved in the development of consultations and consultation processes
- Being involved in the delivery and facilitation of consultation processes

There needs to be a legal requirement to pay people doing any of the above tasks at a living wage, unless they choose to op out of being paid. To do otherwise is exploitative of vulnerable people.

It would be helpful if there was a legal requirement to submit a plan for the involvement of those served by the NHS with respect to the above roles. Clearly there would need to be a time period over which these roles would be introduced.

It may be helpful to have sub-ordinate legislation for the range of roles and other quality criteria for how people are involved to ‘future proof’ legislation and allow for the continuous development of involvement as an evolving area of activity.

Reasons for above:-
We need to move beyond the assumption of basing involvement in service change on voluntary work by vulnerable individuals, who are part of populations with a very low level of paid employment. There are individuals who develop high levels of expertise, whose contributions are considered essential and valuable, but not enough to pay for. Given the greater costs for these people of having to pay for care, that was previously free, the need for income generating opportunities is much higher. People should be paid at least the minimum wage, but preferably a living wage, or more for participation, with support, as supported permitted work, or if the wages are high enough and stable enough, to be able to come off employment support allowance and have enough income to have the aspirations most citizens take for granted.

People need to be able to opt out of being paid, but services should be required to start from the assumption that people in responsible roles will be paid.

There needs to be more invested in the development of service evaluation designed and administered by those who use services most regularly. The need for services to demonstrate higher service user satisfaction is a very effective driver for change and involvement. Government led National universal evaluation questionnaires/surveys, do not work. We need questions relevant to specific services. For instance the mental health evaluation questions would be different, and even within mental health those questions which are relevant to different services vary. The government questionnaire is far too long. We need more customised questionnaires for each service, with far fewer questions, or people will not engage.

Rather than investing in computer systems to automate information gathering, which is not necessarily relevant to those using services, money would be better spent on a more flexible human response that employs service users and carers to develop evaluation through an iterative process, where, as the service changes different questions may need to be asked. Some areas have far more patient experience workers than others. It might be reasonable to set a minimum number of workers per head of health board population, situated within different parts of the service, with an essential employment criterion being extensive experience of service use in the service within which they would be based.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Permanent mechanisms should be legally required, but the nature of those mechanisms should not be prescribed, as best practice is continually evolving. A requirement to share best practice in public engagement could be a legal

duty, together with some sort of bench-marking process. External standards developed by frequent users of services and carers such as those proposed by the mental health National forum, could be an option here.

As above, there need to be paid appointments for the roles described in question 4, and a ring-fenced budget for wider involvement with people who are frequent users of services and their carers. Whilst it might be helpful for those involved in the above roles (in question 4) to meet each other for mutual support and to share views, taking things out to the wider public will give a better evidence base for the service users and carers appointed to contribute directly.

I am sceptical about the value of a separate panel. Service user and carer involvement is far more influential and effective when they have a significant presence in all decision-making groups, alongside other stakeholders on an equal basis. A panel feels like ghettoization and exclusion. It is slightly better if there is representation from the panel on local/regional/national partnerships, such as exists with the professionals' forum and National Board, when it would act as an advisory group. I am a member of the National Citizen's Panel for social care. We recently had a meeting with the two other groups which showed how helpful it is to meet together. We also felt that having people from other decision making groups visit the panel and get involved in discussions would enhance the contribution that the panel could make. It still feels like the different groups both in social care and in mental health are not working to the same agenda. In the Care Council for Wales the model of service user involvement at all levels meant we worked together on the same agenda, which felt more productive.

However, involvement events which enable staff from the front line and management to meet up with, and discuss services with, anyone served by the NHS who wants to turn up, has far more impact than a panel, and is far more accessible. There needs to be a wide range of possible ways for the public to tell services their views, including social media, email, and telephone. It would be really good to have one to one 'surgeries' where frequent users of services, perhaps those delivering the roles in question 4, are available to listen to service user and carer views at the venues where services are delivered, and to report them, on an anonymised basis, back to decision-making groups and professionals.

Any process for involvement needs to be co-produced with frequent service users and carers, and may therefore vary in different localities, and at different times.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Any expert panel, needs to be expert in the issue referred to it, and needs to have a significant frequent service user and Carer presence, at least two of

each and preferably 3 to ensure that there are enough present in case, health or caring duties mean that a panel member is not able to attend on the day.

The problem may be a question of public confidence as to whether the panel is truly accountable, as some seem to perceive a minister as more accountable to the electorate than an appointee. Perhaps if the minister were involved in appointing panel members, or dismissing them, the accountability might be clearer.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?

Legislative measures have their place in the mix.

The reference to the public 'taking control of their health' is unfortunate, as it fails to recognise that the whole system, with the balance of power held firmly by professionals, creates dependency, which many, possibly most, resent. The system does this by insisting on the 'professional knows best', with the control of resources, and god-like decisions about who gets what. We, the public want to get that control back. We want to be, and should be, the first line of defence, through rights to challenge clinical practice. If the families of people in Tawel Fan had had those rights, things would have been picked up so much more quickly.

Therefore the first and most important legislation required is to create a legal right to have a second opinion, which could only be refused on the advice of an independent professional not involved in the person's care, without reference to their notes or to their clinicians, that there is a) absolutely no theoretical possibility that the first opinion could have been wrong, and b) that any error that could theoretically have occurred would not cause harm, or interfere in any way with the patient's recovery – (which may include the patient's ability to trust the clinician whose opinion they are questioning).

There is a total lack of clinical accountability in the current system. Neither the managers, professional leads, or senior managers are willing to get involved in clinical decisions made by service staff. Nor do senior leaders. The regulatory bodies do not investigate individual decisions. Even though we are all well aware that clinical error is common, there is currently no mechanism to identify it or deal with it. Drs know that they do not have to justify themselves to anyone, least of all their patients. This is especially true in mental health where there are no objective tests, and subjectivity leads to high levels of variation with regards to both diagnosis and recommended treatments. Despite the high risks of error, this is an area of practice where the power to coerce is highest, and people's rights can be removed. There is no quality in healthcare if there is no clinical accountability, decision by

decision. This is not about blame or punishment, but about protecting patients from harm, by identifying errors as early as possible, and addressing the problems that they have caused.

Creating a legal right to an independent second opinion would help, but stronger mechanisms need to be in place in clinical management and supervision to pick up the errors that patients and carers haven't noticed as well. A legal requirement to carry out regular audits of clinical notes, and clinical audits comparing actual practice with evidence based and best practice, and looking at outcomes is also essential. The current process for managing clinical performance, exposing errors and quality assuring clinical care is not fit for purpose.

Professional line managers must be the third line of defence.

Members of the board, would be a fourth line of defence responsible for ensuring that the complaints process, access to a second opinion, clinical supervision, and decision by decision clinical accountability through professional line management, are all in place, robust, and regularly audited.

HIW, WG and professional regulators would then be the fifth line of defence, with a duty to set standards and legislation to improve organisational performance, to monitor implementation and fidelity to legal requirements, and take action where problems or non-compliance are identified.

Another quality issue is the need for care which is not compromised by personal relationships, eg when the patient is related to a member of staff, they need to have a legal right to be treated by someone who doesn't work with their relative, in a place where their relative does not work.

A further essential piece of legislation is around the complaints process, to protect patients and service users from negative repercussions of making a complaint, including compromises to their care and health.

There need to be distinct legal rights around complaints. Some of this may already be law, it is certainly what is promised.

1. Whatever the nature of the complaints process, and the service user's legal rights within it, it is essential that staff are legally obliged to have regular training in how to respond to complaints, how to mediate, how to find win win solutions and learning points, and how to repair damaged relationships.

2. Service users must have a Legal right to free access to an impartial complaints process at all times without any threats to withdraw services if they complain

3. Service users must have the legal right to an informed response to their complaint, either mediation or investigation

4. Service users must have a legal right for complaints **not** to be discussed in any clinical meetings, formally or with other clinicians in any informal situations.

5. Service users must have a legal right that no letters of complaint, or mention of complaint is added to or placed in the clinical records. This includes the use of the word complain in clinical records, where a service user has said something about the service during a consultation.

6. Service users must have the legal right to choose which clinician is, or is not, involved in any complaint investigation or resolution process.

7. It would be good to for service users to have the legal right to mediation instead of formal investigation.

8. Service users must have a legal right to a comparable or better service following a complaint

9. It would be preferable for a service user to have a legal right to exclude someone they have complained about from any further part or influence over their care, even if this requires putting in place alternative clinical supervision arrangements.

10. Service users must have a legal right to protection from defensive practice after a complaint – such as only being seen by staff two at a time - if this makes them uncomfortable.

11. Service users must have a legal right to know what action has been taken as a result of their complaint to prevent further similar events, including action taken with respect to individual staff performance, where the complaint is largely about the practice of an individual, or one or two people.

12. All public service organisations must have a legal duty to deliver on the rights of service users under the complaints process.

13. All public services must have processes in place to ensure that their staff are reminded of their duties under the complaints process, such as a note on written records that complaints information must not be included, and automatic flags on computer records systems, every time the word

complaint is used, or a scanned document is added to the record, to remind staff of their duty not to include complaints information on records.

14. All public service organisations should have a legal duty to report publicly on complaints received and actions taken, and to audit the complaints process to ensure it is being faithfully followed, as well as satisfaction figures regarding service user or public experience of the complaints process.

There is also a need for a fast track independent process for appeal regarding complaints before referral to the ombudsman or professional regulators, as these process take such a long time.

There also need to be legal processes in place to fast track complaints which relate to the possibility of clinical error or on-going clinical care, where harm could result from any delay.

There needs to be a strong legal basis for prevention and protection of patients and service users from abuse by staff. Tawel Fan demonstrates what can happen to vulnerable individuals in the mental health service.

All public bodies should have a legal duty to put in place a policy to protect their service users from abuse by their staff. This must be a public facing policy, co-produced with service users, easily accessible to service users, with information in all waiting areas about the policy and what to do if they feel they are being abused.

Service users must have a legal right to have their care audio or video recorded, to protect them from abuse.

Any complaint about abuse of service users by staff must be kept from all other clinical staff, and be investigated by an independent multi-disciplinary team, under the same conditions as safe-guarding processes. Witness from people independent of the health service must be given equal weight to evidence from staff.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
There needs to be more legal duties regarding quality improvement, and safe practice. Key components of quality and safe practice include the quality of records, and the quality of the complaints process, as well as the need for better systems of clinical accountability, especially for professions which are not required to be regulated or on a statutory register. The role of the Ombudsman needs to be extended to include complaints

about unregulated/unregistered individuals, and they must have powers to require evidence direct from the health service, rather than requiring evidence to be provided by service users, whose access to the relevant evidence can be restricted by staff, or by the service user's ability to pay for copies.

It is important that service users are allowed to view and respond to all evidence provided by the NHS.

Access to records for the purpose of complaints needs to be free of charge and independent of the staff against whom the complaint is being made..

Where allegations about service users/patients are made in their clinical records, a process is required for investigation and a fair hearing on the basis of 'innocent unless proven guilty'. There must be good quality evidence of any allegation put on the clinical notes, over and above the witness of staff, in order to prevent institutional abuse. Where allegations are not found to be proved, an official note must be made in the records to clarify this.

It is important that HIW audit and inspect quality and clinical performance processes within services, and complaints processes, and have sufficient legal powers to require action to be taken.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
A legal requirement to co-produce satisfaction/service evaluation measures with service/users/cares/families specific to individual services, and to take action in response to the comments received. The National Forum of mental health service users and carers, have proposed a set of standards within a mental health service charter and dignity pledge (attached). The dignity pledge has been through a process of co-production with forum members, but the charter is at present at the earliest stage of development. The format and contents are likely to change as the process of development progresses. The question was asked as to whether this would be more effective as a voluntary quality mark or as a legal framework. On balance to the seems to be that a voluntary mark would be the most flexible and open to development as well as simpler to enforce. However, it would help if services were legally obliged to meet such external quality standards, or at the very least to have the charter and dignity pledge supported by the Welsh Government. Other suggestions are given in response to questions 7 and 8.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
The health services are large and complex, so the 'responsible individual' process would only work if there was a scheme of delegation with responsible

individuals identified in each discrete service, such as cardio-respiratory, mental health, clinical pathology, etc.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
Everyone working with vulnerable people should be fit and proper.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
If the IMPTs deliver the things you say they will, then including quality would be great. Not sure the required structures are yet in place for these to be truly o-produced though. For that I think you would need legislation to required organisations to pay services user/patients to be involved in the co-production

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Standards for health care need to reflect service user and carer priorities, and views about what quality parameters matter to them. Any measures need to be independently collated, and this could be done by service users and carers on a paid or other reward basis. Common standards will be too inflexible to allow local co-production. It would be better to legislate for the necessity for NHS services to adhere to an independently developed and monitored set of standards, relevant to the area of practice, co-produced, or designed entirely by service users and carers. The same is true of common performance/evaluation measure/service satisfaction measures. The current Welsh Government satisfaction measure is far too long and unwieldy and not fit for purpose in the mental health service. We are finding that service users want no more that 10 or so questions, which need to be specific to the service they are using. It would be better to require NHS services to develop satisfaction measures with service users and to contract out the collation of these to a service user and carer social enterprise. The crisis service questionnaire and the mental health service questionnaire also place administrative priorities above service user and carer concerns, as well as using inappropriate numerical Likert scales, which many mental health service users find difficult to use. Written measure have to be accessible to the majority to give any useful information. The only common standards would be headline standards, such as the need to have a robust quality assurance and continuous improvement policy in place and to have safety investigation and safety procedure development

procedures as well as more robust complaints processes and learning from experience.

14. Could a common standards framework, which covers both the NHS and the independent sector, better deliver a focus on improving outcomes and experience for citizens?
No. Only headline standards about overall quality of governance and quality processes would be relevant, as applicable between organisations. For specific services, like residential mental health services in the NHS or independent sectors, there might be common factors, such as dignity, but not on a whole health service basis.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Accreditation – is the process proposed by the National Forum for mental health service users and carers. The Dignity Pledge and Charter are attached. The adoption of external accreditation to standards designed and administered by service users and carers could and should be a legal duty. However there would need to be some process for quality assuring such accreditation standards and organisations administering them. The Government could consider creating an approved list of standard setting organisations. These organisations could be social enterprises with support from advising agencies, which employ frequent users of services and their carers. There would have to be a funding model, either through charges to the NHS organisations being accredited or through direct government funding. Peer review is a helpful process. However 360° appraisal including feedback from service users or patients, and carers or families would be better. It is essential, especially in mental health where engagement and relationship are so central to recovery, that service users and carers have direct input into supervision and peer review processes. At present supervision only considers the professional's perspective, and therefore misses important issues that could only be flagged up by the service users.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Peer supervision needs to be done in a way that does not compromise individual patient care. For instance, where someone has complained about a professional, that professional should not be involved in supervising other professionals working with the individual. In addition it is essential, especially in group supervision that patient/service user names should not be used, so that someone's care is not contaminated by any errors or relationship problems with individual practitioners.

Concerns raised by service users and carers need to inform supervision processes so that learning can emerge, however this needs to be done sensitively to keep the identity of individuals private and to prevent consequences for their care. It would seem better for such efforts to be made in one to one supervision, to also protect the feelings of the member of staff concerned. Legislation for supervision, therefore needs to include safe-guards for service users. A) that patient/service user names are never used in supervision, whether group or one to one. B) that when concerns raised by service users are discussed in supervision, this is done sensitively in a way that protects the identity of the service user.

17. What arrangements should be put in place for self-employed health professional registrants?
This would need to go through regulatory bodies. Unless Wales bites the bullet and has separate processes/branches for Wales, this will be outside our influence. For not yet regulated staff, such as psychotherapists, it would be really helpful to introduce regulation in Wales, perhaps through the Care Council for Wales. Self-employed registrants should be able/required to provide evidence of independent supervision, however, unless it is a condition of registration, it would need to be imposed in another way, such as through organisational accreditation, or robust inspection processes such as HIW. Either way, there would need to be a campaign to the public to inform them of the requirements on private practitioners so that they can check their status before consulting them.

Chapter 4: Openness and honesty in all that we do

<u>Being open about performance and when things go wrong</u>

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
The complaints process is in major need of improvement. I don't know if this is the answer. I feel the answer is to move away from 'investigation to blame', to 'exploration to improve'. I think there needs to be a mediation option, and more that can be done without complaining, such as a legal right to a second opinion. There needs to be more attention to safety protocol development and exploration of how teams can act as systems where errors are the result of group processes. There is a major gap in the management of performance, which is a complete failure to hold individual clinicians, or teams to account for current individual

clinical decisions, or longer term management of individual cases. At present managers and professional leads are reluctant to interfere with clinical autonomy of staff, leaders at board level are ill-equipped to do so, and professional regulators do not get involved at that level, as they only deal with situations where fitness to practice is in question. It is too late to wait for harm to be done. It is essential that clinical governance procedures are introduced to investigate individual clinical decisions, as they are happening, including audits of notes and team meetings, if anyone, staff, or public, raises a concern..

I myself have suffered greatly from an inability to get anywhere with uncovering clinical 'error', to the point where I could have lost my life. This has felt like orchestrated abuse or neglect at times, with a flat refusal to allow any second opinion or discussion by managers or professional leads, with clinicians about their clinical decisions. For instance I was forced to 'agree to' a very negative view of my personality, which had been reached without reference to any evidence other than the fact that I had complained, and resisted labelling, that didn't fit my self-knowledge and the views of the majority of people who know me. If I did not agree, then I would receive no further care. On another occasion I was told if I did not accept a therapy, which had been used as a vehicle of abuse during my childhood, and which terrified me as a result, I would receive no other care, and no further care. I was told if I continued to ask for a second opinion, or complain about anyone, I would be discharged. Despite a number of robust assessments which didn't support this diagnosis, and even after I have been told I didn't have this diagnosis, it continued to be applied. My attempts to try to resolve this clinical problem, and previous complaints were described as 'acting out', and my letters asking to have the situation investigated were described as 'vexatious'.

I have had many years to reflect on how it might be possible to prevent such situations happening again, or indeed to free me from the on-going oppression of a clinical opinion which repeatedly leads to me being refused the care that I need. I don't think a duty of candour would help, because the clinicians remain stubbornly adamant that they are right and I lack self-awareness, and refuse to see 'my affect on other people'. In mental health there are no objective tests of what happens in people's minds – I wish there were. I wish I could put them inside my head to see my world. I cannot begin to explain how it feels to have a powerful group of people imposing an unrecognisable and very negative, even abusive, view or who I am, what I think and feel, what motivates me, what my relationships, and life history are like, and denying my most distressing experiences as 'imagination' or 'manipulation'. Nor can I explain the confusion of facing refusals to provide care to prevent crisis and hospitalisation, or to promote recovery.

Now I have my notes and can see this on the page, how senior clinicians have seen themselves as above the law, with respect to complaints processes, I have to come back to two things. 1) individuals need legal rights to key protective procedures in the complaints process, and 2) staff training in how to respond to complaints and patient's rights in the process has to be

legally compelled, as is training in safeguarding, fire safety, first aiders, and lifting and handling. In mental health especially where higher levels of complaint are correlated with higher suicide rates, such training and protection will save lives.

The key issues with relation to fear about complaining are the effects on clinical care and relationships. This problem is not going to go away until staff feel comfortable dealing with complaints, through better training, and support, and being able to use learning from complaints as CPD. Any second opinion is an opportunity for independent peer review, and for learning. It must not be seen as a criticism or a blaming process, but as a way to explore and learn from a difficult case, and from a colleague.

It is also critical to recognise the psychological effects on the service user or patient of complaining, and to provide expert psychological support to people during any complaints process, and afterwards as long as they need to help them to move on. (Although this is not a substitute for a resolution)

It is critical that service users/patients are protected from the fall out of the complaints process. This can only happen if they have legally enforceable rights, and individual staff face real consequences if they don't respect those rights. This includes not to have any mention of complaints on clinical records (including placing letters or emails of complaints on clinical files); or any discussion of complaints in clinical meetings; or with any clinicians not directly involved in the complaint; .to be able to exclude people who have been a subject of complaints from any further involvement in their care, even if this means changing supervision arrangements or moving care to a different team; to have equivalent or better care after a complaint; to not be faced with defensive practice after a complaint; to be able to choose who is, or is not informed of a complaint, and to not have a complaint affect care, diagnosis or treatment, or be seen as a clinical symptom rather than a genuine concern.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
In the first instance we need to have greater transparency about the actions taken as a result of a complaint to prevent it happening again, and when those actions are completed. This must include interventions with staff, be that additional supervision, or training, or other sanctions designed to protect the public. Professionals who go through the disciplinary processes of regulators have their sanctions made public, this must also happen at the service level, at least for the information of those affected. It is difficult for the public to have any confidence in the service if they simply get a letter saying 'sorry, it won't happen again'. Transparency must start with individuals. The practice of audio recording consultations must be made easier, and used, as it is with the police, to provide evidence of how people have been treated. At present staff frequently refuse to audio record, and then leave vulnerable people in a situation where they cannot evidence what has happened to them, if they have been treated unprofessionally, or even been abused by staff. If my meetings had been audio-recorded (as I requested) then I could have

proven that my letters were not vexatious – but more likely, the problem would not have occurred in the first place if staff knew they were being recorded. After someone has died a coroner's investigation publishes the findings and recommendations. We should not have to wait until someone has died for this kind of transparency.

Therefore we need legislation to:-

1) Require professionals to be transparent about their own clinical practice, and to respond to the questions of those they serve, eg their patients or service users, openly, honestly, fully and compassionately. To be obliged to be accountable to their patients/service users directly for their clinical practice, and therefore to have to justify their decisions to their patients with evidence, show how they fit with current best practice guidance (eg NICE), and be open to the possibility of clinical error, (such as figures for error rates in their area of practice) and support requests for a second opinion made by their patients. [this needs to be underpinned by legal rights for patients/service users to a second opinion where there is any possibility of error which could cause harm, now or at a later date]
2) Publish error rates for different areas of practice, and plans to reduce these rates, and procedures to pick up on errors quickly and prevent them causing harm to patients.
3) Require clinical governance to be more robust, so that individual decisions can be examined, with all those affected by them, to pick up errors early. (The argument given for not 'interfering' with individual decisions is that doing so would undermine professional confidence. However, in most jobs and professions, people expect to have the quality of their work checked, and to be given instruction and direction from more experienced colleagues or peers. Staff need to learn to expect their work to be scrutinised, and be helped to deal with developing the psychological toughness to cope with that. Given the deadly consequences of some errors, these professions must not be exempt from the quality assurance and scrutiny expected in other careers).
4) To protect staff from blaming processes, and instead require evidence of learning when an error is made
5) To have a duty to publish the results of investigations/explorations related to complaints where harm has been done, identifying what went wrong, who's actions led to the harm, any circumstantial issues which made human error more likely, any cultural or team issues that contributed to the harm, and what will be done by whom, and when, to prevent or reduce future similar harm.

To have specific legislation to protect patients/service users from abuse by professional staff, (such as Tawel Fan). This needs to be consistent with safe-guarding practice, co-produced with service users/patients, and public facing, with information in every service delivery area for patients/service users, describing dignity in care, defining abuse, and explaining the rights of patients should they believe their treatment is undignified or abusive. (see attached dignity pledge from the National Forum of Mental health service users and carers.)

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
We need to be looking at multi-disciplinary working across the piece, not just health and social care, but nurses, Drs, OTs, support workers etc., to develop processes for the investigation of complaints which result from the work of different professionals together. Who is responsible when things go wrong in a team? How does individual professional accountability work in this situation? It is essential to have better recording of team processes, preferably audio recording, so that individual accountability in such circumstances can be clearer. Otherwise individuals can hide behind a team by delegating responsibility to the team, rather than acknowledge their part. The PSOW powers need to be expanded to include the power to investigate complaints about individuals, where those individuals are not regulated professionals and as a result the public would not otherwise have an independent second level complaint process available. The PSOW also need to have the power to subpoena public services to provide records. At present the complainant has to provide the evidence, but may be denied access to critical evidence as a result, such as third party letters. Extending powers to investigate private services, especially if provided by otherwise unregulated individuals, such as psychotherapists, would be helpful.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
The question assumes that sharing information is always good. It is not. The situations where sharing is OK are very limited – should be very limited. It is OK only if there is a potential safe-guarding issue, or when the individual or an advocate or guardian, gives their permission for information to be shared for a particular purpose. The first issue is the quality of that information and the failures of information governance, which have led to significant harm to patients all over Wales. I have spent some time investigating information governance, and the duties under the data protection act to hold accurate, complete and up-to-date records. I have found through a Freedom Of Information request, that the

proportion of staff trained about record keeping in our local mental health service is very low. The person in the Health Board responsible for training staff about record keeping was not aware that WIGB was the body responsible for this in Wales. He was unaware of the guidance recommended by WIGB on making changes on clinical notes to correct errors. This guidance also describes how people should be allowed to see third party letters, where it is likely that they know about the letters. I was refused a copy of a letter on my medical records, from my advocate, written with my consent. When I asked to see my medical records, the first time my mental health team refused. They also failed to respond within the required timescales and I had to push for my right of access. This lack of knowledge of patient rights regarding records is widespread.

The guidance also says that third party letters should not automatically be put on files without checking the facts with the record owner to ensure that such letters were not malicious.

The trainer was not aware that factual errors could be changed, and believed that adding in service user views to records would 'normally require legal action', but that he felt and advised that it should be allowed.

When I got hold of my notes I was horrified. They were full of emotionally loaded, judgemental accusations and serious allegations, and blatantly inaccurate information. They were incomplete, and often entries were made days after complex meetings, where contemporary notes were not taken. They were contaminated with information about complaints, and minutes of clinical meetings where complaints were openly discussed with the whole team, and also process notes and minutes of meetings about complaints. There were letters between staff which justified using my complaint as evidence that I had a stigmatising diagnosis, which cited complaints to justify not providing a service, ignoring my symptoms, refusing to accept evidence about me from outside of the health service, practising defensively and which described me as 'acting out' because I had asked for a second opinion. These notes have over the years caused me deep harm, leading to suicide attempts, and being sectioned. All preventable. Sharing such venomous information is not going to improve care. If anything too much information was shared with too many people.

I know that prejudiced opinions about me have been spread through discussions in meetings with people who have never met me. I remember on occasions speaking in a crisis to people I have never met before, and getting a barrage of aggressive and judgemental accusations before I even had a chance to say what I was phoning about. The balance of sharing information needs to go to ensuring that people have more control over who sees what. This is in keeping with co-production, equality in decision-making and patient's taking responsibility for their own health. Doing things in someone's best interests must be about starting with the assumption that the individual is the best placed to decide what is in their own best interest. It was not in my best interests for people who were angry about my complaint to be telling people who had never met me what a difficult and horrible person I was.

The problem is that medical notes cannot be erased. So harm done continues to harm in perpetuity, unless changes and notes can be added. Abusive comments in notes, unfair allegations, the assumption of guilt without any access to a fair trial, all cause harm on an on-going basis. It is essential to improve the quality of record keeping to make it harder to include abusive material and develop a zero tolerance to non-medical, abusive/insulting material being placed on them. The use of language needs to be openly discussed. When someone is suicidal for instance, it is critically important to record that someone is 'feeling suicidal' rather than recording that someone is 'threatening to commit suicide', because of the implications of the latter and how that will affect how other clinicians respond to the person, in a way that could cost that person their life. If someone says 'I am hearing voices', it should be recorded as 'x describes hearing voices', and not as 'x claims that she is hearing voices'. Again a subtle difference that implies that the person may not be truthful about their experience, which will affect how others approach them.

We need legal rights to the protection of identity in team meetings where people who don't know us are present, by the use of case numbers rather than names, so that we don't end up type caste and treated defensively.

We need to have the right to decide what information cannot be shared with other clinicians – such as information about a history of sexual abuse, which we might feel humiliated about being shared. You cannot have trust in a therapist who might spill all to other clinicians. Therapy has to be private. The ONLY reason for sharing information in mental health would be where there was a risk of serious harm to the individuals or others if the information were not shared, such as suicide or self-harm, or aggression or violence to others. (This does not include harm to staff caused by genuine and legitimate complaints).

Again, as in complaints, there needs to be compulsory training in clean record keeping, how to change records, and how to protect people from harm caused by badly written records. There needs to be a specific working group developing this compulsory training to ensure that proper guidance is followed. It would be really helpful to have a co-productive process with frequent users of health services, with respect to developing record keeping standards that health and social care services would be legally obliged to follow, to underpin the development of guidance, and
audit processes and what needs to go into compulsory training.

22. How can we consider breaking down any barriers?
Please don't. Specific legislation must only be made for extreme and specified situations, such as safe-guarding. Individual autonomy over what happens to our information must be the first principle. Inappropriate sharing is far more of a problem, and far more common, than failing to share. If information were better quality, cleaner and more accurate, people would be

happier for information to be shared

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
If patient identifiable information is only shared with people who couldn't identify the person from that information, then there is not a problem. The DPA requires that you let people know how their information will be used. It would seem fair to offer people an opt out. However, information used for planning services, measuring needs in the community and research by people not directly involved in our care, to look for instance at outcomes and performance of services, I suspect would be welcomed. In fact if everybody is asked by their Dr if they would like to help improve care for all by sharing information you may find a lot of people willing to give more information for these causes.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
Does HIW have any teeth? It seems to me that they can only make recommendations, rather than require change. Independent advice on continuous improvement is not enough. It does not provide assurance. We need an organisation that can enforce action to meet standards. Is HIW big enough to scrutinise all of health services? I haven't seen any evidence of any differences made by HIW to the quality of services. I haven't heard of any regular HIW inspections of mental health for instance. The impact of HIW needs to be better communicated. We need to see what difference they are making, if we are to justify their existence at all. We hear about what the ombudsman does, what difference does HIW make? I hear much more about ESTYN, and how seriously staff take their inspections. I have heard nothing like that about HIW. I don't know of any education services that have not had Estyn inspections, but there are many parts of the NHS that have never been inspected by HIW. HIW do not have enough clout about clinical governance which is the very basis of safe health care? HIW need to have standards that must be met, methods of auditing those standards, reach into every service provided by the NHS, and authority to

insist that changes are made, and to take legal action against services that do not improve to meet the necessary standards.

Perhaps HIW could approve standard setting organisations such as proposed by the National Forum for Mental Health service users and carers – information attached – to ensure standards are met on records, complaints, clinical governance, and clinical accountability.

Someone needs to be auditing and scrutinising services if we are to prevent patient abuse.

A process of service based inspection and regulation would be better than an organisationally based one.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
No. But there must be board membership of frequent users of services and carers with significant caring roles, as in the Care Council for Wales to ensure sufficient citizen voice to keep HIW accountable, and maximise co-production. CSSIW also needs a board like CCW, with significant membership from frequent users and carers. In both cases, as with CCW all board members should be paid at the same rate, unless they need to adjust rates slightly to fit in with supported permitted work.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
I just want to say how much of a mistake I think it would be to create a single inspectorate. The current arrangements do not have sufficient reach. CSSIW struggles with the consequences of merging CSIW and SSIW, leaving it with two still very separate arms. It is difficult to see the advantages of the two organisations coming together. This would be even more extreme if HIW were brought in too. I'm not sure I understand how or why there should be any joint working. Maybe coordinating inspections for jointly provided services, which is quite possible without great difficulty or legislation, but I can think of no other requirement.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?

I think it would be a major mistake, creating an overly complex and unwieldy organisation. In my view the English example is not one of success.

A single board would inevitably mean that there would not be the range of stakeholder interests necessary to do either health or social care inspection roles effectively.

In such situations social care usually gets engulfed and its unique benefits to individuals lost.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
In my view the CHCs are not effective in representing the patient voice, and should be replaced with a completely different model. These days, patients are more than capable of representing themselves, and their contributions are sufficiently valuable to be paid. There does need to be a mediating role in service change at a local level. I don't think a patient's panel could do this. It is essential that there is patient representation at all levels of decision-making, on boards and committees without proxy by anyone, be that CHC or CVS. I think I would feel more comfortable with CHCs and HIW merging than I would CSSIW and HIW doing so. I think there needs to be some real creativity here. A greater role for the patient's voice in HIW would be an exceptional opportunity for re establishing the accountability link between the professional and the people they serve, which has been broken by the public service model. There needs to be funding and support for more opinion research, which would support patient's work in decision making, but this could be done through patient experience in health boards, if service user and carer bodies were sub-contracted to do this work independently, and more patient experience staff were themselves frequent users of services. Appointing people on merit for patient voice work is a useful model. It would be helpful to have some career progression in that process. At the same time there would need to be support for people who have on-going health problems. The CHC advocacy service works well. Being linked to HIW might give it even more influence. An opportunity for such representatives to meet each other would be healthy, as long as there was also a budget for more outreach and listening to citizens in communities. I am not a fan of citizens panels unless they are linked to presence on all decision-making bodies. Discussions on the citizen's panel for social care are interesting, but we struggle with not witnessing how our

views are being heard and taken into account. A recent joint meeting showed the value of other stakeholders hearing our voice directly. A panel can be a bit too 'arms length' to be really effective alone.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
I don't think the current CHC model is fit for purpose in the existing system. I am not convinced of the value of integrating health and social care, because of the danger of generic roles which undermine the speciality benefits, and benefits of cultural diversity of social and health professions, which enable better care. However, a single structure for service user/citizen engagement/voice would have its merits even if health and social care retain their separate identities. I say a structure rather than an organisation as I think there is merit in not creating another administration. It might be helpful to have joint hosting of such a structure within offices in local council and health service premises, with joint funding for administration posts.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
As long as there are specific limits on what the money is used for and how much. It needs to be for investments to save, such as investment in prevention and community services that keep people healthy for longer and mitigate the consequences of chronic ill health, reducing the costs of and need for, acute care.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes.

34. 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.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
Partnerships require attention to training and ensuring relevance and buy in, perhaps through statutory duties for partners to log their attendance at partnership meetings and events and all their partnership based services (such as street triage), showing how their part of partnerships is impacting on their work. There needs to be leadership and governance that continues through a scheme of delegation to all the separate health services. E.g. the Local Mental Health Partnership Board, the Psychological Service Management Committee, etc. There has been research into effective partnerships. We need to look at that, identify best practice, share good practice and look at how to train and develop partnerships as functional teams rather than a collection of disparate individuals who are only there because they have to be and would rather be doing something else.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
I have no problems with the size providing that members pull their weight in terms of scrutiny at a service level through appropriate committee structures. There needs to be a better scrutiny at service level if boards are to be able to provide reasonable assurance of quality and safety of services. I do feel that a smaller board is in danger of becoming cohesive and therefore lacking in challenge and effective scrutiny. Given the size and complexity of health boards, there need to be sufficient members to do the work in committees and sub-committees reporting to the board. However, the membership needs to include a strong frequent user and carer voice as non-officer members. This has proven to provide a high level of challenge on other boards with positive results. It is important not to elect people for 'community representation' but to appoint them on merit, as the best people may not be the people best at running an election campaign or able to afford to do so, especially if they are frequent users of services, who would be better informed about the service and how it feels to use it. Representation is not as effective as perspective. It is important that patient voice and carer voice appointments have the resources to meet and listen to patients and carers on a regular basis to enhance their contribution to the board.

I am not sure about the merit of having cabinet board members of the board, but do feel that the directors of social services should be present at that level. A locally elected politician might be better appointed on merit, rather than on the basis of political success. It is important that representation on the board from the healthcare professionals forum and stakeholder reference group is based on who is best able to take that role, rather than necessarily the chair. If we have a professional representatives forum representative do you also need the medical, nurse, and therapies directors? There needs to be a service user and carer voice representative too, if we are to have any kind of service user and carer stakeholder group, in addition to on merit appointments of service users and carers.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
I like the consistency of particular roles. However what is director of therapies and health science? That sounds like a very odd hotchpotch. Happy with what you've got.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
I am not sure I understand why it is necessary to separate decision-making and scrutiny. Strategy, leadership and scrutiny are complimentary roles that work well together to create good governance and organisational accountability. There is still decision –making involved. Do you really mean a separation between strategy, scrutiny and leadership on the one hand and operational decisions on the other? I am very much against elected membership of the board. We need the best people, not the noisiest. People must be appointed on merit. We need service user and carer voice on the board, preferably at least two of each. It would be very hard for a frequent user of services or a full time carer to effectively carry out an election campaign, or pay for it. The cost of election, would in my view, if paid for by the services, be a monumental waste of money. Real representation does not come from election, it comes from continuous engagement, form getting out and talking to people. We need board members with a service user and carer perspective who are very good at doing that and presenting those views as well as their perspective on the board, without over pushing any agenda or 'manifesto'.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Does this model work? Isn't it confusing when it comes to supervision, terms

and conditions etc.? If it works go for it.

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
I will say again, the best and most effective challenge comes from those who are frequent users of services and their carers. There needs to be a strong voice from these people on the board, preferably at least two of each.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
As with health boards there needs to be a strong voice from frequent users of services and their carers – preferably at least two of each

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Whatever advisory structure you have, it is critical that the service user and carer voice is represented on all the groups you take advice from, as the advice would then be more robust, fit for purpose, and would be likely to be more acceptable to the public, avoiding some of the battles around service change that have happened recently and are likely to continue happening given the current economic climate and need for major change. A small note of accuracy. The CHRE is now the PSA (Professional Standards Authority)

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
We need policy and service delivery to also be based on expert service user and carer advice – if you are serious about co-production. We need to look at the need for on-going engagement in the development of policy and service delivery, and the kind of legislation required to ensure it is meaningful. The National Forum for mental health service users and carers have proposed a charter which would include standards for engagement/involvement/co-production with service users and carers. This model is flexible to continuous improvement of standards of involvement. Legislation to require NHS organisations to work with such quality mark standards would ensure that engagement is effective. It is also critical that in seeking advice the people consulted include front-line

workers who often have the best knowledge of what is or is not working. In addition a model of developing policy through a participative action research model would also help to road test a policy in terms of what we could expect it to deliver in the service. Legislation could require compliance with guidelines which could be changes through sub-ordinate legislation to reflect changes in organisations and engagement possibilities.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Not sure if the regulatory bodies are part of these partners, but it would be good to have welsh branches in order to have a more consolidated and consistent Welsh approach.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
Need clearer governance and leadership arrangements for services which have a clinical role, so that appropriate service user and carer involvement and co-production can be facilitated.

WGGP155 – Sara Hayes – NHS Wales Directors of Public Health
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
There are already many national policies, plans and standards encouraging local collaboration and health boards are building ever closer links with their local partners. The potential impact of the Health, Social Care and Well-being Act and the Well-being of Future Generations Bill also need to be understood fully as both these pieces of legislation will be effective by 2017.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The DsPH are keen to ensure that the current extent of existing legislation is understood and used effectively. Local collaboration may be helped by legislation but will always rely on enthusiastic local leaders to be effective, which is hard to legislate for.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
There needs to be an assessment of the potential for the Health, Social Care and Well-being Act and the Well-being of Future Generations Bill to address existing requirements for closer working. If further legislation is developed it must be consistent with these needs but not lead to duplication. Changes to legislation which allow increased flexibility in organisational arrangements may be beneficial.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Yes

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
No, this would add a layer of management and complicate governance arrangements.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Quality improvement should be delivered through listening to and responding to patient and community feedback, and through peer audit, support, review and challenge, based on high quality data. Legislation should be used to support adherence to standards.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
It would be useful to develop a single view or definition of quality that is shared by health and social care

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
A duty to complete a quality impact assessment could be considered in any planned service development.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
We are not clear what this would achieve. This concept already exists in the post of CEO and certain Executive Directors.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
The advantages and disadvantages are not clear as this test may cut across the Board and Director responsibilities of ensuring staff are competent and are working safely.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
We need to promote quality throughout our work, including when collaborating

with our partners. This needs to be a core requirement within the planning framework and guidance. We consider that some of the key issues that directly impact the quality of healthcare services, including workforce and patterns of investment in health care, were not recognised or addressed by the report.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
It would be helpful to have shared standards across Health and Social Care that reflect the accountabilities of the organisations.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
This would be helpful.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Compliance with accreditation can be monitored routinely. Peer review between the Health Boards has been valuable in developing the Health Board Delivery Plans and could be used during the development of other key plans.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Clinical peer supervision should be seen as routine health board practice and should not require legislation.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
In principle this is supported. Actions should be transparent and no attempt to conceal poor performance should be made. In some situations it could be

appropriate to conduct an assessment of the potential benefits and harms from exercising the duty of candour and informing patients and/or their relatives of incidents where mistakes have been made but there is little or no possibility of harm arising from them. This point needs further consideration.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Transparency on performance requires clear and open presentation of high quality data. Effort needs to be put into developing good reporting systems.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
There is a reluctance to share personal information without the patient's consent in many parts of the NHS. There is confusion over what is appropriate to share and when it is appropriate to share information. There is also weak infrastructure for sharing information easily. Improving electronic information systems across the public sector would help.

22. How can we consider breaking down any barriers?
Legislation is not needed to overcome barriers but simple training on the safe and appropriate sharing of information would be valuable, including for frontline staff.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
This should be encouraged and facilitated, with due regard to information security. Linked pseudonymised information should be made available routinely, but safely, for needs assessment and service design as well as research.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
This would appear to be a sensible solution, creating a single recognisable body and reducing duplication.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
CHCs provide a helpful link to local communities.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
In order to represent the patient voice effectively CHC membership would need to be reviewed and be representative.

Chapter 7: Finance, functions and planning

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
Yes

34. 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, with a view to keeping alignment and governance arrangements clear and simple.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Board membership is currently prescribed. They may benefit from having more autonomy to determine their membership and the skills they require, perhaps within prescribed limits.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Health boards could have some discretion over the number of Executive Directors but we suggest it should be required for there to be an Executive

Director of Public Health.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
Joint appointments can play a valuable role in bringing agencies together and promoting integrated working. The DsPH support the concept of joint appointments with local authorities for the DPH role, other Executive roles and for other roles throughout the organisations. We wish to stress the importance of remaining Executive Directors of the Health Boards in order to promote wellbeing, preventative health care and coordinated pathways between all care sectors.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
The statutory status of the advisory committees should be retained as these are an important source of independent professional advice.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
The implications of the new Health Social Care and Wellbeing and the Wellbeing of Future Generations Bill need to be fully understood so that any additional legislation does not duplicate or undermine them. Joint appointments would help improve partnership working. Increasing public engagement in service design and patient engagement in care and treatment decisions relevant to themselves requires cultural change across society, not just within professional groups. It is unclear how legislation would help in this.

WGGP156 – Carol Shillabeer– Powys Teaching Health Board
Tref / Town – N/A

General comments

It is important that this Green Paper is considered within the context of the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 as both pieces of legislation will be fully effective from 2017. It is also important to be cognisant of the recommendations made within the Williams Review 2014. (The report of the Commission on Public Service Governance and Delivery).

Whilst the totality of the implications of the Social Services and Well-Being (Wales) Act and the Well-being of Future Generations (Wales) Act are not yet fully understood, their introduction will transform the way the health and social care system operates. It is helpful that any legislation being considered as a result of the NHS Green paper will not be developed in isolation and will be drawn up to compliment and be consistent with these emerging legal frameworks.

As health and social care services increasingly work together to define and deliver against agreed aims and objectives through Local Service Boards and Public Service Boards, the current governance and management models operated by the NHS and local government in Wales may require further change. The role of Welsh Government (in its broadest sense) in leading and managing this transformational change is pivotal and clarifying this as part of any legislative change would be helpful. Any new legislation drafted should positively encourage the delivery of an integrated health and social care system across Wales.

Ongoing engagement with the public, patients and partners is critical and determining how this is best managed would require detailed consideration and planning. This would need to include how to facilitate engagement which will help to shape and build the joint plans through Local Service Boards to the Public Service Boards.

In the context of quality it will become increasingly important to consider how we ensure consistent quality and safety standards are in place across the health and social care system. If these were agreed then this would clearly impact on the role and function of the regulators, e.g. HIW/ CCSIW.

If the Health, Social Care and Well-being Act and the Well-being of Future Generations Bill and Williams review have the potential to impact as outlined then further change may be necessary to the current system. How speedily such change could be achieved and whether or not such changes really require legislative support merits detailed consideration.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority? 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
The Health Board recognises the significance of and welcomes the new legislation including the Public Health (Wales) Bill, the Social Services and Wellbeing (Wales) Act and in particular the Wellbeing of Future Generations (Wales) Act in relation to the requirements for closer collaborative working between health and other public services. The totality of the impact of the Social Services and Well-Being (Wales) Act and the Well-being of Future Generations (Wales) Act in practice is yet to be tested, however their introduction is likely to transform the way both the health and social care system and the wider public service operates in partnership. As such we do not currently think that additional legislation is needed specifically to strengthen local collaboration for planning. What will be important is for clear guidance to be available to Health Boards and other public services to facilitate a clear and common understanding of the opportunities and requirements created by the new legislation, notably the Wellbeing of Future Generations Act. This will enable the Health Board and partners to maximize the opportunities around local collaboration. Collaborative planning requires not only the recognition of and adoption of common priorities and outcomes, but a framework and timetable that facilitates joint commitment and resource. Current planning cycles across public service and notably across health and local government are not fully aligned. The potential for this should be explored further in the implementation of the new legislation. As health, local government and other public service partners increasingly work together to define and deliver against agreed aims and objectives through Public Service Boards, the current governance and management models notably operated by the NHS and local government in Wales may require further change. This would have a direct link with many of the areas under discussion within the Green Paper. We would therefore strongly urge consideration of the wider public services governance and how the NHS governance best fits in this wider context. Welsh Government would need to consider whether its current performance management and accountability arrangements would need to change to reflect this. The role of Welsh Government (in its broadest sense) in leading

and managing the system going forward is pivotal and would benefit from being made clearer in this context. If the Health, Social Care and Well-being Act, the Well-being of Future Generations Act and Devolution, Democracy and Delivery (and any associated legislation as a result) have the potential to impact as outlined then further change may be necessary to the current systems. How speedily such change could be achieved and whether or not such changes really require legislative support merits detailed consideration. Any legislation to be considered as a result of the NHS Green paper should therefore not be developed in isolation and will need to be drawn up to compliment and be consistent with the emerging legal frameworks.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
The continuous engagement of patients and the wider public in the planning and provision of health services is increasingly important. Health Board's already have a duty under the NHS Act to ensure that local populations are consulted on service changes and there is already significant case law in relation to the requirement to consult. Each and every service change proposal needs to be considered on its merits. The duty lies with each organisation and governance arrangements should be robust enough to determine when consultation is required. Consideration needs to be given as to how more effective collaborative work and decision-making can be achieved across health organisations and increasingly across health and other public sector organisations such as local government. This does not necessarily require additional legislation. Legislation is not felt to be required to support strengthened continuous engagement, Updated guidance would be useful but ultimately successful continuous engagement is down to the actions, behaviours and relationships between local organisations and communities.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
As the Green Paper states, Health Boards are already under a duty to involve and consult local people and their representatives in the planning and delivery of health services. The option of patient panels has been in operation elsewhere in the UK for some time and there are issues of credibility and legitimacy that need to be

considered.

The role and authority of such groups would need to be clearly defined – particularly in terms of whether they are advisory or whether their views must be acted upon (the latter then raising questions in terms of the Board's accountability within existing legislation).

The other issue relates to the role of the CHC – which later in the Green Paper is put forward as the voice of the public. That premise could seem to be at odds with introducing another statutory group.

Health Board's already have Stakeholder Reference Groups acting in an advisory capacity but their constitution often results in "vested interests" being to the fore in discussions on engagement and consultation. Similar issues could arise with another group being introduced with a similar remit.

There are a range of tools to facilitate continuous engagement and it should be for each organisation to determine the most appropriate local mechanisms. The conclusion therefore is that further legislation is not needed which could potentially tie the hands of Health Boards in the use of innovative engagement methods.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
There are a number of considerations in relation to a permanent national panel including local knowledge, authority and accountability (particularly in relation to the outcomes of a formal consultative process), the role of the CHC and the scope of its work. The notion of an Independent Review Panel is supported but the preference would be for each service change under consideration to have a separate panel appointed. However, it is felt important that the Minister should appoint such a panel when required rather than having a permanent panel. It is felt a permanent panel would not have the local knowledge and accountability/responsibility/scope of powers. The question would be whether Board's in NHS organisations would become be less accountable in terms of decisions made relating to service change. It is felt that a process of referral of issues to the Ministers should remain in place – since this ensures that referrals are not made lightly.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?

There already exists clear lines of professional accountability through Professional Codes. This could be strengthened further by aligning standards used across health and social care to support integration and co-operation. Resources and training to support leaders in their accountability will be key rather than legislative measures. The Health and Care standards are clear in their requirements and expectations.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
We need to continue to build on the existing systems, publishing data on staffing levels which supports and underpins quality. Escalation and whistle blowing where there are concerns are also supported through policy. We need to apply tools which already exist, which evidence the quality and safety of care.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
Quality of care is dependent upon attitude, behaviours and cultures of Individuals and organisations. Prudent healthcare is integral to improving health and health services. Legislation around co-production with partners and patient/ service users may help strengthen accountability. Introducing and mandating Quality Impact Assessments to be used by all agencies providing health and social care would support consistency.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
It must be acknowledged that there exists a duty of quality in the NHS. The duty of quality is detailed within the Chief Executive’s accountability letter, the Chair’s appointment letter and is detailed within professional accountabilities of the Executive Medical Director and Executive Nurse. To include additional ‘responsible individual’ would result in unnecessary complexity rather than clarity.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
The use of this in England and specifically it impact on improving care and governance should be considered before making a decision to follow this in Wales. There are merits from a public facing perspective in this test, however there would need to be sufficient gain above and beyond the existing arrangements (professional codes, contracts, performance review mechanisms etc.).

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
It is not felt that we need to strengthen existing legislation further to promote quality through the NHS planning framework as this already makes adequate provision to to do so. Perhaps what is more important is how this is embedded in practice at a local level. The development and integration of services has to be progressed through co-production between service users, service providers and the wider population so that they are configured to meet local need. We need to ensure support to local GP clusters to focus and tackle and address openly quality of care in primary and community settings in addition to work to improve quality and outcomes within hospital care settings. Current legislation and specifically NHS planning Framework makes this clear and provides adequate provision to promote quality.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
It would be helpful to have an integrated set of standards across health and social care, plus joined up regulatory and monitoring arrangements. This is particularly important given the changes in legislation, such as the Social Services and Well-being Act 2014. Furthermore, the Health and Care Standards have just been refreshed and these need time to be embedded and to be reviewed. The new Health and Care Standards seek to provide certainty for both staff and citizens and provide a key frame through which judgements can be made about the quality of services. They allow citizens to know what they should expect and promote consistency of approach.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
A common set of standards would be supported recognizing that this has implications for the role and function of regulators. The standards should be further developed to ensure full integration of Social Services and the Third Sector, as well as independent care sector.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Peer review and accreditation systems are important aspects of providing external assurance to the public. There is already a plethora of such systems across professions and services. Whilst a more consistent approach would be helpful, this is not an area that would benefit from legislative change.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Appropriate access to clinical supervision should be integral to lifelong learning for all healthcare professionals. This in turn, will lead to improvements in recruitment and retention. Legislation is not the way to enable Clinical supervision however and building on the principles and process of revalidation is key.

17. What arrangements should be put in place for self-employed health professional registrants?
There are a number of regulatory gaps which could be addressed through the requirements for clinical supervision, mandatory training and revalidation.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
The proposal is therefore supported – recognising that there will be training and culture implications that would need to be addressed and the relevant professional bodies would also have to recognise such a duty in their own standards. A national standard/policy would ensure uniformity across NHS Wales. Promptly identifying where things go wrong and providing explanation, support, apology and other forms of redress for the patient and their family should be encouraged. Doing so quickly and efficiently will increase the confidence of the public in their NHS and professionals whilst also potentially seeking to reduce expenditure on legal costs. Thisshould provide a better experience for the patient and their family. Professional standards across all clinical specialties should generally be sufficient to ensure that there is a tacit duty of candour but clearly failings

such as those covered in the Francis Report show that this is often not the case. This should be supported by safe havens for whistle blowers which will support staff to be open and raise concerns. Essentially however, giving greater focus as to the culture and level of staff engagement in organisations as a proven means to improving patient outcomes and experience as well as employee satisfaction and experience. Staff engagement indictors could be considered as a key national outcome prioritised by Welsh Government as a demonstrable, low cost and practical means of understanding cultures.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Transparency will be greatly enhanced by the provision of real time information as many of the systems in healthcare take an extended period of time to produce meaningful data currently. To ensure transparency is the norm, performance and data systems need to be supported, however, it is unclear how legislation in isolation would improve transparency as this would need to be underpinned by cultural change. The performance management framework for Wales could be used to drive improvement in terms of transparency and openness.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
The principle that there should be integration across Health and Social Services is supported and aligns with other legislation. The complaints process should be an integrated process which ensures that the same principles and processes are followed. Health Boards already work across health boundaries and the current system allows for organisations to agree the lead organisation and respond to individual complainants. This could be strengthened either by legislation or requirement for a formal agreement to be in place There is an opportunity as part of the review of PTR that this also includes primary and social care. It is felt important to ensure that PTR applies to all public bodies and healthcare providers. Legislation would make the position clear in terms of a shared duty to manage complaints appropriately rather than the current ad hoc arrangements.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
The Data Protection Act provides a legal framework for allowing organisations to share information appropriately taking into consideration the privacy and confidentiality of individuals. However, it is often through a lack of understanding by an organisation or staff through a lack of training that the legislation is used to prevent the sharing. There is general ignorance about the common law position and the Human Rights Framework which in fact do allow for the dharing og information in certain circumstances, Due to a lack of published national Information Governance Standards in Wales, there is often a lack of trust between organisations to ensure that once their information has been shared, similar systems, processes and security measures will be applied to that information to help prevent damage to the organisations reputation or application of a financial penalty. Organisations need to adopt a culture of sharing information where the benefit is improved care for an individual rather than using consent and other issues as a barrier. It is not felt that further legislation is required but that a different culture needs to be adopted by organisations in an integrated service environment.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
It is vital that our patients have confidence in our ability to protect their privacy, comply with the law and safeguard their personal health data. Information should always be anonymised as far as possible Data holders within the health service must ensure that they obtain information about their patients properly keep it secure and handle it in accordance with the well-established rules of medical confidentiality and the provisions of the Data Protection Act 1998. All patient-identifiable information, relating to living or in some circumstances deceased patients is confidential and must be treated in accordance with the Caldicott Principles. Research which makes use of existing patient identifiable data (and stored samples) must comply with NHS Caldicott Guidelines and have the permission of the health boards' Caldicott Guardian. It is also suggested that a "national research governance framework" is adopted to ensure consistent safeguards are in place to protect patient information, ensure the quality of

information and appropriate consent models are followed. This ois a task for local Research Ethics Committees. Researchers should always be able to justify and provide risk assessments for requiring identifiable information. However, where possible anonymised information should always be a preferred option.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
The role of HIW needs to be reviewed in the light of the move towards integrated health and social care provision. It is strongly suggested that CSSIW and HIW should be integrated to form a single body that becomes independent of Government. It is essential in light of greater focus on 'One Public Service for Wales' that strong collective approaches to regulation and inspection are adopted to include Estyn and HMIC for example, testing regularly the effectiveness of partnership working as a means to promote health and wellbeing and protect vulnerable people. The close relationship between WAO and HIW is commended and should be built upon in future arrangements. The way in which inspection and regulation work requires further review. The complexity of health and social care provision requires a new approach and methodology that is more expansive and reflects the range of service provided. Specific emphasis should be on assessing against 'well governed' organisation frameworks with learning from Scotland and England in this regard.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
There is support for HIW to have a strong independent presence and be integrated with CSSIW. There remains little reason in our view to continue with 2 system regulators for a reasonably small population of 3 million, in a context of health and social care integration.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
We need one integrated regulatory body working within one framework and requires a much stringer response then 'joint working'. It needs legislative change with common standards and common framework.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
As above, consistency in standards and the regulatory framework around holding to account on those standards and an ability to provide clear public and organisational understanding of those.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The role of the CHC is an important one which is strongly supported. It is considered that the greatest element of benefit is harnessing the patient voice to influence service improvement for the population. This should focus on the individual voice (complaints/experience advocacy) as well as wider working groups/focus groups/engagement groups and of course the statutory engagement and public consultation on service change. The CHC should not take a lead role in our view on 'inspections' of health services, but to work as part of the joint approach with CSSIW/HIW as lay reviewers/inspectors to enable a more joined up approach.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
There are two potential options. The first is to amend the current model slightly and retain local CHCs as statutory organisations or to create a CHC for Wales that deploys teams to local areas but with the statutory powers being vested in a single organisation. Any changes would need to address some of the current issues and criticisms in terms of lack of integration between Health and Social Care at a grass roots level. In any restructuring, given the economic backdrop, care needs to be taken not to add further complexity and duplication to the system, but to use this as an opportunity to streamline. The membership of the CHC is drawn largely from lay people and this perspective is important when considering whether service change is for the benefit of the wider population. The CHC role in terms of scrutiny of healthcare and their links to HIW needs to be addressed. Currently, both organisations work largely independently and revising legislation to make the CHC an agent of HIW merits

consideration.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
It would be beneficial for Health Boards to be allowed to borrow, although we understand the risks involved and this would require clear policies to operate across NHS Wales. Some examples of the benefits of allowing borrowing would include: Borrowing will give much greater local flexibility; Health Boards could invest in accelerating capital investments, where these demonstrate a clear revenue saving and payback; It will instil a discipline of longer term planning and assessing business cases on a more commercial footing, securing an even greater focus on due diligence, even in areas where borrowing is not required; It will clarify current arrangements surrounding finance leases and PFI arrangements where Health Boards do, in effect, borrow to fund future developments. Prudential Borrowing codes as used by Monitor and other public sector organisations should be given careful consideration. Careful controls would need to be central to the NHS Wales policy framework in this area to ensure that Health Boards do not become exposed to over borrowing. System changes may also be required. For instance, there may be a need to review the process of capital charges and cash allocations to Health Boards. Within a commercial context, depreciation revenue charges support delivering operational cash surpluses to repay any loans. This would be challenging within the current arrangements.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
We agree with the findings of the Green Paper that producing separate NHS Wales Trust and Health Board summarised accounts provide very little value and do not reflect the current state of the NHS landscape. A summarised NHS Wales account as a whole will provide a far clearer understanding to the public of the activities of the NHS. Within the Health Board, providing summarised accounts are important in terms of demonstrating transparency and accountability to the general public, although the timing of publication (September) detract from this value.

There may be an argument that the timetable for Annual Reports and Annual General Meetings should be shortened to create more timely reporting. Crucially, any change in reporting should encourage more meaningful and understandable analysis. There should also be consideration given to the Annual Report as a whole, to ensure that it can become a document which is understandable and accessible by the general public.

32. 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?
Yes, as outlined above.

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
There should be an equivalent statutory planning duty for NHS trusts as we have for health boards. This would ensure the seamless planning of activities to improve health and for meeting patients' needs across the pathways of care.

34. 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?
It is not felt necessary to review the 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. Public Service Boards will provide leadership and alignment of planning duties to meet our shared aims with our partners.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
In order to strengthen leadership, governance and partnerships the need for clear accountabilities is required, with a route of escalation if concerns arise built on sound principles with clear expectations and outcomes. There is already in place an escalation and intervention process in place for NHS Wales which means that there are clear consequences of how HB's or Trusts are moved into a position of escalation and that this is applied systematically

and consistently.

In order to strengthen the leadership and governance of organisations, clear principles of behaviours over and above the Nolan principles need to be further developed so that they truly reflect the principles of NHS Wales together with what is expected of all public servants. There also needs to be a greater focus on career development and succession planning.

If co-production is truly the way forward then working in partnership with the population is paramount recognising that sometimes this may cut across the views of clinical experts. HB and Trusts would need the latitude to design and co-produce services that truly did meet the populations health needs but also improve population outcomes.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?

The current Health Boards have been in place since 2009 and have faced considerable quality and safety issues, as well as financial and professional challenges.

There is a view that the current size and configuration of Health Board membership inhibits the quality of the Board's deliberations and decision making. Whilst a large diverse membership which includes a broad range of perspectives can be helpful, a narrower membership would provide a more streamlined focus so that the Board could adapt to more strategic decision making. The Commission on Public Service Governance and Delivery commented that Health Boards must be accountable and responsive, accessible to their local populations and provide excellent leadership and direction to their senior executives (and by extension the rest of the workforce) and hold them to account. The need to separate clearly those who make decisions and those who scrutinise them means that the role of a Health Board's independent members is a particularly challenging one.

The Williams Review suggested that the overall size of the Health Boards

should be reduced, however, this does not fit with the recommendation in the NHS Green Paper which suggests appointing appropriate Cabinet Members from each of the new Local Authorities as Independent Members. This is something that Powys would welcome given the direction of travel in respect of integration. Public Service Boards offer a real opportunity for innovation and placing local Directors of Public Health at the centre of these arrangements which could lead to significant and positive change. The relationship between Public Health Wales and Directors of Public Health is incredibly important in managing and mitigating risk and driving innovation and change, this relationship would need to be built on rather than diminished. There should also be other opportunities to look at a broad spectrum of joint / dual roles across a range of executive portfolios. Consideration also needs to be given to how a trade union and staff perspective is brought to the board if the current board composition changes. There is a value in having a TU member from the employing organisation at the board – a different internal perspective to that of the Executives. The advantage of having a full board member is that the individual will have been through the full public appointments process and should therefore have the necessary skills and abilities to undertake the role; however there are inevitable tensions when the TU view may differ from that of the board. The alternative is to revert to the concept of Trade Union representatives at Trust Boards that was previously in place, this allows a TU voice at the board but the reps are not part of the board and therefore not bound by corporate decisions. These reps would usually have been nominated/elected by the local staff side but would not have undergone a formal selection process. A third alternative is to have TU representation from full time officers/TUC however, while the trade union expertise would still be present the local knowledge would be lost. Having local knowledge of the organisation is something that is valued and therefore needs to be built into the final determination. Support should be extended to developing a wide range of potential opportunities for people to develop skills and experience in order to apply for Board membership in the future.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed? 42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
N/A to PTHB

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
The original role of the Board Secretary for NHS organisations was introduced in 2009 when the role was ill understood. Since that time, the variance of the role, including responsibilities has varied to a greater or lesser extent across NHS Wales organisations. The proposal to provide greater statutory clarity is welcomed, ensuring the role is perceived at an appropriately senior level and to effectively challenge and advise Directors (Executive and Independent) at Board level as necessary. The role of the Board Secretary would benefit from being stipulated in the Standing Orders with no deviation from the statutory requirements to protect the independence of the role and eliminate opportunity for conflicts of interest to arise. It is essential that operational management is not allowed to encroach on the stipulated accountabilities of the Board Secretary to ensure potential conflicts are avoided as identified recently by the Public Accounts Committee on review of the Board Secretary role and accountabilities at Betsi Cadwaladr Health Board.

45. How could potential conflicts of interest for the board secretary be managed?
There would not be conflicts of interest if the role is clear, professionally discrete, with no broader operational management responsibilities. The importance and status of the role may also be strengthened if there was a professional head within Welsh Government. Making the role accountable to the Chairman of the Board and providing the role with powers to challenge the Board and CEO team if required.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
Yes. There is a disconnect between national groups / committees and local decision making. This includes the lack of focus for health professional forums as advisory committees of Health Boards which have limited value and impact currently.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
This has to relate to the nature and speed of the advice required. Advice from speciality bodies in Wales could be accessed through a reformed clinical network system given that networks engage multi-professional groups

service users and members of the third sector. The advice should also be gleaned from other Professional Bodies including Royal Colleges, and National bodies such as NICE. Legislation could ensure appropriate consultation with advisory structures/networks.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
The appropriateness or otherwise of existing partnership working arrangements is dependent upon the policy direction Welsh Government wish to set for pay. Currently, most of the contractual arrangements for staff are either UK agreement or are underpinned significantly be UK agreements with Welsh variations to specific aspects. If Welsh Government were to wish to pursue a Welsh Public Service contract for the NHS, Local Government, Assembly Sponsored Bodies and the Welsh Civil service, then Wales specific partnership working arrangements would be required. The development of a Welsh Public Service contract may offer benefits in respect of mobility in employment across public services, but would face challenges in terms of different terms and conditions, pension arrangements etc. It would also cause challenges in border areas – where staff may choose to work outside of Wales if pay was not comparable - and introduce a form of Regional UK pay which has previously not been supported. Whilst there are certain staff groups which are predominately sourced from local labour markets, there are others particularly in respect of medical and dental staff where the labour market is a truly international one. Whilst the terms and conditions of most NHS staff may be determined or significantly influenced by UK processes, it should be acknowledged that there are other Welsh forums which set policy and seek to address public service issues. Notably amongst these are the: Welsh Partnership Forum (NHS) which brings together Welsh Government officials, Trade Unions and NHS employers. Workforce Partnership Council (Public Services) which brings together Welsh Government Ministers, Trade Unions and Public Service employers. The architecture of workforce partnership needs to reflect the policy framework set by Welsh Government.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
The role of Shared Services in a more strategic context would require a standalone entity, which will assist in ensuring that appropriate governance systems can be enhanced. Any such governance should be strengthened through service level agreements with Health Boards to ensure that the entity is fully responsive to the needs of the service and individual clients and can demonstrate it provides value for money for all customers.

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
There is a significant agenda for NWSSP within an NHS Wales context and the service hasn't yet matured sufficiently or demonstrated enough resilience to meet its existing customer demands to extend its reach beyond the NHS to the wider public sector. There are significant risks that a wider expansion will make the service less responsive to the needs of the Health Service, which would need to be carefully managed.

WGGP157 – David H Jones – Monmouthshire County Council Public Protection
Tref / Town – N/A

General comments

I write in response to the above consultation and would wish fully endorse the submission by Welsh Head of Environmental Health on which this response is based on and to make comments regarding para 123 and the question of joint appointments in particular in relation to Directors of Public Health.

The Wales Heads of Environmental Health Group represent the professional heads of Environmental Health services of all local authorities in Wales. It aims to protect and promote public health and help address inequalities in health through the effective, efficient and consistent delivery of environmental health services.

I believe that there is significant merit in considering the establishment of joint appointments between local authorities and the NHS for Directors of Public Health.

I subscribe to the basic public health principle that local people should have a say in matters that impact upon their health and well-being and acknowledge that the concept of LHB Directors having joint accountabilities to local authorities may be one step towards addressing the issue of democratic deficit within the NHS.

Additionally and importantly I feel that such a move can help strengthen the public health perspective of local authorities. Local government has a key role in public health and protection. Indeed Local Government was originally founded to address public health issues. Environmental Health Practitioners have long been seen as the primary public health professionals within local authorities, founded over a century ago. However, as the Wales Audit Office's 2014 Report [1] "Delivering with Less" highlighted, Environmental Health Departments across Wales have experienced savage cuts. There has been significant loss of senior posts and the public health voice in local authorities has been depleted significantly, especially around the "top tables".

In the climate of austerity local authorities are having to make challenging decisions and it is vital that the public health impact of those decisions is adequately assessed and properly considered. We are concerned that such decisions are taken with insufficient regard to public health impact nor sufficient regard to other delivery options. In particular an evaluation of effectiveness of interventions, with the robustness that Public Health Specialist input can bring, may bring significant value. Such an approach is vital if Welsh Government is to deliver its ambitions set out in the Wellbeing of Future Generations Act.

I acknowledge the work of Durham University [2] in assessing the potential for joint appointment of Directors of Public Health in England. Given the implementation in England, we would wish to review the experience some 2 years on. I note also the Local Government Association's publication "Public Health Transformation twenty months on". I reflect the views of many who believe that Local Government is the right place for Public Health BUT only if its resources are adequately protected. However, it is important to acknowledge the importance of the three traditional spheres of specialist public health work – health protection, health improvement and health service quality. I believe that any proposals need to be cognisant of that.

I would suggest that an approach of (merely) joint appointments of DPH's is unlikely to deliver real value within the current structure of local authorities and LHBs in Wales because one LHB could currently have up to 6 local authorities and clearly one DPH could not effectively give time to all 6 plus their LHB! Other models are possible - including appointing consultants to each LA under a jointly appointed DPH.

To conclude. I hold the view that there is real merit in considering this proposal further but work is needed to ensure that potential benefits are realised and unintended consequences are minimised. Consideration of wider issues is also needed to ensure that public health resource (and importantly we do not mean "social care" resource) and public health considerations within local government are protected and strengthened.

I support that we would be very pleased to contribute to further discussions on this matter.

References:

1. *Delivering with Less – the Impact on Environmental Health Services and Citizens*. Wales Audit Office Cardiff, 2014.
2. *Perspectives on Joint Director of Public Health Appointments. Durham University*. IDEA, London, 2008.
3. *Public Health Transformation twenty months on: adding value to tackle local health need*s. Local Government Association, London, 2015.

Response to specific questions

No response to specific questions.

WGGP158– Dr Mark Temple
Tref / Town – N/A
Sefydliad / Organisation – Public Health Wales

General comments

Sorry for being late but I realised on Friday as I read this paper **doi:10.1186/s12885-015-1765-0** entitled "*The adherence paradox: guideline deviations contribute to the increased 5-year survival of breast cancer patients"*

Rather questions the correctness of many of the assumptions underlying the approach in the green paper.

Indeed it appears that the continued centralisation and ensuring conformity to protocols may be harmful to patients. This should not surprise us as data from the US has shown that enforcing non compliance saves 5% of lives, and 10% of costs whilst almost doubling productivity.

It seems this simple change in approach to supporting front line works tailor treatment to patient specific needs not merely saves costs but also makes recruitment easier and improves outcome.

Another feature that the Green paper mistakenly assumes is that centralising services in bigger hospitals delivers better outcomes. Again the evidence is against this but it is so often repeated that it is accepted as true. Small hospitals of about 300 beds maximise effectiveness and efficiency. They are also more resilient in times of crisis; reduce health care infection rates……. Etc.

Perhaps moving to a network of smaller hospitals would be less costly to build and less expensive to run.

Since a recent paper showed that the introduction of managers had effect on population mortality, has the time come to consider removing this tier from the NHS? There is no evidence that it achieves any useful purpose.

Response to specific questions

No response to specific questions.

WGGP159 – Peter Welsh – Cardiff and Vale University Health Board

Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
• **Yes** - This could be undertaken via Wellbeing of Future Generations Act and Public Service Boards as well as the new duties in the Social Services and Wellbeing Act. These Acts will strengthen local collaboration / planning • Legislation is not the answer to everything-existing legislation like the Equality Act is not completely adhered to • There needs to be read across between existing legislation and a combined approach across the Well-Being of Future Generations and the Social Services and Well-Being Act-real risk that a third strand of legislation will be different again • Need to strengthen learning and sharing • How can you demonstrate shift? • Mental Health Measure is an example of legislative simplicity and clarity that can drive up standards. • Need strong policy levers • Frail and elderly needs assessment translates to service provision. We need to tighten the needs assessment to influence of planning not just epidemiological needs assessment • Public Health Bill also forms part of legislative picture • Real risk use legislation to tighten accountability

2. If so, what changes should be given priority?
• Measures • Genuine shift to primary care. • Overarching strategy and alignment with integrated plans. • Hierarchy of plans/strategies. • Single needs assessment between partners

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
• Example of the Mental Health Measure, could it be applied to primary care? • The new Acts already mentioned(Wellbeing of Future Generations and Social Services and Wellbeing Act)

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
• No-this would be difficult to legislate.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
• **No -** Should not be statutory but part of our routing work to engage. • A strategy/approved framework is needed so that we are really clear on how we are going to engage. • We can learn from what the Local Authority does-perhaps utilise its citizen panels. • Mental Health works well with a third sector organisation set up to liaise with service users. • Should we take it out into public services engagement? • Resourcing is needed to do it properly. • We use service users / carers already in developing our service plans

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
• **Yes** - In principle, a very good idea but the panel needs to be carefully constituted. • Community Health Council can comment on process but struggle with service change so should its role be solely about advocacy for citizens. • Need a quality process for how this work is done (to standards). • Not enough business for standing panel-constitute when needed. • The introduction of an expert panel for the occasions when the CHC refer issues to the Minister(if a decision cannot be reached) should be supported as this allows for a number of opinions / experts to consider the matter.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
• Not necessarily – already have many processes in place. • Legislative Framework needs to be aligned to allow behaviours and cultures to facilitate service developments • Behaviour and Culture are vital for equality • Alignment of focus on Quality to have equity within focus on Finance and RTT. • There already exists clear lines of professional accountability through Professional Codes • Legislative Framework so delivery drives on routes aligned to care pathways access organizations, good framework would facilitate commissioning. • Resources and training to support leaders in their accountability will be key rather than legislative measures. • The Health and Care standards set out requirements and expectations. • Need to strengthen national quality and improvement training.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
• Need legislative framework that closes boundaries eg; Health, Social Care and parental obs that is age blind; accountabilities should drive improvements. • Use tools and technique in existence which evidence the quality and safety of care. • Concept of citizen duty could be explained.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
• There is already individual clinicians responsibility to do this, • Framework needs support into 'night care' and be aligned to pathways across organisations! • Focus on Patient needs Pathway names rather than on 'Care' • Quality of care is dependant upon attitude, behaviours and cultures of individuals and organizations • Prudent healthcare is integral to improving health and health services.

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?
• Individual Executive Directors already have this responsibility

• Individuals are held accountable for financial position • How do corporate manslaughter rules effect within individual / multiple person's accountability?

11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
• Legislative framework needs to give Purity and Levity to Quality that is given to Financial Balance and RTT etc (Operational Performance • The principle of the introduction of a "fit and proper persons" test is supported. However, should not Directors and nurses already have as part of revalidation process.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
• Outcomes should be aligned to the three ie: Quality, Finance and Operational Performance. With an adequate framework like this planning could be organized to facilitate Commissioning and planning etc… Also need a framework that allows to flex the three Quality, Finance, Operational Performance. • We need to ensure support to local GP clusters to focus and tackle quality of care in primary and community settings in addition to work to improve quality and outcomes within hospitals, • Opportunity to integrate quality standards between Social Care and Health Care • Aspects of this are already embedded into the IMTP process.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
• **Yes** - Should be a legal requirement but as part of an overarching quality framework and linked to clinical outcome measures • Quality must have some legal standing as financial balance • External Inspectorate function needs to be standard performance indicators designed in partnership by citizens • A more robust and co-coordinating system of inspection would be welcomed. • Healthcare standards which describe minimum standards and best practice aspirations. • Revalidation needs to be standard but not included in 'standards' should be subject to robust regulations if possible.

- Standards need to be reviewed utilizing a common framework for monitoring.
- Healthcare standards could be more integrated between Health and Social Care. Similarly, This could be used for regulatory and monitoring arrangements.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
• **Yes** but dangers for resources, could greatly increase cost which could force independent sector providers out of business • Should not have separate interagency standards-require common set but should not encourage minimum standards.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
• **Yes** but could be part of a commissioning framework. • Again there is a resource implication to this and we are unsure we could cohere this in the current economic climate. • The impact of a holistic, comprehensive healthcare service / Healthcare Professional framework is not fully worked through.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
• **No** - need for legislation should be led by Statutory Registration Bodies. • Should be outcome based, as long as the healthcare professionals are competent and fit to practice then the mechanism may not be relevant. • Many healthcare professionals are not in an obligatory register or even a voluntary register but there are still mechanisms to assess compliance. • Requires continues emphasis on the individual's responsibility to ensure their own professional competencies.

17. What arrangements should be put in place for self-employed health professional registrants?
• Should be some regardless of employments status. • Potential use of NHS PADR/ C.P.D processes and access to tools for self-employed health professionals.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
• **Yes** - need this as a statutory duty (links with the Francis Report) • Need for openness, transparency and candour throughout the health system • Training requirement and change in culture • A statutory duty of Candour on NHS organizations would reflect this duty that is already in place for many health professionals.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
• Require better performance and data systems to ensure transparency • Quality needs pairing with Finance and Performance • Need set agreed behaviours which are suggested by we interact with eg ; WG, Public this is more important than legislation. • Integrate Values and Quality across all performance conversations.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
• Framework should focus on patient and gateways across organizations in order to suggest investigations**.** • Look closely at unintended consequences before new legislations. • Some good examples already in place for joint investigations Legislation could make it much cleaner in terms of a shared duty at the current time different organizations accountability arrangements e.g. Health to Welsh Government and Social Care to Local Authorities.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
• Lack of integrated I.T systems • DPA • Caldicott 2 • ID across organizations • Are we the same standards even within NHS organisation

• We can share more data-barrier can be overcome-need published national Information Governance Standards • Protective including commercial consideration to data • Organizations need to adopt a culture of sharing information where the benefit is improved care. • Family members, patient fear, healthcare officer, sharing sensitive info-duty to protect. • It is not felt that further legislation is required but that a different culture needs to be adopted by organisations in an integrated service environment However, national standards would be a benefit.

22. How can we consider breaking down any barriers?
• Same ID across organisations • Published National Standards around information governance • The use of a single electronic patient record will help to break down barriers • Up-grading to common I.T systems

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
• **Yes** - very important-but with suitable controls in place • Sensitive to new technology • The Caldicott report on the Review of Patient Identifiable Information identified weaknesses in the way parts of the NHS handled confidential patient identifiable data. • Research which makes use of existing patient identifiable data must comply with NHS Calditcott Guidelines and have the permission of the health boards Caldicott Guardian • Researchers should always be able to justify and provide risk assessments for requiring identifiable information.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
• Needs to be separate from WG is supported • Needs to be big hitting-far more visible and powerful-have a Chief Inspector of Hospitals? • Overall public services inspectorate with different branches of expertise. • Ombudsman has a role regarding process/quality standards. • Should we distance the Minister from operational/technical decisions and put something in the middle, the inspectorate? So that it puts organisations

into special measures? Opportunity to change the landscape.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
• **No -** H.I.W does not need full statutory independence to be more effective.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
• A merger of the two to create a single inspectorate would be best and less complex for patients and the public.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
• As long as expertise is preserved then there is no risk. • We encourage integration of service and this should be no different

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
• **Yes -** Support this view. • Change language from "inspections" to "visiting rights". • Another vehicle to hear the patient's voice-could be linked to the Inspectorate-a lay part of it? • Clarity of its role is needed and it shouldn't be focused on service change-rather on representing the patient voice, enabling our conversations with the public and helping patients navigate the system. • Local Government scrutiny function could be used more strongly for social care. • Support the need to retrain CHC's as a means of having service user views.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
• There should be a strong, effective national body to oversee and ensure consistent approaches and standards • Potential strengthening role of CHC via Local Authority.-strengthen health and social care scrutiny.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
• **Yes -** The power to borrow should be granted to Health Boards with appropriate checks and balances incorporated into primary legislation to ensure effective governance framework to protect the public purse (recovering income would need to incl assests of capital) • Local flexibility improves working capital facility • Innovation and efficiency generation • May promote culture-shift • If borrowing power is granted-will need to change capital charging regime • Currently not a having a value for capital is unhelpful • Need to encourage a 'real world' approach to planning and capital investment. • Limited control over income (ie less opportunity to income generate to offset risks of covering costs of borrowing) However, this is a risk rather than a complete barrier. • The opportunities to enter into 3rd party partnership arrangements / commercial arrangements are improvement to support investment in new technology (eg) which will deliver a payback.

Summarised accounts

31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant?
• **Yes** - Needs accountability to the public on how we use public monies. • Not too easy for the public to understand the accounts-too technical

32. 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?
• **Yes** - all NHS organizations should be part of summarisation • Current arrangements inconsistent and do not add value • Improve links between the Annual Report and Accounts which is understandable by the public

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
• **No** - they are providers. The responsibility for planning should remain with commissioning bodies (although they should have delivery plans to respond to commissioners requirements). • Focus should be on improving contracting arrangements.

34. 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** - we should better align the NHS 2006 Act to the 2015 and 2015 legislation to further integrate. LHB planning with public and third sector partners to ensure shared vision, objectives and integrated delivery arrangements to optimize population health. • Opportunities to improve quality and efficiency are being missed across Health Board catchment and a review of either governance and / or statutory framework to develop / implement appropriate strategic service change at a regional level – critical requirement.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
• Form should follow function • Need to explore integrated governance • Should be mandatory to have strong partnership governance in place • Greater scrutiny of current compliance with legislation • Need for clear and transparence accountabilities • Continue to re-emphasise the Nolan Principle of Public Life

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
• Health Boards are complex organizations and Board membership requires adequate Board level resources / time to ensure members fulfill their obligations and accountabilities. The skill mix and community representation is essential to being an effective Board. • Size of the Board should reflect the above and have more local decision making on the competencies of the Board. • Needs to take opportunities to strengthen the partnership presence on the Board.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
• **Yes** - to reflect the needs of the organization / community , roles and accountabilities • Form Follow Function Past history in wider community and other parties-social model of care-not replaced in way we work bigger benefits

• There needs to be flexibility to suit needs of population and what we are trying to achieve

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
• How would this work? • Concern re election of community representation response from the public e.g.: Police Commissioner not supported by all • Should use existing community network and engagement mechanisms already in place.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health) between local authorities and the NHS in the new arrangements for public services?
• **Yes** - Already do this in some areas • Potential is there with planned Local Authority reforms

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
• Re-emphasise the need to have more local 'ownership' of whose on the Board • Current regulations are too perceptive

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
• Need to be consistent with Health Board • Confusion for patients / public re Health Boards, Trusts, Executive Directors, Independent Members, etc. • Need to review Mandatory Committee with particular reference to the need to have a Health Professional Forum given the number of Clinical Networks already in existence.

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?
• Consistency

Board secretary role

43. Does the role of the board secretary need greater statutory clarity?
• **Yes** - should be about independency of Board Secretary-not operational post and Responsibility for the overall governance of the organization and not delivery of services. • Legislation could make it tighter on what it is and give it statutory protection to stop the role being dilated. • Title 'Board Secretary' person who 'takes the minutes' suggest renaming Director of Governance or Director of Corporate Administration operating on equal level to Executive Director as a full member of the Executive Team. • There is support for greater statutory clarity for the role of the Board Secretary. • In an NHS environment the role would need extensive experience of NHS services as well as corporate and governance experience

44. If so, what aspects of the role should be additionally set out in law?
• Independent • Not operational • Standard role profile-reports to Chief Executive and accountable to the Chair should be the Chair only. Should report and be accountable to the Chair.

45. How could potential conflicts of interest for the board secretary be managed?
• Making the role reporting and accountable to the Chairman of the Board and providing the role with powers to challenge the Board and CEO team if required, as currently available for Monitoring officers in Local Government.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
• **No** - current arrangements are working well • Any intervention should be evidence based.

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
• Legislation should be based on the evidence

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
• **Yes** - In relation to Partnership Governance • Emphasis Health and Social Care partnership working • Work across organizations of accountability to enable workforce to work differently • Structures need to promote partnership working. • Opportunity to review with public sector services greater integration

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
• Greater clarity on governance arrangements for hosted and joint shared services

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
• Creates delays in timescales – needs to work more efficiently now. • Would need 1 IT system properly developed , and brought back in house, before The All Wales CE Group to consider current effectiveness and future development

WGGP160 – Dr Alison Strode
Tref / Town – N/A
Sefydliad / Organisation – Welsh Government

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
NHS Wigs Delivery in Health Boards Following a task and finish group including service users to develop an equitable solution across Wales to delivering NHS Wigs the main findings highlighted that to deliver a solution that patients are happy with would require a change in primary legislation to allow Health Boards to implement a voucher or equivalent in the provision of Wig services. The NHS Quality, Governance and Functions legislation in the new Assembly term would seem the obvious mechanism to address the legal issues surrounding wig provision. Therefore it is felt that this would provide the most effective solution to continuing the service the patients are happy with, make it equitable across Wales and provide a completed policy for Shared Services tendering solution.

2. If so, what changes should be given priority?
This change should be given priority.

Chapter 3: Quality in Practice

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
In my view legislation is not needed to deliver this clinical supervision. This should be the responsibility of the clinician to make sure they undertake this and health boards should have this as part of their culture.

17. What arrangements should be put in place for self-employed health professional registrants?

Self employed registrants should take responsibility for undertaking peer supervision and should work with their professional association to be able to access trained clinical supervisors.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
NHS Boards should not be so large as to be unwieldy, but must be large enough to provide the balance of skills and experience that is appropriate for the organisation. Health boards have taken some time to develop their cultures post reorganisation and therefore major changes at board level could bring unnecessary further disruption. Evidence from Mid Staffs etc has suggested that Executive Boards need to engage staff with a compelling vision that inspires them to work towards a common goal (Stewart 2014). Allied Health Professions make up a significant proportion of health boards staff and therefore it is important that executive boards maintain their clinical focus through representation of appropriately qualified members with a clinical background. **References.** Stewart, K. (2014) How can Boards ensure a positive organisational culture, London: The Kings Fund.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Prudent healthcare should be a priority for health boards and therefore any discretion should reflect this policy direction. The development of a role for an Executive Director of Therapies and Health science (DoTHS) has been recognised as pioneering across the UK and further in such countries as in Australia and New Zealand. Therapies and Health scientists are intrinsic to providing solutions to the challenges facing the NHS in Wales and it is important that this role is maintained. The uniqueness of the DoTHS is that as Executive Director they are ideally placed to : 1) Provide a **Collaborative Leadership style to the Board.** Representing more than 60 professions across the Therapy and Healthcare Sciences they represent diverse professional practice covering preventative, diagnostic and therapeutic services as well as maintaining the standards of regulated and non-regulated professions covering the third largest group of professional staff in the NHS. They ensure a synergistic work environment, where multidisciplinary groups are encouraged to work together toward the implementation of effective practices and processes. 2) **Promote Strategic decision-making** is an integral part of the board's role

in formulating strategy and clinical Leadership is necessary for the delivery of excellent outcomes for patients and populations. The skills and knowledge that the DoTHS bring to the Executive role through collaborative clinical leadership is essential in understanding the different professional cultures, facilitating integration and interdependency among the multiple stakeholders so that working practices can achieve outcomes that are greater than the sum of individual efforts.

3) Support the change in culture needed through **prudent healthcare.** The culture of the NHS is changing to promote a much more socially directed model of care that is integrated and also able to easily cross sector and cultural boundaries. The contribution of Therapists and Healthcare Scientists is going to be key in realising this vision. Staff working to the top end of their competences have increasingly been taking on clinical practice previously carried out by medical trained staff and Boards need to be clear about accountability for maintaining standards of care. The DoTHS provides the assurance that the systems of control are robust and reliable for the multiple professions that make up the Therapists and Healthcare Scientists that cannot be readily provided by either a doctor or nurse as the registration and professional practice requirements are quite different.
4) **Foster a strong and healthy organisational culture.** Boards are leading NHS organisations in an enormously demanding environment. Evidence supports the critical role that the Board plays in shaping and exemplifying an organisational culture that is open, accountable and compassionate, puts patients first and hears, supports and nurtures all staff (NHS Leadership 2013). It is important for Boards to develop a good understanding of the current values, behaviours and attitudes operating within the organisation, and to work with the staff to shape the desired values, behaviours and attitudes. The importance of Board visibility in the organisation has long been recognised, a more interactive process allows board members, staff and users to shape organisational values and culture through direct engagement. The Executive DoTHS role brings a clinical mindset to the Board that is creative, analytical and holistic. The need for the role to be a member of the HCPC regulated professions provide credibility with Therapists and Healthcare Scientists, having previously held clinical roles provides integrity and ability in interpreting the complexity that surrounds the diverse professions to support the development of the organisational shared vision and provide an authentic professional view of the Therapies and Health Scientists to the Board.
5) **Encourage innovation.** Creating an organizational climate where others apply innovative thinking to solve problems and develop new services facilitates a culture of innovation

References.

NHS Leadership Academy (2013) The Healthy NHS Board 2013 Principles for Good Governance.

39. Local government reform is underway; should there be a statutory provision for joint appointments (for example directors of public health)

between local authorities and the NHS in the new arrangements for public services?
Agree with this proposition

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
NHS Trusts should have an executive role similar to the Health boards that represents the non- medical /non- nursing healthcare professional workforce

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
It is my belief the statutory status of the advisory committees should not be changed. The Welsh Therapies Advisory committee has been a very productive multidisciplinary committee over the four years I have been the sponsor and has provided a conduit for information exchange regarding local, national and international developments pertaining to the Allied health professions/ therapies workforce and clinical services. This has included promotion of quality and consistency in evidence based practice, quality improvement and clinical governance for the 10 professions it covers. It has also assisted with the creation of strong and clear strategic directions for effective and co-ordinated Therapies clinical services through looking at, where appropriate All Wales approaches. It has supported effective collaboration of multiple professions represented and provided intelligence on: innovative service delivery approaches; the use of new and emerging technologies; developments in evidence based practice; education; training; clinical research and professional development activities.

WGGP161 – Paul Dunning – Welsh Therapies Advisory committee
Tref / Town – N/A

General comments

Response to specific questions

Chapter 3: Quality in Practice

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
We believe the use of legislation to undertake clinical supervision for all health professions in the NHS is unwarranted. It should be part of good clinical practice, clinical governance and part of Health Board culture.

17. What arrangements should be put in place for self-employed health professional registrants?
It would be up to self employed registrants to make sure they maintain up to date skills and knowledge as required to maintain their professional registration.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
NHS Boards must be large enough to provide the balance of skills and experience that is appropriate for the organisation therefore we believe that the current size and configuration does that already. The current approach is now well embedded and does not need to be reformed. A better approach would be Board member development to reflect the changing health and social services landscape

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
We would want to promote the importance of the Director of Therapies and Health Science (DoTHS) role as they represent more than 60 professions across the Therapy and Healthcare Sciences. They bring to the Executive Board knowledge and experience of diverse professional practice covering

preventative, diagnostic and therapeutic services as well as maintaining the standards of regulated and non-regulated professions covering the third largest group of professional staff in the NHS.

They ensure a synergistic work environment, where multidisciplinary groups are encouraged to work together toward the implementation of effective practices and processes.The skills and knowledge that the DoTHS bring to the Executive role through collaborative clinical leadership is essential in understanding the different professional cultures, facilitating integration and interdependency among the multiple stakeholders so that working practices can achieve outcomes that are greater than the sum of individual efforts. The contribution of Therapists and Healthcare Scientists is going to be key in realising the prudent healthcare vision where staff working to the top end of their competences will increasingly be taking on clinical practice previously carried out by medical trained staff. Health Boards will need to be clear about accountability for maintaining standards of care. The DoTHS provides the assurance that the systems of control are robust and reliable for the multiple professions that make up the Therapists and Healthcare Scientists that cannot be readily provided by either a doctor or nurse as the registration and professional practice requirements are quite different.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
It is our belief that the statutory status of the advisory committee should not be changed. The Welsh Therapies Advisory Committee represents 9 professions regulated by the Health & Care Professions Council (HCPC). This gives the opportunity for each profession to be equally represented and for multi professional debate to be held before advice is passed as a single agreed piece of advice. A statutory committee offers two key benefits which may be lost if their statutory status was removed. First, as a statutory committee staff are able to secure time from work to provide advice. If the statutory status is lost there will be greater difficulty in securing the release of staff to attend. Second, because the committee meet regularly they are already aware of policy and are able to both act more quickly and to offer advice without waiting for someone to think to ask them. WTAC provides: ▪ Advice to the First Minister and the Welsh Minister for Health and Social Services on general professional matters relating to health services in Wales; ▪ Receive for comment and advice, documents or issues referred to it by the Assembly; ▪ Advice on matters related to the education and training of staff in the provision of those services. ▪ Act as a conduit for information exchange regarding local, national and international developments pertaining to the Therapies and Health Science workforce and clinical

	services, including evidence based practice, quality improvement and clinical governance. ▪ Promotes quality and consistency in the way that common issues pertaining to the Therapies and Health Science workforce are addressed ▪ Assists with the creation of strong and clear strategic directions for effective and co-ordinated Therapies clinical services. ▪ Supports effective collaboration of multiple professions represented by the committee ▪ Provides intelligence on innovative service delivery approaches ▪ Provides advice on the use of new and emerging technologies ▪ Provides advice on developments in evidence based practice, education, training, clinical research and professional development activities.

WGGP162 – Dr Edmunds
Tref / Town – Pencoed
Sefydliad / Organisation – N/A

General comments

As a qualified nurse and GP, I am very concerned about the field of aesthetic medicine after receiving training in Botox, fillers, chemical peels, PDO threads and Cog lifts and looking further into aesthetic medical training.

My aim was to find a course which focused on practical experience and not try to rush the theory and practice in one day. I thought that I had found somebody who had good credentials and was based locally. The trainer was a qualified nurse who worked in the pharmacology industry selling Botox and fillers. She had trained some of the doctors in my practice and worked in an exclusive clinic. However, the training I actually received was very concerning and after investigating this area of medicine my concerns were raised even further.

1. **MEDICAL ASTHETICS / ASTHETIC MEDICINE**

The name already implies to a lay person that anyone performing aesthetic medicine are medical trained, this is not the case. Anyone can call themselves a medical practioner just after a few hours of training. I found that one could undertake a botox & fillers course in a morning, inject a friend/ colleague without really being monitored and then be judged to be qualified. The worrying thing is that there are many such training programmes in existence, such as cosmetic laser treatments, chemical peels, etc., all of which can cause significant trauma and injury.

2. **NON SURGICAL FACE LIFT**

Again the name implies that there is no surgical element to the procedure. However, in theory the technique is extremely invasive. In this procedure the patient is marked up, then topical anaesthetic is applied to the skin. Local anaesthetic is then injected into the face. Then an approximately 6inch needle containing a barbed thread is inserted into the skin and pushed through ligaments. This is repeated again with more threads. The needle is removed and the threads are pulled. Similar procedure may be carried out on other parts of the body, for example, leg lift, neck lift.
Again the most concerning part of this in my experience is that anyone can undertake and carry out this procedure just after one days training, without having their anatomical knowledge examined. The trainee may only have performed the procedure once with little monitoring, and can then gain a certificate to show that they are qualified and that they can train others. A similar procedure can also be used to carry out a neck lift, arm, leg lift etc.

As way of comparison, in order to remove a small superficial skin lesion a qualified medical practitioner has to pass a minor surgical skills course before they can do anything. They also have to retake the minor surgical course after 3 years to re-assess their skills.

3. **TRAINING**

I believe that in order to mitigate against the practices I have observed I would suggest the following recommendations should be considered:-

a. All procedures that could cause potential bodily harm or danger to health should be regulated by an appropriate regulating authority.
b. A trainer should have appropriate qualifications prior to training others. They should also be assessed regularly.
c. Attendees should prove that they have appropriate medical training
d. Trainers should not assume that attendees with medical training possess in depth knowledge of anatomy and physiology. I suspect that in my experience this was skipped because the trainer did not have this knowledge herself

4. **SAFE ENVIRONMENT**

Since undertaking training in aesthetic medicine I have found places offering aesthetic procedures popping up everywhere, ie hairdressers, in your home. The trainer who taught me non-surgical face lifts and body lifts was carrying out the procedure in the back of the hair salon and in her front living room. This is extremely concerning especially as invasive surgical procedures are being carried out in a non-surgical environment.
All procedures should be a performed in a safe environment. This should be inspected by the appropriate regulatory body. In Wales, I had assumed this would be HIW (Health Inspectorate Wales), but was informed this was not in there remit and that there is no law against anybody carrying out cosmetic procedures in their home. I found this quite shocking..

5. **ANAPHYLAXIS**

Anybody injecting a foreign substance into someone or performing an invasive procedure should be able to cope with a medical emergency that may arise. The aesthetic medical practitioner should have a basic life support certificate. They should also have an action plan if anything goes wrong.
The locations that I undertook my training had no basic emergency equipment, the trainer did not know what to do if the patient suffered from anaphylaxis and she had no plan if anything went wrong.

6. **DATA PROTECTION**

The medical aesthetic practitioner should take the patients details and a full history. This information should be stored appropriately to comply with date protection regulations.

9. **PRESCRIBING**

In my experience the trainer was a qualified nurse who had worked in the business for 10 years. The equipment that she was using was sterile, however, she certainly did not use aseptic technique but covered this by giving antibiotics prescribe by a remote prescriber whom had not seen the patient. Unlicensed fillers were also used.

I feel that patients should not have medication prescribed to them by remote prescribing. Patients should be seen by the person prescribing the medication and a full medical history should be taken. They should have an understanding of the patient's medical conditions and any medication that the patient is taking.
Medication should only be obtained from a certified pharmacist and prescribed by a licenced practitioner.

7. **REGULATION**

Aesthetic medicine is a rapidly growing area. However, it is totally unregulated.

It is very appealing to business, as there is little training, and the profit margins are very high (especially when using unlicensed products). Patients undergoing a procedure are often having procedures carried out due to insecurities. They may not realise that the person performing the treatment may have little experience or training. The patient may often sign away any possibility of recourse by completing a consent form.

GP's undertaking any surgical procedures, surgeons and tattooist, have to be up-dated and are thoroughly regulated.

a. Aesthetic medicine should have a regulatory body, like the GMC and NMC.

b. Any medical aesthetic practitioner should have yearly appraisal and show that they are keeping up to date. They should be revalidated like any other medical practitioner.

10. CHECKING QUALIFICATIONS

In my experience I found it very difficult to check my trainers' qualifications. Although she informed me that she was a nurse I could not check easily this, nor if she was a certified prescriber, as had she claimed, without her NMC number.
I contacted for NMC several times but I even tried to explain why I needed the information and they still refused to let me have any information about my trainer.
Any lay person should be able to check the qualifications of the person carrying out the aesthetic procedures. If the person performing the medical aesthetics had to show a certificate to practice which had their unique number

it would be easier for clients to check the practitioners' qualification and legitimacy prior to having any treatment.

As a doctor I have to undergo extensive training, and ensure that I must do no harm. It concerns me greatly that a person can inject substances in someone with little training. More alarming is the that they can put 10cm needles with threads into the deep tissues of somebody's face, neck and body with little training or knowledge of anatomy.

I do not practice aesthetic medicine even though I was issued 5 certificates stating that I was trained in various aesthetic procedures as I still do not feel that I am qualified enough to perform such procedures. It is concerning that these practices are unregulated, and there seems to be no official governing body to oversee the quality of training and validation of trainers.

I think this should be addressed as a matter of urgency before people are seriously harmed. Thank you for your time on the matter and if you should require any further detail on any point please let me know.

Response to specific questions

N/A

WGGP163 – Warren Tolley – Welsh Dental Committee
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
Better communication between Health and social services would facilitate care of the patient. Social services would need to act in a timely fashion and respond to the recommendations of the health care professional. Ensuring that as much care as possible in done locally will help peoples well being. Patients are often happy to travel to one off specialist treatment in distant centres of excellence, but all too often patients are kept unnecessarily in hospital due to lack of social care.

2. If so, what changes should be given priority?
Ensuring that clinicians are given the authority to ensure that the patients needs come first rather than being delayed by bureaucratic paper work.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
Reduction of central control.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
Legislative powers may help, equally government directives with financial packages also seem effective

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
Prudent health care requires the balancing of both clinical and financial issues. Both should have equal importance

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
The clinical leaders should have the final decision on clinical governance. If the decision is over ruled on financial grounds there should be a clear line of accountability.

10. What would be the advantages and disadvantages of setting out in legislation the role of “responsible individual” for health bodies in Wales?
This would clearly indicate who is responsible for what.

11. What would be the advantages and disadvantages of legislating for a “fit and proper persons” test, and to whom should it apply?
NHS non clinical managers

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
There are already professional standards to be adhered, the health care standards often duplicate standards. It would be helpful if the health care professional bodies could in partnership with WG develop one set of standards.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
The standards should apply across both independent and NHS.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Peer review has been firmly embedded in the dental profession for many years and supported through an established postgraduate deanery.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
Welsh government should recognize the initiative led by those in Wales (through the Wales Deanery) whereby existing processes have been introduced in the clinical and educational supervision of doctors and dentists

in training. The salaried community dental services also have active programmes of clinical peer supervision and training both in house and shared with neighbouring health boards. The hospital dental service in conjunction with the deanery has been providing consultant clinical attachments schemes for many years. Clinicians working in larger teams such as the hospital and community dental services already have a natural level of peer review as care is often shared.

17. What arrangements should be put in place for self-employed health professional registrants?
Self employed NHS dentists and DCP's can access peer review and education through the deanery.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Given the suspicion of there being a lack of openness in the arena, it could be an area where a duty of candour would be helpful. There would need to be clarity on the level of "error" that should be reported otherwise we would create an unnecessary level of anxiety and bureaucracy. The process should be supportive of individuals and realistic otherwise the fear of minor errors will have an effect on the clinicians performance in itself and be counter productive. Errors of managers that have either indirect or direct patient consequences should have equal consideration and consequences to direct clinical errors.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Ensuring only serious professional issues are reported.

Making it easier to raise concerns in an integrated system

20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Patients should only be allowed to complain by one process to avoid duplication.

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient

information?
Often confusion may be a barrier especially with regard to our professional body rules and regulations. However it is important that clinical and relevant social information is shared between individuals. In an ideal world the patients medical records would be electronic and stored centrally with appropriate access given to relevant clinicians. There are also inappropriate barriers in place to schools sharing information with NHS bodies providing medical and dental inspections and treatment, Many schools(often under advice from Local Authorities) refuse to share information with the NHS quoting the Data Protection Act as precluding this. Given the legal requirements for schools to accommodate medical and dental inspections and treatments which the NHS is required to undertake, schools should be registering under the Data Protection Act to share such information.

22. How can we consider breaking down any barriers?
Having a clear all wales policy agreed which is shared and agreed with professional bodies

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
For planning and evaluating health care outcomes is appropriate. Providing information to third party companies for marketing etc. is inappropriate

Chapter 6: Checks and Balances

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
The CHC is valuable in representing the patient and often acting as a mediator.

Chapter 7: Finance, functions and planning

Borrowing powers

30. Should we change the law to give health boards borrowing powers?
No, this increase financial problems.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
HB's need greater focus on clinical issues. Clinical Directors should be made non executive members of the HB

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors?
Possibly, professions such as dentistry need to represented such as above

40. Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?
Strong clinical leadership is essential through clinical directors within the HB's.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
No this ensures that appropriate neutral advisory committees are established and separate from political influence.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
Need amending to reflect devolution.

WGGP164 – John Morgan
Tref / Town – N/A
Sefydliad / Organisation – N/A

General comments

In general there is too much emphasis on legislation. The great deficit is accountability especially to the public.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? 2. If so, what changes should be given priority? 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
This section covers both health and wellbeing and the provision of integrated care. The lack of planning, commissioning and delivery of both the prevention agenda and services is self evident. Joint working does not require legislation per se though it might be required later on to formalise arrangements. What is needed is a commitment from all parties to make it happen e.g. Torbay. Accountability for this needs to be strengthened both upwards and to the public so that bodies who do not work together explain why not. Giving budgets to GP clusters would also encourage local joint working though they need developmnet to take on this new role.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change? 5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups? 6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
Health Boards are required to involve and consult with the public. They should set out their engagement plans for service changes. These should be examined by the local CHC and approved if acceptable. If the CHC does not feel they are adequate then the Health Board should be required to amend them. This ensures the engagement sets off on the right foot and is not

criticised at a later stage for not engaging adequately. The IMTPs are technical documents which are usually meaningless to the public. They need overhauling to make them accessible to the public. If we get the process right then disputes should be less frequent. As a back stop an independent panel could be used it must have lay representation as well as professional input and assess the issue against a set of principles/questions e.g. was their sufficient public engagement, was it informed by best practice, were clinicians invited, is patient care going to be improved.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section? 8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system? 9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations? 10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales? 11. What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?
The discussion relies too much on legislation. Quality Standards have been agreed in Wales. The issue is delivery against those standards. The report that should be read by everyone is the Berwick Report (2013) following the Francis Report into the Mid Staffs scandal. Quoting from this: In the end, **culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime.** We need organisations to create this quality culture and be accountable to the public in how they are progressing with this. The report gives more details on what needs to happen.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
Legislation is not required but a mandate for the revised IMTP (see before) to have quality at its heart.

Chapter 3: Quality in Practice

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set? 14. Could a common standards framework, which covers both the NHS and the independent sector, better deliver a focus on improving outcomes and experience for citizens? 15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality? 16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how? 17. What arrangements should be put in place for self-employed health professional registrants?
Healthcare standards should apply to all providers of healthcare as a matter of principle. Tools for improving professional practice e.g. clinical supervision, peer supervision, accreditation should be left to professional bodies and organisations to implement not be enshrined in legislation.

Chapter 4: Openness and honesty in all that we do

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales? 19. How could we use legislation to further improve transparency on performance in the Welsh NHS? 20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?
Whilst the statutory duty of candour seems attractive at first sight there are problems. There is no good evidence that such legislation makes any difference to quality. There are problems defining what is encompassed in such laws and their interpretation. Given it has been introduced into England I would recommend waiting to see its effectiveness demonstrated before enacting in Wales. Legislation is not required to improve transparency in the NHS - it is public accountability. To illustrate - Publishing performance in an accessible way, local community board members (see later). Complaints that span the NHS and social services should be investigated together, The two inspectorates should be merged as should the CHC cover both health and social care.

Chapter 5: Better Information, Safely Shared

21. What are the issues preventing healthcare bodies from sharing patient information? 22. How can we consider breaking down any barriers? 23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?

Patient information can and should be shared - often the public assumes this happens anyway. The introduction of patient held records and a robust IT programme for health and social care records is needed. Anonymous information can be used for research and there are well established ethical protocols for using such information.

Chapter 6: Checks and Balances

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they? 25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW? 26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change? 27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW? 28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice? 29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?
As health and social care integrate so other bodies need to do so. HIW and CSSIW should be merged and become an independent body. CHC should be reviewed and moved towards a model which operates in Northern Ireland. It should cover health and social services. It should quality assure public and patient engagement carried out by Health Boards, advocate for citizens and seek/receive their views on such matters. It is not an inspectorate.

Chapter 7: Finance, functions and planning

30. Should we change the law to give health boards borrowing powers? 31. Is the legislative requirement to prepare NHS trust and health board summarised accounts still relevant? 32. 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? 33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards? 34. 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?
Health boards should have borrowing powers with appropriate safeguards. All Health providers should publish one set of annual accounts for the public.

The same rules should apply to both Board and Trusts.

Chapter 8: Leadership, Governance and Partnerships

35. What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?
I have already said that strong governance comes from strong leadership and rules and regulations. No further legislation is required however accountability to the public should be strengthened.

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Boards need overhauling the present structure is not fit for purpose. I would suggest aboard size of 12 - anything larger is unwieldy and ineffective.

37. Within a set number of executive directors, could health boards have discretion about the role of some of its executive directors? 38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
Executive officers 6 (CEO and finance are mandated the rest can be flexible roles) 6 Non-executive or Independent members (chair mandated who has casting vote). They should be drawn from local community with appropriate board skills (not as now specified).

Board secretary role

43. Does the role of the board secretary need greater statutory clarity? 44. If so, what aspects of the role should be additionally set out in law? 45. How could potential conflicts of interest for the board secretary be managed?
The role of board secretary is well establish across organisations. The conflicts of the board secretary are rare in my experience - they report to the chair.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the

statutory status of the advisory committees? 47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?
The advisory structure is cumbersome and expensive it should be replaced with task and finish groups.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?
The workforce partnerships should be reviewed.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services? 50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?
A review of hosting, shared partnerships should be undertaken to find the best model or models.

WGGP165 – Dr Rodney Berman – British Medical Association Cymru
Tref / Town – N/A

General comments

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Welsh Government's Green Paper entitled, 'Our Health, Our Health Service'.

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 153,000, which continues to grow every year. BMA Cymru Wales represents over 7,500 members in Wales from every branch of the medical profession.

RESPONSE

BMA Cymru Wales welcomes the opportunity to respond to this very wide-ranging Green Paper, which raises a significant number of questions in relation to the future of health provision in Wales moving forward.

Owing to the number of questions posed, this response does not seek to address every issue raised. Instead, we have concentrated our submission on the issues within the Green Paper which are of most relevance to our membership.

For clarity, we have listed our responses under the chapter headings which were presented within the Green Paper. Where appropriate, we have mapped our answers directly to questions posed in the Green Paper. In other sections, however, rather than answer the specific questions posed (which in some cases are quite narrow in focus) we have instead presented our views on the general topics that have been put forward.

Chapter 1: Quality first and foremost

Questions 1 & 2. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home? If so, what changes should be given priority?

An important issue that we believe needs to be addressed is how to ensure that an appropriate shift in resources, or allocation of additional investment, matches any transfer of hospital-based services to primary or community care settings. Whilst we are unsure if this is a matter which should specifically be addressed through legislation, it is nonetheless an important issue for which a solution is required. We feel it is key to ensuring that services which have been traditionally hospital-based can be delivered in more appropriate

settings that may be more convenient to patients. There could perhaps be a requirement put in place to give consideration to how resourcing issues are addressed when such service transfers are undertaken.

It is also the view of BMA Cymru Wales that clinicians must be fully involved in any decisions that are taken regarding such transfers of services.

Question 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?

BMA Cymru Wales has been calling on the Welsh Government to ensure that health considerations are brought fully to the fore in policy- and decision-making by public bodies in Wales. We feel this would help in ensuring that health and wellbeing needs are considered more widely across the board in service planning and provision, and this could therefore contribute to ensuring agencies work together to better plan to meet people's health and wellbeing needs.

As outlined in our recent responses to the Public Health (Wales) Bill[38] and the draft statutory guidance for the Well-being of Future Generations (Wales) Act,[39] we believe this should be done through the adoption of a sufficiently robust 'health in all policies' approach for Welsh public bodies which is linked to a statutory requirement for Health Impact Assessments (HIAs) to be undertaken in appropriate circumstances.

We suggest that this statutory requirement for the use of HIA should apply in the first instance to Strategic and Local Development Plans certain larger scale planning applications; the development of new transport infrastructure; Welsh Government legislation; certain statutory plans such as Local Well-being Plans; new NHS developments (e.g. new hospitals) and health service reconfiguration proposals.

In relation to the draft guidance for the Well-being of Future Generations (Wales) Act, we have also called for there to be a further guidance document which outlines the required Welsh approach to the application of 'health in all policies' in appropriate detail. This should specify the actions that would be required to deliver a 'health in all policies' approach, rather than merely advising what could be done as a matter of good practice.

Further information regarding our case for placing HIA on a statutory footing in Wales is contained within Appendix 1 of our response to the Public Health (Wales) Bill.[38] And whilst we hope that Assembly Members and Welsh Ministers will shortly agree to include this provision within the Public Health

[38] http://bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/public%20health%20bill.pdf

[39] http://bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-wellbeingfuturegenerations-response-16-11-2015.pdf

(Wales) Bill, should this not be the case then we would hope that the matter would be addressed in future Welsh legislation.

Question 4. Are there ways in which the law could be reformed to shape service change?

In our response to Ann Lloyd's '*Lessons Learned Review*' of health service reconfiguration,[40] we highlighted what we saw as a repeated inability to deliver a joined up approach, provide detailed financial analysis or adequate modelling of the consequence of proposed changes through a lack of credible data. We feel it is important that this is addressed so that consultation and engagement can be meaningful through being undertaken from an informed, balanced and impartial perspective where the impact of different options under consideration on service delivery is properly understood.

As we have highlighted above, we are calling for service reconfiguration proposals and the development of new hospitals to be subject to a mandatory HIA. We feel this would be an invaluable tool, not only for maximising health benefits and minimising adverse impacts as proposals are developed, but also for significantly aiding better understanding of the extent to which proposed changes may or may not be beneficial and how they might compare to the current pattern of provision. We would also suggest that the Welsh Government could give consideration to committing through legislation to greater openness and transparency through which service reconfiguration proposals are agreed.

It is also vitally important, in our view, that there is effective engagement with frontline clinicians in the processes concerning both service reviews and service reconfiguration. The importance of gaining the perspective of those currently undertaking direct clinical practice cannot be underestimated, including by ensuring that there is local clinical engagement in local service development. Further information can be found in our previously published position papers on service reviews[41] and service reconfiguration.[42]

BMA members in Wales have also raised the need for more honesty in the language that may be used. The Welsh Government and Welsh health bodies need to be more upfront in acknowledging that resources are finite. The discussion and implementation of rationing should therefore be more overt so that patients can be clear upfront what services can or cannot be provided. It may also be helpful to provide greater transparency to patients regarding the actual costs of treatments.

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[40] http://bma.org.uk/-/media/files/pdfs/about%20the%20bma/what%20we%20do/lobbying/wales/walesresponselessonslearned12september2014.pdf

[41] BMA Cymru Wales (2013) *Service reviews: what are they, their aims and how should they happen*. Available at: http://bma.org.uk/-/media/files/pdfs/about%20the%20bma/how%20we%20work/uk%20and%20national%20councils/welshcoucilservicereviewpaper.pdf

[42] BMA Cymru Wales (2013) *A guide to hospital reconfiguration for doctors*. Available at: http://bma.org.uk/-/media/files/pdfs/about%20the%20bma/how%20we%20work/uk%20and%20national%20councils/welshcouncilreconfiguration.pdf

Question 6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?

In relation to service reconfiguration proposals, we believe there could be merit in the exploration of such an idea as it may help in avoiding conflict between decisions based on observed political expediency and those which may be in the longer-term interests of improved service provision for patients.

It would be important, however, to ensure that such a panel could be seen to be truly independent from the health bodies putting forward proposals for service reconfiguration. The panel would also need to be able to take decisions that would be both recognised and accepted as being in the best interests of patients.

The difficulty in a country the size of Wales is to find a truly independent view, and perhaps the best way to achieve this would be to acknowledge conflicts of interest and develop a mechanism where diverse views and interpretations of the evidence are worked through collaboratively as part of an open and transparent process.

Chapters 2 & 3: Enabling quality; Quality in practice

A fundamental issue that we feel needs to be addressed is how we can ensure there is an environment within the NHS in Wales in which staff feel confident at all times, and in all circumstances, that they can raise concerns about patient safety issues without fear that they might personally suffer any adverse consequence as a result and with the confidence that appropriate action will be taken to properly consider and deal with their concerns.

We have previously highlighted significant concerns that, all too often, such a desirable state of affairs does match the experience of our members in their day-to-day working environments.[43] Indeed, as we have previously reported, many doctors report overwhelming feelings of disempowerment and isolation, saying that they feel unable to pursue their concerns or to press effectively for change because their organisations operate in what they perceive to be a 'state of denial'.

A survey we conducted earlier this year of secondary care doctors in Wales highlighted some deeply worrying findings.[44] It showed, for instance, that 58.6% of respondents said that had raised a patient safety concern during the previous three months, but that 39.8% of those that had done so had no knowledge that any action had been taken as a result. Equally worrying was

[43] BMA Cymru Wales (2014) *Creating a healthier NHS for Wales.* Available at: http://bma.org.uk/-/media/files/pdfs/about%20the%20bma/how%20we%20work/uk%20and%20national%20councils/po-makingnhswalesbetter-03-11-2014.pdf

[44] http://bma.org.uk/about-the-bma/how-we-work/uk-and-national-councils/welsh-council/survey-results-on-raising-concerns-in-the-workplace

the fact that 60.2% of respondents reported having experienced bullying or harassment as a result of having raised a patient safety concern at some point in their career.

The NHS in Wales needs to develop a culture that avoids serious concerns developing in the first place. We believe this requires a change in attitude and values within senior management and those with leadership responsibilities. We need to move to a situation where raising concerns is welcomed so that it becomes routine, and it is accepted that it is everyone's business to identify and put right early concerns wherever they occur. Wales must take a whole system approach and be willing to accept responsibility for analysing and correcting system failures. We are, however, hugely encouraged by the current work that is being undertaken on embedding values into the NHS in Wales.

One way to help address the need for a change in culture would be to ensure that those in senior management positions, or serving as board members, spend a proportion of their time (e.g. one day a week) working at the frontline. That would give them a genuine opportunity to experience first-hand what the problems are that need to be addressed to ensure the most effective provision of patient care.

We would also call for the Welsh Government to fully explore what legislative safeguards could be put in place to protect staff when they raise concerns so as to remove any fear they might have in doing so. Indeed, we also believe we should also look at how a system could be introduced that goes further by actually showing appreciation to those who speak out, rather than rewarding those who avoid 'rocking the boat'.

Whilst we recognise there would need to be appropriate safeguards against vexatious complaints, what we would like to see would be a move to a system where potential concerns are dealt with in a timely manner and any required changes are then made without fuss as part of the everyday functioning of NHS teams.

Consideration should also be given to having an independent body or individual with appropriate powers to investigate complaints from staff. This could possibly be achieved by extending the powers of the ombudsman. It is also important to ensure there is an open, transparent and timely system within health boards and trusts for dealing with complaints – something that could perhaps be underpinned through appropriate standards set out in legislation.

We would also suggest that any staff leaving the employment of the NHS in Wales should be subject to an exit interview. This can help in identifying areas that might need addressing by giving staff an opportunity to raise issues they might have been fearful of raising during the time of their employment.

Another issue which we believe should be explored would be to ensure that non-clinical managers are subject to a system of regulation in the same way

that clinical staff are regulated by professional bodies. A doctor who fails badly in his or her conduct runs the risk of being struck off, and thereby prevented from working again as a doctor. In contrast, a manager who presides over significant failure may then go on to secure a new management position in a different part of the NHS.

We believe that the Welsh Government should explore how this regulatory imbalance could be addressed. Where a manager has presided over failure that is of sufficient magnitude, and which can be directly attributed to their performance in their role, we would suggest they should also be subject to a regulatory system which could prevent them from taking up a new management position elsewhere within the NHS. This could prove to be a helpful safeguard that could, in time, lead to more effective management of the NHS in Wales. It could also help create a system where non-clinical managers share in the risks that clinicians have to accept, and become more accountable for the role that they play in healthcare delivery.

Delivering more effective clinical engagement in the day-to-day running and planning of the NHS in Wales is something that we believe should also be seen as a priority. Better engagement between health service leaders, managers and doctors should achieve a more coherent and long term vision of health service provision, as well as ensuring there is a consistent focus on high quality care. Frontline clinicians should therefore play a greater role in developing the strategic direction and delivery of services, rather than the current reliance on non-clinical managers who appear at times to be determining service configuration more from the viewpoint of delivering financial savings. We also believe that local doctors working at the frontline should be involved more in day-to-day decision-making given that they can bring greater understanding regarding the clinical impact that such decisions might have.

Another issue we would like to raise is the need to ensure that targets are based on clinical evidence. We recognise the political necessity for targets, and acknowledge that they can help to focus activity and measure progress. However, we are also aware that targets may at times act against clinical priorities.

An example of this is where the existence of referral to treatment targets means that priority is given to those newly referred by a GP to a consultant over and above those waiting for a second or subsequent appointment, for which there is no specific target time by which they should be seen. This can lead to follow-up appointments being delayed because a health board needs to prioritise those with first appointments in order to meet its target. The consultant may be unaware that such follow-up appointments are being deferred by the health board until he or she next sees an affected patient, and we are aware of occasions when this has led to an irreversible deterioration in a patient's condition in the intervening period.

We are aware, as a result of previous lobbying by BMA Cymru Wales, that a pilot was being undertaken within ophthalmology by Betsi Cadwaladr

University Health Board and Abertawe Bro Morgannwg University Health Board to inform the development of clinically-led intelligent targets, with the aim of ensuring that those patients who need to be treated in secondary care who have the greatest clinical need are seen in a timely manner.

These pilots can hopefully inform the adoption of the wider application of clinically-appropriate targets, and this something that we would call on the Welsh Government to implement.

Improving the quality of clinical data should also be regarded as a priority for the NHS in Wales. This should include greater use of data based on outcomes, with more outcome data being routinely collected. We would therefore advocate that there should be a review undertaken to determine where it would be beneficial for more outcome data to be collected. This could be greatly beneficial in terms of monitoring service performance within the NHS in Wales using meaningful measures.

Chapter 4: Openness and honesty in all that we do

In line with the position previously expressed by the BMA at UK level, we support the principle underlying the idea of a duty of candour and believe that all NHS staff must be honest and transparent in everything that they do in order to best serve and protect their patients.

These standards are underpinned by the existing professional duties on doctors to be open and honest with patients about their care, and the sanctions for any failure. There are already a number of ways in which healthcare workers, including doctors, can be prosecuted using both criminal and civil proceedings in connection with dishonest behaviour or action endangering patients.

We therefore believe the introduction of a statutory duty of candour with criminal sanctions for individuals would not add anything substantive to the existing routes and could have the opposite effect of that intended. The threat of criminal prosecution for an act committed in the course of treating a patient (whether accidentally, negligently or purposefully) could, instead, worsen the culture of fear amongst professionals that prevents people speaking out.

However, we do support placing statutory duty of candour on organisations as we believe that the existing mechanisms for holding providers to account require strengthening.

It is our observation that members of the medical profession have been encouraged to be open an honest with patients when things go wrong, but that health bodies have become more secretive and less open with patients. This is leading patients and their families to complain and assert that aspects of their care are being concealed or covered up. We perceive this is often related to fear of litigation or public criticism by health boards, but we feel this needs to be addressed; health bodies need to recognise that they work for patients, and not the other way around.

Further information regarding the BMA's view on a statutory duty of candour are available in a BMA briefing paper.[45]

Chapter 5: Better information, safely shared

Question 21. What are the issues preventing healthcare bodies from sharing patient information?

It is unclear whether this question refers to sharing information for direct patient care or non-direct patient care (often termed secondary uses of data). This lack of clarity is reinforced by the accompanying text in chapter 5 which fails to draw a distinction between the two concepts. For example, paragraphs 71–76 appear to refer to information sharing between organisations for the purposes of direct care, building towards reference to the Caldicott seventh principle (paragraph 76); this is immediately followed by a paragraph which discusses sharing information about complaints (paragraph 77). Paragraph 78 relates to information sharing 'to deliver effective services'.

This suggests that sharing for direct care and sharing for complaints and service delivery can be seen as similar concepts. This is not the case. Using patient information to address complaints and to deliver services falls clearly into the category of secondary uses of data and cannot be seen as part of direct patient care. In our view, it is unhelpful to blur the distinction to between uses of data for direct care and secondary uses as different legal and ethical rules apply for their disclosure. Failure to draw a clear demarcation risks causing confusion leading to confidential data being shared without a clear legal basis.

Our response to this question is therefore in two parts. The first part of the response relates to information sharing for direct care; the second part highlights some areas of concern we have in relation to specific statements in the Green Paper around non-direct patient care or secondary uses of information.

<u>Direct patient care</u>
Given the importance of striking the correct balance between appropriate sharing and appropriate protections for patient data, our answer to this question goes beyond the question of issues which might prevent sharing but considers information sharing for direct care within the context of the existing legal and ethical framework.

Information sharing to facilitate direct patient care is a principle which can be supported by all. All doctors already have clear professional obligations to share information for safe and effective care under General Medial Council

[45] BMA (2013) *Statutory duty of candour with criminal sanctions: Briefing paper on existing accountability mechanisms*. Available at: http://bma.org.uk/-/media/files/pdfs/working%20for%20change/shaping%20healthcare/mid%20staffordshire%20inquiry/duty%20of%20candour%20briefing%20aug%2013.pdf

(GMC) guidance.[46] Other healthcare professionals are subject to similar requirements by their respective regulators. Support for this principle does not, however, negate confidentiality and privacy interests and the importance of securing a clear legal basis for sharing confidential information. We are concerned that this section makes only cursory reference to these interests which the sharing of confidential information will necessarily engage.

The implication of this section is that the Welsh Government is considering a statutory duty to share information for direct care. BMA Cymru Wales would oppose such a duty on the grounds that, if a statutory duty on providers replaces consent as the legal mechanism by which confidential data are shared, patient autonomy and control over information sharing will be undermined and eroded.

It is of particular concern that paragraph 80 refers to 'governance issues' which might prevent sharing. It must not be forgotten that much of the governance is in place to ensure a confidential health service. We hope the Welsh Government, in its laudable intentions to improve patient care, does not intend to encroach upon confidentiality through more widespread sharing of unnecessary information. As is made clear in Dame Fiona Caldicott's review of information governance, only relevant information about patients should be shared on a 'need to know' basis between those individuals who are part of the healthcare team providing or supporting patient care, in-line with current legal and professional obligations.[47]

BMA Cymru Wales fully supports the sharing of relevant information for the provision of direct care and we certainly recognise that there are circumstances when information is not being shared when it would be entirely appropriate and necessary to do so. Given that professional obligations already exist in relation to sharing information for direct care, it seems unlikely that a statutory duty to share will address this problem. Better training and education in information governance would, in our view, be a far more effective solution.

The Green Paper asserts that one of the chief causes of the failure to share appropriately is the 'daunting' legislative landscape which governs the sharing of health data. We would agree with this view. Whilst the legal complexities are more obvious in data sharing for purposes other than direct care, they also exist in relation to direct care. This problem is exacerbated by the lack of training in information governance for healthcare professionals and this issue is considered in more detail in our response to question 22.

<u>Non-direct patient care (referred to as secondary uses of data)</u>
Our overall views on secondary uses of data are covered in question 23. Here we raise some specific concerns with the proposals mentioned in the paper.

[46] General Medical Council (2009) *Good Medical Practice* paras 50 – 51.
[47] Dame Fiona Caldicott (March 2013) *Information: to share or not to share? The information governance review.*

As previously indicated, paragraphs 77–79 relate to information sharing for secondary uses. The purposes referred to in paragraph 79 include research and management with the suggestion that the introduction of statutory duties to share patient identifiable might be considered.

Recourse to legislative steps for requiring identifiable data should not be taken before it has been established that identifiable data are actually necessary and justified for the purpose. We are not aware that the Welsh Government has undertaken any work in this area and therefore suggestions of legislative proposals seem premature. It is worth pointing out that in her review of information governance, Dame Fiona Caldicott is clear that, for commissioning purposes, only a small percentage of situations require identifiable data.[48] We are aware that in England, there are well-established mechanisms for collecting data for medical research, for example the process under the Health Service (Control of Patient Information) Regulations 2002. These include a fast-track route for applications where appropriate.[49] Our understanding is that these Regulations also apply in Wales, so the use of this existing legislation might be an area the Welsh Government wishes to explore.

Before considering new legislation, consideration should be given to whether technological solutions can be used – such as linking pseudonymised data at source, or use of accredited safe havens/controlled environments[50] and 'black box' technology.[51] All these solutions reduce reliance on using identifiable data and must be considered before recourse to the 'easy' option of requiring identifiable data through the law. Such discussions need to include considerations of what type of data are necessary to achieve the purpose e.g. pseudonymous data may be identifiable in some contexts but if handled in a secure, controlled environment they may be considered non-identifiable, We are also aware of the work of the Secure Anonymised Information Linkage (SAIL) databank at Swansea University and we will return to this in our response to question 23.

We observe that the quality of clinical information in secondary care is highly variable, and that the NHS in Wales has failed to deliver a paperless patient record in secondary care which might form the basis of clinical validation of patient information. Therefore, with current poorly validated data, such as that informing handling companies such as CHKS[52], there is a risk that errors are compounded by further analysis.

Paragraph 77 refers to a statutory duty on health boards and trusts to 'routinely share complaints information'. Again, this raises concerns about

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[48] Dame Fiona Caldicott (March 2013) *Information: to share or not to share? The information governance review* p75.

[49] Further information can be found at: http://www.hra.nhs.uk/about-the-hra/our-committees/section-251/

[50] See discussion in Dame Fiona Caldicott (March 2013) *Information: to share or not to share* pages 63 – 68. See also Information Commissioner's Office (2012) *Anonymisation: code of practice*, chapter 7.

[51] Where electronic data flows into a computer system which automatically undertakes processing of the data within the system to render those data pseudonymised before they are viewed by persons undertaking research or work on the data.

[52] http://www.chks.co.uk/home

confidentiality and patients losing control over their health information. It is difficult to see why the sharing of information about individual patient complaints cannot be easily achieved with consent. If it was made clear to patients who would need to see information in order for the complaint to be escalated, and the safeguards in place to minimise risks to confidentiality, then consent could be obtained at the outset of the process. This would provide a secure legal and ethical basis for the sharing and be in line with patient expectations.

Should circumstances arise where there is a complaint of such a serious nature which requires investigation and a patient refuses consent for further sharing, then there are likely to be grounds for sharing in the public interest in order to prevent serious harm.

Question 22. How can we consider breaking down any barriers?

For the purposes of our answer to this question we have assumed that it refers to barriers which can prevent information sharing for direct patient care.

In our view there is a lack of consistent information governance training and this can lead to misunderstandings amongst healthcare staff about when it would be appropriate to share and inappropriate to share. It is our view that better training and education is a more appropriate solution to breaking down barriers than the creation of a statutory duty to share which may risk undermining confidentiality.

It is important that organisations ensure that information governance, and the training that supports good practice, is given a high profile so that staff understand its importance. For some organisations, this may require a cultural change so that information governance training is not seen as a one-off 'tick box' exercise but a continuous process. Organisations should have formal mechanisms in place to ensure every member of staff is up to date with appropriate training in information governance. This should include those who work on a temporary basis such as locums and doctors who are on rotation.

The key issue is to ensure that staff are able to understand the basic principles in-line with their professional role and are therefore adequately prepared to apply their knowledge to different scenarios in their daily working routines. We recognise that this may not always be easy due to the complex nature of information governance and therefore it is also important that staff know from whom in their organisation they can seek advice where there is uncertainty.

We note that most NHS organisations in England are required to complete an annual assessment of information governance practice using the UK Department of Health's online Information Governance Toolkit to provide assurance of compliance. The Health and Social Care Information Centre in England provides an online Information Governance Training Tool which

covers the Data Protection Act as well as other relevant legislation.[53] This training might offer a useful starting point for health bodies in Wales.

Question 23. What are your views on the collection and sharing of patient identifiable information for non-direct patient care, such as research? What are the issues to be considered?

We are supportive of uses of data for non-direct patient care (often termed secondary uses of data) with appropriate safeguards and transparent processes in place. In 2014, we set up a UK-wide task and finish group which considered the issues which arise in relation to this topic. The group's conclusions were informed through consultation with doctors, members of the public and key stakeholders. One of the outcomes of the work was the development of a BMA vision in relation to secondary uses of data.

The BMA's vision in relation to secondary uses of health data

he BMA's vision is for doctors and patients to see improving healthcare and ublic health (through research, education, innovation and the effective anagement of healthcare resources) as a shared endeavour, in a society where:

- patients recognise that the main purpose of collecting medical information is to assist their direct care, and also have a good general understanding of how it can be used for the continuing improvement of health care and public health, and support such use within an agreed framework;
- all data uses are fully transparent and in line with patient expectations;
- there is trust in the safeguards in place to prevent inappropriate disclosure or use of patient data;
- the benefits that can arise from appropriate secondary uses of data are understood and promoted;
- anonymised data are readily available for secondary uses; pseudonymised data can be easily accessed within an appropriate governance framework; and there are practical mechanisms in place to obtain the required authorisation for the use of personal confidential data where such use is necessary;
- within the established frameworks, doctors are confident to release personal confidential data for secondary uses where the patient consents or other legal authority exists;
- information is easily available to the public promoting their understanding of medical research and encouraging opportunities to participate where appropriate– either through active involvement or the use of their data; and
- it is recognised that the full benefits can only be realised where medical records are accurate, appropriately structured and coded and kept up-to-date.

[53] https://www.igtt.hscic.gov.uk/igte/index.cfm

We recognise that there are a number of practical challenges with the current system for collecting and using data for secondary uses and we would be happy to discuss these in more detail if this would be helpful.

As a specific point, we are aware of the SAIL databank which supports research and the improvement of health services in Wales.[54] We supports the principles of this model which extracts data from GP practices using a 'twin track' approach and use of Audit+. Audit+ separates identifiable demographic information and clinical information at practice level and generates a 'join key' which can link the two files back together once the anonymisation process is complete.

Demographic information is sent to NHS Wales Informatics Service (NWIS) and the clinical data are transferred to SAIL. The demographic data undergo anonymisation at NWIS before they are linked with the clinical data in SAIL using the join key. This means that no party ever has access to both demographic and clinical data files in identifiable form. This process allows data to be used for valuable purposes with minimal risk to confidentiality.[55]

Chapter 6: Checks and Balances

Healthcare Inspectorate Wales (HIW)

BMA Cymru Wales submitted a written paper to the Marks Review of Healthcare Inspectorate Wales (HIW)[56] a little over twelve months ago. It sets out the considered view of the profession across a range of HIW's regulatory and inspection functions. That paper should therefore be read in conjunction with this current response.

The specific points we have to make on HIW are, however, outlined below.

HIW's responsibilities and functions are presently drawn from a number of legislative sources. We believe that these should be consolidated into one single statute – thereby giving HIW a clear and unified remit, and moving it on from the complex, piecemeal and reactionary manner in which it has evolved over the last decade towards a future that is more proactive and standard-setting. This would also offer the opportunity to strengthen its remit, streamline its operations and address any gaps or duplication in how it works with other bodies – e.g. the Wales Audit Office, Community Health Councils (CHCs) etc.

We are not best placed to comprehensively assess the merits, or otherwise, of HIW merging with the Care and Social Services Inspectorate Wales (CSSIW) – a central proposal in the Green Paper. However, such a merger, might work to re-focus the inspectorates to better reflect the reality of how

[54] http://www.saildatabank.com/

[55] Examples of the major projects undertaken using the SAIL databank can be found here: http://www.saildatabank.com/major-projects

[56] Ruth Marks (2015) *The way ahead: to become an inspection and improvement body*. Available at: http://gov.wales/topics/health/nhswales/organisations/review/?lang=en

services are now planned and delivered in Wales – albeit, those services are far from fully integrated currently. Generally, we believe that rearranging organisational structures through mergers is often not absolutely necessary, or even sufficient, to produce genuine joint working and more coordination. Instead, the emphasis might be better placed on good information sharing and effective, professional relationships across disciplines and organisations. With that in mind, there is definitely more scope for joint working and information sharing between HIW and other inspectorates and organisations (CHCs for example). However, getting the fundamental principles and mechanisms of inspection and regulation correct – for both health and social care – should come before any operational merger. We look forward to commenting on this proposal in the future should further details become available.

The issue of independence clearly needs to be carefully considered. We would advocate that HIW needs to operate wholly independently of government and, thus, full statutory independence needs to be expressly built in to any new legislation underpinning it. This is an obvious prerequisite for the profession having confidence in HIW and, thus, in order for HIW's work to carry credibility. As part of this, we believe that HIW should not have to obtain the permission of Welsh Ministers to enact its powers to place organisations in special measures.

It is apparent that HIW needs more resources and more capacity. This is especially needed to aid the identification of priorities – to ensure a robust balancing its inspection and regulatory functions, and to better engage clinicians at the coal-face when inspecting or responding to a concern.

HIW is said to be the 'third line of defence' against serious failures, but it has significant influence on the ability of the 'first line' of defence (frontline professionals) and the 'second line' of defence (boards/managers in NHS Wales organisations) to operate effectively in assuring that we have good quality care. We agree that we cannot rely on HIW alone to provide this assurance, but equally it should not function in isolation. Each of the three lines of defence must work seamlessly – and, in our opinion, HIW has the ability to 'set the tone' and provide the leadership needed in order to drive shared learning and establish a culture where staff are confident that they will be supported to raise concerns (and that when they do, something will be done about it).

In looking to reform and strengthen HIW, the potential for it to play a positive role in 'culture-setting' in NHS Wales organisations must not be overlooked. Our vision of HIW being reconstituted towards an improvement agenda would strongly underpin moves to create an improved culture within the NHS in Wales – one of much greater openness, support and transparency.

Given the above, we believe that there is a strong case to be made for HIW to play a proactive and supportive role in healthcare improvement. This could include supporting organisations through a learning/improvement process; exporting best practice across Wales; and focusing on clinician (staff) engagement in the workplace (e.g. one element of inspections could involve

seeking the opinion of relevant staff about how 'engaged' they feel by their managers; when the manger was last on the ward; how often they are seen etc.)

The particular areas in which our members envisage HIW playing a key 'improvement' role are:

1) Highlighting incidences of overstretched services (including appropriate staffing levels) across primary and secondary care and making recommendations – given the clear link with patient safety, quality of care and patients' experiences of receiving care.
2) Improving the quality and accuracy of data collection within health boards (for example on whole-time equivalent workforce numbers and on staff vacancies) and enabling national standardised data sets to be collected. Integrated IT systems (which deliver real time outcome data) are a clear requirement.
3) Assessing how engaged frontline staff are in the design and delivery of services and how they are supported to raise concerns about patient safety.
4) Investigations into other systematic failures, in conjunction with other inspectorates/bodies such as CSSIW and CHCs (such as where the board of the LHB is detached from the reality of the ward, or where staff and patient concerns have not been acted upon).

HIW is a complex regulator as Ruth Marks also acknowledges in her review. It is responsible for regulating and inspecting a substantial number and variety of health bodies across the NHS and the independent sector. However we believe that its inspections, whilst very necessary, must be fair, lean and rare.

We would suggest that the Welsh Government could consider how an inspection regime can be put in place that may be seen as being less designed to root out and punish poor performance, and more to identify how best practice can be more widely shared.

Consideration should also be given to how it can be more effectively ensured that recommendations of inspections are acted on by health boards and trusts, and not simply ignored. This could involve looking into how such recommendations could be made binding.

General practice is subject in particular to an increasing number of administrative and compliance activities (e.g. appraisal, revalidation, CHC inspection, clinical governance toolkit – though not mandatory most do comply – LHB annual inspection, QOF visits, annual inspection, health and safety visits). While these may be seen as necessary, they do take time away from providing direct clinical care. There is a real risk of over-inspection and duplication (not to mention the possible impact on workforce morale, which is already at an all-time low).

Generally, we believe that there remains an NHS-wide uncertainty about what early warning systems and escalation procedures are in place to identify poor care or outlier services. Such systems are fundamental in providing the necessary assurances that standards of care are being met.

Our last comment in relation to HIW is to suggest that any reform should avoid the approach of aggressive micromanagement adopted by the Care Quality Commission (CQC) in England.

Community Health Councils (CHCs)

In relation to CHCs, we expressed concern earlier in the year in response to a Welsh Government consultation on changes to aspects of their governance that what was being proposed could be seen as amounting to the creation of a 'top down' policing system for CHCs.[57] We are concerned to subsequently learn that CHCs have since lost the right to make individual decisions on referring service change proposals they have concerns about to the Minister for Health and Social Services. We understand that they now need prior approval for such referrals from a committee of the CHC Board. This suggests our concern about a 'top down' policing system is being borne out.

We are alarmed by suggestions in the Green Paper that the remit of CHCs could be scaled back to exclude inspections and, perhaps more importantly, service change proposals. We feel this would be a retrograde step and could remove an important safeguard which currently offers an opportunity for poorly thought through decisions by health boards in relation to service change proposals to be re-examined. We also feel this could further undermine public confidence in how such decisions are made by removing an established mechanism through which the concerns of patients are able to be heard. Furthermore, we do not believe that reducing the mechanisms by which such decisions can be scrutinised will lead to better decisions. It is more likely in our view to have the opposite effect.

Sir Michael Marmot, a former president of the BMA, has previously highlighted the need to consider not just the causes of health inequalities (e.g. behaviours and biological risk factors) but also the causes of the causes.[58] In addition to their association with health inequalities, we would note that such social determinants of health (e.g. deprivation, poor educational attainment and poverty) may also be associated with groups of patients who may lack the ability to easily raise concerns for themselves. CHCs can therefore play a vital role in acting as the voice for such groups when challenging decisions taken by health boards that may be target- or finance-driven, rather than serving the needs of patients. CHCs can therefore help ensure that health inequalities are narrowed rather than widened, and our view is that we should not therefore be

[57] http://bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-waleschangestochcs-13-01-2015.pdf

[58] BMA (2011) *Social determinants of health – what doctors can do*. Available at:http://bma.org.uk/-/media/files/pdfs/working%20for%20change/improving%20health/socialdeterminantshealth.pdf

seeking to curtail their abilities to act in the needs of those less able to speak up for themselves.

Chapter 7: Finance, functions and planning

Whilst we do not offer a specific view on some of the financially-based questions posed in the Green Paper, we would like to make clear would be strongly opposed to any further geographical-based restructuring or reorganising of the NHS in Wales. In our view, previous reorganisations have led to significant upheaval but this has not necessarily led to greater accountability or improved service provision.

In relation to the planning undertaken by Welsh health boards, as we previously suggested in our response to the Welsh Government consultation on the draft version of its primary care workforce plan,[59] we believe the variability of the Integrated Medium Term Plans (IMTPs) that they are required to submit to the Welsh Government requires urgent redress. In our view, each should contain detailed data on the primary care workforce and clearly outline how the local needs analysis by GP clusters has informed both strategic decisions and strategic direction. IMTPs should be subject to scrutiny at both national and local level (including by cluster), with an agreed format and standard of data sets to enable effective comparisons to be undertaken.

With regards to workforce planning, we feel it is important for the Welsh Government and Welsh health bodies to take a whole-system strategic approach across primary, community and secondary care. We recognise that high-quality patient care goes hand in hand with a highly-motivated and committed workforce. But the reality reported all too often by our members is that they feel increasingly de-professionalised, repeatedly devalued and worryingly isolated. It is therefore essential that the Welsh Government provides the resources, policy and structures for professionalism to flourish, with workforce planning taking into account the changing service demands and composition of the workforce – in particular, the challenges of an ageing workforce. Action needs to be taken to address urgent recruitment and retention challenges, ensuring we have the right staff in the right place at the right time. High-quality undergraduate education, postgraduate training and continuing professional development need to remain priorities.

Another issue that we believe needs to be addressed to assist in effective workforce planning is the current lack of collection and publication of meaningful data on vacancies. We understand that such data has not been routinely published since 2011. As such, we have had to resort in more recent times to the use of Freedom of Information Act requests in order to obtain such data. Even then, the responses we received would appear to be highly inaccurate – largely due to the use of a fundamentally flawed definition which means a vacancy is only counted as such when an active process is underway to fill it. We fail to understand how health boards and trusts can

[59] http://bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-primarycareworkforce-01-09-2015.pdf

undertake effective workforce planning when those in charge don't appear to be effectively monitoring the extent to which vacancies are impacting on workforce provision.

Not only do we feel that this needs to be addressed by returning to a system whereby data on vacancies is routinely and regularly published, but steps also need to be taken to ensure that workforce data is meaningful and therefore able to be used for effective comparison. This includes publishing workforce data that accurately captures staff numbers expressed in terms of whole time equivalents (WTEs). We realise in certain cases, e.g. in relation to GPs, the definition of what exactly constitutes a WTE is not always straightforward and we are grateful for work that is being undertaken in relation to primary care to identify a suitable methodology for arriving at an acceptable definition for a WTE GP. With many doctors increasingly choosing to work on a less than full-time basis, however, it is important that accurate WTE data is readily available. That way workforce data can be properly understood in a way that enables workforce planning to be more effectively undertaken.

Chapter 8: Leadership, governance and partnerships

Leadership and governance

This chapter refers to some issues we have touched upon earlier in this response. For instance, as we covered in our response in relation to the previous chapter, BMA Cymru Wales would be strongly opposed to any further geographical-based restructuring or reorganising of the NHS in Wales. We consider that previous reorganisations have led to significant upheaval but not necessarily to greater accountability or improved service provision.

In relation to leadership, another suggestion we put forward earlier in this response is our idea that those in senior management positions, or serving as board members, spend a proportion of their time (e.g. one day a week) working at the frontline. As we said, we believe that would give them a genuine opportunity to experience first-hand what the problems are that need to be addressed to ensure the most effective provision of patient care.

Effective leadership, in our view, requires the fostering of a culture that is supportive of staff and provides appropriate opportunities for frontline clinicians to input into decision-making. As we have referred to earlier, we need to create a culture which encourages staff to speak out and raise concerns without fear of recrimination. At the same time, it should also support staff being easily able to put forward suggestions for improvement which can be acted upon and shared. Such a supportive culture needs to be driven from the top, and should therefore be regarded as an important aspect of the leadership we would like to see within the NHS in Wales.

Another aspect of creating such a supportive culture, would be to ensure that those who do raise concerns can receive appropriate feedback. As we previously reported, one of the issues that leads to some doctors failing to raise patient safety concerns is a lack of belief that anything will be done.

Ensuring there is an effective system for feeding back when such concerns are raised would be key to helping address that. We believe that Welsh health boards and trusts should move to adopt a system of continuous feedback to staff on concerns being raised. This would help significantly by ensuring that concerns aren't overlooked. It would also encourage more staff to raise concerns so they can be addressed, and provide greater reassurance to staff that they are working in an environment that is genuinely supportive.

We would also suggest that culture change is required to address the issue of workplace bullying which should have no place in a modern NHS. Bullying can occur at many levels but we need to take action to promote a working environment where all forms of harassment and bullying are regarded as unacceptable, and any incidents arising from such behaviour are not tolerated. Managers and supervisors need to lead by example by treating all employees with dignity and respect. Management also needs to be on the lookout for behaviour that may be construed as bullying or harassment, and must work effectively and quickly to resolve any instances where harassment and bullying have been alleged and ensure there is no victimisation or recurrence after a complaint has been seen to be resolved.

Indeed, the NHS in Wales might consider adopting a lesson from NASA in acknowledging that successful teams utilise 'leadership' and 'followership' at different times in tacking mission-critical tasks. Adopting such an approach might avoid automatic hierarchical assumptions as the role of leader is then shared between team members, and this can lead to improved performance when operating in high-risk environments.

Advisory structure

In 2104, BMA Cymru Wales submitted responses to both a review and subsequent consultation by the Chief Medical Officer (CMO) on proposals to revise the health advisory structures for Welsh Government and the NHS in Wales.[60,61] As we indicated in these responses, we support the retention of the current advisory structure, albeit recognising that there are aspects of the current bodies which could be reviewed in order to enhance the provision and effectiveness of statutory independent medical advice.

Whilst we note that the proposals that were then subject to consultation have not so far been progressed, we would nonetheless maintain our opposition to the suggestion of replacing the National Joint Professional Advisory Committee, the seven Statutory Advisory Committees (including the Welsh Medical Committee) and the 24 National Special Advisory Groups (NSAGs) with a single joint professional council.

[60] http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/SJX5ILFY2IQC7XYRPSFMLJ4JIE4QPB.pdf

[61] http://bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-welshresponsereviewofadvisorystructure-26-09-2014.pdf

We remain concerned that should such proposals be implemented, they would serve to substantially erode the provision of independent and professional clinical advice to the Welsh Government and this would be detrimental to the ability of the Welsh Government to take key decisions on the provision of health services for the people of Wales from a properly informed perspective.

Moving to an appointed body for the provision of advice would also undoubtedly lead to suspicion – whether it is actually the case or not – that any individuals appointed to such a body have been hand-picked in order to facilitate Welsh Ministers or health boards being able to obtain the advice that they would wish to receive, rather than advice which can be unquestionably regarded by outside observers as coming purely from an impartial and professional viewpoint.

The current structure allows a diversity of views to be put forward, with the Welsh Medical Committee then able to distil such diverse views from different specialists and different specialties. This approach fits with the belief that the best way to obtain effective advice on a matter as complex as the development of a health service is to collect a diversity of expert views.

We also remain concerned at the possibility of abolishing the 24 NSAGs as we are aware of a number of examples of tangible improvements in health service provision in Wales that have been developed as a result of clinical advice put forward through this route. Examples include the bowel cancer screening programme and the provision of low vision aids through the Low Vision Service Wales (LVSW). Such initiatives were brought forward after initially being discussed in relevant NSAGs and such opportunities to effect positive change in service provision in specific areas could therefore be lost in future. It is also worth remembering that the regulation of tanning parlours in Wales was in part developed through discussions undertaken within the current health advisory structure, including by the Welsh Medical Committee.

A separate, but related, issue we would like to raise is the need to strengthen the links between Welsh Government policy and the standard-setting work of the Royal Collages. We feel that this is something which should also be considered.

Other issues

Whilst the Green Paper covers a wide-range of issues, there are other points we would wish to raise which do not necessarily fit within the categories covered. In particular, we would like to highlight a number of priority areas where we would like to see the Welsh Government taking action to support people in Wales to lead healthier lives. We want the public to be better supported to make healthy lifestyle choices.

In order to tackle persistent inequalities in health, and to protect the most vulnerable in society, we believe that health and wellbeing implications should to be prioritised in all aspects policy making. There should also be a clear

focus on enabling individuals to develop an increased awareness of, and sense of responsibility for, their own health and wellbeing.

It is important that everyone has adequate opportunities to make informed choices. Welsh Government policies should therefore prioritise challenging the link between poverty and poor health outcomes, in order to address the socio-economic causes of ill health head-on. As part of an overarching strategy, evidence-based policies to tackle behaviours that are strongly linked to health inequalities should be implemented.

We have already highlighted our call for HIA to be placed on a statutory footing which we hope will be achieved within the Public Health (Wales) Bill. In addition to this, we would call on the Welsh Government to:

- *Provide a culture where alcohol is enjoyed safely*
  To achieve this we would support the devolution of further relevant powers enabling 1) minimum pricing at no less than 50p per unit; 2) enforcement of responsible retailing and clear labelling (including calorie content); 3) greater emphasis on the provision of treatment for alcohol misuse; and 4) a restriction on advertising (including sponsorship).

- *Provide more smoke-free open places*
  Despite positive interventions, smoking in Wales remains the leading single cause of serious illness and avoidable early death. We are therefore supportive of the Welsh Government in its aims to create more smoke-free open places, as well as to restrict the use of e-cigarettes in enclosed public places whilst implementing a regulatory framework for their sale and use.

- *Safeguard against the damaging effect of physical inactivity and poor diet*
  Individuals who are overweight and physically inactive have an increased risk of a wide range of serious life threatening and chronic diseases. There are substantial health and social care costs associated with the treatment of obesity, and it is close to 100 per cent preventable. The Welsh Government should therefore develop policy to 1) implement interventions to curb the promotion and availability of unhealthy foods; 2) ensure sufficient and convenient opportunities for sport and exercise; and 3) provide a comprehensive strategic approach to nutrition and exercise.

- *Improve levels of literacy and numeracy*
  Education can be a major determinant of social wellbeing and health and we are concerned by the poor levels of educational attainment in Wales and its implications for the health of the nation. The Welsh Government should act quickly to improve the levels of literacy and numeracy in Wales to similar levels as those enjoyed by the other UK nations.

WGGP166 – Constance Adams – Wales Council for Voluntary Action (WCVA)
Tref / Town – N/A

General comments

1. Wales Council for Voluntary Action (WCVA) represents the interests of voluntary organisations, community groups and volunteers in Wales. It has over 3,350 organisations in direct membership and is in contact with many more through national and regional networks. WCVA's mission is to provide excellent support, leadership and an influential voice for the third sector and volunteering in Wales.

2. WCVA works with the major umbrella bodies and networks relevant to this policy area of health and social care, and the local county voluntary councils (CVCs), and facilitates their involvement in the Third Sector Partnership Council and Ministerial meetings under the auspices of the Welsh Government's Third Sector Scheme. These networks harness the sector's knowledge and experience to inform, shape, influence and contribute to Welsh Government policy, strategies and delivery. The Welsh Government has a Partnership Agreement with WCVA, the CVCs and the Volunteer Centres to provide general support to the third sector, at national, regional and local levels: this recognises and underpins the third sector coherent and integrated support structure, and demonstrates the intrinsic value of the third sector to the quality of life for people and communities in Wales.

3. Our response is informed by our continuing specific work with the sector on health, social care and well being, including facilitating the third sector Health and Social Care Alliance of Alliances. The Alliance of Alliances provides a platform for agreeing common policy messages, and considering strategies to promote and implement third sector service delivery models. Work so far has included the I Matter, We Matter campaign enabling citizen's voice in the Social Services National Outcomes Framework, and input into the consultation and scrutiny processes of the Social Services and Well-being (Wales) Act, and Regulations and Code of Practice. This group is also the core membership for the twice yearly third sector meetings with the Minister for Health and Social Services. Current membership of the Alliance of Alliances is:

    - Age Alliance Wales
    - Children in Wales

- Cymorth Cymru
- Social Care and Wellbeing Alliance Wales
- The Long Term Conditions Alliance
- Wales Alliance for Citizen Directed Support
- Wales Alliance for Mental Health
- Wales Association of County Voluntary Councils
- Wales Carers Alliance
- Wales Disability Reference Group
- Wales Reablement Alliance
- Wales Social Cooperative Development Forum
- WCVA.

4. This response is a summary by WCVA of comments from the Alliance of Alliances made at the presentation session on the consultation on the *Green Paper: Our Health, Our Health Service* from the Welsh Government Healthcare Quality Division to the Alliance of Alliances on 16 October 2015. WCVA understands that members of the Alliance of Alliances have also made individual responses to the consultation, and we have also promoted the consultation to the wider third sector to encourage further responses.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
WCVA and the third sector are committed partners in the development of people's mental, physical and social well-being and are clear that the third sector can make a substantial contribution through working with people and our communities in growing this social capital in Wales. Working towards achieving well-being is essential, recognizing that there are serious issues about people's quality of life. It is not only about helping to keep people in the community, but helping people to become part of their community. More support does not necessarily mean a better life or more independence, and issues of loneliness and belonging are often as critical as the quality of personal care. People are very vulnerable to changes in their community; shops, transport, neighbours, local groups; and the less stable these are, the more people rely on professional agencies for belonging. Co-production's dynamic for well-being including health and social care importantly creates a bigger 'cake' of resources and deploys, not just public

sector staff and budgets, but also service users, families, neighbours, local third sector organisations and the wider community in a 'total service' which goes beyond traditional service provision and releases new resources, skills and energies. It means commissioned services and self-organised support complementing each other rather than operating in isolation.

Co-production brings the co-design and co-delivery of public services, where activities and services are designed and delivered by a wide range of actors – bringing together the third sector and the public sector with the citizen and the community at the centre. It means investing in community capacity and initiative in order to provide mutual support that complements, and reduces demands on state services. The approach can involve:

- Citizen-directed support
- Service user led services
- Community led services
- Mixed volunteer and staffed services
- Integrated services.

Citizen's engagement and active participation is fundamental in maintaining and enhancing wellbeing and prudent healthcare through communal mutuality which includes the state. In co-production, people are central: not being 'done to' but 'with' supported and facilitated where necessary by professionals.

Healthier communities i.e. wellbeing is built when communities and their people are not the subject of the process but design the process themselves i.e. co-produce. Life changing development is most likely to happen when communities come together and tackle problems from the ground up, and when local people have ownership-or at least involvement-in the process. Wales has a long tradition of community action which is the foundation of our vibrant third sector today and there are numerous examples of stronger and more resilient communities being built by community organisations themselves designing and delivering holistic public services that overcome barriers to wellbeing and generate additional wellbeing.

The third sector has the important contribution to make to delivering transformation and improved services through *Putting People at the Centre* http://www.wcva.org.uk/what-we-do/policy-and-influence/putting-people-at-the-centre and its four foci of community engagement; early intervention and prevention; transformational services; and scrutiny.

The Minister's recognises that '*a huge shift is needed toward preventative and primary care'* and we therefore welcome the opportunity this new legislation can afford in better enabling this shift: particularly maximising the third sector contribution to helping meeting more people's health and wellbeing needs closer to home through co-production. WCVA and the Alliance of Alliances strongly believes that the focus of these matters in the social service legislation should be pursued for health boards, primary and independent health service providers in Wales.

The other key issue legislation should address in order to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home is integration. WCVA and the Alliance of Alliances are unanimous in requesting that new legislation, in achieving the shift toward preventative and primary care, focuses on addressing integration: but integration beyond health services and NHS bodies, and beyond the integration of health and social services, to support the integration with in particular the key partners of the third and private sectors and housing.

2. If so, what changes should be given priority?
Above legislation for improved quality and governance, there needs to be enabling legislation that addresses the continuing different systems of health, social services/care and community development that continue to cause issues for care packages and services for people. The principles and enabling practices for co-production that are in the Social Services and Well-being (Wales) Act and its accompanying Regulations and Code of Practice also need to be mirrored for NHS Wales.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
It is not clear where Public Health Wales sits in this proposed legislation, together with its important public health role in prevention and early intervention.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
The principles and commitment to practising co-production with citizens (people who use services, their carers and families, and communities) that is in the Social Service and Well-being (Wales) Act along with its statutory Regulations and Code of Practice needs to be replicated in legislation for healthcare.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Engaging people in service planning so that people's experience full informs decision making is important, however if prudent healthcare and wellbeing is to be achieved, then it is far more than 'patient experience' as people and their communities may have ideas and solutions as well and want to actively contribute to implementing solutions. So while is it important that there should be a statutory requirement for health boards and NHS trusts to use robust engagement mechanisms, it needs to be recognised that it requires a more sophisticated, multi-approach than simplistically a statutory health board panel

and/or focus group in order to engage well and regularly with a wide range of citizens and communities in order to be participatory. There are also the dangers in creating mechanisms solely for health board and NHS trusts of missing the necessary collaborative and holistic solutions to achieve well-being in our communities. This is alongside probable citizen and community fatigue at being asked to take part in numerous panels and groups that will arise if all the public sector bodies set up participation separately: the Green Paper cites GP contracts 2014-15 including patient participation groups and that the Social Services and Well-being (Wales) Act sets up regional citizens panels and gives legal standing to the national panel. The third sector has many existing forums, networks, organisations and groups, and can enable health boards and NHS trusts, as well as other public sector partners, to link with combinations or single expert groups of citizens, down to the very local community level. The third sector can also importantly assist in good practice in continuous engagement including accessibility and advocacy. The County Voluntary Councils (CVCs) support and co-ordinate third sector local activity and they have Memorandum of Understanding with their area's Community Health Councils which recognise and agree complementary roles in enabling community participation and voice in health matters.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
Yes, these are currently too focussed on hospital-based care and would benefit from changes to make them more applicable in community health, home-based and integrated settings.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
The third sector was involved in developing the Health and Care Standards 2015, which revised the 2010 standards making them far more accessible and relevant to the third sector and this has been welcomed by the sector.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within

the NHS in Wales?
If one underlying principle in proposed new legislation should be co-production with the people and communities of Wales, then there is a direct link to candour. Therefore the third sector agrees with the introduction of a statutory duty of candour within the NHS in Wales.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
As stated throughout this response, for the third sector and the people it works with, the integration of health and social services/care has been an aspiration for considerable time. Having to deal with two different systems in supporting an individual and their care has a major impact on third sector often small, local organisations or groups, or branches of organisations.

Planning

34. 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?
It is felt to be becoming an increasingly complex legislative field, which does require clarity and careful complementarity. The Well-being of Future Generations (Wales) Act should be hierarchically overarching and includes important activity such as citizen engagement; longer-term planning; and prevention and early intervention. However concern was expressed that rather than action, this could become wrapped up in reporting and the partnership structures. The accountabilities for the partnerships also are currently blurred. The third sector stressed that it had worked hard in helping shape and develop the Social Services and Well-being (Wales) Act, establishing the social model, as against the medical, together with the principles of well-being, putting people at the centre and co-production. It is essential that new legislation can focus on these enabling principles and carry them over from Social Services into the NHS Wales, prudent and primary healthcare. It was stressed by the Alliance of Alliances that the themes put forward under the Green Paper were in fact functions for NHS Wales, and that rather the bigger-picture view was needed with cross-cutting principles across all the legislation affecting health, social care, housing and wellbeing in Wales.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
Third sector engagement raises issues. There is a lack of clarity for the third sector regarding the current publically appointed third sector non-officer members, in that they are not representatives for the third sector and therefore it raises questions as to the relationship and accountability to what is quite a complex multi-dimensional third sector (national, local and now regional as well). However it is very important to retain the third sector 'voluntary organisation' independent non-officer member for each health board.

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
To achieve more than token community representation is challenging, particularly if the size of health board membership is being questioned. The third sector 'voluntary organisation' independent non-officer members will contribute to community representation, bringing as they do knowledge and understanding of community voluntary activity and local third sector organisations working with a wide variety of groupings across local communities. If good community participation and engagement in planning and service design and commissioning is achieved with the collaboration of partners, then this may enable a process for electing meaningful representation, or indeed not requiring elected representation.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
The third sector feels that advisory committees can enable new voices to be recognised and heard. Without the committees opening up these new channels, there is the danger of advice being very 'top-down' and limited.

NHS Workforce partnerships

48. Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent

healthcare approach in Wales?
Despite having integrated services, improvement and workforce planning is still separate between Health and Social Services, as is Housing and other partners including the third sector. It is not clear how career development or supervision for integrated services can be supported within these separated structures. Amendments in law need to be made to recognise and support the huge part of the health and social care workforce that is made up of un-paid carers.

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?
The issue for people using direct payments for packages of care is a particular area where legislation is needed to achieve the required integration and partnership between services of NHS Wales and Social Services. Third sector organisations supporting and advising people using direct payments will be pleased to work with Welsh Government and partners to develop such legislative measures.

WGGP167 – Sue Evans/Cllr Huw David – Association of Directors of Social Services Cymru and Welsh Local Government Association

Tref / Town – N/A

General comments

Introduction

1. The Welsh Local Government Association (WLGA) represents the 22 local authorities in Wales, and the three national park authorities and three fire and rescue authorities are associate members.

2. It seeks to provide representation to local authorities within an emerging policy framework that satisfies the key priorities of our members and delivers a broad range of services that add value to Welsh Local Government and the communities they serve.

3. The Association of Directors of Social Services Cymru (ADSS Cymru) is the professional and strategic leadership organisation for social services in Wales and is composed of statutory Directors of Social Services, and the Heads of Service who support them in delivering social services responsibilities and accountabilities; a group of more than 80 social services leaders across the 22 local authorities in Wales.

4. The WLGA and ADSS Cymru welcomes the opportunity to comment on the proposals contained in the Welsh Government Green Paper: Our Health, Our Health Service. The Green Paper sets out some of the wider changes that have happened since the last reform of the health system in Wales in 2009. The demographic change has been well documented and as a result, primary and community care services are facing increasing and more complex demands; more people are diagnosed with one or more preventable health condition; and frail, older people increasingly have more complex needs. This comes at a time when we will continue to experience a time of severe austerity in funding for public services across the UK. Given the challenges being faced by public services and the increasing focus on integrated approaches, it is appropriate that there is a serious reflection on the issues and proposals outlined in the Green Paper.

5. There are a number of significant areas for discussion in our response below, grouped under key themes and areas. We welcome the introduction of common standards, the move towards a system of preventative care, with public services working together and the enhancement of honesty, openness and transparency throughout the NHS. The prudent healthcare principles also complement the approach within social care with the Social Services and Well-being (Wales) Act at its heart. When we look towards what changes need to be made to support some of the proposals within the Green Paper, we are mindful of

the current context and the powers and legislation that already exist, or are being planned, to ensure that we have a coherent and consistent approach across all public services in Wales. We appreciate that the Green Paper is the start of the discussion and the issues are open for debate and both WLGA and ADSS Cymru would welcome working with Welsh Government to discuss the proposals further and help to inform the development of the proposed White Paper.

6. In advance of the National Assembly for Wales elections in 2016 the WLGA has published its Manifesto which identifies the key priorities where we believe the Welsh Government can help councils deliver on national outcomes and prioritise services that matter most to the communities of Wales. A number of these priorities are discussed in our joint response, fully supported by both organisations, and need to be considered as part of the Green Paper, including:
   - Commit to fully cost and fund any new Welsh Government initiatives or legislation.
   - Properly commit to multiyear financial settlements so councils can plan more effectively and support the Welsh Government's longer-term 'Future Generations' ambitions.
   - Urgently reform the increasingly outdated finance formula which underpins funding to properly reflect deprivation, sparsity and the challenges of the future.
   - Keep social care within local government as set out in the Social Services and Well-being (Wales) Act 2014.
   - Establish a new Preventative Integrated Care Fund for Wales funded through the potential Barnett consequential from the £8bn annual NHS investment in England.
   - Transfer Public Health Wales function and its funding into local government.
   - Ensure greater democratic oversight of the NHS through locating the powers of Community Health Councils (CHCs) within local government.
   - Switch investment into preventative services such as social care, economic development, transport, housing, libraries, leisure and environmental health. These services increase people's wellbeing and keep people out of care in hospitals, that is both expensive and can lead to people losing control over their lives.

Current Context and Pressures Facing Public Services

7. The Green Paper acknowledges the fact that the historical pattern of policy, investment and delivery of healthcare services has been focussed more on illness and hospitals, rather than people's health and preventative primary and community care. Over the next few years the vision is to see a change in the way services work together, with health boards investing in primary and community care, supported by hospitals and other services where needed. Developing a system of preventative healthcare, with public services working together with their communities to identify and meet the local populations' needs is welcomed and

complements the requirements of the Social Services and Well-being (Wales) Act to jointly undertake an assessment of the population's care and support needs.

8. However the challenges facing healthcare services in Wales are common across all public services, with local authorities, who play a vital role in supporting the preventative agenda, facing significant financial and demand pressures. The financial challenges facing both health and local authority services are significant and will have long standing implications.

9. In 2012 the Institute for Fiscal Studies report on local government expenditure in Wales showed that, until 2009-10, spend had been increasing in real terms by around 5% each year. This kept pace with inflation and service pressures. From 2009-10, spend has been reducing in real terms; had expenditure kept pace with general inflation it would now be over £7bn. The resulting gap of £720m represents a conservative estimate of the cuts and efficiency savings achieved so far by local government.

10. Local authorities cannot continue to bear the burden of austerity, without it having a major impact on their ability to maintain and deliver services. Services vital to economic growth and the general well-being of communities, such as transport, housing, libraries, cultural services, planning and regulatory services have already faced budget reductions of between 20% and 50%. Some authorities are now looking for further reductions of between 40% and 50% in these areas of spend. It is anticipated that there will be a cumulative budget shortfall of £941m by 2019-20. At a time when local health boards and NHS trusts now have helpful flexibility to plan over three years, with the development of integrated medium-term plans, it is vital that the increasingly outdated finance formula which underpins funding distribution for local authorities is reformed, to properly reflect deprivation and sparsity and the challenges of the future. Equally, the reintroduction of multi-year financial settlements for councils would create more planning certainty when looking at future service delivery and allow for the better planning of services with the NHS.

11. The Bevan Commission paper 'Improving Primary and Community Health care in Wales' identifies that the way NHS Wales is funded needs to change, to strengthen primary and community care to better meet the needs of the population. It points to an imbalance in funding for some time with little movement of resources into primary and community care to match the need and help prevent illness and unnecessary admissions to hospital. At the same time social care services are having to meet increasing demand within reduced resources. It is essential that we take this opportunity to invest in NHS primary and community care and look to support preventative services, improving the link between NHS and social services / local authorities.

12. The increasing demand for services and demographic changes at a time of austerity, has increased the importance of providing preventative activity and services aimed at early intervention (with the intention of holding off more costly and potentially intrusive interventions at a later stage) and we consider that now is the time to invest new monies in local government preventative services. In Children's Services, it is now very clear that investment in early years and safeguarding have helped to ensure that children are afforded an equal opportunity to reach their full potential, including their future health. Local government has a key role to play in promoting physical activity and enhancing community support. This approach would fully chime with the principles of the Wellbeing of Future Generations Act in Wales.

13. This is not just a view from within local government; it is shared by the Chief Executive of NHS England, Simon Stevens, who, in the seminal report, "Five Year Forward View" published in October 2014, argued that, "We need to get serious about prevention". As he stated

> "The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences".

14. Achieving greater well-being for people will require action by all agencies at all levels, building community resilience in order to have a collective responsibility – it is not only for social services and health, but requires corporate and far-reaching approaches across a wide range of organisations to maximize a preventative approach to working with citizens. WLGA and ADSS Cymru believe that cultural and leisure services provide a significant role in improving the health, wellbeing and quality of life of people and communities, particularly those that experience social inclusion. These services enhance community integration, as well as promoting access to fitness and recreational opportunities. There is also a need for further focused activity on demand management, for example, the North Wales Regional Board have agreed to develop pilot projects, where they will seek to better coordinate and integrate their services, through a stronger sense of partnership working, with the long term aim of reducing demand and minimising people's vulnerability.

Collaboration and Integration

15. The Green Paper has a focus on how we can strengthen local collaboration in planning and meeting people's health needs closer to home. Collaboration is one of the fundamental principles of the Social Services and Well-being (Wales) Act, with the aim to have stronger partnership working across all organisations that better support people to improve their lives and their experiences of the services on offer. The

Act already introduces requirements for health and social services to work together under Part 9 (Co-operation and Partnerships) and makes provision about promoting the integration of care and support with health services. This includes creating partnership arrangements between local authorities and local health boards for the discharge of their functions and requirements on the use of pooled funds. Part 2 of the Act also requires local authorities and health boards to undertake a joint assessment of the local population's care and support needs. We need to ensure that we build on these and make sure the structures put in place work and embed this legislation in current practice before we look at introducing further legislation that seeks to achieve similar ambitions.

16. The integration of and collaboration between health and social care is only a means to an end, i.e. improving people's lives, whereby they are enabled to play a central part in determining what will best support them to lead fulfilling lives and to have easy access to information that enables them to make choices about their health and well-being.

17. Ham and Curry (Integrated Care. What is it? Does it Work? What does it mean for the NHS? King's Find, 2010) recognise that successful integration of services is dependent on having a shared purpose and a clear vision of what it will achieve. They highlight the clear evidence that demonstrates that, when it comes to delivering benefits to people's lives, the integration of clinical teams and services is far more important than the integration of organisations. The Social Services and Well-being Act firmly locates social care within local government, a position also supported by the Commission on Public Service Governance and Delivery.

18. In Wales the Intermediate Care Fund has provided opportunities to develop new models of service that have involved the integration of and increasing collaboration between health and social care, along with the essential and greater contribution of housing, third and private sector agencies. It is important that we learn from this, as well as from the approaches in other countries, in order to be able to accelerate this agenda in Wales, making better use of available resources across the whole health and social care economy leading to towards more meaningful collaboration.

19. We believe that in Wales, we need to accelerate and embrace a new and radical approach to health and social care integration with local government at its heart. In the recent period, the Welsh Government has increased investment in the Welsh NHS by more than £400m. This means the total budget for Health and Social Services in Wales in 2015-16 will be £6.7bn, a record high. This includes a recent £70m consequential in addition to the extra £295m being invested by the Welsh Government in health and social care in 2015-16. This means the budget for Health and Social Services in Wales in 2015-16 will account for just under 50% of the total Welsh Government budget. In addition, the UK government has pledged to protect the NHS with a guaranteed

£8bn increase in spending per year above inflation, by 2020. If this works on a basis of a Barnett Consequential, this would see additional monies coming into Wales over the next 4 years. If meaningful integration across health and social care is to occur, it needs a step change and any additional consequential resources could be the driver of this.

20. In 2013 the UK government announced the Better Care Fund for England – a local, single, pooled budget intended to incentivise NHS and local government to work more closely together, with the aim of improving people's lives and where necessary to use integrating services as a means to that end. The original intention was for the fund to support adult social care services that have health benefits, helping people to remain healthy and independent within the community. Following a revision to the policy in 2014, the emphasis changed to reducing emergency hospital admissions and achieving financial savings, with a proportion of the fund now linked directly to performance against these goals. The Social Care Act 2012 also introduced health and wellbeing boards as a new local vehicle to promote integration. Whilst concern has been expressed that changes to the fund have undermined its core purpose in promoting locally-led integrated care, creating a dedicated fund to support transformative change could be similarly influential in supporting change in Wales. The King's Fund (Making change possible: a transformation fund for the NHS, Kings Fund, 2015) have made the case for dedicated funding to support transformative change in England and similarly the LGA have called for a £1bn annual transformation fund which would underpin the transition from reactive to preventative behaviours in the health and care system, building on the Better Care Fund. ADSS Cymru and WLGA reinforced this case in our submission to the consultation on the recent Review of NHS workforce.

21. The Social Services and Well-being (Wales) Act provides us with an opportunity to look at how we can support the delivery of integrated services, the Regional Partnership Boards (building on the existing regional arrangements) provide a vehicle to support this work, with the NHS and local government sharing responsibility for leading a mature relationship with other key players, e.g. third and private sector agencies, housing associations and other communities of interest, such as users and carers. Any health and social care partnership arrangements should be subject to effective democratic oversight, with well-defined governance lines being drawn between partnership structures and the parent council and their respective Health Boards.

Legislation

22. One of the purposes of the Green Paper is to stimulate debate and seek views on two main elements – whether legislation may be required to help further improve the quality of healthcare services in Wales and whether any legislation is needed in order to bring the current NHS governance structures up to date and ensure its functions are fit for

purpose. Whilst legislation can have a role in supporting some of these elements, simply legislating in a policy area will not guarantee the changes required to improve the quality of services. The Green Paper comes at a time when there are other significant pieces of legislation being introduced, e.g. the Social Services and Well-being (Wales) Act, the Housing (Wales) Act, the Well-being of Future Generations (Wales) Act and the Public Health (Wales) Bill. Each of these requires public bodies to think about and plan more about the long term, work better with people and communities and each other, to prevent problems and take a more joined-up and collaborative approach. From the outset, we need to reinforce how existing legislation and other powers can support NHS to make the desired changes outlined in the Paper. Legislation does not necessarily lead to the improvement of services, rather it can just end up adding another level of bureaucracy. Our limited time and resources are likely to have more impact in other areas, such as training and capacity building.

23. The Social Services and Well-being (Wales) Act will have a significant impact as it is implemented over the next few years and whilst the Act looks to support greater partnership working and integration of services, we need to look at how best this can be achieved in light of some of the challenges that we are facing. The Act provides future direction for how services can and should be delivered. It is intended to transform the way social services, social care/wellbeing and community health services are delivered through an approach that is focused on achieving the outcomes necessary to promote a person's well-being - as an individual, as part of a family and as part of their community. It looks to drive the development of new models of service to maintain and improve the health and wellbeing of people, e.g. through cooperatives and social enterprises, with a stronger focus on prevention and early intervention. The aim is this will be achieved through greater partnership working and integration of services. This is an area that the Green Paper reinforces and so we need to focus on how, through the existing legislation, we can meet the need for more joined up planning and delivery of preventative services as these could potentially be more effective if they are delivered as integrated services.

Information Sharing

24. Information sharing will always be key characteristic of ensuring the provision of quality services as part of a collaborative and/or integrated system. We welcome this as an area that requires examination and would point to developments such as the Community Care Information System (CCIS), a single integrated solution to be available to all health and social care organisations across Wales. CCIS will be launched in April 2016 and demonstrates local government's and NHS's commitment to support information sharing, case management and workflow between organisations. It is important to recognise that this has been supported by a significant amount of funding from the Welsh Government. This highlights one area, between local authority social services and NHS, where we are working together to find solutions. We recognise that more

needs to be done to build on this example if we are to overcome the inevitable challenges to put in place complementary electronic systems for the benefit of the public, particularly given that Local Health Boards and local authorities currently have multiple and different systems being used by Community and Mental Health staff. The work around CCIS highlights the size of the task and the significant resources required to support this, but that this should not be an insurmountable challenge.

Examination of Roles

25. In terms of the Welsh Government's agenda around wellbeing, the WLGA and ADSS Cymru believe that the time is right for a full examination of the creation of a public health improvement role, located within local government. Public Health Wales was established as an NHS Trust in 2009 and is an organisation with a very good reputation employing some 500 people and with a budget of £81m. On top of that, local authorities currently spend £1,565m on social services, £94m on leisure services and £52m on regulatory services (including environmental health), demonstrating the significant scale of local government's contribution to the wider public health agenda in Wales.

26. Public Health Wales, located in the NHS, is inevitably dwarfed by the larger configurations of secondary care. There needs to be a step change in promoting and enhancing public health in Wales. The BMA in Wales have previously warned "that rising levels of smoking, drinking and obesity, alongside health inequalities across the country, were leading to worsening numbers of chronic diseases that would inevitably place a greater strain on the health service. In this setting it is vital that the public health agenda is pursued in parallel with health service provision".

27. Locating public health functions in local government would give a new impetus to the public health agenda, allowing closer working with GPs and linking into the enforcement role that councils have in areas such as food safety and environmental health matters. Local government fully accepts that where a public health service is deeply intertwined with the delivery of clinical services, or where services are part of the primary care contractual arrangements, there must be an on-going NHS role and the aim would be to strengthen its role across the whole of the public sector.

Community Health Councils (CHCs)

28. CHCs were established over 40 years ago and are one of the longest standing NHS organisations in Wales. Given this and the fact that CHCs have not substantially altered in many years and the significant changes that have happened during the same period within the NHS, it is right that we examine whether this model adequately represents patients' interests.

29. In England CHCs were abolished in 2003. A House of Commons Select Committee Inquiry took evidence on this issue and heard that what

matters is not patient and public involvement structures, but effective involvement of patients and the public. Structures and procedures will have little effect if the NHS is not prepared to listen and make changes as a result of what they learn. Effective patient and public involvement is about changing outcomes, about the NHS and social care providers putting citizens at the heart of everything they do and hence is about much more than structural change.

30. As highlighted in 'Moving Towards World Class? A Review of Community Health Councils in Wales', there remain concerns about many aspects of CHCs' organisation and performance, including the size and composition of the membership, variable performance, their public profile, how they fit together with all the other health bodies, and the extent of their influence.

31. WLGA and ADSS Cymru believe that this is an opportunity to make changes and ensure greater democratic oversight of the NHS, through locating the powers of Community Health Councils (CHCs) within local government. We need to look at how and how far local authority's scrutiny role could engage in and support the scrutiny of Local Health Boards. It could help to address the "democratic deficit" in the NHS, while simultaneously giving councils an opportunity to, more powerfully, represent the views of their communities. Elected local councillors would be able to voice the views of their constituents, and hold relevant NHS bodies and relevant health service providers to account. To this end, it is essential that health scrutiny functions are also carried out in a transparent manner, so that local people have the opportunity to see and hear proceedings. This has the potential to have greater impact than scrutiny by a CHC, particularly in terms of scrutinising strategic policy decisions, and the interface between NHS and other services at a partnership level. A refocusing of CHCs to become the voice of the patient and user as highlighted in the Green Paper, while local authorities scrutinise the overall service, is what we would recommend for serious consideration and both WLGA and ADSS Cymru would welcome working with Welsh Government and NHS Wales, to discuss this proposal more fully.

32. In England the new transparency measure in the Local Audit and Accountability Act 2014 sees Local government making an even greater contribution to NHS since taking on public health functions in April 2013. In Wales, social care and health services are becoming ever more closely integrated and with consequent impact on each other, with the result that scrutiny of one may entail, to a certain extent, scrutiny of the other.

Health Board Membership

33. The Green Paper raises questions over the current health board membership and whether the boards are fit for the present and future

challenges facing the NHS, particularly in light of the Commission on Public Service Governance and Delivery recommendations. The Commission's recommendations included that the appropriate cabinet members from each of the local authorities within the health board area are appointed as independent members and that at least one local authority director of social services should be appointed to the board to support the integration of services with local authorities in the health board area.

34. We would welcome the opportunity to have further discussions around the future membership and structure of the boards – the involvement of both Directors of Social Services and cabinet members is essential to support the work of both NHS and local authorities, particularly around the integration of services. We would want to ensure that any extension of both the roles of cabinet members and Directors of Social Services are aligned with other future changes, such as the Public Services Boards under the Well-being of Future Generations Act and the Regional Partnership Boards under the Social Services and Well-being Act. There are considerable demands already being placed on these roles and so any change has to be measured against the 'added value' that it can bring to ensure that we make the best use of the resources available.

Healthcare Inspectorate Wales (HIW) and Care and Social Services Inspectorate Wales (CSSIW)

35. The Green Paper outlines the fact that certain activities such as pop-up vaccination clinics and private midwifery services are not covered by the existing legislative framework and so it would seem sensible to review the legislation underpinning HIW. The Marks review also promoted the idea of closer working, or even full integration of HIW and CSSIW which merits further consideration.

36. As the Green Paper notes, we are seeing the integration of many health and social care services at a local level and so it is appropriate to explore how similar methodologies could be employed across the inspectorates. We would fully endorse the need for the two inspectorates to work closer together – as the integration agenda moves forward under the Social Services and Well-being (Wales) Act this will become more and more important and it may well be that in time, as further integrated services develop, the full integration of the inspectorates could be of benefit. There is an opportunity here to learn from the approaches of other countries, e.g. Northern Ireland where the two inspectorates are already combined, albeit within an environment where health and social care are more fully integrated at an organisational level. We also need to be mindful of how the inspectorates work within other settings and with other bodies such as Care Council for Wales, Estyn and the Wales Audit Office and it will be important to fully consider the implications on all partners.

Conclusion

37. The Green Paper covers a wide range of issues and suggests a number of proposals all aimed at improving health services in Wales. WLGA and ADSS Cymru support the shift towards preventative and primary and community care, and the ambition to build a culture of continuous improvement with quality at the heart of services within an open, honest and transparent environment. There is already much in place which we can build on and both ADSS Cymru and WLGA are committed to working with NHS and Welsh Government to support this work.

38. Our joint response outlines some of the significant challenges which are facing local government, and social services in particular, and it is clear that local authorities cannot continue to bear the burden of austerity without having a major impact on our ability to maintain and deliver services, including preventative services. We need to consider how best to support continuous improvement in the well-being of the population, through the involvement of and engagement with citizens, alongside greater collaboration between and/or integration of health and social care. The Social Services and Well-Being Act provides the framework for a step change in making this happen and any additional resources being invested into NHS could be the driver of this.

1. We also need to consider the current legislative context in Wales before looking to create any additional legislation. There have been significant pieces of legislation recently enacted and others are passing through the National Assembly. These will all require public bodies to think more about the long term, work more closely with citizens and communities and each other, looking to prevent problems through a more joined-up approach. We need to allow these changes to become embedded before we look to add new legislative requirements. Many of the aspirations of the Green Paper, such as strengthening local collaboration and planning and meeting people's health and well-being needs closer to home, are echoed within these pieces of legislation.

2. ADSS Cymru and WLGA are keen to be involved and, with NHS Wales, jointly shape the discussions and debates as the proposals in the Green Paper move forward.

Response to specific questions

No response to specific questions.

WGGP168 – Alan Bermingham – The Chartered Institute of Public Finance and Accountancy
Tref / Town – N/A

General comments

1.0 Executive Summary

1.1 CIPFA has limited its responses to chapters 7 and 8 of the Green Paper. We have therefore focussed on NHS borrowing arrangements and; leadership, governance and partnerships within this submission.

NHS Borrowing Arrangements

1.2 CIPFA supports the view that borrowing powers should be available to NHS bodies, including health boards in Wales, supported by the establishment of a prudential borrowing framework.

1.3 CIPFA believes that there is a need for borrowing powers by NHS bodies including health boards to be supported by legislation that would underpin the framework for control of borrowing and ensure future financial sustainability.

1.4 The roles of those charged with governance and those charged with financial management and accountability for preparation of budgets and estimates will need to be supplemented with clearly stated responsibilities for any enhanced borrowing arrangements.

Leadership, Governance and Partnerships

1.5 CIPFA believes that working across organisational boundaries and through partnership or collaborative working arrangements requires careful consideration of the supporting governance arrangements.

1.6 In devolving the appropriate codes of governance for NHS bodies in Wales, CIPFA advocates incorporation of the principles contained in the International Federation of Accountants (IFAC) and CIPFA publication 'International Framework: Good Governance in the Public Sector'[62] in order to promote a consistent framework and culture across the sector.

1.7 CIPFA believes that it is essential for chairs and board members to exercise leadership and have the necessary skills and training to allow them to complete their scrutiny and challenge role effectively

2.0 NHS Borrowing Arrangements

2.1 Borrowing powers can provide additional flexibility for funding Capital Investment and, under specific circumstances, support larger one-off

[62] CIPFA IFAC International Framework: Good Governance in the public Sector
http://www.cipfa.org/policy-and-guidance/standards/international-framework-good-governance-in-the-public-sector

revenue spending aimed at future cost saving or re-organisation.

2.2 CIPFA supports the view that borrowing should be available to NHS bodies, however the framework under which borrowing is allowed needs to be established and a set of core principles underpinning the governance and decision making for entering borrowing arrangements fully understood *(see Appendix A)*. CIPFA believes that there is a case to be made for a review of borrowing across the NHS in Wales with the consideration of implementing a prudential borrowing arrangements in the sector.

2.3 A prudential borrowing framework in the NHS would place relevant NHS bodies under the same framework as currently exists in Local Government[63] and has been proposed[64] for devolved government borrowing in Scotland under the Smith Commission.

2.4 CIPFA would contend that there would be a need for a legislative framework to support prudential borrowing powers for NHS bodies in Wales arising from the following:

(a) The fact that any borrowing powers should have a legislative basis

(b) Legislation supporting a prudential approach allows Welsh NHS bodies flexibility in determining overall borrowing levels subject to the agreed fiscal principles. This would potentially enable more effective interventions to support NHS Investment and efficiency measures as required, rather than being restricted to set limits as in the current legislation under the NHS (Wales) Act 2006.

(c) Legislation of this nature fully supports a robust set of institutional arrangements that are designed to ensure financial sustainability in public finances.

(d) The prudential system, underpinned by legislation and regulation, provides a self-regulatory framework that extends into all areas of the NHS in Wales, subject to retention of reserve powers by the Welsh Government.

(e) An important aspect of the self-regulatory environment created by the prudential system is that it closely links with capital and asset management planning and therefore supports more effective value for money decision making on capital investment.

A similar legislative framework to Local Government in England and Wales is in place elsewhere for Local Government in the UK through legislation[65].

2.5 In summary, the operation of this framework will require the Welsh

[63] CIPFA: 'Prudential Code for Capital Finance in Local Authorities' and Prudential Borrowing Arrangements under part 1 of the Local Government Act 2003 in England and Wales

[64] Smith Commission Report for further devolution of powers to the Scottish Parliament – para 95(5) November 2014

[65] Scotland under Part 7 of the Local Government in Scotland Act 2003 and Northern Ireland under Part 1 Local Government Finance Act (Northern Ireland) 2011

Government to consider:

i) The supporting legislation and regulations governing the framework.

ii) Effective Corporate Governance arrangements. This will include identification of the relevant and appropriate NHS body that will oversee and approve the operation of the Prudential Framework. This would include approval of a set of agreed Prudential Indicators.

iii) Clearly defined roles and responsibilities for the Chief Financial Officers of all NHS bodies covered by the legislative arrangements. Particularly, this role will involve responsibility for ensuring that matters to be taken into account when setting and revising prudential indicators are reported to the relevant decision making body for consideration. Preparing and presenting the Prudential Indicators for agreement and also, reporting regularly on the robustness of the estimates used in this regard.

2.6 Alongside the prudential framework there needs to be a comprehensive Treasury Management and Borrowing strategy. This will ensure that the principles of security and liquidity of funds is secured and that yield from investments is considered but not at the expense of security and liquidity.

2.7 An important point to observe in this framework is that borrowing is not linked to asset purchases, i.e. the Welsh NHS Bodies should not be borrowing for specific assets, but for its need to finance capital requirements. This means that should the relevant bodies have freely available funds in reserves, it may decide to utilise those funds in the short-term rather than borrow at an increased cost.

2.8 Adopting this approach may also necessitate that the charge made to revenue budgets for the cost of borrowing reflects the organisations borrowing need and not its actual loan debt. In local government this is facilitated by local authorities making a minimum revenue provision against revenue budgets for their underlying need to borrow. How and when they actually borrow the funds is a matter for their treasury management strategy.

2.9 Approval, alongside the Prudential Indicators, would be required for the Treasury Management Strategy and Policy and any minimum revenue provision against budgets.

3.0 Accountability and Governance

3.1 If the Welsh Government adopts a Prudential Framework approach within the NHS in Wales, this does indicate a move towards a more self-regulated process and away from fixed limits on borrowing. As a

result the accountability and governance arrangements need to be robust and effective for the system to be successful.

3.2 The Prudential Indicators and the approval of them, form an important element of the accountability and governance process. The approval requirements arise from the necessity that decisions about borrowing and its affordability are matters of judgement, which must be made by those charged with governance and accountability.

3.3 To support these arrangements, CIPFA would strongly advocate that the roles of those charged with governance and accountability and the timing of events in the approval and monitoring cycle are fully documented and understood.

4.0 Leadership, Governance and Partnerships

4.1 CIPFA has carried out significant work in leading the debate on governance arrangements in the public services. Our most recent generic project in the area of governance is the development and promotion of the *International Framework: Good Governance in the Public Sector* which was drawn up in association with the International Federation of Accountants (IFAC).[1]

4.2 The International Framework was developed after a review of relevant current governance literature from across the globe, and builds on this literature, particularly IFAC's and CIPFA's earlier work on governance, including *Governance in the Public Sector: A Governing Body Perspective* (IFAC, 2001)[66] and *Good Governance Standard for Public Service Organisations* (CIPFA/OPM, 2004).[67] It sets out seven core, high-level principles characterising good governance in the public sector, that bring together a number of interrelated concepts.

4.3 The International Framework positions the attainment of sustainable economic, societal, and environmental outcomes as a key focus of governance processes and structures in the public sector. The Framework also considers sustainability and the links between governance and public financial management in order to encourage a recognition of the need to focus on the long term. The principles from the International Framework are illustrated in the diagram overleaf.

4.4 Our governance work in health includes *Practical issues in the governance of Clinical Commissioning Groups* which was published in October 2015.[68] This guide is intended to give Clinical Commissioning Group (CCG) members an introduction to best practice in governance.

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[66] IFAC Public Sector Committee: Governance in the Public Sector: A Governing Body Perspective International Public Sector Study – August 2001

[67] CIPFA and Joseph Roundtree Foundation Good Governance Standard for Public Service Organisations http://www.cipfa.org/policy-and-guidance/reports/good-governance-standard-for-public-services

[68] CIPFA Practical issues in the governance of Clinical Commissioning Groups http://www.cipfa.org/cipfa-thinks/insight

5.0 The principles of good governance

"Governance comprises the arrangements put in place to ensure that the intended outcomes for stakeholders are defined and achieved.

5.1 To deliver good governance in the public sector, both governing bodies and individuals working for public sector entities must try to achieve their entity's objectives while acting in the public interest at all times. Acting in the public interest implies primary consideration of the benefits for society, which should result in positive outcomes for service users and other stakeholders.

(International Framework: Good Governance in the Public Sector, CIPFA/IFAC, 2014)

5.2 The diagram from the *International Framework, below* illustrates how the various principles for good governance in the public sector relate to each other. Principles A and B permeate implementation of principles C to G. The diagram also illustrates that good governance is dynamic, and that an entity as a whole should be committed to improving governance on a continuing basis through a process of evaluation and review.

6.0 Comments and Conclusions

6.1 CIPFA supports the emphasis in the Green Paper on the need to consider carefully the governance aspects associated with

working across organisational boundaries when services are provided through partnership and collaborative working.

6.2 The NHS in Wales will continue to operate in a difficult economic environment for some time to come. At the same time, the development of new collaborative structures and ways of working provide challenges for ensuring transparency, demonstrating accountability and, in particular, for managing risk.

6.3 When working in partnership, NHS organisations must ensure that robust governance arrangements are established at the outset which ensure that there is a shared view of expected outcomes supported by effective mechanisms for control and risk management thereby ensuring that the public purse is properly protected.

6.4 A key issue emerging from those responding to the CIPFA/SOLACE consultation on an updated Framework for *Delivering Good Governance in Local Government* was that there should be some correlation between governance frameworks, guidance and codes used in different parts of the public sector in order to ensure that they are useful when establishing governance arrangements for collaborative working. This links with the overall intention behind the *International Framework: Good Governance in the Public Sector.*

6.5 The International Framework is not intended to replace national and sectoral governance codes. Instead, it is anticipated that those who develop and set governance codes for the public sector will refer to the International Framework in updating and reviewing their own codes.

6.6 When codes of governance are updated for NHS organisations in Wales, we believe that it would be helpful if the International Framework formed part of the basis for the review. The principles for good governance set out in the International Framework provide for a shared understanding of what constitutes good governance across the public sector.

6.7 In our view, it is crucial that governance arrangements are applied in a way that demonstrates the spirit and ethos of good governance which cannot be achieved by rules and procedures alone. We therefore support paragraph 113 of the Green Paper which acknowledges the importance of a consistent culture in achieving good governance.

6.8 Such arrangements need to be matched to be effective in practice. It is therefore helpful for board members working in partnerships to receive appropriate training. Working in partnership requires the ability to work across organisational boundaries and to confront and influence those who might put up barriers to co-operation. Training should also include guidance on how to deal with apparent competing and/or conflicting demands in respect of the partnership versus their role in their own organisation.

6.9 Challenge and scrutiny contribute to good governance by being a key part of transparent and accountable decision making, policy making and review. It is essential that board chairs and members exercise leadership and have the necessary skills and training to allow them to scrutinise and challenge effectively and that concerns are taken seriously and where relevant incorporated into appropriate recommendations.

6.10 It is important that the governance of partnership arrangements is scrutinised closely. Although those responsible for scrutiny may not be permitted to access all the information they would like owing to contractual arrangements, oversight of outsourced services and joint operations should still allow for an element of openness and accountability that might otherwise not exist.

APPENDIX A

Principles and the Operation of the Prudential Framework

The main principles behind the prudential framework, as used in Local Government, are the affordability, sustainability and prudence of borrowing decisions. The framework supports improved strategic and asset management planning and we believe will underpin a good practice in capital and investment planning.

(a) Affordability

The fundamental objective of affordability is to ensure that capital plans remain within sustainable limits and in particular, to consider its impact on revenue resources and therefore service delivery. Setting affordable limits for borrowing within a prudential framework is a specific requirement and helps ensure that the further objectives of sustainability and prudence are addressed.

(b) Sustainability

The sustainability of public finances underpins the overall UK fiscal framework and this is supported within the operation of the prudential code. Sustainability of public finances relates to the ability of a government to sustain its current spending, tax and other policies in the long run without threatening government solvency or defaulting on of its liabilities or promised expenditures.

With increasing devolution to the Welsh Government, this will bring increased volatility in revenues and the need to ensure the consequences of long-term investment in capital assets through borrowing or public private partnerships are fully understood. Putting such arrangements in place within the NHS in Wales will provide a solid platform to work towards ensuring financial sustainability at all levels of the Welsh Government.

(c) Prudence

The prudent level of borrowing is linked to ensuring that ensuing debt will only

be for a capital purpose. External debt should not, except in the short term, exceed the total of its capital financing requirement. This is a figure that represents the total value of prior year capital that remains un-financed. It is also prudent that treasury management activities are carried out in accordance with good professional practice. Within the CIPFA Prudential Code, local authorities are required to adopt the CIPFA Treasury Management Code of Practice[69].

The borrowing levels within the prudential framework are linked to their implications on affordability within the revenue budgets rather than capital budgets. This means that the impact on running costs is the driver of affordability rather than the level of capital budgets available. This also helps underpin the longer-term inter-generational affordability and prudence of capital investment plans.

Response to specific questions

No response to specific questions.

[69] CIPFA's Treasury Management in the Public Services: Code of Practice and cross sectorial guidance notes 2011

WGGP169 – Leighton Veale – The Royal College of Surgeons
Tref / Town – N/A

General comments

Response to specific questions

Chapter 1: The changing shape of health care

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?
As part of the current process of reconfiguring health services in Wales, there needs to be a clear requirement for the individual health boards to collaborate on their planning and co-operate on the provision of services across health board boundaries. The College is concerned that clinically necessary service changes, such as those necessary for emergency surgery or vascular surgery, have progressed too slowly. Any further changes to laws on service change therefore need to avoid lengthening the process while maintaining sufficient public consultation.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
At present, when a Community Health Council challenges a reconfiguration decision the Health Minister can ask the Chief Medical Officer to convene a panel of experts to review the proposal and make recommendations to the Minister. We believe the Welsh Government should consider adopting the model of the Independent Reconfiguration Panel in England to bring an additional level of independence and public confidence to any reconfiguration review.

Chapter 3: Quality in Practice

Meeting common standards

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
The Royal College of Surgeons of England is committed to enabling surgeons achieve and maintain the highest standards of surgical practice and patient care. The delivery of good surgical care is not always straightforward, however, and there are many daily challenges for surgeons and the teams

they work in. The College is committed to providing assistance wherever this is required and to helping to ensure that patients receive good quality care.

When a healthcare organisation needs an external expert opinion on a surgical service or an individual surgeon, the RCS is able to offer an invited review which can provide expert independent and objective advice. We have provided this service to a number of Boards in Wales.

The College believes that invited reviews offer a highly valuable resource by providing healthcare organisations with independent expert advice. Through reliable and trustworthy peer review processes standards can continue to be improved and concerns can be addressed.

Invited reviews are a partnership between the RCS, the specialty associations and lay reviewers representing the patient and public interest. An invited review supports - but does not replace -existing procedures for managing surgical performance.

NHS Wales should make full use of the various review mechanisms provided by professional bodies.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
Yes. Candour and openness are a fundamental part of what it means to be a healthcare professional. To drive up standards of care, professionals and organisations need to be honest about their mistakes in order to quickly deal with errors and learn from them. Candour also allows the public to understand why decisions have been made, encouraging patients to be involved in their care. Openness and transparency need to be led by the top of the organisation to engender real culture change and drive professionalism in the Welsh NHS. A statutory duty of candour was introduced in England in 2014. Keith Evans' review of the Welsh NHS recommended a similar duty be put in place in Wales, which we clearly support. In April 2015, the College published a best practice guide on how to implement the principles of duty of candour in everyday practice. In this we outlined steps that surgeons should take on an individual level, to ensure that the principles of the duty of candour are at the forefront of everyday work. Specifically, we outlined the following considerations for surgeons and their employers: • How to nominate an individual to carry out the disclosure discussion • The process for apologising and understanding liability

- Details on timing, location and persons to notify should an error occur
- How to ensure that the patient is well supported
- How to facilitate an open dialogue with patients
- What documentation is required
- What to do if the error occurred in a different organisation
- The support that should be available for surgeons and surgical teams who have been involved in harm
- How to report the incident and ensure lessons are learnt
- Ensuring that there is a culture of openness, focusing on patient safety

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
Data collection in Wales needs to be improved. Specifically, outcomes and recording activity has not been well resourced in the past. As a consequence there has not been any imperative for organisations to collect this data in the same way as there has been in England where Payment by Results and tariffs for procedures has been an important part of the medical organisational landscape. Data and outcomes have not been seen as an organisational responsibility. We strongly supported the announcement by Welsh Government in July 2013 that they would work to publish surgical outcomes data in Wales at a unit level with consideration given to individual outcome data at a later date. It is disappointing that more progress has not been made since this announcement, as the publication of unit outcomes data will drive forward improvements in care. We urge the Welsh Government to make this an urgent priority, and we have already expressed our willingness to work closely with Welsh Government on this. In Wales, there is no routine publication of data on how many operations are cancelled and whether the cancellation is for a clinical or non-clinical reason. Having access to this data would help to clarify why operations are being cancelled and where there are pressures in the system which might be contributing to high waiting times for some types of surgery.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

24. Are there gaps in the current legislative framework to enable HIW to operate effectively? If so, what are they?
In Wales the supervision and governance of the NHS is the responsibility of Healthcare Inspectorate Wales. HIW was established and funded by the Welsh Government but is independent of it. Its stated purpose is to provide assurance of standards of the NHS in Wales to the public.

The RCS believes there needs to be a much clearer system of inspection and external challenge in the health service in Wales. This should continue to include specialist clinical leads in inspection teams, the need to incorporate intelligence and data collected by other third party organisations, a comprehensive programme of peer review, and further unannounced visits. Consideration should be given to appointing a Hospital's Inspectorate within HIW as in England to support the wider work of HIW. Changes to HIW need to happen quickly as the public need urgent assurance about the standards of care in Welsh hospitals. We believe there is merit in reviewing all hospitals in Wales – perhaps through HIW's revised inspection regime – to provide that assurance and to reassure the public about standards following a number of instances of poor care and long waiting times. Given the above, the Royal College firmly believes that a strengthened HIW, fully independent of Welsh Government is vital to put safety and patient care at the heart of the Welsh NHS.

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
The Royal College of Surgeons strongly supports a fully independent Healthcare Inspectorate Wales for the reasons we set out in our response to the previous question.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

36. Does the current size and configuration of health board membership best promote an effective focus on decisions, priorities and scrutiny? If not, how might health boards be reformed?
The Royal College believes that there needs to be greater collaboration between clinical and managerial leaders in the NHS in Wales. There has been an historical culture of financial priority in decision-making within Health Boards although the move to a three year financial planning cycle should help to mitigate against this. As well as financial prudence to balance the books, Local Health Boards should ensure a patient centred approach to service development. At present, with the exception of the Medical Director, there is no medical staff representation on Board or Executive roles in Health Boards in Wales. There is therefore a need to elevate the professional and clinical agenda within the decision making process in Health Boards. We believe lay or patient representation should also be sought at all levels of the NHS, especially on NHS trust boards, specifically in developing standards.

This would help the patient voice to be heard at the highest levels in the NHS, to ensure the focus of decision-makers is on improving patient care.

Advisory structure

46. Given the many ways that Welsh Ministers and NHS leaders can access expert professional and clinical advice, should we seek to change the statutory status of the advisory committees?
As mentioned, there are now a number of bodies producing guidance and recommendations about how to improve clinical standards in healthcare in Wales. These include the Welsh Government, medical royal colleges (including the RCS), other professional bodies, and the National Institute for Health and Care Excellence (NICE) which publishes both technical appraisals and non-statutory guidance. Adoption of relevant guidance can help to drive standards in healthcare and reduce regional variations in access to services and their quality. Though we do not give a view on changing the status of the advisory committees, we believe there is merit in reviewing the role of the National Clinical Forum (NCF) and other Government appointed committees providing clinical advice. An expanded NCF, or its replacement, needs to become more proactive in assessing such guidance as it applies to Wales, encouraging health boards to implement advice where appropriate, and monitoring uptake. Ideally, any new body should be more independent of Government to create public and professional confidence in its recommendations and actions.

WGGP170 – Mansel Aylward – Bevan Commission
Tref / Town – N/A

General comments

Summary
The following provides an overview of the thinking and views of members of the Bevan Commission in response to the Welsh Government Green Paper. Bevan Commissioners have responded by highlighting a number of key strategic themes which it felt were key and of greatest significance to the health and well being of people in Wales.

The Commissioners recognised that legislation was necessary to define matters such as representation, functions, responsibilities and accountabilities. They also recognised its value in defining some aspects of policy making and implementation. However they felt that it had a much smaller place in shaping the things that really matter in influencing the quality of healthcare which depends so clearly on the values and behaviours that we recognise as leadership, commitment, duty, taking responsibility and accepting accountability.

The Green Paper covers a wide range of issues of significance including leadership, governance, information and managing change of the health services in Wales. This requires an integration of system thinking around a number of traditional models of health and care including; the medical model, the public health model and a social determinants model understanding the impact of wider determinants. The Bevan Commission will be considering this in further depth in the coming months and will produce its model based upon a social model of health which takes account of a range of factors in sustaining health and well being consistent with a prudent approach to health.
The Commission recognises the new ground breaking laws being made in Wales, however the challenge will be in their implementation.

1. Welcome emphasis on quality.
With particular exceptions legislative means are neither appropriate nor an effective means of improving quality. There are other, tried ways of achieving this. Ensuring quality and seeking improvement reflects the cultural and behavioural aspects of health professionals and their management colleagues, operating collaboratively under the influences of leadership, commitment and motivation at service level locally.

There might be a case for legislating for the introduction of a Quality System (eg ISO) which emphasises quality at individual as well as corporate level (Kaiser Permanente assessed system). This could be an area for future exploration. We must look for other means by which to embed an attitude which assumes responsibility and ownership for the provisions of care which best meets the needs of individuals.

The Green paper sets out four lines of defence against quality failures and refers to the forthcoming OECD paper on health care quality in the four UK countries. This raises a question around the need for objective and independent agencies to reassure the public about the quality of care being delivered and whether there is a case for a review of information governance including an independent statutory agency as in other countries such as Australia.

2. Over emphasis on the use of legislation

Commissioners had some concerns about the apparent over emphasis on legislation as a solution to a broad range of issues. There is the potential that when overused legislation can actually lead to a detriment in quality as managers and clinicians concentrate on meeting the letter of the legislation rather than the spirit behind it as has been the case in recent high profile cases.

It is evident that currently legislation still reflects the separate commissioner and provider system and organisations, and no longer matches the philosophy and needs of integrated health services and NHS bodies in Wales. For example, the NHS (Wales) Act 2006, which sets out the purpose of local health boards and NHS trusts, does not accurately reflect their combined roles. So there is a need for change, some of which may require a change in legislation but this will not be the only answer.

3. Lack of emphasis on culture change and leadership

The consultation does not emphasise the need for a change of culture sufficiently. Welsh Government needs to consider how to modify the current culture, both within health and social care, and between the services and the people who use them. The Green paper has a section on leadership and governance but this seems limited in its coverage and needs to be amplified as this will be crucial to manage and achieve sustainable change. Many of the requirements to achieve the changes being consulted on require only limited changes to regulations but are more about transformational leadership, management, organisational culture and the need for better health literacy across all communities.

Stewardship is complex but crucial and successful leadership and governance will require strategic policy frameworks combined with oversight, coalition building, accountability and appropriate regulation and incentives. Acquiring the capacity, competence and capability is essential and legislation and regulation alone is not the answer.

To empower people to take greater responsibility for their own health and well being and be supported in that undertaking by health and social care staff , we need to move away from the more traditional ‘passive acceptance’ approach to one of ‘proactive participation’.

To achieve this prudent approach, there is a need to remodel the relationship between the citizen and the state, so that professionals and the

public work together as equal partners; co-producing new services and enabling people to gain a greater control over their own lives.

4. Prudent Health Principles

While it is pleasing to see that the concept of prudent healthcare is referred to throughout the consultation document, Commissioners were disappointed to see a lack of measure of any proposed changes against the Bevan Principles.

These principles which are further supported by the Bevan Commission's Prudent Healthcare Principles, underpin the ethos upon which services should be based to ensure that all skills and resources are used, both within and outside of the NHS, to achieve the best possible outcomes for the people of Wales.

5. Health and Social care workforce

There is an absence of any significant inclusion of workforce change within the consultation document. This will be essential both in the respective roles and responsibilities as well as in accountability and governance. There is great scope for using the NHS and Social care workforce more efficiently, effectively and where appropriate differently. Different roles and responsibilities will be needed as well as a workforce which is more flexible and 'future proofed' working across traditional boundaries in order to meet individuals needs and not vice versa. Further details of the Bevan Commissions views on this can be found in their paper 'A Workforce Fit for Prudent Healthcare'.

6. Advice to Welsh Ministers and NHS leaders

It is crucial not only that Ministers and NHS leaders can access expert professional and clinical advice, but also that advice should be an inherent part of healthcare policy development and made public and answered. Only with a committee or organisation with statutory powers can this essential function be properly discharged with professional and public confidence. It is not sufficient that many sources of advice are available, seeking appropriate professional advice should be obligatory.

Community representation is more difficult. Whether or not the election of community representatives to Health Boards would improve transparency, public engagement and accountability in the health service would depend chiefly on the quality of the individual. They should however be appointed independently.

7. Access to and sharing of Information and Data

While we fully support the sharing of information between agencies to improve services and care provided (apart from obvious technical weaknesses of Health and Social care IT systems in Wales) we believe there remains the question of protecting confidentiality. This becomes problematic as increasing numbers of organisations become healthcare bodies. It is crucial to be clear on who needs to know particular patient-sensitive information.

Patients must give consent to the collection and sharing of their information in this regard. To aid the sharing of information a service user/patient "opt out"

should perhaps be considered so that the norm is that information will be shared when it is in their best interest.

The Bevan Commission has previously produced advice on data and data availability (Bevan Commission 2013 Bevan Commission Data and Information in NHS Wales) and this concluded that' the visible hand of transparent information, freely and openly provided to funders, patients and public, can enable and encourage excellence in healthcare in Wales'. Yet it identified serious issues most notably that the situation relating to data and information is unacceptable and represents a major obstacle in driving the health system in Wales forward in line with strategic intent.

Response to specific questions

No response to specific questions.

WGGP171 – Emma Sands – Royal National Institute of Blind People
Tref / Town – N/A

General comments

RNIB Cymru welcomes the Welsh Government's aim to develop a model of health in Wales which promotes physical, mental and social wellbeing. We recognise that the Green Paper sets out the systems proposed to support quality and governance in NHS Wales. We hope that although this consultation is at the end of an Assembly term, will support the development of goals which will place the needs of people with sensory impairment at the heart of a health and wellbeing agenda for Wales. Irrespective of where people live in Wales it is imperative that they receive timely, high quality services, where the focus is on prevention, health improvement and inequality.

1. About RNIB Cymru
RNIB Cymru is Wales' largest sight loss charity. We provide support, advice and information to people living with sight loss across Wales, as well as campaigning for improvements to services and raising awareness of the issues facing blind and partially sighted people.

2. About sight loss
There are 110,000 people living with sight loss in Wales.[70] This number is expected to double by 2050. Sight loss impacts on every aspect of a person's life: their physical and mental health, their ability to live independently, their ability to find or keep a job, their family and social life.

People with sight loss are significant users of health care services, spanning the spectrum of care, from primary to community to secondary care, as well as specialist and tertiary services. The prevalence of sight loss increases with age. Thus many people with sight loss are older and therefore have other health conditions, including chronic health conditions which are not linked to their sight loss.

People with sight loss frequently experience barriers in accessing and using health services. For this reason, All Wales Standards for Accessible Communication and Information for People with Sensory Loss[71] were launched in 2013. It is vital that these standards are reflected and their implementation monitored through any new NHS model.

[70] Population estimates based on: Access Economics 2009. Future Sight Loss UK: Economic Impact of Partial Sight and Blindness in the UK adult population. RNIB and Mid-2015 Population Estimates, Office for National Statistics (released 25/06/2015).
[71] Welsh Government (2013) The All Wales Standards for Accessible Communication and Information for People with Sensory Loss.

Response to specific questions

Chapter 1: The changing shape of health care

Promoting health and well-being

1. Should further changes to the law be made to strengthen local collaboration in planning and meeting people's health and wellbeing needs closer to home?
RNIB Cymru fully supports the overall principles underpinning the primary care plan, based on a model where the needs of local communities are assessed and the resources required are planned by and through the 64 primary care clusters with an emphasis on prevention and early intervention. We note the existing legislative framework and the future requirements for local authorities under the Social Services and Wellbeing (Wales) Act 2014 and the Well-Being of Future Generations (Wales) Act 2015 and believe that existing standards for quality of care are predominantly hospital focused and so there is a need to consider how these standards can be extended to primary care providers to ensure a seamless quality experience wherever patients enter the service, whether it be from GP surgeries, Pharmacists or Clinics. Fifty per cent of sight loss is avoidable. In order to tackle preventable sight loss, eye health messages must be included in public health campaigns, so that people in Wales are well-informed about risk factors and how best to look after their eyes. If Wales is to meet its objectives of delivering a prudent healthcare agenda, it is extremely important to ensure that those working in primary healthcare are given additional training to enable the early detection of eye related problems and can signpost people to regular eye checks as part of their wider healthcare role. The Welsh Government Eye Health Care Delivery Plan[72] has a range of actions aimed at preventing sight loss, these include: the development of a new public education strategy, increasing awareness of eye health, including eye care services, to specific at risk groups and amongst health professionals; working with Care and Social Services Inspectorate Wales (CSSIW) to ensure that the importance of good quality eye care is promoted in residential care and regular sight tests are included in individual personal care plans for residents; a prompt to encourage older people to go for a sight test has also been included in the Over 50's Health Check. It is vital that the delivery plan is fully integrated into the refocused health service, in order to make real progress in reducing the number of avoidable sight loss conditions, whether this is through the delivery of existing legislation or through new legislation.

[72] Together for Health: Eye Health Care Delivery Plan for Wales 2013-2018

2. If so, what changes should be given priority?
Sight loss has a significant impact on the well being of a person, both in terms of the devastation it causes to the person initially and the inevitable costs associated with sight impairment or blindness in terms of the other health implications such as loss of independence, more frequent falls and depression. Increasing eye health awareness and early intervention to reduce avoidable sight loss and to facilitate accessible healthcare should be a priority for any new arrangements.

3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?
It is clear that there is a lack of capacity within the health service to meet the increasing demand for ophthalmology services. We know that ophthalmology departments are working at full capacity, but they still cannot meet the level of demand. There is a mismatch between demand and capacity – the number of ophthalmology patients is growing, however the capacity to treat them is not. Achieving an appropriate staffing mix must also include consideration of how more patients could be dealt with in primary care and Ophthalmic Diagnostic and Treatment Centres – for example, as demonstrated in Cwm Taf UHB where patients were seen in a community hospital, rather than the eye clinic, for treatment of stable glaucoma or ocular hypertension. The clinic was directly managed by an optometrist and overseen by a consultant. This is consistent with a prudent healthcare approach, that healthcare is provided in the right place, at the right time by the right professional. It is also consistent with the 'only do what only you can do' principle, where all people working for the NHS in Wales should operate at the top of their clinical competence. Nobody should be seen routinely by a consultant, for example, when their needs could be appropriately dealt with by an advanced nurse practitioner. RNIB Cymru, supported by the Big Lottery, funds six Eye Clinic Liaison Officers (ECLOs) in five health boards in Wales. ECLOs work in eye clinics, and offer support to people with sight loss at the point of need. They are recognised by the Royal College of Ophthalmologists as an integral part of a minimum service team within the eye clinic. The presence of an ECLO improves patient experience and supports improved long term outcomes for patients, and can therefore contribute to achieving the health and wellbeing objectives sought in the Green paper. RNIB Cymru believes that ECLOs are a vital part of the appropriate staffing mix in eye clinics. ECLOs work alongside health professionals in eye clinics and offer practical and emotional support to patients recently diagnosed with an eye condition. They help patients deal with their sight loss and maintain their independence at a difficult time in their lives. Not only this, but research conducted in Singleton Hospital eye clinic in Abertawe Bro Morgannwg Health Board has demonstrated that for each pound invested in the ECLO support

service, there is a saving of £10.57 for health and social care budgets.[73]

We believe that the patient should be at the heart of the health service and it is there is a very real need to ensure that the NHS recognises the important role that the third sector can play, facilitating meaningful co-production and engagement.

If the Government's aspiration is to encourage preventative primary care then it is vital that initiatives such as the Wales Vision Strategy is fully resourced to ensure that real steps are made to implement preventative measures and the necessary duties are used to underpin the new local wellbeing plans required under the Future Generations (Wales) Act 2015.

Continuously engaging with citizens

4. Are there ways in which the law could be reformed to shape service change?

Public confidence in health boards can either be improved or damaged by the way in which local people are involved in the processes leading to major changes in local health services.

Involving local people appropriately throughout the process is just as important as ensuring that the right clinical and financial information is available and that a robust business case is prepared.

The Ann Lloyd review[74] highlighted the importance of continuously engaging with local communities and not just when specific changes are being considered.

One of the major challenges to improving the levels of engagement is how to get communities involved in the process. The NHS has, by its nature, developed a paternalistic approach to patients and there is a need to move away from the current approach to create a model which helps communities become better informed, confident and able to engage with the professionals. To this end, the third sector has an important role in this process as it can help bridge the gap between communities and the Service through advocacy, education and capacity building.

It is not clear from the Green Paper what Welsh Government's vision of co-production is but we believe that there is a great opportunity to enshrine the role of the third sector in engaging communities either through the community health councils (CHC) or a wider co-production role.

We see co-production as an approach to public services which involves citizens, communities, and the professionals who support them, pooling their

[73] Sital Sing, P. Economic Impact of Eye Clinic Liaison Officers: A Case Study – Full Report. July 2013. RNIB

[74] Lessons learned independent review into NHS Service Change Engagement and Consultation Exercises by Health Boards in Wales Ann Lloyd CBE, November 2014)

expertise to deliver more effective and sustainable outcomes and an improved experience for all involved.

The co-production process begins with the question ‘how do you want to live your life?’ rather than ‘what services are you eligible for?’ This starting point recognises that citizens and service-recipients are experts by experience and can identify what is important to them, and they also have rights and responsibilities as equal partners in the process.

In a co-production scenario, service-users and their communities should be involved in defining the need or problem, designing the solution, delivering it, and evaluating it, either with professionals or independently, or anything in between.

This approach demands longer-term engagement by service-providers but leads to profound and sustainable change.

In a paper to inform the priorities for the remaining term of the Eye Health Delivery Plan we set out steps which would embed significant and real engagement within the work being undertaken.

These were:
1. Reinforce commitment to co-production at national and local groups with an emphasis on engagement from concept through to delivery and evaluation.
2. Advise or instruct Health Boards to recruit at least two patients to join Health Board Eye Care Groups.
3. Work with Community Health Councils to ensure effective representation at Eye Care Groups
4. Establish a Patient panel (could be called customer or user forum) to inform, influence and make decisions to support the implementation of the plan.
5. Whilst the wider representation on groups should support implementation of key priorities it is recommended that the patient panel is given specific responsibility for key priorities such as reviewing patient letters, correspondence, feedback on pathways, Patient Reported Outcome and Experience Measures (PROMS and PREMs) for example.
6. Significant opportunities exist for a co-production approach to ensure community engagement and participation; however caution should be taken to avoid a tokenistic approach.
7. Scrutiny and recommendations for additional or alternative representation on task and finish groups to ensure a co-production approach.

5. Should we consider establishing, on a statutory basis, the requirement for health boards and NHS trusts to constitute permanent engagement mechanisms, such as patient panels or participation groups?
Based on Ann Lloyd’s review of the way in which local health boards undertake engagement and consultation before major service changes, RNIB Cymru recognises the current duty on health boards to involve and consult local people or their representatives in the planning and delivery of services,

including change, but believes there is merit in looking in more detail at the recommendation which would replace the need to refer decisions to Welsh ministers, with an independent expert panel.

As outlined above, identifying the barriers to co working and engagement will be fundamental in helping to deliver the primary care preventative care agenda.

RNIB Cymru speaks to blind and partially sighted people every day as well as those at risk of losing their sight. This means we are ideally placed to offer the NHS the patient perspective on any plans and initiatives to improve community engagement.

We also have a network of people with sight loss/sight conditions across the country that would be willing to take part in local activities such as focus groups, commissioning meetings and consultation events.

If permanent engagement mechanisms are adopted on a statutory basis, it is important to ensure that they are flexible enough to allow for changes to be made to reflect improved co-production models and more informed community representatives in future.

There are also many panels or methods of engagement which are being set up across Wales as a result of legislation introduced in the Fourth Assembly. Particularly within the context of fewer resources, this may mean that a statutory requirement on local Health Boards without additional guidance or funds will only achieve the simplest of engagement activities.

Anecdotally, we hear stories where patient's concerns are not escalated as any reporting (for example on the Accessible Healthcare Standards) is filtered through different layers of management and therefore may not always be passed on. A meaningful engagement process would remove this issue.

We would also highlight the importance of capturing patient's experience of the service as a fundamental basis for improving communication and collaboration.

6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?
We support Ann Lloyd's recommendation that in cases where the local agreement with the CHC cannot be reached, referrals should be made to an expert panel rather than Ministers as is currently the case. The composition of such a panel and its powers should be subject to a separate consultation, but we believe that third sector representation is important.

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?
The existing duty of quality established under the Health and Social Care Act 2008, predates the integrated model of the NHS in Wales and this has meant that the focus on the development of quality systems and assurance has been on hospitals and directly provided services. We believe that there is a real case for extending the need for quality standards to all levels of the NHS, to ensure that wherever patients enter the service there is a seamless, quality driven focus on services. There are a number of strategies and measures in place which could address issues which are raised by RNIB Cymru members. Accessible Healthcare standards[75] for example would be adequate if fully implemented; however the lack of an effective IT system makes it difficult for people's needs to be recorded and implementation is unlikely to be achieved by legislation unless sufficient resources are made available to support its development. If a fully integrated service is to be realised in Wales, the current lack of connectivity between community eye health services and the rest of the NHS needs to be addressed to improve IT systems and link community and secondary care services. This would mean that optometrists could refer into secondary care easily and patients could be referred back upon discharge for regular monitoring (where appropriate). This would also help ensure that optometrists are sent follow-up information on the patients they have referred, which is currently not the case. This level of connectivity could allow electronic transfer of data and images, enabling primary and secondary care professionals to discuss patients in real time and decide whether a referral is needed. Linking patient records also means that professionals can review a patient's eye health alongside any other long-term conditions that they might have. It could also help professionals identify non-adherence to treatments for chronic conditions. Linking patient records also improves access to treatment and thus could prevent avoidable sight loss.

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?
As outlined above there is a need to develop a single common standards framework which does not unduly increase the level of bureaucracy or time

[75] All Wales Standards for Accessible Communication and Information for People with Sensory Loss, July 2013 NHS Wales

demands on frontline staff, but does help deliver a more holistic approach to quality standards. The use of multidisciplinary teams is a must if eye care services are to meet demand. Patients should receive the right care, at the right time, in the right place, provided by the right professional. Enhanced training will be vital in making this happen. A greater number of health and social care professionals should be trained to understand the signs and symptoms of eye conditions, in addition to their referral pathways and treatment, for example, pharmacists, GPs, care home staff, community health workers, health visitors, school nurses etc.

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?
All staff dealing directly with patients and carers have a duty of care and must be encouraged to speak up to prevent failings in care standards. Ultimately, the leaders of organisations are accountable when things go wrong and so must be able to effectively monitor quality of care and create a culture of openness and transparency. Welsh Government also has a part to play in reassuring the public that providers are meeting certain quality standards and taking action when local organisations fail to resolve issues. RNIB Cymru does not have any views on what legislative measures could be put in place to improve quality, but rather it is a case of culture change and ensuring that when things go wrong blame culture is not part of the Welsh Government and NHS.

Integrated planning

12. Do we need to strengthen our existing legislation further to promote quality through the NHS planning framework?
The integrated medium term planning (IMTP) framework is vital to ensuring that health boards and NHS trusts are planning for the demands and change that a modern integrated NHS needs with quality service at its heart. As outlined above, we believe that there are real opportunities for incorporating the Patient Related Experience Measures currently being developed as part of the Eye Care Delivery Plan and also for the development of effective and inclusive co-production opportunities to ensure that quality planning is driven from the bottom up by local health boards and NHS trusts working with staff and citizens, to develop a more inclusive and effective planning framework.

Chapter 3: Quality in Practice

Meeting common standards

13. Is there a case for changing the basis under which the healthcare standards for use in the NHS are set?
The Ruth Marks' review of Health Inspectorate Wales (HIW)[76] proposed that common standards should apply across all health services, including primary medical care, dentistry, optometry and pharmacy; she also advocated independent healthcare settings, which would help to deliver the vision of a fully integrated health service where quality standards are the same wherever patients enter the service. RNIB Cymru contributed to the recent review of the Health Standards Framework for Wales and we welcomed the adoption of many of the positive suggestions we submitted which will directly benefit those with sensory loss. We do note however that whilst Welsh Government might expect the Health and Care Standards, published in April 2015, to cover all NHS funded services, including the independent and voluntary sectors, under current legislation there is no legal obligation on providers comply. Whilst independent healthcare services are obliged to meet minimum standards for independent healthcare in Wales under different legislation, we believe that there is a compelling argument for aligning these standards under a common legislative framework, which would also align those proposed in the Regulation and Inspection of Social Care (Wales) Bill for residential care, domiciliary care and other regulated social care services, to produce a common approach to standards across both health and social care.

14. Could a common standards framework, which covers both the NHS and the independent sector better deliver a focus on improving outcomes and experience for citizens?
As outlined above, we believe that In order to deliver the notion of common standards across all health and social care services as proposed in the Ruth Marks' review of Healthcare Inspectorate Wales (HIW) and the Regulation and Inspection of Social Care (Wales) Bill, there is a need to develop a common standards network which presents a single common standards framework across health and social care, underpinned by a statutory framework.

15. How could we further require the use of mechanisms such as accreditation and peer review to promote better service quality?
Peer review should be aimed at securing patient focus and value in the performance of teams, organisations, or as in the case of care pathways, the

[76] The way ahead: to become an inspection and improvement body, Ruth Marks, November 2014

coherence and effectiveness of working relationships between organisations such as hospitals and GP practices. Continuous Professional Development practices could underpin these mechanisms, ensuring that professionals share work and best practice. Assessment could be based on but not limited to the work of a specialist clinical team in a hospital, assessing both the working of the team in delivering in-hospital treatment within and between teams and considering the quality of care pathways developed by the hospital in conjunction with GPs and other elements of the primary and independent sector, to treat and support patients with an integrated, quality service. We also believe that health boards should work with RNIB Cymru and other third sector partners to develop accreditation for delivering accessible services to people with sensory loss. Customer care training should be made mandatory for all NHS staff and should include a compulsory module on sensory impairment. In addition we would want to ensure that the recommendations of the Wales Vision Strategy Implementation Plan 2014 – 2018 are fully incorporated as part of the process to promote better service quality.

Clinical supervision

16. How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?
We have no formal position on this question, although any proposals which encourages revalidation and clinical/peer supervision to improve quality outcomes are to be welcomed.

17. What arrangements should be put in place for self-employed health professional registrants?
As outlined above.

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

18. Do you agree that we should introduce a statutory duty of candour within the NHS in Wales?
RNIB Cymru fully supports the principle of advocating co-production as a principle of prudent healthcare and agrees that in order to move towards a system where individuals are equal partners in their own health there is a need for a culture of openness, transparency and honesty to refocus the system back on to the individual. The Duty of Candour is already a legal duty on hospital, community and

mental health trusts in England and acts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.

The Duty of Candour aims to help patients receive accurate, truthful information from health providers and could help in developing a transparent culture in health provision in Wales

We would recommend that the standard on dealing with concerns and managing incidents is amended to include a focus on ensuring processes are accessible. It is vital that people with sight loss have equal access to report concerns and that processes are capable of communicating with people in a way that is accessible to them.

Currently, NHS Wales is required to measure and report serious incidents across disciplines, including ophthalmology. However, we are aware that this is not taking place consistently or in line with guidance. The definition of harm as stated by the Royal College of Ophthalmology is "deterioration of vision in at least one eye of 3 lines of Snellen acuity or 15 letters on the ETDRS chart or deterioration in the visual field of 3 decibels".

This level of reporting must be enforced through whatever means the Welsh Government has at its disposal.

19. How could we use legislation to further improve transparency on performance in the Welsh NHS?
A report commissioned by RNIB Cymru in 2014[77] on ophthalmology capacity found that when appointments are cancelled or postponed patients are not informed of the potential risk to their sight due to the delay. It is vital that communication with patients is improved. Patients have a right to timely and relevant information on the length of waiting times, and what to do if appointments go beyond the time recommended by clinicians or those set out in NICE guidance. Without appropriate information, people in Wales will not be informed and enabled to manage their own health. Many blind and partially sighted people experience barriers to accessing information because of their sight loss. For example, appointment letters and patient information leaflets are usually in standard print format which many people with sight loss are not able to read. The All Wales NHS Standards for Accessible Communication and Information for People with Sensory Loss requires Health Boards to ensure that all frequently used information leaflets and documents intended for patients and the public to be available in accessible formats. However, to date, there appears to have been little action to achieve this. RNIB Cymru still hears from members that information is sent out in standard print format, and when alternatives are requested that they are not always made available.

[77] "Real patients coming to real harm", Ophthalmology services in Wales Dr Tammy Boyce

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

21. What are the issues preventing healthcare bodies from sharing patient information?
We strongly support moves to improve the sharing of relevant patient information to improve patient experience and to promote an integrated health system, providing the relevant data protection protocols are adhered to. We believe that the complexity and confusion surrounding the sharing of patient data has to be addressed if Welsh Government is to realise its vision of a new model of preventative healthcare. The Data Protection Act 1998, gives individual people the right to know what information is held about them and what it is used for, this is supported by other regulation which allows individuals to access their personal health records, although as yet there is no formal process they can follow in order to do so. RNIB Cymru is calling for a comprehensive review of capacity and demand in ophthalmology to inform future planning of services. Currently much of the data needed to review capacity in ophthalmology is simply not available. For example, the report we commissioned found that basic information is not collected – such as who is waiting (e.g. glaucoma or diabetes patients), how long patients are waiting for follow up appointments, or how many appointments are postponed or cancelled. It is vital that health services are designed to meet population needs, and that data collection mechanisms are put in place to facilitate this. There is already data in existence to inform this process. For example, RNIB's sight loss data tool (http://www.rnib.org.uk/knowledge-and-research-hub-key-information-and-statistics/sight-loss-data-tool) provides information about blind and partially sighted people and those at risk of sight loss at a national and local level throughout the UK. In addition, the Public Health Observatory for Wales has produced a detailed eye health equity profile of eye health in Cwm Taf University Health Board area. It includes a description of the population of Cwm Taf; the epidemiology of the main eye conditions; the provision of services within Cwm Taf and considers the provision of services in relation to need. We believe that eye health equity profiles should be produced for other health boards.

22. How can we consider breaking down any barriers?
We would support a process which encourages citizens and healthcare professionals to work together in order to develop trust and good working relationships, so that patients are confident that any sharing of their personal information is done in the interests of the safety and quality of their care. We note the standards for medicines management are aimed at ensuring

people receive the right medication and right amount of medication for the correct reason, at the right time. Because of current capacity problems in ophthalmology services, we know that this is not always happening. Not only this, but there are inconsistencies in recording when patients are losing their sight while waiting. The “Real Patients Coming to Real Harm” report found that only one Health Board in Wales completes patient safety incident forms as a result of patients permanently losing their sight whilst waiting to be seen. It is vital that Health Boards record this information in future so that the data can be used to prioritise actions to ensure safer care. The standards for patient information and consent include “providing timely and accessible information on people’s conditions and care”. We strongly support this standard, and hope it goes some way to addressing the issues, already highlighted, that patients are not being given sufficient information to make informed decisions about their ophthalmological care, and that, more generally, people with sight loss are not receiving accessible information in a timely manner. This can mean that in some cases, their ability to make an informed decision, or even give consent, is limited by the lack of information available.

23. What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?
We have no formal position on the sharing of patient identifiable information for non direct patient care, believing that in a fully co-production role patients would have the confidence to allow the release of their personal data for research etc., if they feel fully informed of the need and objectives of any such programme of data collection.

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?
Given the background to some of the concerns underpinning the Marks review, we would support the recommendation that if HIW is to become an effective regulator it must be seen to have independence from Ministers to implement special measures if it deems necessary. There are synergies across the NHS and independent sector and the harmonisation of Health Standards and inspection models would seem to be justified.

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?
HIW should promote a culture of continuous improvement and innovation in the delivery of health services and we believe that HIW needs to be part of the journey of transformation and innovation in public service delivery alongside the NHS. The burden of regulation should be efficient and minimised and co-ordinated with other bodies such as the Wales Audit Office (WAO), CHCs and Royal Colleges. It is important that all of these bodies share information and the findings of their inspections to minimise unnecessary duplication and bureaucracy. We also believe that consideration be given to strengthening the current memorandum of understanding between HIW and CSSIW to ensure that where possible, they reflect the integrated health and social care services at local level.

27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?
Whilst there are obvious advantages to bringing HIW and CSSIW together under a single inspectorate, there is a need to consider what functions can be merged and what structures will be put into place to cover those elements do not have joint responsibilities. We believe that this issue should be part of a wider debate on the merits of bringing social services and health under a single department which is beyond the scope of this document.

Representing patients and the public

28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?
As previously highlighted, if the NHS is to deliver on its vision of a truly integrated service with co-production at its heart, it is vital that the CHC's can fully engage and encourage the participation of local communities who can play a fundamental part in building the capacity and confidence of citizens to engage with the service at a variety of levels. We believe that engagement can be facilitated from community patient focus groups, advocacy and support from the third sector to ensure that the continuous communication approach not only channels through formal structures such as the CHCs but goes far wider in seeking more effective ways in which to engage communities at all levels.

29. Is the current CHC model fit for purpose in a more integrated system? If not, how would you suggest it needs to be changed?

RNIB Cymru supports the recommendations stemming from Professors Marcus Longley's review of Community Health Councils in Wales[78] and would support changes which would encourage members from a far wider demographic base than the current make up (white, middle-aged male).

Consideration needs to be given on how to enthuse and encourage a wider range of people to get involved in representing the patient's voice and a move towards making the work of CHC more focused on advocacy and engagement may help engage those with sensory loss and from minority communities.

Many partially sighted and blind people have a great deal to offer the health service in Wales, but their confidence to engage with these CHCs may be low.

It is also important to ensure that the third sector remains fully enshrined in any refocused CHC model and that their role and experience in engagement and advocacy provides the basis for any new ways of working.

Chapter 8: Leadership, Governance and Partnerships

LHB size and membership

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?
As outlined previously we would support this approach as a means of encouraging greater transparency and accountability in the health service. It is however important to ensure that any process adopted to institute the election of community representatives is inclusive and helps to enthuse and engage people to participate with their local health board.

NHS Trust size and membership

41. Does the current size and configuration of NHS trust board membership best promote an effective focus on decisions, priorities and service provision? If not, how might NHS trust boards be reformed?
We would support the recommendations of the Williams Commission[79] that health boards need to be responsive and accessible to their local populations and through the election of community representation improve transparency and public engagement in the service. Under current regulations, boards consist of eight executive members (staff) and nine non executives who are not health board employees and must

[78] "Moving Towards World Class? A review of Community Health Councils in Wales," Professor Marcus Longley, June 2012
[79] The Commission on Public Service Governance and Delivery (Williams Commission)

include trade union, third sector and local authority representatives.

Other independent members are appointed through a competitive Welsh Government appointments process and we have some concern that the evidence based application procedure may be a deterrent to many, particularly those with sensory impairments.