Papur Gwyn – Ymatebion
White Paper – Responses

Cynnwys/ Contents

WGWPMB001: D Kenny
Location: Monmouthshire

Response to Specific Questions

Board Secretary
Do you agree with these proposals?
Difficult to think that one person would have sufficient capacity and reach to scrutinise the local NHS. Not sure it would make much difference.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes, who could say no to this?

Duty of Candour
Do you support this proposal?
Not against this but isn't it a little sad if it needs legislation to require professionals who work in health and social care to be open and honest?

Setting and Meeting Common Standards
Do you support this proposal?
Yes, who could say no to this?

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes, the complaints process should be seamless between health and social services where both are involved.

What further issues would you want us to take into account in firming up this proposal?
Very important that complaints investigations link closely with inspections. Our local CHC always ensured that a serious complaint or a pattern of complaints in a particular area of the service would trigger an inspection visit –sometimes that would be organised within a day. This is the value of a local focus. I don't see remote inspection agencies working as quickly.

Representing the Citizen in Health and Social Care
Do you support this proposal?
No Extremely vague "arrangement". I agree that the monitoring should cross health and social care boundaries

Can you see any practical difficulties with these suggestions?
Yes, The fact that this will be advisory rather than statutory will make the "arrangement" all too easy to ignore.

The “Scottish Model” on which Welsh thinking is based has come in for criticism within Scotland for not being sufficiently independent.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?
No. I had always assumed that clinical advice was independent.

What further issues would you want us to take into account in firming up this proposal?
Unless we have a statutory health “watchdog” the advice from the lay citizen voice body will never be seen as authoritative as the clinical view.

Inspection and Regulation and single body

What do you think of this proposal?
Undecided.

Are there any specific issues you would want us to take into account in developing these proposals further?
It was never demonstrated to my mind that HIW had much time for the lay view in inspections – that should be built in to any new arrangements.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
Not sure. Why would a Welsh Government Sponsored Body necessarily be seen as independent?

WGWPMB002: Dame Carol Black
Location: Unknown

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
AGREE

What further issues would you want us to take into account in firming up these proposals?
FULLER DISCUSSION ON MEMBERSHIP AND SIZE OF THE BOARD

Board Secretary
Do you agree with these proposals?
AGREE

Duty of Quality for the Population of Wales
Do you agree with these proposals?
AGREE

What further issues would you want us to take into account in firming up these proposals?
FOR FULLER DISCUSSION

Duty of Candour
Do you agree with these proposals?
AGREE

What further issues would you want us to take into account in firming up these proposals?
FOR FULLER DISCUSSION

Setting and Meeting Common Standards
Do you support this proposal?
IN PRINCIPLE, YES

What further issues would you want us to take into account in firming up this proposal?
FOR FULLER DISCUSSION. STANDARDS SHOULD BE MEASUREABLE, NOT MERE ASPIRATIONS

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?

YES

What further issues would you want us to take into account in firming up this proposal?
FOR FULLER DISCUSSION. PRECISE FUNCTIONS, STRUCTURE AND ACCOUNTABILITY OF THE COMPLAINTS BODY.

Representing the Citizen in Health and Social Care
Do you support this proposal?
IN PRINCIPLE YES, BUT THERE ARE SERIOUS PRACTICAL CHALLENGES.

Can you see any practical difficulties with these suggestions?
FOR FULLER DISCUSSION.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
IN PRINCIPLE YES. SUCH AN INDEPENDENT BODY SHOULD COMMAND THE KIND OF AUTHORITY COMMANDED BY NICE –

What further issues would you want us to take into account in firming up this proposal?
FOR FULLER DISCUSSION

Inspection and Regulation and single body
What do you think of this proposal?
A RATIONAL CONSEQUENCE OF THE AIM FOR CLOSER INTEGRATION OF HEALTH AND SOCIAL CARE.

Are there any specific issues you would want us to take into account in developing these proposals further?
FOR FULLER DISCUSSION

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
FOR FULLER DISCUSSION
IN PRINCIPLE, YES.

What issues should we take into account if this idea were to be developed further?
FOR FULLER DISCUSSION

WGWPMB003: H Randall
Location: North Wales

General Comments

I wish to declare that I am totally against the proposed changes to the present structure
Of the CHC.
The independence factor will be lost.
They have statutory rights at present and won't in the new proposals.
They provide excellent value for money as many volunteers do notclaim expenses.
They undertook nearly 1000 visits to the local hospitals etc.
Members attended over 250 external health related meetings in the year in order
To represent etc the patients voice.
Over 2000 people were helped to raise issues about their care.

As compared to HIW figures they are like comparing a Sinclair C5 to a Lambhorgini!!

I sincerely hope that our AMs will vote to keep the CHCs as they are and perhaps
Even give them extra rights such as visiting Care Homes in the future.

WGWPMB004: Anonymous
Location: Unknown

General Comments

Many managers do not understand what they are managing, they need to take the trouble to learn what they should know and less of them are required.
Some of the plans are to some extent implemented know and to do more would require more staff as most are very overstretched already, the health services runs on goodwill.

Most hospital staff are honest.

WGWPMB005: G James
Location: Unknown

General Comments

Please do not replace the current statutory CHC's with the proposed new suggestions. I believe the system, as it is now, works well. For what reason would you change something when it appears fit for purpose? The cost of change could be used elsewhere.

WGWPMB006: D Hart
Location: Unknown

General Comments

The CHC has helped me twice regarding my mental health as without them i would have not known what to do. I feel that it is my right to complain and they sorted out contacting the right people in charge, sending emails and letters, a lot of people do not complain as they are not sure how to or feel they cannot do it. The currently CHCs key role will be abolished under the new arrangements which I feel is wrong and I feel the importance to keep CHCs in place to fight for peoples right is so strong.

WGWPMB007: M Boyle
Location: Flintshire

General Comments

I agree that the way we check services can be improved, but to say members of The CHC just attend meetings and go around looking at places like hospitals and doctor's surgeries must have been written by an incompetent Academic or Civil servant. I find this kind of terminology offensive and juvenile within such important documents produced by the Welsh Government.

The CHC follows set guide lines and carries out a series of structured, organised inspections, plus the CHC do not look at social care as it had a Directive from Welsh Government which asked the CHC to stop such inspections. The CHC also responds to any complaints made by the public or from professionals within a few days.

From the white paper, I noted that you are suggesting to get rid of CHC, and form a new agency The People Voice based on the Scottish model. But this model is not working in Scotland, even the MSP say it's a toothless hamster and regret the move. I don't know much about the HIW only what I have read, and been told. That they don't do much, and they take forever to follow up on recommendations they have made unlike the CHC.

It would be good if agencies like the HIW and the CSSIW worked with the CHC who are providing information on how the health boards are performing on the ground. If we are to have a new body it should combine the three HIW, CSSIW and CHC and it should have more powers and money than present. I feel if we follow the Scottish model which is out of date, patient's rights like me and the general publics will not be lessened. The new body and the should be able to Scrutinise all service in the way the present CHC do in north wales. Otherwise the new body will end up a toothless hamster like in Scotland.

The white paper should also cover the way the health minister works and performs, as the paper takes about making people more accountable. So why has the health minister left the board of BCUHB in place after the board was put into special measures? The present health minister knows we are short of GP in North Wales so why do GP's from England wishing to work in Wales have to wait at least two months to be put on the Welsh performance list, why have one when the have be working as a GP in England.

WGWPMB008: Age Cymru
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes – ensuring Boards of both NHS and Health Boards share common principles relating to partnership working and person-centred care should help to remove barriers to integrated working at a strategic level and consequently operational level. 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. A focus needs to be maintained on the overall outcome: delivering a seamless service that maintains wellbeing and independence.

What further issues would you want to take account in firming up these proposals
We agree that ensuring boards have a mixture of key positions alongside a degree of flexibility in appointing additional members will ensure consistency across Wales whilst allowing boards to be responsive to local need and demographics. For example, in areas with a high BME or Welsh speaking population, we would expect the board membership to reflect this diversity.

Board Secretary
Do you agree with these proposals
Yes

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

What further issues would you want to take account in firming up these proposals
We agree that a duty to improve all-Wales planning and collaboration between health boards, local authorities and the third sector is needed. Many third sector organisations currently work in partnership with statutory services to deliver person-centred services to vulnerable older people, often living with life limiting conditions. However, it is often very difficult to achieve the national roll out of good practice. We hope that this new duty will encourage health boards and local authorities to collaborate with partners to identify and develop services that have demonstrated positive outcomes for citizens across Wales.

Duty of Candour
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
In the past, health sector colleagues have been wary of commissioning third sector and other external organisations to undertake work on their behalf as they could be held accountable if the other party fails in service delivery. Whilst such a reticence persists, it will be difficult to achieve the ambition of an integrated and person-centred health and social care service. By increasing transparency when an unintended or unexpected incident occurs, a duty of candour should increase trust between health and social care organisations and improve commissioning practices.

Setting and Meeting Common Standards
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
Age Cymru fully supports this proposal. 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.

A common set of high level standards should help to remove the many entrenched barriers between health and social care services which make it extremely difficult to deliver whole-person care. Making standards apply regardless of the location of care could provide the impetus for leaders across sectors to innovate and improve collaboration.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes

Representing the Citizen in Health and Social Care
Do you support this proposal?
Yes

Can you see any practical difficulties with these suggestions?
We agree with the proposal to replace CHCs with a national arrangement to represent the citizen voice. We acknowledge that there will be challenges in putting the citizen at the heart of decision-making, but support the Welsh Government's view that it is essential in order to ensure the best outcomes for citizens.

The new national arrangement will need to ensure it represents the voices of all citizens in Wales, especially those of seldom heard groups. Any new arrangement should include funding for outreach work with BME communities, people living with sensory loss or limited mobility and groups who are known to present to health and social care services when their condition is already quite severe. For example, awareness of the causes and symptoms of dementia is low among some BME and gypsy, traveller communities which means that they access support at a later stage.

If health and social care is to be fully accessible to all, the views of the groups mentioned above should be considered in the early stages of design and planning. Without this involvement in service planning and provision, many older people will continue to feel that they are expected to fit in with the delivery patterns of formal services rather than the services being designed to meet their individual needs.

Aligning the new arrangement with HIW and CSSIW should enable the citizen voice to influence positive change and also to support and champion the national roll out of good practice. We hope that any arrangement will be viewed as vital part of the process to improve health and care services and not merely as a 'tick box' exercise to demonstrate citizen engagement has been undertaken.

In addition, the Welsh Government must ensure that there is adequate resource for the structures that replace CHC so that any new structure is able to effectively able to represent citizen voice. The new structures should use both formal and informal engagement so that the voices of those that those who would not traditionally respond to a policy style document are heard.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes

Inspection and Regulation and single body
What do you think of this proposal?
We agree that this should improve integration between health and social care.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
Yes – any moves to improve independence in regulation and inspection and to strengthen the citizen voice should be welcomed.

What issues should we take into account if this idea were to be developed further?
When considering how to improve patient voice, the use of expert patient groups should be considered. Such 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 and suggest they be used as a way to provide more independence in regulation and inspection.

WGWPMB009: Vale of Clwyd Trades Union Council
Location: Rhyl

General Comments

At our monthly meeting we discussed the Welsh government's white paper of 29 June relating to "Quality and governance of health care in Wales". It advocates the abolition of CHC's. We feel that because of its make up the north Wales CHC is the ideal body to be our patient's voice and watchdog.

A third of its members are councillors who, like yourselves, deal with the public on a daily basis and listen to their problems. Another third are from the voluntary sector being members of local groups. This is important as many of the groups deal with vulnerable people. They include UK wide organisations looking after people suffering from ailments such as arthritis, autism, dementia, diabetes and a wide range of disabilities who are regular users of the NHS. The remaining third are appointed by the Welsh government with many having experience of the NHS at all levels.
As our health board is in special measurers its performance has to be monitored. CHC members do this by visiting hospitals, surgeries and dentists reporting on what they see and hear. They attend stands, and speak to people, at public events like the Llangollen and national eisteddfods and agricultural shows. They also give talks to community groups.

An important fact about CHC members is that they are ordinary people who keep their eyes open when on duty. They talk to people and as health and the NHS are major topics of conversation they pass on what they hear. There is an advocacy service which deals with patient's claims for bad or negligent services. That means that patients don't have to contact the money making medial negligence firms.
The white paper states that the Welsh government wants to strengthen the patient's voice. We agree with that but believe it should mean more powers for the CHC. Replacing unpaid volunteers with paid officials would be an expensive alternative and a waste of money.

Bearing in mind that in north Wales there are 12 CHC members in each county, 72 in all. So just what can the Welsh government do to strengthen the patient's voice? How are they going to replace 72 unpaid volunteers from varying backgrounds and a wide range of work and academic experience? CHC members dedicate a good three days a month to their duties with some doing twice as much.
The Welsh government is consulting on its proposals until 29 September. So please respond and ask for the retention of CHCs, the NHS's critical friend and the patient's voice.

WGWPMB010: Community Recovery Education and Skills Training Group
Location: Swansea

Response to Specific Questions

We might change the law to make it easier to get the best group of people to make the right decisions on how health services in Wales are run**.**
What do you think?
Nice ideas how to you intend to implement it?
Had laws before sounded good, but nothing really changes.
How can you screen to get the correct people with the correct knowledge and training.
Who decides who are the correct people?
We might make a new law to make sure workers and organisations will always tell the truth and speak to people

If workers and organisations are not honest then the new law will mean they could get into trouble.
What do you think?
This is laughable!!! Surely these laws are already in place.
Pity this nor for every politician.
Passing more laws doesn't change the people.
Actual penalties rather than being pensioned off.
We might make a new law to make everyone work together to plan and give good quality care.
This means organisations will have to decide and work together on what is best for all the people, not just the ones in their own areas.
What do you think?
Surely this is a given. As resources are getting shorter people are struggling to provide care for people in their own areas. And often do not look further a field at good practice or a bigger picture. I thought that was what the Welsh government did.
We might make a new law to ensure the same standards apply wherever you get your care.
What do you think?
Get rid of the postcode lottery same service for everyone regardless of where you live. All Gp's surgeries offering the same service. And all other services offering the same access to services regardless of where you live.

We might make a new law to make health and social care organisations work together to look into a complaint. This should make things easier for the person making the complaint.
What do you think?
As long as they are separate organisations with separate budgets, there will be the tendency to pass the buck.
Also people are afraid to flag up complaints for fear of reprisals especially mental health and learning disabilities.

We might make a new law to set up an organisation in Wales which makes sure people are having a say about health and social care

What do you think?

Good idea to have a named person/dept that is clearly advertised /signposted as the contact for the Health Board for the public (Telephone/letter/Email

Why replace one organisation with another. Why not give the existing CHC's the teeth it needs?

Support/fund projects to support people to have a say.

We might make a new law to make it clear about what will happen if people can't agree about a change to heal services. This will mean that minsters will be able to decide but they will have to take advice first.

What do you think?

Common sense for a consultation with ministers. And don't forget the people who use the services as they may see things differently. Sometimes it is the simplest things that are needed.

We might make a new law to set out what HIW can check. We will put all the new law in one place so it is easier for people to find and read it.

We might also make a new law to ensure HIW and CSSIW work together better. Another idea is to have a new organisation to bring together HIW and CSSIW.

What do you think?

Bring them together things are complicated enough when you have to organisations provided services.eg health and social care. Often you will hear the local authority saying they will fund one part of a care package for a person and then time is wasted will they fight for health to pick up another bit of the funding. We are one person not bits to be funded.

Extras

Ideas and laws are great, but if the bottom line is money, none of this will be implemented and this exercise will have been a waste of time.

Perhaps it is time to go back to the roots of this system. What is really needed to provide a better future. Go back unravel all this see where the money goes and to whom and start again.

Laws to make people do what they should be doing as decent human beings really and we are supposed to be the "crazy ones".

Yes it is about the right people leading at the top, people who care and are not just accountants. How often do people who actually use services have a say in who is appointed. A good service that meets the need of the people have to be cheaper in the long run. DO it right in the first place and you won't have to do it again.

WGWPMB11: Your Voice Advocacy
Location: Swansea

General Comments

- Our organisation supports adults with learning disabilities. As you are aware, many adults with learning disabilities have additional health problems and are regular users of NHS services. From our experiences of supporting individuals with learning disabilities, they often find difficulties in accessing the correct services. Additionally, when these services are accessed, they often find it difficult to understand the processes and the information given to them. Advocates can support individuals to have a voice and representation in health and social care. This can be on a one to one basis or in a community group setting through peer advocacy.

- Advocacy can build people's confidence which in turn enables them to effectively participate in citizens panels to represent themselves and others with learning disabilities.

- Advocates can also create easy read documents to help the sharing of information to people with learning disabilities.

- The role of advocacy can continue to provide a person-centred approach to health care. This can include supporting individuals to make a complaint or voice concerns when common standards are not met.

- Advocacy organisations have the skills and resources to provide appropriate support to meet the needs of the ''Services fit for the future'' proposals. In particular –

1) Person-centred health and care which includes setting and meeting common standards, including joint investigation of health and social care complaints
2) Effective citizen voice, co-production and clear inspection. This covers citizen representation in health and social care, co-production of plans and services with citizens and better co-ordinated inspection and regulation.

- We have witnessed first-hand how providing independent voices to people can improve an individual's wellbeing and quality of life. Currently within local areas, we have supported individuals to set up and facilitate peer advocacy groups. These groups give people the opportunity to have a stronger and more confident voice with support from their peers. We believe that citizens deserve the right to comment on NHS services and have an active part in the future of health and social care.

WGWPMB12: B Stapley
Location: Unknown

General Comments

We, in the area covered by Forge Road sugary (North West of Wrexham) are about to lose our doctors, this also I am told the sugary in Brymbo, what cover will be given to the people, this should have been sorted a long time ago.

We have people of all ages that have a mobility problems and some of these can't drive, it's about time the health authority got it sorted, the money that tax payers over the years have put into the NHS, seems have got lost in the system.

WGWPMB13: Janet Finch-Saunders AM/AC
Location: Llandudno

General Comments

A number of points of concern have been raised to my attention with regards to the proposals outlined in this White Paper, with particular reference to Community Health Councils (CHCs), which I wish to be noted:

- The work of CHCs is important to many across Wales. The Welsh Conservative Party has consistently supported them in this work, and I am deeply concerned with the proposed direction the the Welsh Government intends to take with regards to their future, as outlined in Services Fit for our Future.
- Proposals outlined threaten to damage public service accountability in the health sector. The scrutinising role of CHCs is a vital monitioring tool, and enables real changes and improvements to be made by Local Health Boards (LHBs). Across my own LHB in north Wales, for example, the CHC undertook 352 inspections of healthcare premises, including 137 CareWatch inspections, during both day and night, over the course of 2015-16.
- Additionally, these proposals may weaken the voice of Welsh patients. The mediation role carried out by CHCs between patients and LHBs/healthcare professionals is also of benefit to many. Again, across north Wales, the CHC dealt with 385 complaints, 231 enquiries, and successfully closed 262 cases in 2015-16. Clearly, the CHC plays a significant role in citizen advocacy and mediation across the LHB area.
- Given the ongoing crises healthcare in Wales faces, I do believe that CHCs are vital to holding the Welsh Government accountable for the state of our NHS. This is of particular importance in north Wales, where Betsi Cadwaladr University Health Board remains under the Welsh Government's special measures, with progress being slow (and in some areas non-existant – for example, waiting times for trauma and orthopaedic surgery).
- I note that the Board of Community Health Councils in Wales have made clear their concerns that the proposals outlined for a new 'citizens voice arrangement' do not include a role to 'hear directly from people about their health services, e.g. by visiting people accessing care', nor to 'scruntise and hold NHS organisations to account on behalf of local people and communities for the way in which they deliver their services'. Both of these are crucial roles for CHCs currently, the exclusion of which, going forward, would be to the severe detriment of accountability and patient voice across healthcare in Wales. An independent and effective voice for Welsh patients is essential.
- Rather than disbanding CHCs, I feel strongly that it is crucial that the Welsh Government works to ensure that their role is maintained and impact enhanced across Wales.
- I trust that full consideration of these concerns will be taken with regards to this consultation.

WGWPMB14: S Sandham
Location: Monmouthshire

General Comments

I am not writing to you via the form attached to the white paper since I feel that the document is badly worded and misleading.

I have been a patient since 1951, an NHS Professional since 1971 and a voluntary member of a CHC for 8 years.

Consequently most of my life I have been involved within the NHS and I think the points which I am making are both valid and relevant.

No I do not agree that CHCs are not well known and their functions misunderstood. Patients who have problems do find us via word of mouth, website, facebook, twitter, leaflets in hospitals, surgeries and other CHC members all of whom have other interests apart from CHC involvement.

Yes I believe that Welsh Government has paid little attention to CHC business only interviewing potential volunteers, keeping funding down and not supporting CHCs to attract a more diverse population. Only when certain CHCs went beyond their remit did people take notice and it seems that those who did not cause trouble are being tarred with the same brush.

Yes, It is true that a few years ago some CHCs lost their way and caused a lot of overspend by not using a Team approach to object to Gwent establishing the SCCC, now known as The Grange Hospital.

Yes they have been underfunded for years so publicity has not been one of their priorities.

Yes CHCs need more and varied publicity. The finance should be made available. I am sure that you have noted that locally ABCHC has been doing more public engagement activities, they are very successful but it does mean that our valuable work doing hospital visits, surgery visits, in patient visits have had to be reduced due lack of time.

Yes our membership should be more diverse but without enough advertising and facilities to attract Asian people and young working people it is difficult to motivate the same.

Yes comprehensive information about our services is sent to WG, ministers and many other people in the public eye. You and your colleagues should have noted the vast numbers of visits of varying types that ABCHC has done and we are doing more every year. You cannot compare the number and quality of visits done by CHCs with HIW since their visits are pre-planned when CHCs are mostly done unannounced, HIW mainly liaises with staff, also their staff are funded.

Recently HIW staff worked much more closely with the other Welsh CHCs in a collaborative way.

Finally, NO CHCs should not be disbanded, or combined with other groups. I don't object to changing the name to something catchy and easy to understand and remember.

The COMMUNITY HEALTH COUNCILS IN WALES serve their purpose well. Look at the health issues which arose in England when CHCs were abandoned and CQCs took over. Why spend more money when the system is in place?
The Scottish system looks to be breaking down so theirs is a model to avoid.

YES! ALL patients need an independent body to represent their views and needs to avoid the unfortunate problems that could come up otherwise. A good service cannot police its own staff, humans are not infallible and do make mistakes. Sadly sometimes criminal acts are performed by greedy staff.

Organisations, independent from Government, as the Community Health Councils, involving dedicated volunteers who truly care about "THE PATIENT" are a must in the 21st Century where cost and profit can get in the way of PATIENT CARE.

WGWPMB15: Community Pharmacy Wales
Location: Cardiff

General Comments

CPW fully supports the Welsh Government's review of quality and governance and its intent to unlock the potential of health boards to demonstrate that they can govern and behave strategically.

The community pharmacy network across Wales has often struggled to engage with health boards on a strategic level and this has held back the development of the network and the delivery of local, accessible health and well-being services to the people of Wales. The OECD commented in their 2016 report 'Healthcare Quality in the UK' that heath boards are showing less innovation and radical approaches to system change than would have been expected and recommends that Welsh Government play a more supportive and prescriptive role in making this happen. CPW would fully support this position and calls on Welsh Government to move away from community pharmacy services being commissioned on an adhoc local basis to more national services where the people of Wales receive the same service at their local pharmacy regardless of where they reside.

The OECD further noted the role of Community Health Councils (CHCs) and questioned some of the value added by some of their functions. From a CPW perspective this issue is highlighted by the role that CHCs have in visiting and inspecting community pharmacies as this role overlaps with the inspecting role of the professional regulator the General Pharmaceutical Council and the local health board. This results not only in duplication but triplication of community pharmacy inspection. CPW would be happy to see this responsibility removed from whatever body replaces CHCs.

On a similar theme the consultation proposes common standards of inspection and regulation across the sector. Whereas this make be a sensible proposal for most parts of health and social care, CPW would remind Welsh Government that it has itself established effective national regulators for all independent contractors such as GPs, dentists and pharmacists and should therefore seek to avoid putting in place processes which could result in dual inspection of these professions.

CPW fully supports Prudent Healthcare principles and welcomes the move towards co-production. Pharmacists across Wales do however sometimes struggle to deliver the services a patient requires as the services it is able to provide are often not determined by the needs of the patient but rather the commissioning arrangements in each health board. This has often resulted in postcode provision of services and as a result a lack of ability by Welsh Government, as part of their choose well strategy, to be in a position to inform the people of Wales what services they should access through the community pharmacy network.

One of the challenges faced by the community pharmacy network in Wales has always been to ensure its voice is heard on the boards of LHBs. While CPW is not unsupportive of the reduction in the number of places on the boards of LHBs it has natural concerns that the network will find it even more difficult to influence health board strategic agendas. One solution to this could be to build into legislative requirements that whoever represents community pharmacy and other similar professions on the board of LHBs has a non-delegable duty to meet with representative organisations on a bi-annual basis so that lines of representation can be strengthened.

Section 1.1.22 refers to the Healthcare Professionals Forum which was initially put into place to provide a representation vehicle for community pharmacy and other local healthcare professionals. Our experience to date is that these forums have only taken place on an infrequent basis and are not meeting their intended objectives. CPW would support the need for a vehicle of this nature to be in place and would ask the Welsh Government, as part of its review, to strengthen the regulatory requirements and governance arrangements for Health Professional Forums.

CPW support the proposal to increase the number of independent representatives on LHB Boards provided safeguards are put in place, through clear requirements in relation to appointment processes, to ensure that these representatives are truly independent and that appointment processes are both open and transparent.

In relation to the proposal to allow a degree of flexibility to health boards in relation to board roles, CPW believe that if health boards are to be held accountable for the delivery of improved services in their areas then it is only right for them to be provided with the means to achieve this. The only caveat that CPW would have is that it remains clear to organisations that do not have a direct representative on the boards who is their official nominated representative on the board.

In section 2.1.43 it is noted that ‘we also need to have a changing focus to promoting good health and well-being so developing services to promote wellness rather than the traditional focus on treating ill health’. This intent has appeared in many Welsh Government strategies over the years and the lack of concrete actions to underpin this aim is a major disappointment for CPW. The opportunity to develop the community pharmacy network into a network of ‘health & well-being centres’ across Wales has not been taken and as the focus for health boards has moved to one of cost saving initiatives to take forward this aspect of the strategic agenda are consistently being put on the backburner.

CPW is supportive of Welsh Governments proposals through this consultation to ‘place a new enhanced and extended duty of quality on NHS bodies to enable and require them to demonstrate that where needed they collaborate on planning’. CPW is however less supportive of the need for this to be at a local or regional level as this

has to date resulted in post code provision of services at the expense of equality. CPW is supportive of the principle contained in the Prudent Healthcare philosophy of 'Do it once and do it for Wales'. Too often the perceived need to 'tailor services to the needs of the local population' becomes a means to cost cut at the expense of quality or to become a cloak for inactivity.

Section 2.2.54 of the consultation proposes that the 'Duty of Candour' that was put in place in England following the Mid Staffordshire NHS Foundation Trust inquiry should be similarly placed on GPs dentists and pharmacists in Wales. This proposal is not opposed by CPW however as a requirement to be open and honest in the event of an error is a requirement placed on all registered pharmacists and pharmacy technicians by their regulator this is an unnecessary change and duplication.

As the intention of the consultation is to improve clarity in relation to quality and governance, CPW would ask the Welsh Government to ensure that any proposals for change to the inspection or regulation of independent contractors do not result in duplication as duplication is a recipe for confusion and unnecessary administrative burden. If the area under review is already covered off by the duties of a Government appointed regulator, in pharmacy this is the General Pharmaceutical Council, then it would not be helpful for Welsh Government to seek to add in the same requirement through another channel.

WGWPMB16: Medical Protection Society
Location: London

General Comments

The Medical Protection Society (MPS) welcomes the opportunity to respond to the Welsh Government's consultation on its "White Paper: Services Fit for the Future: Quality and Governance in health and care in Wales."

MPS supports the Government's overall aim in this White Paper, as delivering a high, consistent standard of patient care in an integrated system is very important. The proposals put forward in this White Paper will require detailed thinking as future legislation takes shape. These are complex issues – of significant importance to both healthcare professionals and their patients.

The overarching and aspirational principles set out in the introductory paragraphs of this consultation are very positive. We agree that patients, together with healthcare professionals, should be able to make joint decisions about their own care. This concept has already been made very clear in the GMC's consent guidance. The GDC's Standards for the Dental Team also contains a section on consent. Hence, most of what is desired is already delivered at an individual and local level, and we recognise that improving the wider healthcare system requires greater attention now. MPS is interested in initiatives that address the need for culture change in healthcare and issues around openness and learning. However, we are concerned that a statutory Duty of Candour is not the most effective way of embedding that openness in healthcare. We are concerned that a statutory Duty of Candour across health and social services, consolidating existing duties, risks creating additional administrative burden and could ultimately have an adverse effect on the quality of healthcare. When it comes to bringing different organisations together to carry out investigations and handle complaints, the process will become more complex. Therefore it will be essential to have clarity from the outset as to how the coordinated approach will be handled.

We also place great importance on issues around inspection. If the proposed new inspection body is not established correctly, we are concerned that it can create additional regulatory burden rather than be of real improvement to the existing process.

Below, we provide high-level input on the sections of the consultation that are most relevant for MPS.

We hope our comments are helpful and constructive as the proposals for legislation take shape, and MPS would welcome the opportunity to discuss them with the relevant government officials in more detail.

Response to Specific Questions

Board Membership and Composition
MPS has no specific views on this proposal, other than to note that a flexible composition of the board is favourable, and structured leadership (professional and lay representation) with clear accountability on the Board is in our view essential.

Board Secretary
MPS supports the proposal that the roles and responsibilities of the Board Secretary should be clearly defined to avoid the possibility for dysfunction or isolation of this person. As well as appropriate professional healthcare expertise, it is important that the Board Secretary is also well versed in ethical decision making and the Duty of Candour.

Duty of Candour
MPS fundamentally supports a culture of openness in healthcare. Safeguarding the public and improving patient care must be a priority; however adding additional legislation to the healthcare profession is not always the best way of achieving this. In MPS's experience, a reliance on legislation and regulation risks creating defensive behaviours, where self-preservation becomes a dominant influence, instead of a focus on the best interests of the patient. MPS strongly believes that a change in culture would be far more effective at promoting openness, professionalism and accountability amongst those working in healthcare. Focusing on legislation and regulation as the key methods of driving behavioural change may undermine this. Professional healthcare providers (doctors, dentists and nurses) already have a professional duty of candour. While this does not necessarily address the social care setting, which might need separate consideration, it is worrying that the White Paper does not acknowledge the professional duties that already exist for healthcare professionals. For instance in the GMC guidance on *'Good medical practice'* it is explicitly stated in paragraph 55 that:
"You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:
a) Put matters right (if that is possible)
b) Offer an apology
c) Explain fully and promptly what has happened and the likely short term and long term effects"

This and a number of other paragraphs in the guidance already deal with candour and openness.
Going forward, MPS would appreciate it if the Welsh Government could make it clear that although the Duty of Candour will apply to organisations, many doctors and dentists practise individually and therefore represent the organisation or practice as an individual.
The introduction of a statutory Duty of Candour in Wales in such a way would be comparable to other similar developments in the UK. MPS remains of the view that this new statutory duty is not the most effective way of embedding openness in healthcare. We are concerned that a statutory Duty of Candour across health and social services, consolidating existing duties, risks creating additional administrative burden and could ultimately have an adverse effect on the quality of healthcare. Equally, if the policy decision has now been made, we stand ready to play our part, working with the Welsh Government, to ensure the duty of candour regulations are

properly communicated to the profession – and that professionals have clarity about precisely what that duty entails.

Setting and Meeting Common Standards

In this section it is suggested that health and social care delivery should adhere to a common set of standards. We have a number of concerns about how plausible this would be in practice. As referred to in paragraph 61, care provided in the patient's own home will, by virtue of its location and the resources available, be very different to the care provided in a clinical environment. If one standard were to be applied across the whole care spectrum, it would be very important to ensure that quality of care is not jeopardised by the expected standard being reduced. Healthcare organisations may no longer feel incentivised to improve the care they deliver and this cannot be the desired outcome of this proposal.

Joint Investigation of Health and Social Care Complaints

We would support this proposal.

MPS agrees that patients should be given a complete and coherent response to any concerns that they may have about the care received. This response must be delivered in a sensible manner and must take into account the additional administrative resources required. It should also set reasonable and proportionate expectations for the outcome; cross agency investigations will require a realistic time frame and this should be reflected within the new regulations. While a timely response would be preferred by all parties, this should not be at the expense of accuracy. It may take some time before all the facts, and perhaps the reasons why and how the events occurred, are understood. Until these are established, speculation should be avoided as this is unhelpful to all involved. However, this consideration should not hinder a prompt response to a complaint being forthcoming.

Compelling different organisations to work together to investigate complaints would appear to be a reasonable approach. There is already a provision within the current regulations1 that requires a coordinated response between health service agencies with a duty to cooperate. This should form a basic framework to extend the provision to social care. A joint health and social care complaints procedure is already in place in England the experience of which could form useful feedback.2

The redress arrangements only cover secondary care and there needs to be clear legislation and guidance on handling joint cases where redress is an issue.

Finally, it is important that changes to the regulations retain the need to provide an investigation plan (see para 22 (4) of current NHS regulations). This will be even more essential when the investigation is more complex, involving a range of different services, so that there is clarity from the outset as to how the coordinated approach will be handled.

Inspection and Regulation and single body

MPS supports the principle of joint investigations, but the practicalities need to be clear. Responsibilities and leadership must be well-defined, ensuring that all involved are kept up to date and have their say into response meetings with complainants.

MPS agrees that organisations such as HIW are best placed to inspect individual premises and (non-clinical) procedures and understand the need for registration with that organisation. However, it must be ensured that inspections in a certain area are always carried out by people with appropriate expertise and independence.

Inspections in private dental care, for example, should be carried out by dental registrants who fully understand the dental working environment.
If not established correctly, we are concerned that this new inspection body can create additional regulatory burden rather than be of real improvement to the existing process. Before rolling this out, we would also encourage that the possibility of consolidating existing bodies that are well-placed to inspect is properly examined.
This specific section of the White Paper is of considerable interest to MPS, given our wide ranging experience in this area. We look forward to engaging in further discussion on this topic with the Welsh Government.

WGWPMB17: Gwent Association of Voluntary Organisations and Torfaen Voluntary Alliance
Location: Newport

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes, agree with the overarching principles.

What further issues would you want us to take into account in firming up these proposals?
95% of these structures already exist they just need to work more effectively.

There is no obvious local or regional scrutiny provision for the Health Boards. The Stakeholder Reference Group along with the Gwent provider forum and citizen panel provide a suitable structure and mechanism to provide effective governance and scrutiny for both the Health Board and social services thus supporting better integration.

The current HB structure feels akin to an internal board, an integrated regional H&SC partnership would be a better format.

Board Secretary
Do you agree with these proposals?
No

What further issues would you want us to take into account in firming up these proposals?
The role of the HB secretary is an employee and too closely aligned to the board, an independent person from outside of the NHS would be more appropriate.
For example, WLGA, Wales Audit Office, an Ombudsman type role. Taking this type of approach would negate the need for statutory protection and any type of dismissal process. Remuneration would be at the appropriate civil service pay scale.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
In part.

What further issues would you want us to take into account in firming up these proposals?
The recent legislative framework already provides the vehicle for encouraging cultural change. Embracing the spirit of these pieces of legislation will support integration and cultural change.

We support the notion that the NHS should consider the needs of the whole population rather than just patients, they would then have a more active role in supporting wellbeing as well as responding to illness. They need to plan for everyone and provide service for those who need it.

The relationship between public health Wales, public health locally the Health Board is currently unclear. The white paper implies an intention to address this but plans are not clear within the document.

Duty of Candour
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
A duty of candour already exists in terms of safeguarding why do we need any more than this. We have data protection and confidentiality laws and safeguarding regulations, introducing further legislation may muddy the water.
There is sufficient legislation already, just needs to be adhered to and "policed".

Setting and Meeting Common Standards
Do you support this proposal?
What's new?

What further issues would you want us to take into account in firming up this proposal?
The Health and Care Standards 2015 were to fit with social services and public health as well as the Health Board. They were intended to cover all health care services, settings and locations. This appears to supersede the processes referred to on page 25 (70) and (71) we support the proposals in the 2015 and recommend them being formally introduced. We recommend that these standards also be applied to all contracted service providers and should be encouraged as good practice for ALL service providers including registered social landlords.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Totally support this proposal, an individual who already feels they have been badly treated should not be subjected to the ordeal of pursuing 2 separate or multiple complaints.

What further issues would you want us to take into account in firming up this proposal?
The social services process in paragraph 71 appears more robust but it is often the case that the "independent investigator" is an employee of a neighbouring social services department so can they truly be deemed to be "independent"

It is interesting that the health service process outlined in paragraph 70 makes no reference to the Community Health Council who provide independent advice, support and advocacy.

Whatever investigatory body is formed they should be independent and have the authority to carry out unannounced inspections where they deem appropriate. They should also have the opportunity to call upon profession expertise when required e.g. pharmacist to investigate medication issues

There should be a clear time line for the acknowledgement and investigation of complaints which can be scrutinised by the investigatory body.

Representing the Citizen in Health and Social Care
Do you support this proposal?
In part

Can you see any practical difficulties with these suggestions?
It is interesting that the white paper proposes to replace the Community Health Council but Health Inspectorate Wales and Care and Social Service Inspectorate Wales do not seem to be subject to even a review – why is this?

The Community Health Council (CHC) is truly impartial and independent and facilitates the citizen to have their voices heard. It seems ironic that the one clear mechanism for citizen representation is being abolished. How will this independent advocacy role be fulfilled in the new structure. If the CHC was properly resourced and the recruitment process simplified it would alleviate the need to incur the expense of forming a new national body.

Is a “Top down”, national approach really the best way of engaging citizens in the creation, design and evaluation of services. An alternative could be to expand the services delivered by the County Voluntary Councils. (CVCs) Most of the core functions of the Scottish Health Council Model (paragraph 85) would be a natural fit with the role of the County Voluntary Council. The CVCs are also independent organisations which would been advantage.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
No

What further issues would you want us to take into account in firming up this proposal?
The proposals around service change appear only to refer to Health Boards when the whole document talks about integration. The white paper suggests that the steps in Figure 1 page 34 would be implemented when certain criteria are met but the document gives no indication of what this criterion is the threshold that would invoke the process. It does not seem appropriate for individual organisations to determine their own thresholds and criteria. This practice currently exists in terms of commissioning and confusions reigns.

Inspection and Regulation and single body
What do you think of this proposal?

Rather than an underpinning legislative framework why not merge HIW and C&SSIW in line with the integration of H&SC services but do not feel that a national body is the best way of engaging citizens so would need to better understand the local infrastructure to support this.

Are there any specific issues you would want us to take into account in developing these proposals further?

However, we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Are you suggesting something similar to the WCVA / CVC structure? We could see how this would work?

Would you support such an idea?
Would need to better understand what is being proposed.

WGWPMB18: P Edwards
Location: Conwy

General Comments

I am responding to your consultation document regarding the above.

I am a long term campaigner for improving health services in North Wales, I am a former Conwy County Councillor cabinet member for Health and Social Services and recent former chairman of Betsi Cadwaladr Health Board's Stakeholder Reference Group.

I write to express concerns about some aspects of the Welsh Government's proposals. I would also take the opportunity to raise some issues that do not appear to be a concern within the White Paper.

Health Boards
It is self evident that Health Boards are quite ineffective in the provision of many aspects of health care and out of touch with their communities. This is particularly true of BCUHB. It is an arrogant, self serving inward looking organisation that is badly lead and badly managed and gives lip service only to partnership working. The make up of the Boards has always been a bone of contention, they have a severe democratic deficit, and they are largely left unchallenged and poorly scrutinised. I agree they could and should be more effective. Key to this is the make up of the board, there are too many staff members with self interests and insufficient truly independent members. They should also be served by senior local authority members, for instance cabinet members for social services.

In theory, the chairman of the Health Boards are accountable to the public, but in practice this is meaningless. Also the public has no say in their appointment or removal from office. That needs to change as do the roles of board members who say they are accountable only to the minister. The public nor the organisations who represent them, for instance the Community Health Councils, have a right to speak or address meetings. That needs to change.

Telling the Truth
There is no culture of openness and transparency within the health service historically. This needs a major change within management and on health boards in particular. The culture is one of fear and being afraid to speak out and is reminiscent of the police service twenty years ago. It is a very unhealthy organisation and I believe this is a poor reflection of the attitude of the Chair and Vice Chair positions at BCUHB. There needs to be a major change of attitude at these two pivotal positions.

Good Quality Care
As I state above, the ethos of partnership working is not working well, in particular by the health service. Partnership working within Local Authorities is now well embedded. You do not need to create more laws, rather you need to ensure that current recent (good) laws are working to best effect.

Making a Complaint
Handling of complaints needs to be taken out of the hands of those complained of. This clearly doers not work well within the health service. I raised this on numerous occasions with staff as chair of SRG. Lessons do not seem to be learnt or taken on board and the Health Board itself has no direct input on the various complaints that litter the local press almost on a daily basis.

Making sure People have a Say
The Community Health Councils are universally accepted and highly respected as being one of the most trusted organisations involved with healthcare on behalf of patients. They are diligent, transparent, effective and efficient and most important, seen to be apart from the health boards and staff.

I would strongly urge you not to dismantle this organisation but rather build on it and invest in it. I firmly hold the view that an expanded Community Health Council could represent the interests of the Welsh Government and Service Users alike if they were tasked with ensuring that Health and Social care worked together for people as you rightly envisage. I would also urge you to consider appointing senior members of the CHC onto Health Boards as full members.

Checking How things are going
From experience, it is my view that Health Inspectorate Wales and the Social Services Inspectorate have a unenviable history of letting people down. They are not fit for purpose. If you want to make real headway, I would suggest you scrap both these organisations, give more responsibility to Community Health Councils and create one publicly appointed board to oversee, guide and support Health and Social care and ensure real partnership working. You might even consider giving this responsibility to the CHCs themselves, who would without doubt, be up to the task.

Finally
One aspect not covered by the White Paper is funding, which is fundamental.
We are regularly told that health boards and social services departments are ‘over spent’. We are also told time and again that WG has increased budgets, but we know also that the demand continues to grow as the age of the population grows and so do their needs. I believe as do many others that rather than being overspent, the truth is that they are under resourced and this is a fundamental debate that could and should be contained within this White Paper.

WGWPMB19: Blaenau Gwent People First
Location: Blaenau Gwent

General Comments

Blaenau Gwent People First has worked with the following Groups on the easy read version of this Consultation

Vision House : 7 people
Tredegar Resource Group: 10 people
Bert Denning Group:10
Lakeview Day Centre: 4

The Tredegar Resource Group struggled to understand even the easy read version so were not able to comment.

Monies for the NHS should be shared out equally and more should be coming to Wales and not kept in England.

Response to Specific Questions

Good Leaders
Its ok to have a group but people with learning disabilities of all ages on this group. With accessible information.
Yes they should and why are the right people not doing these jobs already. They should understand learning disabilities and peoples needs.
People are not doing their jobs properly even though they have already some good leaders

Telling the Truth:
Yes this should be done
Doctors and nurses should be honest when things go wrong and tell us about it so that it can be better next time.

Good Quality Care:
No response did not understand the question
Yes this should be done and should have been done all along.

High Standards:
Until those who work at the top change the way they work and think then this can not happen on the ground.

Complaints:
How will this work?
Having a say? Who will be involved in this? How will it work?
It seems that things are merging back like they were years and years ago.

Organising changes to Health Services
People doing the day to day support need to be involved in this as they are the ones that are working day to day with people.

Checking on how things are going?
This is going to get messy and to large.
People with learning disabilities should be involved in checking this out.
There should be an independent person alongside someone who access services checking if people are having a say.

WGWPMB20: Professor R Moore
Location: Flintshire

General Comments

Initially I was reluctant to respond to this consultation, but have – with some misgivings – responded to some of the questions. My reluctance derives from the fact that the proposals make no mention of the diversity of the Welsh population and the need to comply with the requirements of the 2010 Equality Act. This consultation is in part a reply chapter 3 (*Health care quality in Wales*) of the OECD report *Reviews of Health Care Quality: United Kingdom 2016* in which the inadequate representation of the *patient's* voice in the NHS in Wales is emphasised. The *Parliamentary Review of Health and Social Care in Wales (Interim Report)* repeatedly emphasises the important of the public voice. I expected therefore that the problems of hearing the voice(s) of a multi-cultural population, as either patients or citizens, would be addressed directly in these proposals. It cannot be assumed that equality concerns are now so embedded in Welsh culture that they can be taken for granted. There is evidence that this is not the case. In undertaking any higher-level strategic approach to changing the structures of governance, the commitment to equality and the creation of a fairer and more equal Wales needs to be stated at the outset. Unless this is done issues of equality and of enabling all voices to be heard will be an add-on to policies rather than intrinsic to them.

Response to Specific Questions

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Only providing the Welsh Government set out how the proposals will meet the requirements of the Equality Act 2010 and that due consideration was given to the Human Rights Act 1998 in framing them.

What further issues would you want us to take into account in firming up these proposals?
The Welsh Government's equality and anti-poverty policies.

Duty of Candour
Do you support this proposal?
Yes

Setting and Meeting Common Standards
What further issues would you want us to take into account in firming up this proposal?
Problems of accessing care (of whatever standard) in the rural and more sparsely populated areas. The obvious issue to take into account here is the lack of adequate public transport and the further deterioration of provision.
Can alternative methods of delivering certain kinds of care (e.g. IT and internet based approaches). As these develop – as they surely will – how will common

standards be measured and ensured for services delivered by new and innovative methods?

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Yes

What further issues would you want us to take into account in firming up this proposal?

A common point of access for complainants because it may not always be clear whether the complaint is best directed to health or social services – or to both. System needs to avoid people, especially those who may be vulnerable of distressed, from having a complaint returned and told to make it to another agency

Representing the Citizen in Health and Social Care

Do you support this proposal?

Conditionally: Health Boards have made substantial investments in outreach work within their regions, and certainly in the case of North Wales made progress in ensuring that ethnic minority and other less-heard and hard-to-reach groups are heard in the development of policy and the evaluation of services. It is not at all clear from this paper how 'new national arrangements' would build on this. 'Citizen voice' is singular, the Welsh population is diverse and cannot have a singular voice. The Welsh Government needs to specify clearly how diverse citizens' voices will be represented 'in health and social care, to advise and provide independent assurance.'

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

Clinical matters are mainly matters for clinicians but the quality and representativeness of the advice they receive through the citizens' voice depends on the composition and processes of the body – see comments on *Questions on Citizen Representation* above.

The proposal to follow a Scottish model does not augur well for Wales given that the Convenor of the Scottish Parliament Health Committee described the Scottish body as a 'toothless hamster'.

Inspection and Regulation and single body

What do you think of this proposal?

This seems a reasonable proposal but it is very important that the underpinning legislative framework incorporates a requirement for inspection fully to comply with the Equality Act 2010 and have due regard to the Human Rights Act 1998. This may be intended, but the lack of reference to this legislation in this consultation leaves a degree of uncertainty. Is everyone fully 'on boards'? Agencies need to be sure that the evaluation of their performance includes equality and human rights provision. The very slow progress of the equality and human rights agenda in Welsh education is almost certainly attributable to the fact that equality, diversity and human rights performance does not have any high priority in inspections.

WGWPMB21: Caerphilly 50 plus forum
Location: Caerphilly

Response to Specific Questions

Board Membership and Composition
Whilst the proposals on membership of LHBs seem reasonable, they are all facing into the NHS. The recent legislation has given LHBs new responsibilities in respect of social care and for integration with social services. The requirement for pooled budgets for care homes by 2018 is an immediate example. The proposals in the consultation do not make any direct mention of this dimension or how social services can be given a higher priority by LHBs through its Governance arrangements. Having mandatory Board roles for Local Council politicians and senior professionals from social care should be re-enforced in the membership model. It would perhaps show a real commitment to Partnership if one of the Council nominated politicians was given the role of Vice Chair.

Duty of Quality for the Population of Wales
We agree that NHS bodies should also be placed under a reciprocal duty with local authorities to co-operate and work in partnership to improve the quality of services provided and for their duties to be aligned with recent legislation impacting on local authorities. A great deal of time and resources has been devoted by Councils to meet the new Population Needs Assessment (PNA) requirements and the systems are in their infancy; any changes to the NHS duties should therefore not introduce any substantial change for Councils and the new requirements on the NHS should be complimentary to the further development of the existing PNA arrangements.

Setting and Meeting Common Standards
Common standards for person-centred health and care across NHS, independent health sector and social care (where appropriate) which organisations are required to comply with are in principle laudable. However, when this has been attempted in previous years it has proved very difficult to shape in practice. The aim of “high level standards” that have meaning across such large and diverse sectors, with different service areas which often having little in common with each other, can lead to superficial results that citizens cannot make any sense of or utilise if they are wanting to access services or have complaints to make. Additionally, to fairly reflect the quality standards needed in the “medical model” of the NHS and the “Social Model” of Social Services seems an impossible task. Even the academic literature on what constitutes Person-Centred Care differs between the two sectors. Instead of investing in the proposed complex and difficult approach, we would want to see strong quality standards for each sector that are regulated and inspected robustly but with high level common standards at the inter-section of health and social care where they could drive up the quality of services provided jointly and provide transparency for the public in the way they are written. Another issue needs to be addressed before Common Standards can be implemented – Paying for Care. Whilst progress in Wales with raising the capital limit is very welcome, until the broader issues highlighted by the Dilnot Report are substantively addressed, the disparity between “free at the point of delivery” NHS and chargeable and means tested Social

Services cannot be addressed or at least improved in the increasingly integrated manner that the legislation and policy statements want to see services delivered. Unless a solution is found, the concept of Common Standards is seriously undermined.

Joint Investigation of Health and Social Care Complaints
We would support the proposals set out in the consultation which have already been addressed in England. It is essential that the investigating team comprises investigators from both organisations. These individuals must have been trained to deal with complaints into both health and social care provision, rather than specialising in only one of these areas. If not, the system will become fractured and impact on the public adversely. It is also important that the different aspects of a complaint are investigated in a timely manner and that they are taken forward as a whole case rather than separately. The new arrangements need to be properly resourced as delays or failures in getting access to services or their grievances resolved can have a significant impact on the lives of older people. Good information and advice about how the new system will operate is an essential requirement with access to advocacy on an even and joint H&SC basis where that is needed.

Representing the Citizen in Health and Social Care
Whilst a reasonable evidence base is provided to highlight the deficiencies with the current CHC Model, there is no argument put forward about how that model could be changed and improved. CHCs have a long history and many achievements and should not be dismissed so readily. For example, members of Aneurin Bevan CHC have spoken to over 800 people in the last year. They average about 150 visits to hospitals, GP surgeries and ambulance stations annually and are able to respond flexibly when reported problems arise. These inspections are patient-experience based as opposed to the far fewer HIW inspections which are clinically based: they should not be seen as duplication of the HIW role. The Health Board have to provide a comprehensive Action Plan for all recommendations made and this requirement should be continued for visits made by any replacement body.

The White Paper does not contain adequate arrangements for independent scrutiny of the Health Service, which is a role currently carried out by CHCs. Staff members scrutinise statistics provided by the Health Board daily and raise relevant issues very quickly. The CHC's advocacy work feeds in to the choice of locations to visit and the committed volunteer membership base provide considerable flexibility in this respect. Health Board professionals address regular meetings of Scrutiny, Planning and Executive Committees and answer the many questions asked by members on behalf of the public. It would not be difficult to extend the scope of these committees to include Social Care.

Instead of CHCs, a new approach based on the Scottish Health Council is proposed but without sufficient detail to know whether it will add value or whether it will work in Wales. What evaluation of the Scottish model has been undertaken? This is currently under review in Scotland as the Scottish Government is unsure that it is fit for purpose.

A visit to the SHC website shows it is largely dominated by health care with little information relevant to Social Care. Paragraph 4.3 provides more details about how the new model might work but that is all about health care and clinical governance – how will Social Care fit into the new approach? In summary, therefore we believe that a lot more work on the new proposed model is needed, its responsibilities and how they relate to other bodies, especially Social Care Wales and CSSIW and in particular, far more detail about how it will operate in respect of social services and social care more generally. A separate engagement with citizens about the detail of this and a consultation exercise is needed when that work is completed.

Inspection and Regulation and single body

Whilst closer integration and joint working between CSSIW and HIW is essential in the short term, we believe that the case for a single body for regulation and inspection of health hand social care outside of Welsh Government is undeniable. Wales is the only country in the UK where both inspection bodies are directly within Government and separate. Despite their operational independence, the overall Ministerial responsibility for them and potential for or perception of political interference cannot be ignored. The Inspectorates are also fettered in the strength and transparency of their professional advice they can give about new policy proposals. With new legislation and strong policy drivers to integration of health and social care, it makes no sense to continue with separate health and social care regulators – other parts of the UK have long since taken this step. Any structural change is problematic and needs resources but that should not be used as an excuse for the status quo. A clear commitment and timetable to create and introduce a single regulator should be given as soon as possible. Jointly provided services for older people can only be improved if they are regulated on a joint basis too.

WGWPMB22: Liz Saville Roberts AS
Lleoliad: Dolgellau

Ymateb i Gwestiynau Penodol

Aelodaeth a Chyfansoddiad y Bwrdd
Pa faterion eraill hoffech i ni eu hystyried wrth ddatblygu'r cynigion hyn?

Mae'r Papur Gwyn yn cyfeirio at ddau opsiwn ar gyfer Byrddau Iechyd Lleol ym mharagraffau 28 a 29.

Dylid darparu mwy o wybodaeth am y swyddi allweddol a gyfeirir atynt yn Opsiwn 1, paragraff 28, ym mhob bwrdd iechyd lleol, a rhesymeg dros hyd a lled eu cyfrifoldebau.

Mae'r annibyniaeth a amlinellir ym mharagraff 28, sef Opsiwn 2, yn nodwedd bwysig, a gellir pryderi bod Gweinidogion yn rhy awyddus i sicrhau cysondeb ar draul llywodraethiant safonol sy'n atebol yn lleol ac yn ystyrgar o anghenion cleifion yn eu cymunedau.

Rôl Ysgrifennydd y Bwrdd
Pa faterion eraill hoffech i ni eu hystyried wrth ddatblygu'r cynigion hyn?

Mae angen eglurdeb ynglŷn â phwy sy'n gyfrifol am bendodi Ysgrifenyddion Byrddau.

Dyletswydd Ansawdd i Boblogaeth Cymru
Pa faterion eraill hoffech i ni eu hystyried wrth ddatblygu'r cynigion hyn?

Deellir bod yma fwriad i ganiatáu cynllunio all-ranbarthol er mwyn gwneud defnydd gwahanol o gyfleusterau ac adnoddau dynol, a newid agwedd sefydliadol tuag at iechyd a ffyniant unigolion.

Gofynnir i'r ymgynghoriad ddangos ystyriaeth briodol o hygyrchedd gwasanaethau, a chynllunio i leihau effeithiau negyddol gwledigrwydd a phellenigrwydd wrth arfarnu Dyletswydd Ansawdd.

Dylai ansawdd darpariaeth yn ôl anghenion ieithyddol y claf fod yn berthnasol yngyd-destun Dyletswydd Ansawdd.

Dyletswydd Gonestrwydd
Pa faterion eraill y byddech am inni eu hystyried wrth fynd ati i ddatblygu'r cynnig hwn?

Ai 'didwylledd' a fwriedir yn lle 'gonestrwydd'? Y nodwedd a ddymunir yw parodrwydd i gynnig atebion llawn yn agored, nid peidio â bod yn gelwyddog yn unig.

Mae gwireddu dyletswydd ddidwylledd yn egwyddor i'w chroesawu, ond mae angen mwy o fanylion am sut byddai dyletswydd o'r fath yn cael ei gwireddu: -

- Pa unigolion/cyrff fydd yn cael eu dal yn atebol ac i bwy?
- Os bydd enghreifftiau o unigolion/cyrff yn tramgwyo'n erbyn dyletswydd ddidwylledd, beth fydd y canlyniad?
- Pa hawliau fydd dyletswydd ddidwylledd yn rhoi i'r claf unigol? Sut bydd cleifion yn cael eu hysbysu am eu hawliau?
- I ba raddau a sut mae dyletswyddau ansawdd a didwylledd yn berthnasol i weinidogion?

Cynrychioli'r Dinesydd ym maes Iechyd a Gofal Cymdeithasol
Ydych chi'n cefnogi'r cynnig hwn?

Mae Cynghorau Iechyd Cymuned yn cynnig strywthur rhanbarthol gydag is-bwyllgorau lleol sy'n darparu gwasanaeth craffu ar ran y cyhoedd ynglŷn â materion iechyd.

Gan mai rôl statudol sydd ganddynt, gellir deall bod angen deddfwriaeth i newid y rôl hwnnw; cytunir bod angen dod â chraffu o safbwynt defnyddwyr, eu teuluoedd a cymunedau i faterion gofal fel rhan o gytgordio cyd-gynhyrchu.

Gellir gweld hefyd fod rôl i gorff cenedlaethol a fyddai'n cyd-weithio gydag Arolygaeth Iechyd Cymru, ond nid ar draul yr ymyrraeth ranbarthol a lleol sy'n hanfodol i leisiau annibynnol cleifion a dinasyddion gael eu diogelu.
Croesewir cyfle i ail-lunio cyfrifoldebau a phŵerau cyrff lleol ar sail Cynghorau Iechyd Cymunedol gyda remit ehangach o ran gwasanaethau gofal yn ogystal â iechyd, ond teimlir mai camgymeriad dybryd fyddai sefydlu corff trosfwaol cenedlaethol ar draul cynrychiolaeth sy'n agos at boblogaethau yn eu cymunedau ac sydd â'r awdurdod i gynrychioli unigolion.

Gyda dim ond 16 aelod o staff hŷn a phrif swyddfeydd ym Merthyr Tudful a Chaerdydd, nid oes gan Arolygaeth y capasiti digonol i gymryd lle'r CICau, ac ni ddylid disgwyl i'r fath weithgaredd fod yn rhan o'i dyletswyddau.

Byddai'r cynnig hwn yn diddymu gwasanaeth cwynion a gwasanaeth eiriol personol y CiCau, ac yn berygl o arwain at ddiffyg democratiaeth. Byddai'n golygu na fyddai adroddiadau o safbwynt y dinesydd ar wasanaethau lleol: mae'r rhain ar hyn o bryd yn adlewyrchu profiad uniongyrchol y claf o ddinesydd yn y lleoliad y mae'n derbyn triniaeth. Ni fyddai colli'r manylder a'r berthnasedd hon yn cryfhau llais unigolion i'r dyfodol.

Petai'r strwythur presennol CICau yn cael ei haddasu i gynnwys cartrefi gofal, byddai modd cynnal rhaglen hynod ddefnyddiol o ymweliadau gyda'r nod o ddod i farn ar ddarparu gwasanaethau o safbwynt y dinesydd.

Derbynir bod angen bwrw ati i godi ymwybyddiaeth y cyhoedd o wasanaethau CICau.

Derbynir hefyd fod angen ehangu cynrychiolaeth y CICau presennol, yn enwedig o safbwynt pobl ifanc, ond dylid nodi mai un agwedd ohonynt a feirniadwyd yn y gorffennol oedd diffyg annibyniaeth oherwydd penodiadau uniongyrchol Llywodraeth Cymru i gorff sydd â remit i weithredu'n annibynnol. Mae gwasanaethau iechyd a

gofal Cymru'n haeddu gwell na sefyllfa lle gellir gofyn a yw gweinidogion yn osgoi craffu cadarn, ac yn cynllunio i'w danseilio.

Pryd bydd gwasanaethau o dan bwysau, nid ymarfer rheoli cyfathrebu sydd eisiau, eithr dyletswydd ddidwylledd wirioneddol sy'n ymddiried mewn eraill ac yn parchu'u barn.

Ôl-nodyn
Nodaf nad oes lleoliad eto (Llun 11 Medi) ar gyfer ymarfer ymgynghori yng Ngogledd Cymru a gynllunir ar gyfer Llun 18 Medi a Mawrth 19 Medi. Nid yw hyn yn enghraifft o ymarfer da o ran cyrraedd llais y cyhoedd.

Llunio Cynlluniau a Gwasanaethau ar y cyd â dinasyddion
Ydych chi'n cytuno â'r cynnig hwn?
Gan nad oes manylion darpar gyfundrefn, mae'n anodd i gynnig barn arni.

Fodd bynnag, awgrymir mai ymrymuso'r gyfundrefn bresennol fyddai'n well na mynd â llywodraethu ansawdd a diogelu llais yr unigolyn yn bellach oddi wrth y dinesydd.

Archwilio a Rheoleiddio a chorff unigol
Fodd bynnag, rydym hefyd yn credu y gallai fod gwerth ystyried corff newydd - er enghraifft, Corff a Noddir gan Lywodraeth Cymru - i roi mwy o annibyniaeth o ran rheoleiddio ac archwilio a rhoi llais i ddinasyddion.
Gweler sylwadau uchod.

WGWPMB23: Newport 50 plus forum
Location: Newport

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
The Forum agrees with these proposals in general and that consistency across Health Boards needs to be balanced with flexibility which allows for regional differences.

What further issues would you want us to take into account in firming up these proposals?
The Forum would welcome informal carer/service user/elderly representation at all levels of governance to ensure that feedback from these sections of society is listened to and openness and transparency prevails. Such representation could also provide valuable insight into governance.

Board Secretary
Do you agree with these proposals?
The Forum is in agreement with this proposal.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Collaborative working between Health Boards and Local Authorities is essential, but such a relationship has been very slow to develop. The Forum therefore welcomes legislation to enforce this.

What further issues would you want us to take into account in firming up these proposals?
The well-being of unpaid carers is essential to maintain the quality of care provided to disabled and elderly people. However, in practice, this is largely overlooked. There is inadequate support and preventative health measures for carers. There is also a breakdown in support when carers are unable to fulfil their caring role due to illness. This impacts directly the health of the people they care for. It is essential that the experiences of carers and cared-for is fed back when planning healthcare services. The direct involvement of such individuals is essential when co-designing and co-producing solutions.

Duty of Candour
Do you support this proposal?
Candour and transparency are essential in restoring public confidence in medical and other support services provided by Health and LAs. A Duty of Candour will provide enforcement of this.

What further issues would you want us to take into account in firming up this proposal?
In spite of a duty to inform, staff are still concerned that whistle-blowing will result in their dismissal. A culture of secrecy exists at present and this will be difficult to overcome. However, this needs to change.

Setting and Meeting Common Standards
Do you support this proposal?
This is an important step forward.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Where a complaint involves both Health and LAs (and Care Homes?), a joint complaints procedure will facilitate the process. However, it should be possible to separate complaints against one organisation. The procedure must be clear and straightforward for complainants and backed up by an independent advocacy service.

What further issues would you want us to take into account in firming up this proposal?
The time taken for a complaint to run its full course can be lengthy. By combining Health and Social Care complaints, this should not be an excuse for cutting staff and, in doing so, making the complaints procedure longer.

Representing the Citizen in Health and Social Care
Do you support this proposal?
We believe that the proposal to replace CHCs with another organisation at the present time would be detrimental to the recognition of patient/service user/carer experience, and their influence upon quality improvement. The outline of the new organisation seems to be nebulous and not completely thought through. The present powers of entry and inspection of premises are vital to quality of service, and duplication of service means that this can be done in a timely fashion. Again, we are concerned that streamlining services will lead to fewer staff doing the same amount of work. Also, CHCs provide an independent service which needs to be maintained. At present, we understand that there is no other organisation that has the right in law to monitor the delivery of NHS services and the experiences of its patients. We feel that the voice of the citizen will be greatly reduced by changing this service.

Experience leads us to believe that LAs and Health need scrutiny in the implementation of the involvement of citizens in the design of user-led services. At present it is too easy to pay lip-service to involvement of service user and carers in such schemes, rather than real engagement. CHCs could be strengthened to encourage fuller representation of and engagement of local communities.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?

The Forum would welcome greater citizen involvement.

What further issues would you want us to take into account in firming up this proposal?
The involvement of Forums such as ours, Citizens Panels, support groups. Engagement with these groups seems to be largely overlooked at present.

Inspection and Regulation and single body
What do you think of this proposal?
The Forum agrees that HIW and CSSIW should work jointly where appropriate. However, we believe that the two bodies work in different environments and should remain separate until a more detailed plan is developed. Again, there is the fear that combining would lead to cut-backs and greater inefficiency.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
More detailed proposals would be appreciated, please.

WGWPMB24: Royal College of Anaesthetists
Location: London

General Comments

While the Ministerial foreword to the consultation alludes to the challenges of a changing demographic with longer life expectancy and the impact of preventable risk factors, which influence comorbidities, the consultation does not address this directly nor the resource pressures which – in part – inform the need for this White Paper. An October 2016 report from the Health Foundation6 found that maintaining the current range and quality of services would see spending rise from £6.5bn in 2015/16 to £10.4bn in 2030/31(in 2016/17 prices) if no efficiency growth is achieved over the period.

Sustainability of the NHS is intertwined with sustainability of other public services, crucially social care. Demands on adult social care are projected to rise faster than demand for NHS care; an average of 4.1% a year through to 2030/31.7 With past trends indicating that social care funding is unlikely to rise at the same rate, there is a real risk that the level of unmet health and social care need in Wales could further increase.

The challenge of ensuring sustainability of the health and social care system in Wales are not strictly limited to financial pressures. For example the 2016 survey of NHS staff in Wales revealed that 46 per cent of staff felt they could not meet all the conflicting demands on their time and 30 per cent stated that there was not enough staff for them to do their job properly.

Response to Specific Questions

Board Membership and Composition

Do you agree with these proposals?

We broadly agree with the proposals. However, it is extremely important that Boards are made up of high calibre individuals who are selected on a considered and equitable basis – notwithstanding the provisions of the NHS Wales Escalation and Intervention arrangements. Thought needs to be given to who is likely to apply for these roles and the assessment process for their appointment, to ensure all appointments would be beneficial to the functioning of the Board.

Regarding the 'Core Key Principles for all NHS organisations', we would welcome further clarity on the procedures and safeguards to ensure that a Board (or any NHS organisation) will be able to attract suitable individuals as "public members".
We would also welcome further information about the contingencies which will be put in place should a Board not be able to identify and appoint a majority of suitable "public members", to ensure that important decisions can continue to be made.

What further issues would you want us to take into account in firming up these proposals?

It will be important to ensure clinical memberships on all Boards as we do not believe the proviso for the involvement of senior management, below the level of Executive Director, will guarantee sufficient clinical representation.

We believe that the following Core Key Principle should be introduced: 'Each organisation will ensure that mechanisms for consultation with essential medical professionals will be in place, underpinned by written process and guidance'.

Board Secretary

Do you agree with these proposals?

Yes we support the proposal for the role of the Board Secretary to be placed on a statutory basis, with statutory protection to ensure the required independence of the role.

What further issues would you want us to take into account in firming up these proposals?

While we acknowledge that the White Paper addresses this issue, finding the right person to fill the position may be challenging, particularly following the 2014 report, 'Overview of Governance Arrangements at Betsi Cadwaladr University Health Board', which raised issues in relation to the role's considerable conflict of priorities.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

Yes, we encourage and support any proposals which facilitate Local Health Boards' vision beyond their own boundaries to improve the health of the entire population of Wales.

What further issues would you want us to take into account in firming up these proposals?

We support the principle that there should be no legislative barrier to regional or all-Wales solutions, which can deliver a greater benefit to more people.

Duty of Candour

Do you support this proposal?

Response: Yes, we support the proposal for a statutory duty of candour which, as is the case in Scotland, applies to all health and care services, including GPs dentists and pharmacists.

What further issues would you want us to take into account in firming up this proposal?

Response: All doctors should be open, transparent and honest and we support the proposal to put this principle in statute. However, it will be vital to ensure that the introduction of statutory powers does not undermine the development of no-blame learning culture which prioritises the safety of patients and the training of staff.

Setting and Meeting Common Standards

Do you support this proposal?
Yes, to some degree. The use of common standards, applicable across all areas, is a logical and sensible move which should facilitate the continuity of quality care being delivered.

However, it should be recognised that there are circumstances in which variation is acceptable and may reflect a particular demographic, financial or clinical situation. There is a distinction between the proposal for common standards to 'provide a framework for continuous improvement in the overall quality of care people receive' - which we fully support - and common standards to 'provide a common set of requirements' – which could (unintentionally) limit the ability to adapt to provide care which reflects acceptable variation.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?
Not completely. While it would be desirable to ensure the complaints system crossed boundaries easily and was simple for the patient, care needs to be taken to ensure that such a system doesn't result in long delays in responding to a simple complaint due to a larger number of people being involved, working across multiple locations. Complaints may still get 'lost' in a more cumbersome system.

What further issues would you want us to take into account in firming up this proposal?
In an environment where resources are sparse, care should be taken to ensure that this will not cost more and create an avoidable drain on health and social care services. These changes should be at the worst cost neutral, but to be considered a full success the proposals should lead to some reduction in the use of resources. If these obstacles can be overcome then the proposals are desirable.

Representing the Citizen in Health and Social Care

Do you support this proposal?
The RCoA fully supports the involvement of patients and the public in the co-creation, development and design of services. However, we believe that these proposed changes do not guarantee that patients and the public will engage to a greater extent than at present. The proposal could therefore create similar issues of delayed decision-making as described in relation to existing Community Health Councils (CHCs).
The positioning of the new body alongside Healthcare Inspectorate Wales (HIW) and the Care and Social Services Inspectorate for Wales (CSSIW), working dependently only when required, could be beneficial.

Can you see any practical difficulties with these suggestions?
These roles are best fulfilled by individuals with a reasonable understanding of health and social care provision. If this is not the case, public / patient expectations can be unrealistic, demanding every type of service 'on the doorstep', whilst expecting the standard that only a larger regional service is able to provide.

With consideration to the geography of Wales - and the pattern of population density - there is a risk that public / patient representatives are in favour of centralisation and specialisation of services as long it is local to those representatives, whilst opposing any change which involves travelling a greater distance to access a service.

Ensuring a diversity of representation which reflects all areas of the country is vital; even though this may not reflect a proportional representation of the population, owing to the factor of population density noted earlier.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

The difficulties in service change are well recognised. Currently any numbers of bodies / groups appear to be able to derail a logical, evidence-based service change, and often no change can occur because there may be one group who can see some disadvantage to them despite the proposal being overwhelmingly beneficial.

Therefore, while this proposal is welcomed we believe that these new mechanisms should be piloted on a small scale prior to full adoption / legislative change.

What further issues would you want us to take into account in firming up this proposal?

Although public / patient input on proposed changes is very important - as outlined above - bold decisions from elected politicians can be essential when informed by independent clinical advice which reflects the limited resources available. We support decisions informed by public / patient input and clinical expertise; not public opinion which could deter Ministers from making difficult but necessary decisions.

Inspection and Regulation and single body

What do you think of this proposal?

We would support a clearer legislative framework if it will improve joint working and integration of HIW and CSSIW as is indicated in the proposals.

However we also believe there could be merit in considering a new body for example, a Welsh Government Sponsored Body to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?

We will need to have more information regarding this proposal to inform a considered College position.

From the outline of the proposal provided, we would have concerns about how to guarantee full operational independence of a single, government sponsored body, which may also introduce new costs in its establishment.

A clearer legislative framework to improve the integration of HIW and CSSIW would be preferable.

WGWPMB25: Newport Carer's Forum
Location: Caerleon

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
The Carers' Forum agrees that consistency across Health Boards and Trusts needs to be balanced with flexibility which allows for regional differences.

What further issues would you want us to take into account in firming up these proposals?
The Forum would welcome informal carer representation at all levels of governance, as well as disabled and elderly representation, to ensure that feedback from this section of society is listened to and openness and transparency is effective. Such representation would also provide direct experiential information into every level of governance.

Board Secretary
Do you agree with these proposals?
Newport Carers' Forum is in agreement with this proposal.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Collaborative working between Health Boards and Local Authorities has long been desired by carers, but such a relationship has been very slow to develop. Newport Carers' Forum therefore welcomes legislation to enforce this.

What further issues would you want us to take into account in firming up these proposals?
The well-being of unpaid carers is essential to maintain the quality of care provided to disabled and elderly people, as outlined in the Social Services and Wellbeing (Wales) Act. However, in practice, this is largely overlooked. There is inadequate support and preventative health measures for carers. There is also a breakdown in support when carers are unable to fulfil their caring role due to illness. This impacts directly the health of the people they care for. It is essential that the experiences of carers and cared-for are fed back when planning healthcare services. The direct involvement of such individuals is vital when co-designing and co-producing solutions.

Duty of Candour
Do you support this proposal?
Public confidence in medical and other support services provided by Health and LAs is low. A lot of mistakes in treatment could be avoided by involving carers and families at an early stage, yet this seems to be hit and miss with some wards

involving carers much more than others. A Duty of Candour should go a long way to restore confidence in services.

What further issues would you want us to take into account in firming up this proposal?
In spite of a duty to inform, staff are still concerned that whistle-blowing will result in their dismissal. A culture of secrecy exists at present and this will be difficult to overcome. However, this needs to change.

Setting and Meeting Common Standards
Do you support this proposal?
This is an important step forward.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Where a complaint involves both Health and LAs, a joint complaints procedure will facilitate the process. Care homes are mentioned, but then disappear, which is unfortunate as these need to be monitored as much as Health and LAs.

However, it should be possible to separate complaints where only one organisation is involved. The procedure must be clear and straightforward for complainants and backed up by an independent advocacy service, such as that provided at present by CHC.

What further issues would you want us to take into account in firming up this proposal?
The time taken for a complaint to run its full course is often lengthy, and by the time an outcome is received, the complainant has lost the will to pursue the complaint further. The time limit must be strictly adhered to. By combining Health and Social Care complaints, this should not be an excuse for cutting staff and, in doing so, making the complaints procedure longer.

Representing the Citizen in Health and Social Care
Do you support this proposal?
We believe that the proposal to replace CHCs with another (unspecified) organisation at the present time would be detrimental to the recognition of patient/service user/carer experience, and their influence upon quality improvement. The outline of the new organisation seems to be not thought through. The present powers of independent entry and inspection of premises are vital to quality of service, and we understand that there is no other organisation that has the right in law to monitor the delivery of NHS services and the experiences of its patients. Therefore, cutting this means less openness and candour, and is therefore not in line with other outcomes specified in this White Paper.

Again, we are concerned that streamlining services will lead to fewer staff doing the same amount of work. Also, independence which could be lost. We feel that the voice of the citizen will be greatly reduced by changing this service.

Experience leads us to believe that LAs and Health need scrutiny in the implementation of the involvement of citizens in the design of user-led services. At present it is too easy to pay lip-service to involvement of service user and carers in such schemes, rather than real engagement. CHCs could be strengthened to encourage fuller representation of and engagement of local communities.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

Newport Carers' Forum would welcome greater citizen involvement.

What further issues would you want us to take into account in firming up this proposal?

The involvement of Carers' Forums such as ours, Senior Citizens groups, Citizens Panels, support groups. Engagement with these groups seems to be largely overlooked at present.

Inspection and Regulation and single body

What do you think of this proposal?

Newport Carers' Forum agrees that HIW and CSSIW should work jointly where appropriate. However, we believe that the two bodies work in different environments and allowance should be made for this. Again, there is the fear that combining would lead to cut-backs and greater inefficiency.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

More detailed proposals would be appreciated, please.

WGWPMB26: M Watts
Location: Unknown

General Comments

I would tick "yes" to the proposals, but wonder whether more control should be retained at local level with the people who probably understand the needs of the people in their area more fully than perhaps a more central control system.

WGWPMB27: J Browne
Location: Pentre

General Comments

The Welsh Government's White Paper 'Services fit for the Future' seeks to ensure that the future provision of health and social care will provide the people of Wales with the best care possible in those two areas of concern. The White Paper argues that this can best be done by health and social care working together and proposes measures aimed at achieving these objectives. So far, so good. Unfortunately, the pursuit of these admirable aims is marred in places by an incorrect analysis and understanding of what is already being achieved in certain areas. This is no more apparent than in the proposal to abolish the Community Health Councils (CHC); a proposal based on an incomplete and sometimes incorrect perception of what CHCs already achieve.

For example, the authors of the White Paper fail to comprehend that the "citizens voice arrangement" they seek to 'create' will, in reality, weaken and even destroy the very system already in existence and already achieving the results they wish to 'achieve'. The CHCs through direct local contact with people accessing NHS services, already ensure that such people hear directly about changes etc. to their local health services and have an opportunity to have their voice heard. In another example, the White Paper also seeks to 'create' a situation whereby NHS organisations are scrutinised and held to account on behalf of local people and communities for the way in which they deliver, or fail to deliver, their services. CHC volunteers and staff already carry out this key role on a daily basis, week in and week out.

Below are some real and concrete examples of how the CHCs successfully perform that role:

- A team of CHC volunteers was conducting a visit to a hospital when one of the team was informed by a patient that two other patients were being brought over-the-counter pain-killers by their visitors. The CHC team quickly and quietly brought this to the attention of the Ward staff who took immediate action to prevent and discourage this dangerous practice from recurring in the future. Without the visit of the CHC team, the practice would have continued, unseen and unknown, with possibly disastrous consequences for the two patients involved.
- CHC volunteers conducted an inspection of the 'loop' hearing system, fitted to help patients and visitors with hearing aids, in one of the hospitals and found the system failing in nearly all locations. After repeated visits by the CHC, the UHB finally took the required steps to correct this situation.
- A CHC team was informed by patients that an agency nurse working on the night shift was both rude to patients and inefficient in her duties. Following an immediate report and complaint from the CHC team, the agency nurse was indeed found wanting in those respects and never employed again by the hospital. The patients who told the CHC team about this agency nurse did not, for a number of reasons, feel able to tell hospital staff and presumably, therefore, that agency nurse would still be used by the UHB if the CHC team had not been present and inspired the trust and confidence of the patients.

- CHC volunteers and staff attend the meetings of the many bodies formed by the local health boards and ensure the patients voice is heard and taken heed of during those meetings. This system ensures the interests of patients are represented at such meetings and any potential problems dealt with at an early stage in planning.

The above comprises just a very small indication of the work carried out week in and week out by CHC volunteers and staff. The small budget allotted to the CHCs only allows for a small number of paid staff so the bulk of the work is carried out by unpaid volunteers. Without a shadow of a doubt, this system of providing a 'patients voice' is one of the most financially efficient whilst ensuring that patients' interests are cared for by volunteers drawn from within the very communities they represent.

Of course, in an NHS that is constantly changing and improving, CHCs must also develop and adapt accordingly. This has been acknowledged and acted upon by the CHCs as demonstrated by the positive reaction of CHCs in response to the Marcus Longley report Moving Towards World Class? A Review of Community Health Councils in Wales, 2012. The present White Paper proposals in relation to CHCs represent a tragic misunderstanding of the work carried out by CHC volunteers and staff and ignores all the work carried out to meet the challenges contained in the Longley Report.

There is an old saying "If it ain't broke, don't fix it". Hopefully the Welsh Government will heed those wise words and withdraw the proposal to abolish CHCs and instead work with the CHCs to ensure the good work already being carried out will be sustained and continue to be adapted and improved to meet the new challenges which undoubtedly lie ahead in the future.

WGWPMB28: N McKenzie
Location: Llangollen

General Comments

I understand the Welsh Government proposes to abolish Community Health Councils and along with them powers that exist to hold the NHS to account on behalf of patients and the public. How will the proposed new organisation strengthen and facilitate the process of consultations of the views of patients and the public and the resulting impact on the NHS of these views?

How will the proposed new law ensure that membership of the organisation genuinely represents patients and the public?

Plans include introducing a new body with a remit based on the Scottish Health Council, an organisation that is facing an uncertain future following significant criticism of its role and remit. How far does the proposed new law avoid the weaknesses identified in the Scottish system?

I am keen to see a stronger people's voice organisation but one that is independent, can hear directly from people about their experience and has the teeth to challenge care providers when they find that improvement is needed.

How much will this new organisation cost p.a?

Who will monitor its cost-effectiveness?

How often will it be reviewed and by whom?

What public involvement will be included in this review process?

What process is included in the proposed new law for closing down the new organisation if it fails to perform satisfactorily?

What process is proposed to remove ineffective members of the new organisation?

WGWPMB29: K White
Location: Denbighshire

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

Board Secretary
Do you agree with these proposals?
Yes

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

Duty of Candour
Do you support this proposal?
Yes

Setting and Meeting Common Standards
Do you support this proposal?
Yes

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
Need to take into account the current expertise of the CHC's.

Representing the Citizen in Health and Social Care
Do you support this proposal?
NO

Can you see any practical difficulties with these suggestions?
This is my response to the above White Paper in which the Welsh Government seek to amalgamate Health and Social Care provision. I am a user of health care provision and an ordinary member of the public. My wife and I are constant users of health provision I need to ensure that health provision is properly managed and inspected.

I wish to target my response to ensuring effective accountability and proper inspection of health provision and whilst supporting the plan to bring together Social Services and Health provision I am astounded at the plan to remove the very thing

the public hold dear. That is, the ability of the Community Health Council to challenge poor practice and to take up complaints by users of the health service and to provide a voice for people who otherwise are helpless against the might of an indifferent health service.

I am a strong supporter of the CHC and the intention to abolish the Community Health Councils in Wales is based on false beliefs.

The CHC already works with the health organisations to represent the citizens voice in health. CHC is already and independent and statutory organisation providing independent assurance to the public and, indeed, politicians and voluntary organisations.

The CHC already works alongside HIW in a collaborative way even though they seldom reciprocate in similar fashion. Such a holistic approach is already well developed.

The CHC is independent and respected. It is known by local health organisations and it matches the demographics of the area it serves. This required no inventing.

For some reason, you seek to abolish the CHC and replace it with a failing model used in Scotland. I have researched the Scottish system which is useless and lacks any teeth or influence. It costs a fortune and gains nothing for the public in terms of health service accountability. Scotland is backtracking and wants to replicate the Welsh model of CHC. They like the idea that Welsh CHC's costs £3.5m in total as opposed to the many millions they waste on their useless system. Why does the Welsh government want to do the opposite? Do not do so!

Welsh government want to abolish the CHC's and replace them with a new 'Citizen Voice Body' which will provide clinical advice. A disaster waiting to happen if you expect current volunteers to be trained up to do this.

The proposals are being made on flawed evidence caused by intellectual distance from reality. The CHC's are already a strong and independent organisation which currently holds hospitals, GP surgeries and Dental practices accountable for their treatment of vulnerable people with health problems. CHC's should be used to strengthen you ambitions. You abolish them and you throw patients and health users at the mercy of large bureaucratic providers who have other targets other than to improve quality care. You will be left with health users with no protection against poor standards and no statutory body to take forward their worries and concerns

Expand and use the CHC's. Do not abolish them!

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?

Do not forget the social model of disability. It's not all about clinical health.

Inspection and Regulation and single body
What do you think of this proposal?
Doesn't need legislation. Just needs sound professional practice and policies.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
NO. Do not need more strong arm political measures.

WGWPMB30: Nick Ramsay AM
Location: Monmouth

General Comments
I have deep concerns about the direction the Welsh Government's White Paper seems to be taking as regards the future of Community Health Councils in Wales.

In my view, Community Health Councils play a key role in scrutinising Wales's healthcare provisions and are vital to help hold the Welsh Government accountable for the state of the NHS in Wales. Patients in Wales need a strong voice, and I fail to understand how the abolition of Community Health Councils will achieve this in view of the experiences in England and Scotland, where replacing CHCs has been far from successful.

I have had a number of meetings with members of my local CHC and the local Chief Officer to hear their concerns about this consultation on the future of CHCs in Wales. All are of the view that this is change for changes sake. Members have stressed that they are not against change provided this produces a better and stronger service for the public that is truly independent.
Members also question the cost involved in making changes when members under the current system provide their services willingly as volunteers.

I feel that we should be extending the remit of CHCs to enable them to become involved in social care and nursing home issues also so that the quality of patient care does not decline further. If the White Paper recommendations are followed we will be losing the day to day oversight of the NHS from the patient point of view, and this would be potentially disastrous for the patient with the quality of patient care suffering as a result.

WGWPMB31: Abergele Town Council
Location: Conwy

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes agree with all proposals.

What further issues would you want us to take into account in firming up these proposals?
Board members should only sit for a set term

Board Secretary
Do you agree with these proposals?
Yes agree on these proposals

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes agree with these proposals

What further issues would you want us to take into account in firming up these proposals?
Taking a centralised approach to procurement when integrated.

Duty of Candour
Do you support this proposal?
Yes support the proposal

What further issues would you want us to take into account in firming up this proposal?
All parties should work together to ensure that the patient is protected

Setting and Meeting Common Standards
Do you support this proposal?
Yes support the proposal

What further issues would you want us to take into account in firming up this proposal?
There should be no post code lottery with regard to care and drug administration

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes agree

What further issues would you want us to take into account in firming up this proposal?
A clear path for raising a complaint irrespective of whether the care is privately or publicly funded; with statistics on outcomes/performance readily available to the public

Representing the Citizen in Health and Social Care
Do you support this proposal?
No the current system should be retained

Can you see any practical difficulties with these suggestions?
Yes the brief of CHC should be strengthened and modified. The creation of a central body will take control away from the local communities.

Co-producing Plans and Services with Citizens
What further issues would you want us to take into account in firming up this proposal?
Unable to comment as not enough knowledge of the Scottish model

Inspection and Regulation and single body
What do you think of this proposal?
Yes agree

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Not as an additional body a merge would be agreeable.

WGWPMB32: P Rendle
Location: Sir Ynys Mon

Response to Specific Questions

Representing the Citizen in Health and Social Care
Do you support this proposal?
Most definitely not

Can you see any practical difficulties with these suggestions?
I feel reassured, that as a patient, I have the expertise and backing of the CHCs in any dealings with the NHS

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
No This already exists on a local and regional level. North Wales will yet again be ignored if a national body is brought in.

What further issues would you want us to take into account in firming up this proposal?
Stay with the existing bodies and strengthen their remit to access social care.

Inspection and Regulation and single body
What do you think of this proposal?
HIW should be more proactive

Are there any specific issues you would want us to take into account in developing these proposals further?
Increase the patients' voice in social care through the existing CHC model

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. If the Welsh Government sponsors the body, how can it be independent? Would you support such an idea?
NO

What issues should we take into account if this idea were to be developed further?
Why change what is working already. The body should have right of access, unannounced, to all NHS and Social Care establishments.

WGWPMB33: Public Services Ombudsman for Wales
Location: Cardiff

General Comments

I am pleased to have the opportunity to respond to the Welsh Government's White Paper 'Services Fit for the Future'.
As Public Services Ombudsman for Wales (PSOW), I investigate complaints made by members of the public who believe they have suffered hardship or injustice through maladministration or service failure on the part of a body in my jurisdiction, which essentially includes all those organisations responsible for delivering public services devolved to Wales. These include:

- local government (both county and community councils);
- the National Health Service (including GPs and dentists);
- registered social landlords (housing associations); and
- the Welsh Government, together with its sponsored bodies.

I am also able to consider complaints about privately arranged or funded social care and palliative care services. Health is the most complained about subject area (38% in 2016/17) whereas I currently only receive a small volume of social care complaints, despite the introduction of the Social Services and Well-being (Wales) Act 2014. The own initiative powers I have requested under the new draft Public Services Ombudsman (Wales) Bill would allow me to identify systemic failings in the social care sector, even if service users themselves are not raising complaints. My response to this consultation reflects evidence from PSOW casework. It is in this context that I am responding to the consultation and my comments on various aspects of the White Paper are set out below.

Response to Specific Questions

Duty of Quality for the Population of Wales
Health boards working together or working collaboratively with local authorities could create additional complexity for the citizen/complainant in terms of who has ownership of a complaint when it is received by my office. It is my view that a public service must be accountable for all of the services it offers, whether it delivers that service itself or contracts it to another public body or external party, and the process for complaining about that service should be clear for the service user. So whilst I agree in principle with this proposal I believe a lot more work is required to ensure that it is effectively implemented and regulated with clarity and transparency for the service user at its heart. If the Assembly passes the new draft Ombudsman Bill this year it will give me the power to establish a Complaints Standards Authority which would facilitate the standardising of public bodies' complaints procedures and put the service user at the heart of the complaints process.

Duty of Candour
A statutory duty of candour should be introduced for whole organisations. In my recent thematic report 'Ending Groundhog Day: Lessons from Poor Complaint

Handling' I highlighted effective governance as key to transforming the fear and blame culture that is innate in public bodies, which will consequently end the cycle of poor complaint handling and poor service delivery.

Whilst I recognise that there already exists the GMC/NMC/CQC professional statutory duty of candour for individual practitioners, which is applicable across the UK, a statutory duty for health and social care bodies in Wales as corporate entities would reinforce this.

The current proposal for a Duty of Candour omits general practitioners and other primary care providers. I believe they should be included along with all other health professionals.

Joint Investigation of Health and Social Care Complaints

I actively encourage the alignment of complaints processes across health and social care and believe one national process is required to maintain consistency across the sectors.

The current social services complaints procedure states that local authorities should coordinate their investigations and responses with other public bodies involved unless there is a good reason not to. The NHS Wales 'Putting Things Right' process is currently silent on this. I believe the process needs to be better coordinated, for example to include a requirement for both sides to inform each other when a complaint is received, and to jointly agree on who will lead on the complaint response. Where one body takes ownership of a joint complaint, it must have the authority of both bodies to make the final decision in response to a complaint and to decide on redress amounts/recommendations.

As mentioned in point 2.1, if I am given the power to establish to a Complaints Standards Authority this would facilitate standardisation of public bodies' complaints procedures. This would also allow the gathering and reporting of consistent and comparable data across public services and, subsequently, areas of improvement to be identified. Consistency in complaints processes would facilitate the process for complainants, particularly in joint funding environments, and would remove any ambiguity over who has ownership of a complaint when it reaches my office.

Representing the Citizen in Health and Social Care

Advocacy is extremely important from my office's perspective, as our impartiality prevents us playing an advocacy role to assist complainants when making a complaint. Currently there is no advocacy provision for social care or joint social care/health and so I would welcome the introduction of a body that offers advocacy for social care.

However, if the current proposal is progressed, more details of the organisational architecture of the proposals are required to ensure that stakeholders can be assured of the independence of the new advocacy body and the level of co-ordination expected with HIW/CSSIW, as well as their respective levels of autonomy from Welsh Government.

Inspection and Regulation and single body

Reiterating my comments when responding to the Green Paper in November 2015, the nature of health and social 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.

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 either be one framework that covers health and social care, or better still one inspectorate with full statutory independence from government bodies. Such an inspectorate could also have the potential to bring about cultural change along with new processes. I also believe the decision to merge the two inspectorates should be based on future-proofing services to meet the needs of our ageing society, rather than one shaped by the interests of the organisations involved. Recent lessons from re-organisation in England might be valuable in this regard.

In addition if the proposal for an independent inspectorate body in place of HIW/CSSIW is to be realised then there needs to be a separate body to ensure that the vital advocacy services, currently provided by CHCs to individual complainants, are maintained.

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 submit a complaint to the relevant body and subsequently, if required, to this office. Advocates can also support complainants through the complaints process. 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, and that this should include a similar service in respect of social services.

However, if CHCs are not retained in their current form, robust arrangements are required to ensure that valuable local intelligence, informal feedback from patients and relatives, and routine observations from hospital visits etc. are retained, and if they are to be abolished in their entirety, an improved advocacy body for patients should be established in their place.

WGWPMB34: Wales Progressive Co-operators
Location: Unknown

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Wales Progressive Co-operators agree these proposals are sensible and we support the idea of prescribed core membership with flexibility about other appointments, together with the Minister able to make additional appointments if there are serious problems in a Health Board. It is positive that there should (a) be a majority of non-Executive members, (b) a clearly defined role for the Board Secretary with the capacity to challenge decisions/proposals of the Board or Chief Executive.

Board Secretary
Do you agree with these proposals?
Yes, Wales Progressive Co-operators agree, please see above.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Wales Progressive Co-operators comments are as follows. A Wide Duty of Quality is proposed to encompass the population needs of Wales, promote collaboration at Health Board, Regional and National levels and across Health Social Care and other organisations. Key points are promoting co-production, prudent health care and being person centred. These are in line with the Social Services Act 2014 and the Wellbeing and Future Generations (Wales) Act 2015 and would reference the Regional Partnerships (LAs) and Public Service Boards. Promoting health and well-being is part of the underlying philosophy although prevention, including education is unmentioned. Co-production includes the respected involvement of citizen-users in the co-design and co-provision of their services. The Codes of Practice to the 2014 Act give detailed guidance about how to achieve co-produced well-being, and this includes promoting user-led organisations, co-operatives, social enterprises and third sector organisations because they lend themselves to being “democratic membership organisations” and because they “add social value”. Under the same Codes, Regional Partnership Boards are required to establish Social Value Forums in order to promote, engage with, and benefit from, these “social value” organisations. In the interests of proper alignment between health, social care and well-being activities, and between Boards with over-lapping responsibilities for these activities, it would helpful to see the mirroring of the promotion of care co-operatives and other social value organisations in the arrangements for promoting cultural change supported by access to co-operative education and support.
Wales Progressive Co-operators agree that whilst there can be little objection to a Duty of Quality the reservation is how will it be embraced by health and social care organisations? In addition to the comments above regarding how to achieve co-producted well-being and prudent health care, it should be noted that social value organisations, especially ones which aspire to a meaningful membership democracy

and local grass-roots engagement, need to be properly supported and not be confronted by a commissioning landscape which is geared more towards established and market-oriented organisations. It is positive that there is a proposal for a common set of high level standards applied to health and social care which would apply regardless of the location of care.

Duty of Candour

Do you support this proposal?

Wales Progressive Co-operators agree this is a welcome proposal already introduced in England and Scotland. Wales should use the Scottish scheme as a model.

Setting and Meeting Common Standards

Do you support this proposal?

Wales Progressive Co-operators support, but easier said than done!

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Wales Progressive Co-operators agree welcome changes to proposed regulations which would require different organisations to work together if the complaint relates to more than one organisation. Wales Progressive Co-operators does not believe this alone will encourage organisations to learn lessons to improve their services. Clarity required about the importance of using democratic methodologies such as Appreciative Inquiry and Community of Enquiry

What further issues would you want us to take into account in firming up this proposal?

Using democratic methodologies such as Appreciative Inquiry and Community of Enquiry.

Representing the Citizen in Health and Social Care / Co-producing Plans and Services with Citizens

Do you support this proposal?

Wales Progressive Co-operators does not for the reasons set out below.

Effective Citizen Voice, Co-production and Clear Inspection: It is proposed that CHCs should be replaced by a new organisation "Citizen Voice to advise and provide independent assurance". It is clear that Health Boards and Welsh Government are unhappy about the degree to which CHCs challenge Health Board proposals for substantial change. Therefore it is proposed that new arrangements for Citizen Voice should only have a consultative role on the acceptability of a Health Board's public engagement process. Citizens Voice would lose the current CHC powers to visit premise but focus on engaging with community groups. It is not clear if the new organisation would have any rights at Board meetings. The proposal for the CHC/Citizen Voice to cover health and social care is sensible as is the intention to maintain the advocacy service hosted by the CHC. The danger is that for all its faults the present system of CHCs has been very effective about holding Health

Boards to account and is a repository of considerable expertise and knowledge about the health service and its operation at the patient level. Issues about overlap with inspection are already sorted out.

Our real concern is that Citizen Voice is not described in any detail. It will have reduced functions and ability to challenge Health Boards. It will have less opportunity to engage with patients directly in health settings which at present gives CHC members essential understanding of how the health services work. Other unanswered questions are: How is the membership to be recruited? What will be the local and national structure? What will be the level of resources to the new organisation? Pressing ahead with a new organisation without a thorough picture of how it will operate is a high risk strategy which unintentially could significantly weaken citizen contribution to health service design, operation and quality. Welsh Government are urged to issue a separate consultation document making the argument for abolishing CHCs, reducing the "clout" of patient/citizen voice and giving full details of how a new body such as Citizen Voice would function.

We are unaware of evidence that CHC powers are mis-used. If a Health Board faces awkward decisions because of the different interests and views of patients in different geographical areas, limiting CHCs (Citizens'Voice) to commenting on the consultation methods, rather than also giving views based on their knowledge of the actual operation of services, would seem to substantially weaken citizens' ability to question plans. Much of the emphasis on continuous engagement with patients /community seems to reflect a mindset which is proactive in getting comments on the current detailed operation of services but resistant to involvement in big decisions. One of the CHC strengths is that claimed benefits for changes can be checked by the CHC once the changes have been introduced.

If Government is modelling Citizens' Voice on the Scottish system, we emphasise that Scotland is reviewing its current system with a view to going back to a quasi CHC model as they are unhappy with the purely consultative body.

Inspection and Regulation and single body

What do you think of this proposal?

Wales Progressive Co-operators would value more detail before commenting further.

Are there any specific issues you would want us to take into account in developing these proposals further?

Wales Progressive Co-operators: an analysis of costs and benefits.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Wales Progressive Co-operators would value more detail before commenting further. Our main concern is with the lack of sufficient resources within the system at a time of increasing demand and more expensive treatment/technology.

Would you support such an idea?

Wales Progressive Co-operators would value more detail before commenting further.

What issues should we take into account if this idea were to be developed further?
Wales Progressive Co-operators: Additional costs and the role of UK wide regulation. Clarity about the importance of using democratic methodologies such as Appreciative Inquiry and Community of Enquiry.

WGWPMB35: Co-Ops and Mutuals Wales
Location: Newport

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Co-ops and Mutuals Wales agree these proposals are sensible and we support the idea of prescribed core membership with flexibility about other appointments, together with the Minister able to make additional appointments if there are serious problems in a Health Board. It is positive that there should (a) be a majority of non-Executive members, (b) a clearly defined role for the Board Secretary with the capacity to challenge decisions/proposals of the Board or Chief Executive.

Board Secretary
Do you agree with these proposals?
Yes, Co-ops and Mutuals Wales agree please see above.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Co-ops and Mutuals Wales comments are as follows. A Wide Duty of Quality is proposed to encompass the population needs of Wales, promote collaboration at Health Board, Regional and National levels and across Health Social Care and other organisations. Key points are promoting co-production, prudent health care and being person centred. These are in line with the Social Services Act 2014 and the Wellbeing and Future Generations (Wales) Act 2015 and would reference the Regional Partnerships (LAs) and Public Service Boards. Promoting health and well-being is part of the underlying philosophy although prevention, including education is unmentioned. Co-production includes the respected involvement of citizen-users in the co-design and co-provision of their services. The Codes of Practice to the 2014 Act give detailed guidance about how to achieve co-produced well-being, and this includes promoting user-led organisations, co-operatives, social enterprises and third sector organisations because they lend themselves to being “democratic membership organisations” and because they “add social value”. Under the same Codes, Regional Partnership Boards are required to establish Social Value Forums in order to promote, engage with, and benefit from, these “social value” organisations. In the interests of proper alignment between health, social care and well-being activities, and between Boards with over-lapping responsibilities for these activities, it would helpful to see the mirroring of the promotion of care co-operatives and other social value organisations in the arrangements for promoting cultural change supported by access to co-operative education and support.

Co-ops and Mutuals Wales agree that whilst there can be little objection to a Duty of Quality the reservation is how will it be embraced by health and social care organisations? In addition to the comments above regarding how to achieve co-producted well-being and prudent health care, it should be noted that social value organisations, especially ones which aspire to a meaningful membership democracy

and local grass-roots engagement, need to be properly supported and not be confronted by a commissioning landscape which is geared more towards established and market-oriented organisations. It is positive that there is a proposal for a common set of high level standards applied to health and social care which would apply regardless of the location of care.

Duty of Candour
Co-ops and Mutuals Wales agree this is a welcome proposal already introduced in England and Scotland. Wales should use the Scottish scheme as a model.

Setting and Meeting Common Standards
Co-ops and Mutuals Wales support, but easier said than done!

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Co-ops and Mutuals Wales agree welcome changes to proposed regulations which would require different organisations to work together if the complaint relates to more than one organisation.

What further issues would you want us to take into account in firming up this proposal?
Co-ops Mutuals Wales does not believe this alone will encourage organisations to learn lessons to improve their services. Clarity about the importance of using democratic methodologies such as Appreciative Inquiry and Community of Enquiry.

Representing the Citizen in Health and Social Care/ Co-producing Plans and Services with Citizens
Do you support this proposal?
Co-ops and Mutuals Wales do not for the reasons set out below.
Effective Citizen Voice, Co-production and Clear Inspection: It is proposed that CHCs should be replaced by a new organisation "Citizen Voice to advise and provide independent assurance". It is clear that Health Boards and Welsh Government are unhappy about the degree to which CHCs challenge Health Board proposals for substantial change.Therefore it is proposed that new arrangements for Citizen Voice should only have a consultative role on the acceptability of a Health Board's public engagement process. Citizens Voice would lose the current CHC powers to visit premise but focus on engaging with community groups. It is not clear if the new organisation would have any rights at Board meetings. The proposal for the CHC/Citizen Voice to cover health and social care is sensible as is the intention to maintain the advocacy service hosted by the CHC. The danger is that for all its faults the present system of CHCs has been very effective about holding Health Boards to account and is a repository of considerable expertise and knowledge about the health service and its operation at the patient level. Issues about overlap with inspection are already sorted out.

Our real concern is that Citizen Voice is not described in any detail. It will have reduced functions and ability to challenge Health Boards. It will have less opportunity to engage with patients directly in health settings which at present gives CHC members essential understanding of how the health services work. Other unanswered questions are: How is the membership to be recruited? What will be the local and national structure? What will be the level of resources to the new organisation? Pressing ahead with a new organisation without a thorough picture of how it will operate is a high risk strategy which unintentially could significantly weaken citizen contribution to health service design, operation and quality. Welsh Government are urged to issue a separate consultation document making the argument for abolishing CHCs, reducing the "clout" of patient/citizen voice and giving full details of how a new body such as Citizen Voice would function.

We are unaware of evidence that CHC powers are mis-used. If a Health Board faces awkward decisions because of the different interests and views of patients in different geographical areas, limiting CHCs (Citizens' Voice) to commenting on the consultation methods, rather than also giving views based on their knowledge of the actual operation of services, would seem to substantially weaken citizens' ability to question plans. Much of the emphasis on continuous engagement with patients /community seems to reflect a mindset which is proactive in getting comments on the current detailed operation of services but resistant to involvement in big decisions. One of the CHC strengths is that claimed benefits for changes can be checked by the CHC once the changes have been introduced.

If Government is modelling Citizens' Voice on the Scottish system, we emphasise that Scotland is reviewing its current system with a view to going back to a quasi CHC model as they are unhappy with the purely consultative body.

What further issues would you want us to take into account in firming up this proposal?
Co-ops and Mutuals Wales: Clarity about the importance of using democratic methodologies such as Appreciative Inquiry and Community of Enquiry.

Inspection and Regulation and single body
What do you think of this proposal?
Co-ops and Mutuals Wales would value more detail before commenting further.

Are there any specific issues you would want us to take into account in developing these proposals further?
Co-ops and Mutuals Wales: an analysis of costs and benefits. Clarity about the importance of using democratic methodologies such as Appreciative Inquiry and Community of Enquiry.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Co-ops and Mutuals Wales would value more detail before commenting further. Our main concern is with the lack of sufficient resources within the system at a time of increasing demand and more expensive treatment/technology.

Would you support such an idea?
Co-ops and Mutuals Wales would value more detail before commenting further.

What issues should we take into account if this idea were to be developed further?
Co-ops and Mutuals Wales: Additional costs and the role of UK wide regulation. Clarity about the importance of using democratic methodologies such as Appreciative Inquiry and Community of Enquiry.

WGWPMB36: Dr I G Higginbotham
Location: Conwy

Response to Specific Questions

Representing the Citizen in Health and Social Care
Do you support this proposal?
No. The Proposal is deficient in several respects.

The white paper does not set out any measureable objectives in relation to the areas where improvement is expected and there is no clear statement of what that improvement might be.

It seems strange to create a body to promote, assist and monitor the co-working of Health and Social Services Boards before structures have been established to bring these Boards together. Only when the new structures have been established will we be in a position to know how best to monitor and evaluate their effectiveness.
Talk of a new body to work alongside HIW and CSSIW is premature. If Health and Social Care are to merge in some way, then there would inevitably be some restructuring or merging of these two inspectorates.

The White Paper talks of a new body that would (a) support health and social care organisations in improving the way they engage with their communities and (b) monitor and evaluate the way in which health and social care organisations involve local people. This is an inappropriate mixture of roles.

The proposed 'new national arrangement to represent the citizen voice' seems to have a similar structure to the current arrangements in Scotland. The OECD Reviews of Health Care Quality state that: 'Scotland needs to look for ways to support bottom-up approaches with stronger national frameworks'. It also finds that: 'Scotland should also reconsider whether the mixing of scrutiny and quality improvement activity within Healthcare Improvement Scotland represents a conflict of interest'. These findings do not support the notion that Wales should adopt a model similar to that in Scotland. Indeed, Health Improvement Scotland launched a public consultation last month on the future shape and role of the Scottish Health Council. This can only suggest that the current model is not working sufficiently well and should therefore not be held up as a model for Wales to follow.

The CHC runs at very low cost – only £3.4m for the central Board functions and for seven local organisations. This includes provision of an Advocacy Service, a statutory provision delegated to CHCs. A minimal number of staff provide excellent support for volunteer members who fulfil many important functions.

These members are local people, contactable by local residents. In North Wales, members make unannounced visits to every hospital ward (General and Community) at least twice a year. In this 'inspection' activity, the CHC is not duplicating the work of HIW, who have the capacity to make far fewer visits. HIW inspections are necessary – they investigate professional and medical matters in which CHC members have no expertise. However, the extent of their interaction with public and

patients is necessarily tiny compared with that of the CHC in the course of hundreds of visits each year.

CHC members also visit GP surgeries, pharmacies, NHS clinics, NHS dental surgeries, hospital kitchens and laundries, minor injuries units and emergency departments. In all these settings, it is the interests of the public and patients that members consider. Through their observations and their conversations with the recipients of those health services, members gather a detailed knowledge of the strengths and weaknesses of the provision.

Informed by this knowledge, CHCs maintain regular contacts with their Health Boards. Contacts occur at many levels – written reports, one-to-one meetings of Chairs and Officers and formal scheduled meetings where Health Board plans are discussed and challenged.

This free detailed inspection of every aspect of healthcare provision is constantly challenging providers to improve standards. It is valued by the Health Board.
Any new national arrangement to represent the citizen voice in health and social care and to advise and provide independent assurance will be detrimental to standards of health if it removes or undermines these functions of CHCs.
It is obvious that CHCs will need to change. If Health and Social Services are to be merged more closely, then quality assurance systems will also need to change. However, a revised model should not lose the strengths of current provision. Rather, it should extend them to a wider range of services.

Consultation with the public and patients can be difficult to undertake. People naturally have little interest in expressing their views about an aspect of healthcare of which neither they nor their relatives have needed to avail themselves. Indeed, having no experience of the service, it is unlikely that they would have informed views to express. CHCs, as currently constituted, are very effective at engaging with the people who are most involved with the service that is the focus of a consultation. Recent CHC national reports on loneliness in hospital and dementia have been valuable precisely because they have reflected the views expressed to members by patients and their relatives. This personal contact with members of the public most involved with the issues is something that any reorganisation of CHCs cannot afford to lose.

The first all-Scotland survey on health and social care, conducted on-line, had only 51 responses. There is no evidence from England or Scotland that their systems are better at engaging the public than those we have in Wales. The first review of the Scottish system states that they have failed to engage the public well and that they need to work harder to make sure any new body is seen to engage. The English system has been criticised for not holding health authorities and hospitals to account. Paragraph 87 of the White Paper refers, rather disparagingly, to the recruitment and retention of members. I do not know of an organisation that does not need to recruit and retain members. Recruitment to the CHC could be enhanced if WG recruitment processes were streamlined. My own recruitment spanned over 12 months, from application to appointment. Several potential members have lost interest and taken up alternative volunteer work while the recruitment process was grinding on.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

The OECD has stated that, in Wales, while local autonomy and innovation [are] encouraged, local Health Boards do not appear to have sufficient institutional and technical capacity to drive meaningful innovation and quality gains. A stronger central guiding hand is now needed to play a more prescriptive role.

An independent mechanism to provide clinical advice on substantial service change decisions, with advice from a citizen voice body, would be an appropriate response to this finding. (I am not certain that an 'independent' mechanism can sit easily within 'a more directive and guiding role on the part of Welsh Government'.) My main concern, however, would be the nature of this new 'citizen voice body'.

In answer to question 4.1, I have set out some of the functions of CHCs, as currently constituted; that I strongly believe should not be lost. Several of the functions of this proposed new body, set out in paragraph 86 of the White Paper, are, at least in embryo, currently undertaken by CHCs. (I have previously pointed out the conflict between bullets 3 and 4 of that paragraph.) The challenge would be to create a new body, with its wider remit and greater powers, without destroying the invaluable functions currently served by CHCs.

If there is currently (as the White Paper hints) difficulty in recruiting to CHCs that take actions of interest to local volunteers, how much more difficulty will there be to recruit to a body that advises the Cabinet Secretary on the level of engagement undertaken by a health board?

There needs to be far greater clarity about the precise meaning of the first three bullets in paragraph 86 and whether these functions can be fulfilled by volunteers or whether they would require the skill and time commitment that could be provided only by teams of paid officers throughout Wales.

Inspection and Regulation and single body

The Welsh Government believes that ensuring a clearer underpinning legislative framework for HIW will help to foster closer integration and joint working with CSSIW and at the very least this should be taken forward.

What do you think of this proposal?

As Health and Social Services are more closely integrated (as they were in Northern Ireland some 40 years ago), so the bodies that inspect these services will need to be similarly integrated. However, see my response below.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Would you support such an idea?

Yes.

What issues should we take into account if this idea were to be developed further?
While the intention of WG is to involve citizens more extensively in the production and delivery of services, the danger is that the White Paper plans will make it harder for citizens to be involved. The challenge is to create services fit for the 21st century without making those services more remote from and less accountable to the people of Wales. Neither the English nor Scottish replacements for CHCs have proved effective. Indeed, it has been claimed that if England still had its CHCs, the issues at North Staffordshire hospital would have come to light earlier and before they were so grave.

The future holds great opportunities, but also severe dangers if Wales throws away the work of its CHCs and the good will of its members.

WGWPMB37: Royal College of Speech and Language Therapists, Wales
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Broadly, the Royal College of Speech and Language Therapists in Wales (RCSLT Wales) supports the proposals for board membership and composition. We are in agreement that boards and trusts should share core key principles and can see a number of benefits to this approach.

We understand that there may be potential under the new arrangements for discretion about a number of board roles to ensure robust decision-making and scrutiny. Whilst mindful of the need for agile decision-making, we would caution however that, in our view, the integrated nature of local health boards in Wales and their wide-ranging responsibilities and services requires a very different model from that in operation in other nations. For example, foundation trusts and primary care commissioning groups in England lead on one particular type of service. RCSLT Wales would not wish to see a return to a tiered arrangement with a small executive and a wider board which would mean that some current board members would be excluded from high level decision making processes. The danger is a return to a restricted 'medical model' which loses the strength and depth that has been brought to the current boards.

We believe that given the integrated model of care in Wales, the Executive Directors of Therapies and Health Sciences (DOTHs) role brings unique perspective, skills and knowledge to boards and should be regarded as a key position under proposals for board membership. To ensure quality, itt is essential to ensure a full range of professional leadership across health and social care on LHBs and trusts. Expertise from the three professionally regulated executive directors (GMC,NMC, HCPC) are crucial to delivering for citizens across health and social care. The Health and Care professions Council (HCPC) equates to 25-30% of the NHS workforce and the DOTHs executive role spans professionals working in both health and social care. DOTHs' role is unique in bringing expertise and experience in working in the community, therapeutic and complex, cross-boundary working - skills not routinely available in other board member roles. The role is vital to supporting the policy shift to moving care closer to people's homes and is well-positioned to lead in co-operational and partnership responsibilities in relation 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 shift to community services provision and progression of workforce modernisation in primary care.

With regard to other proposals to update board membership and composition, we support the creation of a Vice Chair role and agree that Ministers should be able to appoint additional Board members on a time-limited basis if Boards/Trusts are underperforming or under escalation procedures.

What further issues would you want us to take into account in firming up these proposals?
The white paper provides an opportunity for the three trust boards to be brought into line with the local health boards. Therapists and health scientists are employed in significant numbers in the three trusts and clear director level leadership would be equally as valuable in trusts as in health boards with regard to clinical governance and for the reasons outlined in response to the above question.

Board Secretary
Do you agree with these proposals?
Yes. RCSLT notes and supports the proposals pertaining to the Board Secretary role.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes. The College is supportive of a more integrated approach in this area to ensure quality across health and social care. We believe that the existing planning duty should be reviewed to improve alignment with the Social Services and Wellbeing Act and the Wellbeing of Future Generations (Wales) Act. As part of this review, definitions of key concepts within legislation such as wellbeing must be updated to ensure a common understanding.

Duty of Candour
Do you support this proposal?
RCSLT would welcome the introduction of a statutory duty of candour and are pleased that in the white paper this has been extended to cover both health and social services in Wales. We agree the legal duty should apply to organisations rather than individuals to avoid duplication and/or possible conflict with the requirements of the regulatory bodies for registered practitioners.

Setting and Meeting Common Standards
Do you support this proposal?
RCSLT supports the development of a common standards framework, covering health and social care to help ensure effective quality assurance and accountability. We agree that these changes will enable people receiving care to feel confident that standards will remain the same regardless of where they receive their care.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?

RCSLT supports this proposal as a means of enabling people to raise concerns about integrated services without making multiple complaints and encouraging the better management of complex concerns which span different organisations.

What further issues would you want us to take into account in firming up this proposal?
We do not wish to highlight any further issues.

Representing the Citizen in Health and Social Care
Do you support this proposal?
We believe there is an opportunity to review how the citizen's voice may be maximised in integrated services. We would be keen, for example, to understand how such plans will fit with the National Social Services Citizen Panel and how functions may be aligned with those of the inspectorates to reduce potential duplication of effort.

We would also be keen to explore how we can ensure effective representation of diverse needs within the new national arrangement and would welcome a conversation with regards how the proposed new organisation could ensure an inclusive approach to communication. Nearly 20% of the population experience communication difficulties at some point in their lives (Scottish Executive Social Research, 2007) – many people with communication difficulties will be living with conditions which require regular medical treatment and/or social care support or such as dementia, following a stroke, learning difficulties. Any new body should ensure an inclusive communication approach to enable everyone to have a voice. By an inclusive communication approach, we mean an approach which seeks to create a supportive and effective communication environment using every available means of communication to aid understanding and expression of need and choice. This includes spoken language, written language and all forms of non-verbal communication. Inclusive communication is vital to equality of access to services and increased participation. We would recommend that the five good communication standards may be used as a practical resource in this regard. (https://www.rcslt.org/news/docs/good_comm_standards)

Can you see any practical difficulties with these suggestions?
We would require further detail before commenting on the new national arrangement.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Require further clarification.

What further issues would you want us to take into account in firming up this proposal?
RCSLT notes that the proposals in the consultation remove the requirement for an independent consultation for substantial change as is currently carried out by the Community Health Councils. The new independent citizen advice body will only be advising on whether public engagement processes undertaken by the Health Board comply with guidance. We believe this to be a substantial change and would

welcome further detail on progress on this development in Scotland before expressing a view. True co-production must involve citizens as equal partners in developing plans for service change and involve 'inclusive' continuous engagement.

Inspection and Regulation and single body

What do you think of this proposal?

RCSLT supports the need for a clearer legislative framework for HIW in order to foster closer integration and joint working with CSSIW.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?

RCSLT members are of the view that there could be merit in considering a new body but that there are a number of inherent risks in such a proposal, not least the size of the proposed body. Comprehensive planning will be required to ensure the functions currently carried out by CSSIW, HIW and the CHC continue to be carried out appropriately and effectively.

What issues should we take into account if this idea were to be developed further?

There will be a clear need to ensure clarity about function and independence of the different parts of the new body. There will be lessons to learn from the recent mergers which led to the creation of National Resources Wales and Health Education and Improvement Wales.

WGWPMB38: Nursing Midwifery Council
Location: London

General Comments

We welcome the opportunity to respond to the consultation on the Welsh Government's White Paper. Our response is provided within the context of our regulatory remit… and therefore we do not provide views on some areas of the consultation. We have provided comments on:

Duty of Candour (paragraph 49-56 of the consultation document);

Setting and meeting common standards (paragraph 58-66 of the consultation document);

Joint investigations into complaints working (paragraph 67-75 of the consultation document); and

Inspection and regulation (paragraph 103-110 of the consultation document).

We have not felt it appropriate to comment on the structure and governance of NHS Health Boards and a potential merger of the Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales into a single body.

Response to Specific Questions

Duty of Candour

We welcome the Welsh Government's ambition for health and social care organisations and staff to be open when things go wrong. The consultation document highlights that Welsh Ministers do not currently have the power to provide for an express statutory duty of candour for health services and that the existing duty for NHS organisations, as set out in the Putting Things Right regulations, need to go further (paragraph 51 of the consultation document).

We do not have a view on whether legislative changes are appropriate to achieve the Welsh Government's ambition. However, we encourage the Welsh Government to consider how any new requirements could be aligned with professional requirements we set on a UK wide level to provide consistency and clarity for nurses and midwives, and the public.

Our Code, for example, sets out that nurses and midwives must:

- "Recognise and work within the limits of your competence" (paragraph 13 of the code);
- "Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place" (paragraph 14 of the Code);
- "Always offer help if an emergency situation arises in your practice setting or anywhere else" (paragraph 15 of the Code); and

- "Act without delay if you believe that there is a risk to patient safety or public protection" (paragraph 16 of the Code).

In addition to this the NMC and the General Medical Council have developed joint guidance for nurses, midwives and medical professionals on 'Openness and honesty when things go wrong: the professional duty of candour' (http://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf) We would encourage the Welsh Government to take account of this when considering new duty of candour requirements, and how the two can align.

Setting and Meeting Common Standards

We do not have a view on whether the proposal to introduce a mechanism to set and meet common standards is appropriate to achieve the ambition set out in the White Paper. However, we encourage the Welsh Government to consider how its plans to setting and meeting common standards could be aligned the UK wide professional standards as this would allow for clarity and consistency for health and social care professionals and the public.

It is important to highlight that as a UK wide professional regulator our regulatory functions are set out in legislation (http://www.nmc.org.uk/about-us/our-legal-framework/) and reserved to Westminster under the Wales devolution settlement. This means that standards we apply to all nurses in midwives in the UK, including in Wales.

The standards we set include:

- **Standards for pre-registration nursing and midwifery education.** We set standards for pre-registration nursing and midwifery education and approve nursing and midwifery programmes. All students on our approved programmes are required to meet these standards before registration.
- **The Code for nurses and midwives.** Our Code sets out the professional standards that nurses and midwives must uphold in order to be registered to practice in the UK.
- **Standards of proficiency for specialist community public health nurses (SCPHNs).** The standards set out what SCPHNs must meet when they qualify and the standards they must maintain consistently throughout their careers.
- **Revalidation.** All NMC registrants are required to revalidate with us every three years to renew their registration. Revalidation is about promoting good practice and to raise awareness of the Code and to raise awareness of the Code and professional standards expected of nurses and midwives. To revalidate with us nurses and midwives must meet our requirements, including for example the required number of practice hours (https://www.nmc.org.uk/standards/additional-standards).

We encourage the Welsh Government to consider how its proposed common standards could be aligned with the existing UK wide professional standards. This would ensure that there is consistency in the regulatory approach and provide clarity for health and social care professionals regarding what is required of them.

Joint Investigation of Health and Social Care Complaints
We understand the proposal to mean that there would be a joint process for complaints which cover both health care providers and social care providers, and that the joint process would involve the health and social care providers working together to investigate the complaint.

We are fully supportive of the Welsh Government's ambition to encourage health and social care professionals and organisations to work together for the benefit of patients and the public. We currently have a Memorandum of Understanding with both Healthcare Inspectorate Wales and Care Council for Wales, outlining how we share information and work together (https://www.nmc.org.uk/about-us/who-we-work-with/mous).

Our core duty is to protect the public, and one way we do this is by investigating and taking action against a nurse or midwife who does not meet our standards for skills, education and professional conduct.

We have concerns that if the Welsh Government's proposal was wider and involved mandatory joint investigations between health and social care organisations and professional regulators it could have unintended consequences and negatively impact on patient safety. For example if any joint working arrangements delayed or prevented the sharing of information with us that we may rely on as part of an ongoing investigation. This consideration is particularly important in the context of our power to take urgent action to restrict or suspend a nurse or midwife's right to practice while our investigation is ongoing. If the risk of harm to patients makes that action necessary.

While we do support the principle of regulatory bodies working more closely together, we encourage the Welsh Government to consider how the proposal could be designed in a way that does not unintentionally undermine the role of the professional regulators or limits our ability to carry out our regulatory functions.

The relevant parts of our Code for nurses and midwives relating to raising and acting on concerns are:

- "Keep to and uphold the standards and values set out in the Code" (paragraph 20.1 of the Code)
- "Act without delay if you believe that there is a risk to patient safety or public protection" (paragraph 16 of the Code)
- "Raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other healthcare setting and use the channels available to you in line with our guidance and your local working practices" (paragraph 16.1 of the Code);
- "Tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can" (paragraph 16.3 of the Code); and
- "Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection" (paragraph 16.3 of the Code); and
- "Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection" (paragraph 17 of the Code).

In addition to this our Code put in place additional requirements for senior nurses and midwives. These requirements are:

- “Provide leadership to make sure people’s wellbeing is protected and to improve their experiences of the healthcare system” (paragraph 25 of the Code);
- “Identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first” (paragraph 25.1 of the Code); and
- “Support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for any safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken” (paragraph 25.2 of the Code).

Inspection and Regulation and single body

We do not have a view on the Welsh Government’s proposal of merging the Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales into a single body (paragraph 103-110 of the consultation document). However, we welcome and encourage the focus on joint working and believe this is an important element of maintaining public protection.

WGWPMB39: Gelligaer Community Council
Location: Hengoed

General Comments

Following our ordinary full council meeting on 20th September 2017 Gelligaer Community Council resolved to reply to the Welsh Government consultation on Services Fit for the Future as follows.

We support the retention of Community Health Councils with enhanced functions to cover social care as well as health.

The committed and trained volunteers provide good value for money and an excellent service to their local communities

We believe that CHC should have greater flexibility to recruit their own members. We do not feel that replacing the existing Community Health Council with a new body to represent the citizen's voice will necessarily lead to improved services for citizens. However if a new patient's voice organisation is established it should have the statutory right to carry out visits to both NHS establishments (hospitals, doctors surgeries and ambulance stations) and social care establishments.

It should have a strong scrutiny function which is lacking in the proposals put forward in the White Paper. The new body should also be completely independent of Welsh Government and local health boards. It should have a local rather than a national focus.

WGWPMB40: T Brooks
Location: Porthmadog

Response to Specific Questions

Representing the Citizen in Health and Social Care
Do you support this proposal?
NO

Can you see any practical difficulties with these suggestions?
SEE BELOW

Co-producing Plans and Services with Citizens
Do you agree with this proposal? NO

What further issues would you want us to take into account in firming up this proposal? REALISE HOW DAMAGING THIS SUGGESTION WOULD BE TO THE HEALTH AND WELLBEING OF RESIDENTS IN WALES – SEE BELOW

Detailed response
No evidence is provided with the proposals in this consultation to suggest that there is any prospect that the proposals, if implemented, would improve the healthcare and wellbeing of the residents of Wales. Quite the opposite! The white paper document stresses the need for change but does not offer any change that would lead to improvement. The white paper fails to provide any measureable objectives that could demonstrate the areas where improvement was expected and the white paper does not clarify what that improvement would be.

I am well acquainted with both Ministers who have signed the foreword to this consultation paper. I have respect for both of them, but recognise that their experience in office is not extensive. In this consultation they appear to have relied heavily on their NHS Wales officials with regrettable consequences.

The consultation White Paper makes a number of references to the OECD report published last year. (OECD Reviews of Health Care Quality United Kingdom Raising Standards) That report states “Less than two decades after devolution, the Welsh health system remains a relatively young one; many of the institutions and mechanisms needed to promote high quality care are in place, but now a further push is needed to move towards a more mature, robust quality architecture”. (Chapter 3 summary)

OECD Comments on the Welsh NHS
The direction that the “push” needs to take was spelt out by the OECD when it said: “It may now be appropriate for the partnership between the Welsh Government and Health Boards to be revisited. (Page 191)” Italy is offered as an example of how Wales could manage its Health Boards better. “The national programme monitors

129 healthcare indicators (input, process and outcomes) across hospitals and municipalities in Italy. The results of these indicators are published. (Box 3.1)"
"The Wales Prudent Healthcare agenda now needs to be backed up by a detailed roadmap – an Implementation Action Plan – containing a clearer vision for what services will look like, and should look like, in Wales in the next decade. The Implementation Action Plan should be made up of measurable, time-bound and deliverable changes. (Page 194)"

Hence the OECD statements in its report express a need for the NHS Wales HQ management team to improve its performance, and to help, the OECD makes some useful suggestions.

But at no point did the OECD report suggest that the CHCs should be replaced, as is implied by the drafting of paragraph 14 of the consultation document. The OECD did NOT recommend an alternative "Patient Voice". The proposal to dilute, indeed damage, the patient voice in Wales appears to have come from the NHS Wales HQ management team, itself identified as having scope to improve its practices.
The Ministers in their foreword are more circumspect in their views. They state "The OECD challenged us to strengthen the voice of the citizen and build more accountability and challenge into the system". Such an approach would align with what the OECD actually suggested and recommended; that is that CHCs be given more powers to challenge, and to hold to account, failing health boards with their role extended to some elements of the Wales Care System also.

The OECD's overall recommendation to help Wales achieve its ambition is based on evolution, not on any precipitative action in relation to any institutions and especially there is no recommendation to close down CHCs. The OECD reports:
"The ambition for an excellent, patient-centred health system, promoting quality is clearly there in Wales. This report's aim is to help answer the question – How can the governance model, institutions and policies that make up Wales' quality architecture evolve to deliver ever better health care" (Opening Summary)
The OECD report acknowledged that the scrutiny role of the CHCs in Wales on behalf of patient and the public has been a positive role.

"There is a high level of scrutiny around plans from government, management, clinical staff, patients and the public" (Page 189)
The OECD report acknowledged that CHCs play a critical part in the quality improvement process in Wales and are the bodies that many residents trust most. Without the CHCs the quality improvement process is liable to experience widespread distrust. The OECD description of the focus for quality improvement fits well the existing CHC role with its early inspection and review processes and with CHC members deeply embedded amongst the patient communities. The OECD report says:
"The main focus of quality improvement strategies and architecture should be, first, of ensuring that appropriate mechanisms for identifying shortcomings early are in place and fit for purpose. These include systems and indicators which are regularly reviewed, public reporting of performance, an effective inspection and assurance function for services and a robust patient feedback and complaints system (Page 196)."

Sadly, there are significant numbers of concerns and complaints raised by patients in Wales. In practice, intervention by the CHC on significant numbers of issues obtains a degree of resolution before the complaint becomes irresolvable. The OECD acknowledged in its report the help of the CHC advocacy services to people making complaints, as follows:
"There are established routes for patient complaints and feedback in Wales, notably through the Public Service Ombudsman. The Ombudsman publishes an annual report summarising the cases considered. Complaints can also be directed through the advocacy services provided by Community Health Councils. (Page 223)"

The OECD recognised that the Community Health Councils played a supplementary role to formal outcomes and quality meetings between the Welsh Government and the Health Boards. The OECD report recorded:

"Accountability against the NHS Outcomes and Delivery Framework is through Quality and Delivery Meetings between the Welsh Government and all NHS Health Boards and Trusts. These meetings will periodically review other key area highlighted through external bodies' reports such as Community Health Council recommendations (Page 214)".

<u>OECD Advice on Patient and Public Involvement in Improving Healthcare Quality (Section 3.8)".</u>
The OECD advocates that CHCs should focus their activities on reflecting the patient voice. The OECD does NOT propose replacing the CHCs by any other body. It does NOT seek to define an alternative "Patients Voice". The OECD reports:

"Community Health Councils are a key feature in the architecture of Wales, with a clear role to engage with and ensure that the patient voice is heard. (Page 225)".

"The potential for CHCs to engage with the local community and advocate for patients around their concerns seems clear. With comprehensive representation and advocacy of patient views, for which the CHCs have an important role to play, public scrutiny of NHS Wales can be appropriately maintained". (Page 225)".

The OECD report states further,
"There is potential for Community Health Councils to play a valuable role in reflecting the patient voice, but some attention to the scope of their activities and remit is needed (Page 223)".

The OECD report further records in its conclusion its advice to evolve the CHC roles, "in the absence of patient choice, patient voice needs to be amplified as an important quality assurance check (Page 232)".

<u>The White Paper's Other "Evidence"</u>
The evidence offered by the NHS Wales HQ management team for the case "to replace Community Health Councils", is listed as "Footnotes, 29, 30 and 31" in the White Paper. Footnote 29 refers to Marcus Longley's review of CHCs. That review was conducted specifically on the premise that CHCs were needed in Wales, where the Government had implemented a Welsh healthcare model which rejected the "purchaser- provider split" and denied patients the right to choose their provider. At

no point in his report did Prof Marcus Longley challenge the continuation of CHCs. It is regrettable that the NHS Wales HQ management team should have been disingenuous in these references.

Both Ann Lloyd and Ruth Marks (Footnotes 30 & 31) are of course “in-siders”. It was professionally substandard of the NHS Wales HQ management team that they referenced these two in-siders opinions in the White Paper but not the views supporting the need for CHCs expressed by many healthcare service recipients in the Green Paper consultation.

The Marcus Longley Review and Other Evidence

In his report “MOVING TOWARDS WORLD CLASS? - A Review of Community Health Councils in Wales”, Prof Marcus Longley described some of the benefits that Wales obtains from its CHCs (11.2.1). He records:

There are several areas where the current arrangements serve the people of Wales well, and are clear strengths of CHCs:

1. Where there is an effective relationship between the CHC and health bodies (LHBs, Trusts, primary care, regulators etc):
    I. important deficiencies in the provision of services (which had not been discovered in other ways) are promptly brought to the attention of the relevant body and remedial action is taken;
    II. the health needs of communities who would not otherwise have a powerful voice are heard and acted upon;
    III. service plans are improved from an early stage by the CHC championing the patients’ perspective;
    IV. a host of decisions taken by the LHB and others are improved because they are conscious that they may subsequently be scrutinised by the CHC; and
2. Local communities have greater faith in the NHS because they feel that CHCs give them a voice.

3. Individual complainants get effective, empathetic and efficient support from the CHCs’ complaints advocacy service which delivers the best possible outcome for them CHCs mobilise well in excess of 200 volunteers across Wales every year to improve local services, making a total of around 13,000 days of effort, equivalent to about 60 paid staff.

The tangible benefits that the CHCs bring are supported by other observers and commentators. The small selection reproduced below illustrate the widespread acceptance that active local community scrutiny of a health service is needed to deliver quality results.

The Francis inquiry found that “the bodies which replaced Community Health Councils – Public and Patient Involvement Forums and Local Involvement Networks – were preoccupied with constitutional and procedural matters. And, in doing so, failed to represent the patient voice in Stafford”. The same risk is likely in Wales. The Nuffield review of ‘Trust in the NHS’ demonstrates that where independent scrutiny takes place, trust of patients in their healthcare service is higher.

The International Alliance of Patient's Organisations reported that "The 68th World Health Assembly in May 2015 in Genèva, Switzerland expressed concern that some countries were preventing health systems in delivering an adequate supply of affordable, acceptable and quality health services and public health programmes to their patients". It concluded that if "patient-centred health systems were to be delivered, which ensured the availability, accessibility, affordability, acceptability and quality of health services within its health system, local and international patient scrutiny on the actions and inactions of their national governments and their health systems" was needed.

The White Paper Impact Assessments

In respect of "Representing the Citizen in Health and Social Care" and "Co-producing Plans and Services with Citizens", the impact assessment is of a decidedly low quality. The incisive analysis expected in such papers to justify the proposals, or to suggest improvements to them, is absent, replaced (in Para 11 of the Impact Assessment) by "direction of travel", "more integrated fashion", "seamless experience", "along a pathway" and other waffle.

It is disappointing that in choosing to refer to the "Francis Mid Staffordshire enquiry" the Impact Assessment recorded the advice on the 'Duty of Candour', but did NOT include the Francis comments on Community Health Councils which regretted the closure of the CHC. (See para 19 above). This reflects adversely on the consistency of this Impact Assessment.

The Impact Assessment is disingenuous in claiming under Citizen Voice "The OECD report asked questions about the value of the CHC's current functions". Where in the OECD report is such a statement? The positive comments made in the OECD report about the CHCs have been extracted for use in this consultation response. (paras 8 to 15). Again, such disingenuous statements reflects adversely on the reliability of this Impact Assessment.

The Impact Assessment on "Duty of Quality for the Population of Wales" omits an assessment of the population group most affected by the proposals in the White Paper, Older People.

Older People

The Impact Assessment identifies the Older People's Commissioner for Wales as a key stakeholder. This is unsurprising since Older People are the category most affected by health and social care services. It was therefore surprising that an Impact Assessment on Older People will only be prepared after decisions on whether or not to implement any proposed change has been made. In most countries, Impact Assessments are important evidence to be considered in making decisions. The absence of the inclusion of any Impact Assessment on Older People again reflects adversely on the reliability of the documents prepared in this consultation.

The Impact Assessment rightly makes reference of Article 12 of the UN Convention on the Rights of the Child. It is regrettable that no mention is made of the General Assembly resolution 46/91 on older persons rights, which the UK and Welsh Government has endorsed, which declared:

“An appreciation of the contribution that older persons make to their societies, declaring, inter alia, their determination to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small and to promote social progress and better standards of life in larger freedom declared:

- Older persons should have access to health care through the provision of family and community support;
- Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being
- Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment
- Older persons should benefit from community care and protection in accordance with each society's system of cultural values
- Older persons should be able to enjoy full respect for their dignity needs and privacy and for the right to make decisions about their care.”

The local CHCs have been the custodian (sometimes called the watchdogs) of such basic rights for older people

I am able to provide from personal experience evidence on the value and effectiveness of the current North Wales CHC format and practices. Under the late Mrs Mary Burrows’ leadership, the healthcare service in North Wales was seriously damaged. Since then a significant number of ‘Older People’ have relied upon assistance from the North Wales CHC to address the difficulties that they far too often experience in obtaining healthcare assistance. Following the descent into “Special Measures” by Betsi Cadwaladr since Mrs Burrows’ strategic management errors, it is the patient, who from time to time, experiences the real negative effects of a health service deservedly in “Special Measures”.

‘Older People’ in North Wales obtain help when they need it from the Bangor and Wrexham offices of the CHC, but very often they approach one of the 72 individual CHC members who reside in North Wales. CHC members are local, they are known, they are contactable and they are supported by committed staff who work hard on the patients’ behalf.

These unpaid but skilled volunteers, who are the eyes and ears of the public, have also been instrumental in alerting the Health Board Management and Assembly Members to major issues such as in the mental health and infection control failings we have experienced. This is the type of action that the OECD report recognised as a benefit of the current CHC structure (para 13 above) and what Prof Marcus Longley predicted in his report (para 18 above)

Some Betsi Cadwaladr managers have said that 72 CHC members across North Wales is too many. There are 700,000 patients residing in the area served by Betsi Cadwaladr which translates into just 1 CHC representative for every 10,000 people! Such a ratio represents hard work for many CHC members but they serve their communities diligently and current numbers of CHC members and their support staff would appear to need to be retained.

The Board of CHCs under its Chair Ms Mutale Merrill OBE, has supported the call to close down individual CHCs and to create just one statutory body with non-statutory sub-committees. However, on September 19th, the Secretary of State for Wales issued a statement regretting the tendency of the Welsh Government to seek to centralise statutory bodies in Cardiff.

I agree with the sentiments of the Secretary of State for Wales: North Wales needs a local statutory watchdog, not a potentially ineffective sub-committee of a distant "national" body.

Financial Impact Assessment

Inexplicably, the Impact Assessment contains no financial assessment. In respect to the Community Health Councils, we know from Prof Marcus Longley's report that the cost of the CHCs is some £4million per annum. In the context of a healthcare budget leaning towards £7billion per annum this is a miniscule sum to engage the public with a local statutory role in the quality monitoring and improvement of the Welsh NHS.

No cost estimates have been produced for the "Patient Voice System" that the Ministers have in mind to replace the CHCs, nor had any detail of this "Patient Voice System" been published to enable cost estimates to be made.

When Prof Longley analysed the cost of the current CHC service he limited his assessment of the financial benefits gained to being "equivalent to about 60 paid staff". (Para 18 above). This was a significant, but incomplete statement of the financial benefits derived.

The value of effective community scrutiny of publically funded healthcare services is well attested internationally. The financial benefits arise from various elements of cost avoidance, including delayed intervention, patient readmission and reduced litigation.

The American Healthcare Risk Management reviews have examined the various cost avoidance elements and highlighted the benefit of reduced readmission rates. The financial circumstances are not the same as in Wales so figures derived are not comparable. On litigation cost avoidance it reports "Litigation costs reduce where the possibility of continuous scrutiny causes clinicians to exercise more care". It remarks "More people pay parking fees when scrutiny to detect parking violations is anticipated."

Were the NHS in Wales to undertake a competent financial cost and benefit review of the Community Health Councils, it is likely, in my opinion, that the benefits identified would be at least 10 times greater than the £4m cost.

Conclusion

I note the Ministers' acceptance of the OECD recommendation to "strengthen the voice of the citizen". Many in Wales would agree with the importance and priority that should be given to the views of patients and their families in moulding quality local healthcare services in Wales. When something works reasonably well, as the North Wales CHC certainly does for older people, sensible organisations do not change it:

they improve it! Patients and recipients of health and social care services in Wales consider that this should be achieved by enhancing the roles and authority of the CHCs and not by closing down the most effective of the patient voice avenues that we possess.

WGWPMB41: Glamorgan Voluntary Services
Location: Barry

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
The Core Principles as listed are comprehensive.

GVS agrees with the proposal to appoint additional Board members on time limited appointments as appropriate and agrees with the proposal to appoint consistent key positions across health boards.

Allowing some flexibility in membership would allow for a focus on regional priorities. We do not think there should be a distinction between 'core' and 'none core' members as this may result in some members being considered less important than others and their voice disregarded.

What further issues would you want us to take into account in firming up these proposals?
The role of the Third Sector Independent Member of the Board has been vital in taking forward a third sector voice and improving partnership working between Health Boards and the third sector. We feel this has worked especially well in Cardiff and the Vale. We would strongly support a continuation of this specifically identified role and an emphasis on their continued links to the CVCs.

Board Secretary
Do you agree with these proposals?
GVS agrees with the proposals about the role of the Board Secretary.

What further issues would you want us to take into account in firming up these proposals?
We note that the White Paper advises NHS organisations to allocate resource to support the role of Board Secretary and that this may prove a challenge due to financial constraints.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
GVS agrees with the proposal to update the duty of quality, but is unsure how the effectiveness of this will be measured.

GVS supports any proposal which aims to improve partnership working between statutory bodies and, in particular, with the third sector, with the aim of improving the quality of service provision. Cardiff and Vale University Health Board has worked with GVS and C3SC over recent years to develop a Framework for Working with the Third Sector and this has proved vital in supporting ongoing partnership working. The work undertaken via the Framework is overseen by a Third Sector Steering

Group, with regular reports provided by leads on specific areas of the Framework, including the CVCs.

There are many good examples of the results of partnership working in Cardiff and the Vale, eg the Age Connects Third Sector Broker service which is co-located with the Contact Centre in the Vale, the co-location of Age Connects and the British Red Cross with the CRTs/CRS in the region, the RNIB Eye Clinic Liaison Officer based at the University Hospital of Wales and numerous third sector organisations which work closely with the Health Board's Patient Experience Team.

Sometimes successful partnership working is achieved through the willingness of individual staff in various sectors to work together and, whilst this is to be applauded, at times this type of partnership may be transient and/or fragile as it depends on those particular staff. A duty to work in partnership is welcomed and we would also welcome a stronger expectation from the Welsh Government that local authorities and NHS bodies will need to demonstrate evidence and effectiveness of partnership working with the third sector.

Duty of Candour

Do you support this proposal?

GVS agrees with this proposal, but is unsure how this will be implemented and how it will be measured.

What further issues would you want us to take into account in firming up this proposal?

We would welcome guidance on how this would affect third sector providers, particularly those who are commissioned by statutory bodies to provide health and social care services.

Setting and Meeting Common Standards

Do you support this proposal?

GVS agrees that the current standards used are complex and confusing for individuals. A common set of high level standards would help to reduce confusion if they are easily understood by all providers, service users and carers. We hope that the common standards would be produced in consultation with health and social care staff, service users and carers.

What further issues would you want us to take into account in firming up this proposal?

GVS would like to see guidance on how third sector providers who are commissioned by statutory bodies will be able to apply these standards (as there used to be with the Healthcare Standards and the third sector toolkit). The common standards could usefully be applied, on a voluntary basis, by all third sector providers of health and social care, regardless of where their funding comes from. As such, we would welcome some further work on the common standards which would help

the third sector use them and would ensure alignment to other third sector quality standards, eg Pqasso.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

GVS agrees with the proposal to make it easier for people to complain when their complaint is about both health and social services, but feels that setting up a process which allows this will be complex. The White Paper isn't clear on how this will be brought about.

Representing the Citizen in Health and Social Care

Do you support this proposal?

GVS recognises the challenges faced by CHCs in terms of their capacity and recruitment of members. We have advertised third sector CHC member opportunities in the past and have found that potential applicants are deterred by the time commitment and the relatively bureaucratic recruitment process. Despite this, Cardiff and Vale CHC has some experienced third sector members and the CHC role in gaining patient feedback via GP monitoring visits and the advocacy service provision appears to be well regarded.

It would be useful to have a body which focuses on the citizen voice in both health and social care, but would advise caution in ensuring that the elements of good practice of the current CHC model as outlined above are not lost.

Additionally, GVS would like to highlight the role of County Voluntary Councils (CVCs), and the wider third sector, who also support the citizen voice, via the third sector, across health, social care and wellbeing. We believe that there may be a risk of duplication of existing work in terms of the proposed functions, specifically the function which relates to working with community organisations to promote co-design of services and supporting the building of local networks and effecting join up across health and social care groups. The CVC Health and Social Care Facilitator (H&SCF) role, which was set up by the Welsh Government Building Strong Bridges initiative over 10 years ago, continues in every CVC throughout Wales. Most Facilitators have health and social care networks and these provide an effective way of involving the wider third sector in partnership working. In Cardiff and the Vale, the Health Board funds the Health and Social Care Facilitator roles which are firmly embedded in GVS and C3SC and which report quarterly to the Health Board.

Both H&SCF have Networks. In the Vale there is a Health, Social Care and Wellbeing Network which has over 400 members from all sectors and GVS co-ordinates the Cardiff and Vale Carers Support and Information Network Group (CSING) and a virtual older people's services reference group. There are also a number of third sector services which specifically support people to have a voice in their care and in co-designing services, e.g. Diverse Cymru, Hafal, Nexus, Cavamh.

There has always been a distinction between CVCs and CHCs in that the CVCs, such as GVS and C3SC, support the third sector to have a voice and CHCs support

service users, families and carers to have a voice. Both of us have a shared aim in improving services and people's experience.

GVS therefore emphasises the importance of ensuring that any new arrangement has a clearly defined role, avoids duplicating existing services and is encouraged to work with CVCs. There are many positive ways in which CVCs and the newly established body can work together with a shared aim.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

GVS understands the mechanism, but we are not sure that the result will be continuous engagement, but it may well increase the pace of strategic change.

There have been examples of good engagement, e.g. the South Wales Programme, the Population Needs Assessment. There is a dilemma in that individuals may not always see the benefits of services being provided regionally (in this case across South Wales) and not necessarily locally, which is presumably why there was such a large response to the South Wales Programme (as well as public perception of services closing). In that respect it is hard to reconcile the need to listen to individuals as outlined throughout this White Paper with the rationale of increasing the pace of strategic change also outlined in the White Paper.

We understand how the decision about where health services should be located is not easy when local health boards have defined geographical areas (although Cardiff and Vale Health Board provide services across geographical boundaries). GVS suggests that the complicating factor here is that people value their local/regional health services and, when asked for their views, express this quite clearly via channels such as their politicians and the CHC who will then take their views forward and the pace of change is thus slowed down.

Messages about health service change need to be communicated clearly and honestly with transparency about the rationale behind the change and this may go some way towards managing public expectations about health and social care services.

Inspection and Regulation and single body

What do you think of this proposal?

GVS agrees with this proposal.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?

We think it would be difficult to have one organisation which combines the role of inspection of both health and social care services and facilitating the citizen voice. This would require a range of staff with specific and different skills and an ability to

work with different audiences and would ultimately combine too many different functions.

What issues should we take into account if this idea were to be developed further?
As above, avoid duplicating existing mechanisms for engagement.

WGWPMB42: British Dental Association
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
BDA Wales agrees that Vice Chairs should be appointed to create focussed and skilled leadership. It is crucial for Health Boards to fulfil their responsibilities and BDA Wales is supportive of measures that will allow them to do so. BDA Wales also agrees that key positions should be consistent across local health boards with flexibility to only be used where necessity dictates, i.e. rural areas etc.

What further issues would you want us to take into account in firming up these proposals?
BDA Wales believes it is vital for all people living in Wales to receive an excellent level of care. Therefore, consistency among Health Boards is crucial. Flexibility in roles should be based on area specific challenges and should not occur at the detriment to any Health Board.

Board Secretary
Do you agree with these proposals?
BDA Wales agrees with this proposal and feels that for the Board Secretary to be a true guardian of good governance independence and clear key principles are key. As previously stated, for Health Boards in Wales to work well consistency is vital, and having an independent Board Secretary to uphold the key principles of good governance for each Health Board is a good step.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
BDA Wales agrees with these proposals to an extent. The NHS in Wales has changed significantly since duty of quality legislation dating back to 2003 and this should be reflected in legislation. BDA Wales also agree with collaborative, regional and all-Wales solution to service design and delivery.

What further issues would you want us to take into account in firming up these proposals?
While BDA Wales agrees to the proposals, to truly make sure that the Health Boards work together it is important that the Welsh Government considers that the legislation should incorporate measures to allow the Welsh Government to scrutinise Health Board actions in creating collaborative solutions.

Duty of Candour
Do you support this proposal?

BDA Wales agrees with the development of a statutory duty of candour across health and social services in Wales. BDA Wales agrees that the current duty set out in Putting Things Right should go further as the current system relies on a concern being notified.

Setting and Meeting Common Standards

Do you support this proposal?

BDA Wales agrees with this proposal, particularly its focus on person centred care. However, it is vital to have an understanding of locations of care prior to these standards being set in place to avoid penalising care givers who are facing difficulties due to their location.

What further issues would you want us to take into account in firming up this proposal?

Every patient deserves a high level of care regardless of the location of this care. It is also true that every care giver deserves to be able to provide a high level of care regardless of their location. It is important that those who are providing care in locations that create difficulty are not penalised. For example, a community dentist treating a bariatric or bedbound patient in a rural area is going to face significant difficulties. Currently, the Welsh Ambulance Service can only transport community dental patients to a hospital dentist, rather than a community dentist. This means these patients are subjected to a 26-week waiting list and are not receiving care from the dental professional that is more suited to their needs. BDA Wales feels that these standards are a very positive step and that those providing care in difficult locations should be supported to allow them to uphold these standards.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

BDA Wales agrees with this proposal.

Representing the Citizen in Health and Social Care

Do you support this proposal?

BDA Wales feels that if the white paper wishes to abolish Community Health Councils in Wales then the new body needs to be an improvement. BDA Wales feels it is important that the replacement of CHCs does not weaken an already weak patient voice. Community Health Councils have played a vital role in delivering independent public service accountability and providing a strong voice for patients in Wales. It is important that if CHCs are replaced that this commitment to accountability and providing a strong patient voice is not only upheld but improved on.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

BDA Wales agrees with this proposal in terms of a more transparent process with the Welsh Government taking a guiding role. As this proposal links in to the abolition of CHCs, it is important to remember that not only do CHCs refer disputed

substantial service change proposals to the Cabinet Secretary, they provide patients with a strong voice. Consultation with the proposed independent new citizen voice body must be a vital step when making substantial service change decisions.

Inspection and Regulation and single body

What do you think of this proposal?

BDA Wales agrees that a clearer underpinning legislative framework for HIW would allow closer integration and joint working with CSSIW. BDA Wales would like to highlight that while HIW may have limited regulatory powers, many of the services HIW regulates have their own regulators. For example, the General Dental Council regulates individual dental practitioners whereas Health Inspectorate Wales regulates dental practices.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?

BDA Wales would support the idea of this new body provided that it strengthens it patient voice in Wales and that the Welsh Government understands the bodies that regulate health care other than HIW.

WGWPMB43: Welsh Local Government Association
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
We support the need for the Boards of both health boards and NHS trusts to share some core key principles, including delivering in partnership to deliver person centred care and a strong governance framework to enable the Board to work effectively and meet its responsibilities. We also support the notion that there should be some key positions consistent across local health boards, though further discussion would be needed to determine what these positions should be. We would advocate that these should be minimal with a need for some flexibility to allow health boards to determine how best to meet local needs and priorities.

Given the existing Boards membership includes both local authority Elected Members and Directors of Social Services we would welcome the opportunity to have further discussions around the future membership and structure of Boards. The involvement of both Directors of Social Services and Elected Members is essential to support the work of and make appropriate links across both the NHS and local authorities, particularly around the integration of services and so we would be keen to see this involvement continue. We would want to ensure that any change to the membership also fits with other 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 to ensure consistency and alignment. We do however need to be mindful that there are considerable demands already being placed on the roles of Elected Members and Directors 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.

Board Secretary
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
The role of the board secretary is important in order to try to ensure that effective challenge and advice is provided to achieve greater independence and integrity. Defining the role in statute would firmly establish and protect the role and there may be lessons that can be learned from similar roles within the public sector. For example, local authority Monitoring Officer's have the specific duty to ensure that the Council, its officers, and its Elected Councillors, maintain the highest standards of

conduct in all they do. Section 151 officers are another statutory role local authorities are required to appoint to for the proper administration of its affairs.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

Yes

What further issues would you want us to take into account in firming up these proposals?

Given the duty already placed on local authorities under the Social Services and Well-being (Wales) Act to cooperate with their relevant partners, persons or bodies to ensure well-being and safeguarding of those who require care, and improve the quality of care and support needed, it makes sense that a similar, reciprocal duty is also applied to health, aligning with those duties already placed on local authorities.

Legislation on its own, however, is not particularly effective in addressing quality. The main issues related to quality are cultural, training, resource and educational. Any legislation needs to be supported with the promotion and adoption of best practice, ensuring more involvement of staff, with strong leadership to improve quality.

Duty of Candour

Do you support this proposal?

In part

What further issues would you want us to take into account in firming up this proposal?

We can see some merit in introducing a statutory duty of candour, though it will also be important to build in protection and support for those who raise concerns. However, we believe that the focus should be on building a culture of openness, rather than legislating a contractual duty of openness. While you can mandate disclosure, legislation cannot deliver the attributes of high-quality and open communication such as empathy, sincerity and comprehensiveness that patients and service users expect. Staff need to be supported in fulfilling professional and ethical obligations to be open with patients and service users when things go wrong by providing ongoing support, training, mentorship and ensuring senior staff lead by example. Merely legislating a duty of candour into existence will not accomplish the cultural changes that patient, service users and practitioners seek.

There are already measures in place within social care aimed at ensuring social care staff operate openly and honestly. For example, the Code of Professional Practice for Social Care which is the primary document that sets out the standards for professional conduct and practice required of those employed in the social care profession in Wales. The code states that social care workers, ‘must be accountable for the quality of your work and take responsibility for maintaining and developing knowledge and skills’. This includes, ‘being open and honest with people if things go wrong, including providing a full and prompt explanation to your employer or the appropriate authority of what has happened.’ Given the existing responsibilities

covering social care staff, we should consider whether a new statutory duty is required, or whether we can build upon what is already in existence.

There is also a question over how feasible it will be for regulators to monitor behaviour under a regime of mandatory disclosure for serious adverse events both consistently and effectively and how regulators will enforce any prescribed sanctions for non-compliance with a disclosure. What sort of event will have to occur, to engage the new legal duty to disclose?

Setting and Meeting Common Standards

Do you support this proposal?

Yes, in time.

What further issues would you want us to take into account in firming up this proposal?

We support the need for there to be common high level standards that are citizen and outcome focussed to underpin care regardless of whether the focus is health or social care. This can help to ensure consistency across health and social services, particularly as we see an increasing focus on the integration of services across health and social care.

However, we are mindful of the considerable amount of work that has already been undertaken in social care, including the recent consultation on Phase 2 of the Regulation and Inspection of Social Care (Wales) Act, as well as other developments such as the National Outcomes Framework. It would be beneficial to give these elements an opportunity to be further embedded and reviewed before introducing changes, with a need to ensure that any standards introduced complement and fit in with the work that is already well underway.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Yes

What further issues would you want us to take into account in firming up this proposal?

As set out in the White Paper the statutory complaints processes for health services and social services differ, both in terms of timescales and actual process, including who investigates the complaint. There may be benefit in having a single, clear, patient-focussed process to enable staff, patients and service users to raise concerns and a duty for organisations to provide evidence of outcome to incidents and lessons learned.

Whether this requires new legislation is open to debate as better joint investigation could be achieved through clear and consistent guidance, or through amending existing legislation such as the Putting Things Right guidance and The NHS (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2011.

Representing the Citizen in Health and Social Care
Do you support this proposal?
In part

Can you see any practical difficulties with these suggestions?
We fully support the need for meaningful engagement with the public and communities, with the voice of the citizen a crucial element in supporting the way in which health and social care is planned and delivered – it is essential that we enable the views and concerns of patients and service users to receive maximum prominence throughout the systems that we operate.

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.

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.

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. The Commission on Public Service Governance and Delivery recognised that the work of CHCs appears to duplicate the work of other organisations, such as Healthcare Inspectorate Wales (HIW), in their role of inspecting health services; and the Public Services Ombudsman for Wales in his role of complaint investigations.

WLGA support the need for change and believe that this is an opportunity to ensure greater democratic oversight of the NHS, through locating some of the existing powers of the powers of Community Health Councils (CHCs) within local government. We note that the White Paper is quiet on what will happen to some of the existing responsibilities of the CHC if they are to be replaced, in particular around their current scrutiny role.

We believe that this is an opportunity 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.

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.

CHCs' functions of inspection, scrutiny and formal complaints investigation, are or could be, provided by other bodies. As noted by the Commission on Public Service Governance and Delivery, "CHCs cannot match their resources, expertise and statutory powers and risk both duplicating them at a lower level and spreading their limited resources too thinly in the process." A refocusing of CHCs to represent the voice of the patient and user, while local authorities scrutinise the overall service, is what we would recommend for serious consideration and we would welcome working with Welsh Government and NHS Wales, to discuss this proposal more fully. In looking at this refocused role we need to be mindful and give careful consideration as to how this new arrangement would fit into existing arrangements in place, particularly across social care, complementing rather than duplicating effort.

Local authorities are already under a duty to involve people in the design and provision of services under the Social Services and Well-being Act, and this is supported by the requirement for Regional Partnership Boards to have both service user and carer representatives, as well as an expectation that the boards will work with regional citizens' panels, or other relevant groups, to ensure the citizen voice is heard to inform the development and delivery of integrated services. In addition, the Minister for Social Services and Public Health has recently established the National Social Care Partnership Board, which replaces the National Social Services Leadership Alliance, comprised of the Partnership Forum, Leadership Group, and the National Citizen Panel. The role of this group is to provide advice and support on the implementation of current government social care policy, and on the development of future policies in the field of social care and importantly includes citizen representatives.

The White Paper makes reference to the Scottish Health Council's model, with the view that these new arrangements would be based on this model. It is worth noting that the legislative picture in Scotland is different, particularly with the implementation of The Public Bodies (Joint Working) (Scotland) Act 2014, which establishes the legal framework for integrating health and social care in Scotland, placing a requirement on NHS Boards and Local Authorities to integrate health and social care budgets. The picture in Wales around integration is different and so it is not as straight forward as just taking a model from one country and applying it to another, particularly where they are taking different approaches to integration. We therefore need to examine whether it is appropriate for any new arrangement to cover both

health and social care, particularly given the arrangements highlighted above that are already in place in social care. Again we would welcome further discussions around this aspect. It is also important to recognise that the future role of the Scottish Health Council is currently being consulted upon and there will be a need to identify and reflect upon any learning that might be able to be taken from this process.

There also needs to be a note of caution over the possible tensions that could be created if this new arrangement was asked to both act as a professional quality assurance body, examining how effectively NHS organisations engage patients and the public over service change and act as an independent patient, service user, carer and wider public feedback body. To be both 'referee' and 'player' would be unlikely to succeed, along with significant governance issues, and so we need to be clear on the exact role and expectations placed on the new arrangements to ensure that issues like this are avoided.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

More detail required

What further issues would you want us to take into account in firming up this proposal?

The experience in Scotland has found that there is an increasing perception by people and communities that there is importance in having a change identified as 'substantial', in order that the decision is ultimately made by the Cabinet Secretary rather than at local level. Whether something should be seen as 'major' or 'minor' (thus not requiring a formal consultation and Ministerial decision) has become divisive, confrontational and detrimental to public confidence in the NHS. The most important element is to ensure that all service changes follow a proportionate process to involve people and communities regardless of whether or not they are identified as 'substantial'. There is a need to ensure broader engagement to consider the significant issues relating to the process through which the public are engaged in proposals for major and non-major service change and the definition of such change.

The proposal has the potential to be able to bring a more consistent process and focus to reviewing service change on behalf of the public and depoliticise the decisions. However, such a mechanism could also add another, potentially unnecessary, layer of bureaucracy. As with many aspects of the White Paper greater detail is required, for example to determine how a group would be set up, how independence would be secured, how members would be recruited to ensure relevant expertise and a lack of bias, and what the impact would be on existing arrangements and mechanisms.

Inspection and Regulation and single body

What do you think of this proposal?

Yes

Are there any specific issues you would want us to take into account in developing these proposals further?

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.

The introduction of the Regulation and Inspection of Social Care (Wales) Act has created a clear statutory framework for CSSIW that is centred around people who need care and support, and the social care workforce. There are differences in the way in which services are currently regulated across health and social care, for example services being regulated and inspected on an establishment rather than service basis, which means that it would make sense to bring the underpinning legislative framework for HIW in line with that of CSSIW. This should help to foster closer integration and joint working across the inspectorates.

However, we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Would you support such an idea?
More detail required

What issues should we take into account if this idea were to be developed further?
Far more detail would be required to understand the implications of the proposal. Whilst a new independent inspectorate covering both health and social care, working to common framework and standards would likely be in line with a more integrated approach in health and social care which would be easier for both service providers and users to understand there are a number of potential disadvantages. These include the fact that the process of merging can divert resources and attention away from inspections and that integration could lead to an organisation which is too large and unwieldy with a loss or imbalance of specialist expertise.

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.

WGWPMB44: N Blanluet
Location: Cardiff

General Comments

I wish to offer a response to the Services Fit For The Future White Paper Consultation, particularly to part 4 on the items regarding citizen voice and co-production. I'm writing as an independent co-production consultant, and as one of the founders of Co-production Wales which has now become the funded Co-production Network for Wales. I have been involved in coordinating and working on the materials for the public engagement sessions around the White Paper, and this has given me the opportunity to study the proposals in some detail.

I agree that the roles of the CHCs need revising as they are not visible enough to citizens and not meaningfully representative of the citizen voice of the communities they should be serving. However I can't see how replacing them with a new national body will effect radical change and public engagement. The local and regional scale are important as well as a national coordination level; without the local knowledge and networks it will remain ineffective. Citizen engagement happens through relationship building and this can only occur at a local, personal level. With the level of detail provided in the White Paper it is hard to see that the proposed new body would actually lead to a stronger citizen voice.

Instead of replacing the CHCs which already have a regional structure as well as a national coordination through the Board of CHCs, they could be retained while reviewing and adjusting their role. There is a wealth of experience and capacity there which it would be shameful to discount, though some skills building in terms of co-productive ways of working would no doubt be required. Ideally CHCs could morph into an on the ground, hands-on organisation, deeply connected to their communities and versed in and committed to co-production, with the breadth of diversity to work across both health and social care.

However - while I am imagining what the future might look like, I am not seeking to offer a prescriptive solution, merely a vision of what an effective citizen-engagement body could be. The possibilities are rich but what matters is how a solution is arrived at, and I don't think we are anywhere near this goal through the White Paper proposals. Welsh Government needs to take a truly co-productive approach at this early stage and convene an entirely different conversation. This may result in CHCs remaining, or it could mean the creation of a new body - one does not enter a co-productive conversation with a fixed idea of what the end result will look like.

I would like to urge Welsh Government to take a courageous, and yet obvious, position: to take a more innovative approach to designing citizen-centred health and social care services. This will mean putting on hold the proposed plans presented in the White Paper for a new national body, and convening a conversation with key stakeholders who must include "ordinary" citizens as well as engaged citizen activists and advocates, and a range of organisations who have an interest in this work from various angles - including the CHCs themselves and may I also recommend the Co-production Network for Wales.

Only then will Welsh Government - and this collective - be able to develop a proposal for a service that acknowledges and leverages the wealth of experiences and assets present throughout our communities and organisations, and create a solution that is truly co-produced. This will not be simple and fast, but it will be effective and sustainable. We can keep tweaking the system through successive Green and White Papers, or we can bring our collective wisdom to design something world-leading.

Let's co-produce co-production. What do you say?

WGWPMB45: B Parker
Location: Unknown

General Comments

In the spirit of candour it is necessary for me to say that whatever the ultimate make up of the ideal Board the more important question is: Is the Welsh Healthcare Administrative Structure with regional Health Boards appropriate and as cost effective as it could be?

I do not believe that the proposals address that question at all. Indeed bearing in mind the difficulties in recruiting the best people, in terms of experience and more importantly proven performance, for all Board positions, it is imperative that their efforts are focused for maximum effectiveness across the whole system, where they do exists their talents are not contrained by their geographic area of responsibility, and not distracted by the wasteful ,partnership, collaborative, and representative activities necessitated by the need to participate across seven Health Boards and twenty two local authorities.

I venture to suggest that among the existing Boards there are likely to be a few Board members whose proven ability and in depth knowledge of the structure, administration, and daily activities of a general hospital are of such high quality so as to distinguish them from the rest. There will be others of similar inate ability that have not had the opportunity to gain experience in the best general hospitals nor had the good fortune to serve on a Board with the truly best executives.

These two groups should fill the core directorate team within a Board responsible for the General Hospitals across Wales.

Core leadership teams comprising those of proven ability and in depth knowledge relative to the Board's tier of responsibity together with those of similar inate ability but lacking the relative experience should fill Director positions within Boards (one for each tier of care) across all Wales.
Thus there would be expert led Boards for:

1. Retail Primary Care (Opticians, Pharmacies, Audiologist)
2.General Practitioners
3. Community Hospitals, Health Centres
4.Acute General Hospitals.
5.Tertiary Hospials.

Assuming the very desirable full integration of Adult Social Care and Health Care there should be public sector Residential/Nursing homes administered by another Board which would also have responsibility for domiciliary care.

It is worth saying here that partnership working between a patient led organisation i.e. Health Boards who simply must ultimately put patient care first and foremost, even if additional expense is incurred, and a politically led organisation with officials seeking to please their political masters, common sense suggests is rather like

mixing oil and water. Local Authorites will always cut their services to fit their allocation, indeed I believe there is statutory requirement that forces them to do so.

Additionally public opinion, surely ,cannot, should not, and will not continue to accept the phoney democratic decision making process, apparently implemented by Welsh Government whereby the final decisions relative to all Council matters rest with the Council Cabinet members(in Ceredgion just eight councillors representing eight wards of forty) the more so when they are making decisions relative to Health Board/Council partnership matters that can and will also affect residents in Carmartheshire, Pembrokeshire, Powys, and Gwynedd.

The OECD recommendation that Government should play a more supportive and prescriptive role has, it appears, been interpreted as more control and drive towards partnership/collaborative working. It is clear that the inherent waste built into partnership and collaborative working is considered to be a price worth paying to preserve civil service jobs,excessive numbers of local authorities and their officials, as well as directorate, and management positions within the healthcare system.The current experience suggests the ability to deliver services is increasingly fragile whilst the numbers of staff seeking to tinker at the edges of inappropriate organisations is probably increasing. I believe that present structures were not set up to deliver services as efficiently as possible but rather to protect the sensitivites of those involved,and this mindset continues to this day. Whatever Welsh Government believes to be the 'right' approach,the evidence suggest that the present organisational structures are not sustainable,and it is their responsibility and theirs alone to do something about it.

Common High Level Standards of Care across Health and Social Services regardless of locality can be written down and passed into law.Law which as is so often seen reflects the distance between the perception of Government, their Civil Servants and reality. Such are the vast number of locations where care is delivered (In addition to its own estate Hywel Dda Health Board commissions in excess of 1500 beds where it has a duty of care}.At the 2011 census there were 8063 informal carers in Ceredigion where Health and/ or Social Care is being delivered in the community (this figure is set to rise by 60% by 2030) If one adds into the mix the fact that there are severe predicted shortfalls in both the Informal carer workforce and the commissioned domiliciliary care workers to say nothing of the problem of clinical nurse and GP recruitment and retention, maintaining any care from professionals in some locations begins to look extremely fragile.

When representing the citizen in Health and Social Care the representatives will immediately find themselves struggling with the divide between patient led organisations, and elected local politician led organisations and many citizens find it extremely difficult to understand the internal workings of either Health Boards or Local Authorities. I would go so far as to suggest that there is considerable ignorance of each others systems and requirements among even management staff in these organisations and Councillors(with the exception of the relative few that are Health Board members) have little understanding of present day Health Administration.

In addition working alongside Health Inspectorate Wales and CSSIW both of whom have demonstrated, in my experience, that they have 'no teeth' and do not want to put their heads above the parapet, will quickly ensure an addition to tokenism.

I observe too that this 'independent' body will have autonomy to decide how it operates at a local level which by definition means that it will be acting very much with Government/civil service contol at top level.

Rather than this further job creation scheme I suggest that Health and Social Care should be fully integrated under one ministerial department. That would enable there to be one inspectorate. That inspectorate should include citizens with high level internal auditing experience who can demonstrate a full understanding and be able to explain in detail the accounts of all providers and all fuctions within the integrated Health /Social Services System. Futhermore the inspectorate should have people with high level proven experience in directing and managing large organisations outside the public sector in very competitive industries, who are able to oversea action deemed to be required in response to the management accounting data. At a local level I am confident that the time will shortly be upon us when citizens will use their own voices very loudly and all that will be necessary will be for politicians follow the concensus.

Such a situation should not be feared particularly if services are designed with a large input from patients which is listened to and acted upon rather than dictated by inappropriate, often politically led, government strategies.

The paragraphs immediately above in bold type repond to questions 4.2 and 4.3
The citizens voice in design of services (question 4.1) should be engaged by the Board responsible for the delivery of the services(which ideally would be an All Wales Board as mentioned above) through as many means as possible, from the very beginning concept stage.Citizens with appropriate skills should be embedded to 'sign off' every phase of development to ensure that the citizens voice consensus is implemented.

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
No

What further issues would you want us to take into account in firming up these proposals?
Please see my general comments

Board Secretary
Do you agree with these proposals?
Yes

Duty of Quality for the Population of Wales
Do you agree with these proposals?
No

What further issues would you want us to take into account in firming up these proposals?
Please see my general comments.

Duty of Candour
Do you support this proposal?
Yes
What further issues would you want us to take into account in firming up this proposal?
Please see my general comments.

Setting and Meeting Common Standards
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
Please see my general comments.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
No

What further issues would you want us to take into account in firming up this proposal?
Please see my general comments, where you will see I do not support the designing in of inherently wasteful partnership/collaborative working. No person needs Social Care unless they have a health problem and it is time to recognise, the politically inconvenient truth that full integration under the Health portfolio is the outstandingly obvious way forward in order to deliver high quality, efficient, joined up delivery.

Representing the Citizen in Health and Social Care
Do you support this proposal?
No

Can you see any practical difficulties with these suggestions?
Please see my general comments.

Co-producing Plans and Services with Citizens
What further issues would you want us to take into account in firming up this proposal?

Please see my general comments.

Inspection and Regulation and single body

What do you think of this proposal?

I think closer integration and joint working between HIW and CSSIW would be an addition to the current proliferation of partnership and collaborative working now being encouraged throughout Local Government and Health Care delivery organisations, which have only one demonstrable 'merit'; the retention of Directorate, Management, and Administrative Jobs notwithstanding that technological advances will allow far fewer people to carry out the necessary functions.

It is very doubtful that unless each organisation within any collaborative or partnership needs to be more efficient in order to survive in a competitive market that more effective practices will be achieved by it. One function,one organisation,one Board is much more likely to be an improvement where competition does not exist

Are there any specific issues you would want us to take into account in developing these proposals further?

Please see previous two paragraphs and my general comments.

I think there is merit in a single body with a strong ' citizens' voice. That body will need a considerable level of expertise in the audit of Clinical delivery organisations and powers to engage experts from among clinicians in Outcome assessment. I would suggest that the temptation to have political representatives from any level of Government should be totally resisted. I think numerically a strong citizens group should be embedded in the single body, and the groups members should be drawn from the public manufacturing, finance, legal, retail, transport, and information technology sectors . That groups function within the body would be to provide objective scrutiny and to organise and provide on-going citizen feedback.

Please also see my general comments.

WGWPMB46: Cilybebyll Community Council
Location: Swansea

General Comments

Whilst proposals to coordinate health and social care are to be welcomed, it is important that the new arrangements build on the good work undertaken by CHCs in the past and provide an effective mechanism for that type of representation in the future. The Council hopes that this will be achieved by the proposed mechanism but is concerned that it will not.

In particular, Council hopes that the following principles will be reflected in the Terms of Reference of the new representative body -

- enshrine the principle of decisions being taken as close as possible to the people impacted
- provide for local determination of priorities according to evidence of local needs
- provide for the agility to take decisions that impact locally, regionally and nationally
- provide for clear lines of accountability within a strong standards & governance framework

I hope that you can ensure that the Council's thoughts are reflected.

WGWPMB47: P Allen
Location: Caerphilly

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
NO

What further issues would you want us to take into account in firming up these proposals?
In my opinion there is insufficient solid information in the body of the White Paper to make an intelligent and meaningful decision on such an important matter eg

- Who appoints the non-key positions
- Length of tenure for these non-key positions
- Would a key position include someone from local Gov't (there are responsible for provision of social care)
- Etc
- What would the new board composition cost and who where would the finance come from?

Vague proposal with little supporting evidence.

Board Secretary
Do you agree with these proposals?
NO

What further issues would you want us to take into account in firming up these proposals?
The proposals in the White Paper do NOT make it clear how such a post can be truly independent.

How can such a role act in both a supporting role (to the Board) yet be independent, when it is likely that the they will be co-located with the senior Board officials?

Could a single person be able to scrutinise to an adequate level? Is the intention that this role has a separate 'back office'? More costs
How would the post be funded? To ensure some degree of INDEPENDENCE it cannot be funded from either NHS or Local Govt budgets.

The White paper is, in my opinion, very weak on solid information to support the proposed change or the potential benefits.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
NO

What further issues would you want us to take into account in firming up these proposals?
It is unclear in the White Paper how the proposals are sufficiently different from the legal obligations that already exist on the NHS to consult with interested parties and the population, when planning the delivery of healthcare services.

I am not aware of any similar obligations on local authorities to carry out similar consultations. I was unable to find anything in the White Paper which provided me with this information. Another example of poor supporting evidence in the preparation of this document.

This is, in my opinion, muddled thinking.

If there is a perceived weakness in the co-operation between health boards and local authorities (and the White Paper is woefully short of any real evidence to support this perception) surely there are existing powers to ensure that this is properly monitored and controlled by the Welsh Government.

It would be better to publicly recognise the strengths of the current processes and build on those strengths whilst addressing any perceived weaknesses.

What is the rationale for imposing more, and probably onerous, obligations on organisations which are currently overstretched?

I am not convinced that the proposal would provide any significant improvement to the services ACTUALLY provided to the population of Wales?

I see very little original thinking is the correct proposal. It appears to be change for change sake

Duty of Candour
Do you support this proposal?
NO

What further issues would you want us to take into account in firming up this proposal?
My own experience of both the NS and Social Services, would suggest that both health and social services already have a firm ‘person-centred’ ethos.

The White Paper is vague on its definition of this much mis-used term and how it differs significantly from the work currently carried out by both health and social services.

There is no substantive information within the body of the White Paper to support the premise that the current ethos within health and social services has significant shortcomings, to justify a need for any change

Openness and transparency are required in all services provided for the Welsh population. Experience would suggest that government, in all its forms, may adopt

buzz phrases such as ‘Duty of Candour’ as an excuse for their poor overall management or providing a mechanism for management at (even greater) arms length

Setting and Meeting Common Standards

Do you support this proposal?

NO

What further issues would you want us to take into account in firming up this proposal?

My experience of ‘high level standards’, Performance Indicators etc are that they are so vague and ambiguous that they become virtually meaningless.

Whilst the current aims of both health and social care organisations are to provide the best service within the limits of their resources (eg financial and staffing) it is unclear how there could be any meaningful ‘high level’ standards which would differ significantly from those already in existence.

Once again, the White Paper is (at best) vague about what is actually being proposed or the potential benefits to its service users.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

NO

What further issues would you want us to take into account in firming up this proposal?

Is there not an existing body to support/arbitrate in complaints that could involve health and social services – It’s called the Ombudsman and then the Minister

Whilst the concept of a joint complaints organisation has merit (in principle) the White Paper is, again, silent on how this might be implemented and what the associated costs/funding might be.

Are these proposals a means of further removing the voice of the people from the senior legislative body in Wales and the access to the relevant Ministers?

Representing the Citizen in Health and Social Care

Do you support this proposal?

NO

Can you see any practical difficulties with these suggestions?

Why is it necessary to replace the CHCs, when it would appear more reasonable and practical to build on their experience and statutory powers to provide the ‘citizens voice’ mechanism to cover both health and social care?

1. OECD

The OECD
- highlighted the strength of the CHC in being independent in their role of representing patients (para 83 of the OECD report
- commented (positively) on CHC's interaction with HIW)
- the effectiveness and responsive advocacy service provided by the CHC

The OECD did raise the issue of duplication of functions with the HIW but CHC in respect of inspections but, like the White Paper, provided no definite examples of what this actually meant.

2. Duplication

My understanding of the work of the HIW is that their inspections do not concentrate on how the service actually impacts on patients but more on
- the prescribed processes and procedures within the Health Boards against national standards
- The standards of infrastructure (eg buildings etc)

The CHC's remit for their visits is to concentrate purely on the patient experience – how they feel, how they are being treated by staff, the environment etc. They also actively encourage patients to be open a frank.

The health staff are also encouraged to give their views, because they appreciate the independence of the CHC. No-where in the White Paper is there any indication of any health staff (or social services staff) input into any mechanism for gathering the 'citizen's voice'
This is, in my opinion, a serious omission.

Both organisations have a statutory right of entry and both are able to hold the Health Board to account and to seek remedies for any reported issues.

Whilst on paper, this may appear as duplication, in reality, the end results are significantly different.

Nothing in the White Paper appears to recognise this fundamental difference between the roles and remit of the two organisations.

The White Paper fails to acknowledge or compare the amount of work carried out by both organisations eg 2016/2017 - HIW carried out 154 inspections; Welsh CHC undertook 933 visits. Aneurin Bevan CHC, alone, carried out 171 visits and completed over 800 patient surveys)

The White Paper fails to explain how this volume of work by the CHCs would be replicated under a new system for health alone. There is nothing to indicate the citizen's voice will be heard to a comparable level for social care service users.

3. Independence

The CHCs are an independent body; not part of the NHS; not reporting to the NHS. It is vital that this independence is maintained.

They are able to scrutinise all proposals for change by the NHS after consulting with and taking notice of any concerns raised by the residents within the boundaries of the local health board.

They can and do (despite what the White Paper implies) seek the view of CHCs adjacent to them (Cardiff & Vale of Glamorgan CHC, liaises with Aneurin Bevan CHC on specific health issues, particularly the treatment of Cancer, Cardiac and Renal) and nationally on Mental Health Ophthalmology etc.

CHCs are already have the mechanism and flexibility to address both local and national health issue.

The White Paper proposal does not assure me that the new body would have the INDEPENDENCE or the FLEXIBILITY of the current CHCs

Can the new body be truly independent if it is to work “alongside Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales” ?

4. Citizen’s Voice

The function to listen to and record the ‘citizen’s voice’ and then to hold the health boards and the Social Services accountable has not been explained way.

How is this function to be achieved by this new body?
The single example of patient surveys mentioned above does not include the CHCs external representation on numerous patient groups within their area. Without the volunteers how could a single organisation hope to match this, assuming such representation would continue, what would the potential costs be?

Having attended the White Paper forum in Newport (23 Sept 2017) I am less inclined to believe that the White paper proposals are either practical or realistic. The invitation was NOT open to everyone.

- The invitation was NOT open to everyone. There were exclusion (eg CHC representatives)
- The facilitator had no background knowledge of the White Paper; reading from a pre-prepared script
- The questions for consideration did NOT match the options in the White Paper
- There was approx. 30 members of the public there.
- It was clear that they had been arranged at short notice.
- These should have been held much earlier on in the consultation process, NOT days before the consultation ends
- One event is scheduled for 28th September, the day before the consultation period ends!
- Is this a example of how it is likely to work in the future?

5. Population Representation

There is current criticism regarding how ‘representative’ is the current composition of the CHC. It is an understandable criticism but it is, regrettably, one that could be levelled at any organisation which uses volunteers.

There is nothing the White Paper to suggest how this problem could be overcome. One alternative may be to use paid staff. Would this be more representative; what would be the financial impact?

Notwithstanding this implied criticism, it is not possible to ignore the work that such volunteers carry out (visits, patient surveys etc) at an overall cost of approx. £650k per year across Wales

Public engagement is, and in my opinion, a major problem now and in the future, whatever structure is implemented. Adequate resources (ie money, materials and manpower) must be made available to support public engagement.
Whilst the CHS have been criticised for their efforts on both engagements and representation, no account has been taken regarding the limited budgets available to them from the Welsh Government

Can a single body truly represent the whole of Wales? Do the rural areas of Wales have the same issue/priorities as the urban areas?
The White Paper criticises CHCs for being too locally focused but then proposes that local issues need to be recognised.
Again very muddled and contradictory thinking.

Where are the financial details to underpin any and all of this White Paper's proposals?

6. Statutory Power

As mentioned above, the CHC's have certain statutory power. Whatever is put in place MUST have similar powers.
To truly represent the population it is essential that the new body should be able, in its own right, to hold the health and social care providers accountable for their actions/inactions.

There must be an obligation of the new body to provide reports to the health and social care in a timely manner (eg not months after the event) and, similarly, an obligation on the health and social care providers to take action in a timely manner on all the issues raised in those reports

There is nothing in the White Paper to indicate any such obligation on anyone

Without this obligation how can the new body be considered to be representing the 'citizen's voice'?

7. Scottish model

There is reference in the body of the White Paper to adopting some elements of the Scottish model (ie the Scottish Health Council) without stating what elements would be under consideration.

How is it open and transparent to omit this vital part of an argument?

The reasoning behind this is flawed.

- The current Scottish model is currently under review as it has many critics
- Its current procedures do NOT give any emphasis to the 'citizen's voice' other than confirmation that a consultation procedure has been carried out
- It does not have the statutory remit to hold health authorities to account
- It is a small organisation with 60+ members of staff covering the entire country

On these four points alone, to consider adopting any part of the Scottish model would be a retrograde step

7.Conclusion

I am concerned that the proposals in respect of the 'citizen's voice' will

- Not be independent
- lack teeth and power
- not be able to hold health a and social care providers accountable
- further remove the citizen from the Minister

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

NO

What further issues would you want us to take into account in firming up this proposal?

The six step proposal set out in 4.2 contains, in my opinion, a fundamental flaw – the determination of what service change is considered 'substantial'. Where is the independent challenge to this decision?

Currently all changes to health services (not just those that have been arbitrarily given a classification of substantial) must be referred to the CHCs for consideration. This is a statutory obligation on the NHS.

I am not aware that social care service changes are subject to the same level of scrutiny?

Again, would it not be more realistic and practical to adopt the current NHS/CHC model of consultation at all levels, than try to invent something new and untried?

When the White Paper was being drafted did no-one take account of the experience in England, where CHC were disbanded and a number of alternative and significantly weaker and ineffectual bodies put in their place.

The proposal aims to "… increase the pace of strategic change through enabling a more evidence-based, transparent process …". This is an admirable objective.

It is unfortunate that the White Paper is woefully short of solid evidence to support its proposals and it is questionable if it is also being fully transparent.

Does the White Paper meet the requirements of DUTY OF CANDOUR? Not in my opinion. There is far too much that has been left unsaid.

Inspection and Regulation and single body

What do you think of this proposal?

NO

Are there any specific issues you would want us to take into account in developing these proposals further?

Is legislation the only tool available to achieve such an objective? There already exists processes and procedures for both health and social services to work together. Surely it would be easier to develop and re-inforce the current processes and procedures, without the need for the 'sledgehammer' of primary legislation

Once again this is another weakly argued proposal.

The only real impact (as currently drafted in the White Paper and with nothing but the vaguest idea of its Terms of Reference) is to create yet another layer of bureaucracy, further separating the citizen from the Minister responsible.

Nothing in the White Paper would suggest that such a proposal would produce any real, tangible benefits for the population – eg the provision of better services.

Without even a vague idea of the financial implications of such a proposal it is unreasonable and unrealistic to ask the public to even consider, let alone give its support!

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?

NO

What issues should we take into account if this idea were to be developed further?

There already exists an independent body that provides both "inspection and the citizen voice' in respect of health issues. It is called the Community Health Councils.

Whilst the CHC's current remit only covers health issues, would it not be a simpler proposal (and probably more cost effective) to build on this current model to encompass social care matters?

Use the lessons learnt from the CHCs to develop a stronger body whose aim is to collect and listen to the citizen's voice and, more importantly, have the statutory role to hold organisations to account for their actions

I do understand the apparent need to 'start from scratch' whenever there is a perceived (and I would stress 'perceived') problem

My overall opinion of the proposals in the White Paper is that

- Appears to have been poorly researched. Was this a paper exercise?

- Lacks substantive evidence to support its conclusions.
- Is vague in respect of the actual proposals being put forward
- Gives no indication of the potential financial impact of the proposals
- Gives no indication of any substantive benefits to the population of Wales (eg what services could actually be improved)
- Provides no concrete evidence to support any perceived benefits

I do not believe that the White Paper addresses any of the criteria one would expect when taking into account Duty of Candour, openness and transpaency

WGWPMB48: Bro Taf Local Medical Committee
Location: Cardiff

General Comments

There is a case to be made for a stronger and more effective GP presence on Health Board Executive Boards. This has been absent and has prevented an effective grass roots primary care voice being heard on a regular basis at Executive level. The traditional support role of the Health Board Vice Chair in relation to primary care and mental health services has not, in our experience, been effectively or meaningfully discharged. We have no evidence of their close working with primary care, so this part of the structure needs to improve.

- We note the arguments made in favour of CHC reform, but believe that the patient advocacy role that CHCs have discharged is very important and should be retained in the proposed new citizens voice body.

- "Introducing an independent mechanism to provide clinical advice on substantial service change decisions, with advice from the proposed new citizen voice body, will encourage continuous engagement...". We are not sure of the rationale for this in a time of austerity: the point of consulting a 'citizen voice body' on service changes when there is little or no financial flexibility.

WGWPMB49: Vale of Glamorgan Council
Location: Penarth

General Comments

Thank you for the opportunity to respond to the consultation regarding proposals to improve quality and governance in health and social care. This response has been considered by the Council's Cabinet and the Healthy Living and Social Care Scrutiny Committee. Our response has also been developed within the context of work being undertaken through the Regional Partnership Board and our work with the Cardiff and Vale UHB and Cardiff Council to integrate services and respond to the needs of our customers. We therefore welcome the work being undertaken by Welsh Government to ensure services are fit for the future.

In responding to the consultation we have considered the proposals set out in the following areas and have addressed each one in turn:

- Effective Governance
- Duties to Promote Cultural Change
- Person Centred Health and Care
- Effective Citizen Voice, Co-production and clear inspection

Effective Governance

In response to the proposals regarding governance we would like to pick up on a number of points.

It is important that the roles and responsibility of Board Members are made clear. For example if a Director of Social Services is required to sit on the Board what is the purpose and value of this and is this necessary if there are robust arrangements in place for joint working through the Regional Partnership Board (RPB). Attendance at board meetings is a significant commitment and therefore in determining who needs to be involved there must be clarity regarding the benefits and whether there are other interfaces which already enable input from relevant individuals or organisations. The expectation upon only one Director of Social Services in each region needs to be made explicit for the region if this remains a requirement.

Clarity is also needed regarding the role of the 'public member' and how they will be supported to engage effectively. If this role is to be meaningful then thought needs to be given to the mechanisms that will support these members, what training will be provided to enable them to effectively engage with the issues for discussion and to participate in meetings. Are there lessons that can be learnt from representation on existing boards or RPBs? It will also be necessary to consider how public members would seek the views of their communities and represent them coherently. It is important that the board is accountable and that there is challenge within the board but this must be meaningful and complement other governance arrangements e.g. citizens panels, the RPB, Public Services Board (PSB) and any stakeholder groups.

Duties to Promote Cultural Change

It is critical that when considering a duty of quality that due consideration is given to the regional work being undertaken and the partnership arrangements and duties already in place under the Well-being of Future Generations Act and the Social Services and Well-being Act. We would welcome any steps that emphasise the importance of person centred care and how this can be facilitated by closer working within the region and across Wales. This would be consistent with activities already being taken forward through the RPB and PSB and this should be reflected in any changes to the duties on local health boards/trusts to ensure that we build on the current momentum of the Area Plan and Well-being Plans and our joint commissioning arrangements. The duty of quality must be consistent across the health and social care sectors and also recognise the role of the Third sector.

We support the intention that 'We want to ensure that all health and social care organisations and providers are under similar duties to be open and transparent, because then the public will know what they should be able to expect.' We agree that this would be consistent with a more person centred system and this is something that should be progressed. However we have some reservations regarding how this might work in practice where different organisations have different policies and procedures which may hamper any joint investigations and where there are different lines of accountability for different professions.

Person-Centred Health and Care

We recognise that for customers, their family/carers and service providers the separate standards which exist for health and social care creates issues when care arrangements transfer from one organisation to another. We would therefore support the proposal to have common standards regardless of the location of care and welcome changes which enable seamless care to be provided for individuals. Any changes should lead to greater levels of choice and control over care arrangements to be given to service users in receipt of CHC funded care for example by enabling the use of Direct Payments and other personalised approaches.

We also agree that it is far too complex for our customers when separate complaints processes are followed for health and social care. It is not acceptable that during a difficult time they have the added burden of having to follow more than one complaint processes.

We should work together to investigate complaints and it is hard to understand why two separate complaint regulations are required. If they remain separate then there will always be the potential for divergence despite any requirement to work together. A single process with a requirement for joint investigation when needed and perhaps a lead agency depending on the primary nature of the complaint could resolve this and also address some of the issues raised earlier in response to the duty of candour proposals.

This would also be reflective of the work on contracts/standards and joint commissioning that we are currently taking forward and would be a natural progression of our work on integration, again placing the needs of our customers above the workings of our organisations. We agree with the ethos of the Putting

Things Right report – that a complaints process should be people centred and not service centred

Effective Citizen Voice, Co-production and Clear Inspection

The proposals set out in this section are of particular interest in terms of our work within the RPB and PSB to ensure citizens are more involved and how we make sure their involvement is meaningful for them and adds value to the work we are undertaking.

Citizens are already involved in the planning of services through our citizen's panels etc., stakeholder engagement and representation on the RPB. In our view it is important to distinguish between involving citizens in the planning and co-production of services and their involvement in assessing the quality of services. Although there is clearly a link and one may lead to the other these are distinct functions. The proposals seem to be asking citizen representatives to be able to encompass a wide remit (locally and nationally) and some of this would require specific skills, experience and capacity which go above what may be reasonably asked of a volunteer/lay person. We need to be clear what we are asking people to do, the commitment we expect from them and what we will offer in return.

In terms of the proposals around disbanding Community Health Councils (CHCs) and strengthening the citizen voice with a new organisation we have some reservations about whether the proposals will lead to more effective engagement. It is important that there is clarity about the purpose of involving citizens, at what point this is considered to be meaningful for all parties, issues around representation and accountability as highlighted earlier and how this might sit with the work already being undertaken in response to the Social Services and Well-being Act. The limitations placed currently upon the CHCs (e.g inability to advertise their role) appear to prevent them from functioning as the true patient voice
At present the arrangements for CHCs seem quite bureaucratic in terms of the appointments process and also their involvement in changes to health services. It is unclear from the consultation paper the value of their contribution to date in terms of holding health boards to account or in helping shape service delivery at either the local or national level. We appreciate that CHCs may find it difficult to take a more objective regional and national view but this may again be in part due to the support and training provided and it is not clear whether the new proposals will resolve this. Before a decision is made about whether to disband CHCs there needs to be a robust analysis of what may be lost and what the gains would be.

The expectations of the SSWBA already provide for citizen engagement and allow a local approach to be used. It is not clear how our local arrangements under the Act would sit with the proposals for an independent body. The key is the support and training made available to those citizens who are expected to become more involved in the shaping of services and in holding our organisations to account. We are not confident that there is a sufficient business case to support the existence of a new citizen body with such a wide remit and whether it would enhance or confuse local arrangements.

For local authorities citizen voice is also integral through the presence of Scrutiny Committee's made up of elected members with oversight of key areas such as social care. The absence of reference to the role of the Council's scrutiny functions represents a significant omission within the consultation document. The added value and the potential for Scrutiny Committees to broaden their remit does not appear to have been considered.

Additionally the CSSIW also include service user perspectives within their inspection work. It is important that any new body does not inadvertently denude these important areas of scrutiny and challenge.

Based on the information contained within the consultation document we find it difficult at this time to support the establishing of a national citizen's independent body. However we would echo our earlier points regarding clarity in the purpose of any engagement and ensuring that the right levels of support are in place to ensure it is meaningful.

In keeping with the move towards greater integration we would support a feasibility study regarding an amalgamation of CSSIW and HIW. A single inspection body could potentially be more efficient and bring together a range of expertise across the health and social care sector and take a more holistic view of these services and the experience of our customers. To retain the inspectorates as two separate entities seems out of kilter with the progress on integration being made elsewhere.

Although we have reservations about a new citizen voice body and its role it may be feasible for a new single Inspectorate to have a role in setting out some core standards and responsibilities and in training/supporting citizens to be effective representatives on different boards and to participate in inspections.

WGWPMB50: W Thomas
Location: Unknown

General Comments

I welcome the opportunity to respond to the above document and particularly to Chapter 4: Effective Citizens Voice, Co-production and Clear Inspection.

I am a volunteer member of Aneurin Bevan Community Health Council having been in the role for almost six years. Prior to retiring - I would add at the age of 50 - I worked for HSBC for some 33 years and therefore have no NHS background. This, I believe, enhances the membership of the CHC as what may be acceptable to ex-NHS staff may not be acceptable to someone from outside the organisation.

In the consultation you give mention that the CHC's membership is not at all representative of local communities and that the member appointment process has over recent years grown increasingly unsustainable. You also mention that it is becoming difficult to attract people to the role, whether it is through the public appointments process, local authority or third sector nominations. You also add that CHCs also lack visibility within the community.

In response to this I would like to draw to your attention that members are volunteers. In order to give time you have to have time. This is why many members are retirees - I consider myself extremely privileged and fortunate to have been able to carry out my role prior to normal retirement age. The public appointment process, as created by Welsh Government, is a total shambles. It was some six months before my application was accepted and having worked in a banking background I could not believe the inadequacy of the process. Is it any wonder therefore that people think after such a long period of time they won't bother - the process is too laborious and drawn out. CHCs - you say - lack visibility in the local community - if funding is not forthcoming from Welsh Government how do we achieve this going forward?

I, like my fellow members, are all in favour of strengthening the Citizen's Voice but in order to do this CHCs must remain Independent & Statutory Organisations.

Your suggestion to replace the existing CHC model with that similar to the Scottish model leaves a great deal to be desired. The Scottish Health Council has already been scrutinised by the Scottish Government and is deemed unfit for purpose. The abolition of CHC's in England resulted in many English Health Boards going into "special measure" and findings, such as the Mid-Staffs report, revealed ineffective monitoring of healthcare services resulting in a detrimental affect on patient and public services.

Aneurin Bevan CHC have an excellent working relationship with our Health Board. Members are given the opportunity to sit on external committees such as Gwent Dementia Board, Nutrition and Hydration Groups, Maternity Services, Armed Services Forums, Eye Care Pathway, Falls Group, Infection Prevention & Control - this list is endless. We are welcomed by staff and patients alike when undertaking

Unannounced Visits to NHS premises - the objective being we see it as it is at that moment in time.

Raising the Citizens Voice is welcomed by CHC members but in order to do so it is essential that:-

We must be independent
We must have statutory rights
We must be integrated
We must be service wide
We must be people focussed
We must be representative
We must be transparent
We must have a national body to co-ordinate and set standards

The value of the volunteer membership of CHCs across Wales cannot be underestimated. The monetary value relates to a mere £643K. What will it cost to disband the current organisation and put a new one in place.

I would suggest, as would my fellow colleagues, not to abolish the CHCs in Wales but to enhance them.

Why follow England and Scotland when Wales could lead the way in representing the interests of the patient and public in the National Health Service. We are and want to continue to be the INDEPENDENT "Watchdog" in Wales concerned with all aspects of NHS Care and Treatment.

I hope my views, like those of everyone who respond to this document, are taken into consideration when a decision is made on the future of CHCs in Wales and that the wrong option will not impact on the provision of NHS services for the population of Wales.

WGWPMB51: M Jones
Location: Gwynedd

General Comments

The thrust of the paper in relation to Health and Social Care Services working together to provide the care people need when they need it is welcomed. This will require partnership working on a National, Regional and Local level with clear transparent guidelines set to ensure standards are of the highest quality and available to all

Response to Specific Questions

Board Membership and Composition
All Boards must have a Vice Chair and I am very surprised that this is not the norm at present.

Patient Centred Care and sound governance again must be the norm

Ministers must ensure when appointing additional Board members that there is a fair representation of the geographical area and that the relevant key skills are available. Job descriptions and a clear open selection process should be followed.

Board Secretary
The role of Board Secretary is key to the smooth and effective running of the Board

Setting and Meeting Common Standards
Agree that there should be a common set of high level standards applied to Health and Social care and they should apply regardless of location of care. This is vital within the present climate where there are grave concerns regarding the standards of care across the health care sector in Wales.

Joint Investigation of Health and Social Care Complaints
Whilst it is ideal if different organisations work together to investigate complaints this will not make it easier for people to complain as the systems will need to be set up and to be proved to be effective and simpler this usually takes time and good planning. A sound Advocacy system would help and support individuals.

Representing the Citizen in Health and Social Care
I do not support the proposal to replace the present statutory CHCs and their function with a new national arrangement to represent the citizen voice in health and Social Care. The CHCs are well established in Wales and having worked with CHCs and within a CHC as an appointed member I have seen the development of the

organisation with a very crucial role in ensuring the citizens voice is heard across the Region. It is vital that we have continuity in Health Care - constant changes in policy can only cause anxiety among the population especially the elderly. How will the Welsh Government ensure that the new body will be representative, how will it be monitored and what are the practicalities of costs. CHCs members at present are voluntary this new body if it is to mirror Scotland can prove to be very expensive.

Criticism has been made that the public do not know who the CHCs are but this is often in my experience not the case and would it not be better to strengthen the role of CHCs across Wales ensuring that there is a consistent pattern of work with common standards and framework ensuring that the public are fully informed of their role.

As CHCs are independent organisations and have a statutory right to hold Health Boards to account and to carry out unannounced inspections of health services they are in an ideal situation to pick up problems very early and liaise with the Health Board to ensure that high standards are set and maintained at all times. The role of the new body is not clear and its role very vague.

Co-producing Plans and Services with Citizens
No

The new Citizens advice Body appears to have a wide remit and I am not sure if it will have the skills and expertise to provide clinical advice within service change decisions this is a very broad role with key skills required.

Inspection and Regulation and single body
I am not clear how this new Body would work more detail is certainly needed

Again would it not be more cost effective to ensure that the roles of HIW and CSSIW be re examined in the light of joint working. Could not the CHCs have a clear role in this process instead of a new body again. The Citizens voice would again be encompassed in the CHC role.

WGWPMB52: Wales Co-operative Centre
Location: Caerphilly

General Comments

Summary of key points

- We welcome the recognition of the need for a strong citizen voice across health and social care in Wales.
- We have some concerns about how the White Paper's proposals will lead to a truly co-produced citizen panel.
- Further details on the proposed citizen voice organisation are needed. We would welcome details on how membership of the organization will be recruited, its local and national structure and the level of resources for the new organization.
- It would helpful to see the mirroring of the promotion of care co-operatives and other social value organisations in the Social Services and Well-being Act in the arrangements for promoting cultural change supported by access to co-operative education and support.
- Based on our experience, we would also welcome the commitment to additional resources to aid the development of co-produced services in Wales, particularly in leadership development and training.
- The new citizen voice organisations could also oversee elements of the Social Services and Well-being Act. For example, they could hold local authorities to account on the development of Social Value Forums across Wales.

Introduction
The Wales Co-operative Centre welcomes the opportunity to respond to the above consultation. The Centre delivers the Welsh Government funded Care to Co-operate project. Our Care to Co-operate team provide support to people in Wales who want to set up or run well-being services in a more collaborative, co-operative and inclusive way. Through this project, we have developed expertise in supporting co-produced, citizen directed services.

Citizen voice and co-production
We welcome the recognition of the need for a strong people's voice across health and social care in Wales. This reflects the values of the Social Services and Well-being (Wales) Act. However, we have some concerns about how the proposals outlined in the White Paper will achieve this.

We echo the concerns outlined in the response from Co-operatives and Mutuals Wales the citizen voice organisation proposed is not described in detail. We would also welcome details on how membership of the organization will be recruited, its local and national structure and the level of resources for the new organization. We also support Co-operatives and Mutuals Wales' suggestion that it would helpful to see the mirroring of the promotion of care co-operatives and other social value organisations in the Social Services and Well-being Act in the arrangements for promoting cultural change supported by access to co-operative education and support.

Based on our experience, we would also welcome the commitment to additional resources to aid the development of co-produced services in Wales. This includes investment in leadership development and training people who are currently involved in co-production on the ground. While there is significant interest in co-production there is a need to support this to ensure that co-produced services and projects come to fruition.

Additional duties

The new citizen voice organisations could also oversee elements of the Social Services and Well-being Act. For example, they could hold local authorities to account on the development of Social Value Forums across Wales.

WGWPMB53: Directors of Therapies and Health Science Peer Group
Location: N/A

General Comments

Please find below the collective response from the Directors of Therapies and Health Science to the White Paper Consultation Document – Services fit for the future: Quality and Governance in health and care in Wales.

We welcome the Welsh Government's focus on quality and governance in health and care services and feel that these principles must be at the very core of service transformation in order to develop and deliver a sustainable model of health and social care for the future. We feel that the White Paper is timely and will support the recommendations from the Parliamentary Review of Health and Social Care in Wales.

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

With regards to Health Board Executive Officer membership, the Directors of Therapies and Health Science (DOTHS) believe that the current size of Boards is fit for purpose and the current level of clinical Executive leadership should remain as strategic leadership for all the professions is necessary to make the transformational changes needed. However, we believe that there could be a level of flexibility within the non-clinical Executive and Independent Member posts.

Whilst there may be a view that smaller Boards may be more agile and dynamic, the breadth of responsibility for our large integrated and complex organisations requires a full range of knowledge and expertise across the Executive team. Smaller Boards may be appropriate for organisations with a focus on a specific element of service provision such as an English Acute Trust or Primary Care Commissioning Group, however, we are concerned that reducing the size of Boards across the Welsh Health Boards would impede informed decision making.

Wales has taken the lead in establishing an integrated clinical leadership approach to support the transformation of health and social care services, to move away from traditional models of care, via the appointment of DOTHS in addition to Medical and Nurse Directors at Board level.

DOTHS provide professional leadership and advice at Board level for over 60 distinct professions / specialties, making up a third of the clinical workforce. DOTHS provide the Board with regulatory assurance for Health and Care Professions Council (HCPC) regulated staff.

The DOTHS have been key in promoting the social model of care, leading collaboratively with Medical and Nurse Directors, in terms of quality, safety, patient experience and service transformation. The therapy and health science workforce has a unique and core role to play in population health, prevention of ill-health, multi-disciplinary diagnostics and treatment, and rehabilitation. These staff groups are experts in co-producing personal goals with patients and clients and in empowering citizens to take control and manage their own physical and mental well-being across all age groups and all clinical conditions. As such they are key players in driving and supporting the service transformation that NHS Wales has identified as needed to make it sustainable.

The creation of the DOTHS roles has driven change and ensured that Health Boards have access to the unique perspective, skills and knowledge to make different decisions to meet the transformation agenda. These posts have brought the skills of the Allied Health Professions, experience of inter-agency and community working and an understanding of the social model of care to Health Board decision making. Their different perspectives have added value to Board membership discussions, raising different ideas, knowledge and solutions and will become ever more relevant as NHS Wales seeks to move from hospital based to community services.

Examples of areas where these posts have delivered are:

- Chairing and leading a large number of National programmes e.g. Planned Care, Eye Healthcare, Stroke, Neurological Conditions, Respiratory, National Imaging Academy, Pathology, Point of Care Testing;
- Planned Care: accelerated change in delivery of RTT pathways, e.g. Audiology in ENT pathways, Orthoptists in Ophthalmology;
- Unscheduled Care: leading Patient Flow programmes, leading integration across health and social care, delivering innovative models of care to support admission avoidance and early discharge;
- Primary Care: establishing new workforce models to underpin sustainable services in primary care e.g. primary care Physiotherapists, Paramedics and Occupational Therapists and supporting roll out of primary care point of care testing;
- Patient centred care and experience: leading on coproduction to co-create pathways of care e.g. stroke, dementia, children with additional needs, informed consent, development of national PROMS and PREMS;
- Partnerships: driving joint working between health boards and partners, e.g. Physiotherapists with WAST in the management of falls; influencing PSBs, social care and third sector agencies in developing integrated services and delivering on legislation such as Wellbeing of Future Generations Act and Social Services and Wellbeing (Wales) Act;
- Corporate roles including information technology, health and safety, risk management across the organisation, including regulatory compliance e.g. IRMER in Radiology, MHRA in Pathology, HTA in mortuaries, veterans and armed forces, volunteers, medical equipment, decontamination, technology;
- Leadership across academic activities including research and development, education (undergraduate and postgraduate), innovation and service improvement;

- Workforce planning and redesign across 60 professions / specialties, including commissioning with WEDS,

Whilst we see the potential benefit of allowing organisations some flexibility around Board membership to support local challenges, remit and priorities, we feel that a lack of prescription around Executive Director roles could lead to Health Boards across Wales designing Boards with little commonality. Each of the current Executive Director roles provide an important and unique voice/perspective that spans the responsibilities and professions of our integrated organisations. We feel that the current balance between clinical and non-clinical Executives is appropriate and struggle to identify any specific Executive roles that do not add value to the Board. The removal of any of the current Executive Director roles could reduce the effectiveness of the Board in making decisions about complex matters by excluding those with specific skills, expertise and a sound understanding of any of the facets that support high quality and safe services.

The risk associated with identifying a small number of core Executive roles could lead to a perception of greater value placed on these areas/specialities compared with the remaining roles. This could prove divisive and lead to an inequitable level of influence associated with the Executive posts.

We believe the current regulations do allow a level of flexibility around individual roles and responsibilities, which can be linked to the skill set of the individual.

With regards to the membership of NHS Wales' Trust Boards we appreciate that the smaller, more focussed remit of these organisations may not require the full range of membership afforded to the Health Boards. However, the lack of an Executive lead for the therapy and health science professions in Velindre NHS Trust and the Welsh Ambulance Service Trust has been noticeable and the DOTHS across the Health Boards have been providing advice and support to those organisations in relation to those professional groups.

We agree that the Boards of both Health Boards and NHS Trusts should share core, consistent key principles as described in the consultation document. The principles that we agree with are:

- A culture of openness and transparency, operating within a highly trusting, challenging and engaging environment
- Showing clear leadership in quality improvement, embedded in everything it does, including board member training
- Working in partnership with the public and partners to plan and deliver person-centred care

We believe that these principles are fundamental to the development and provision of high quality, safe and effective services and care for our populations. Furthermore the Board should have a strong, executive, multi-professional clinical leadership. This is required to drive the Prudent Healthcare agenda in terms of workforce redesign, service integration, and value based, sustainable models of care.

A strong and effective governance structure is paramount, and we agree with the following principles to support this:

- There should be at least an equal number, if not a majority of independent members over executive officers on the Board to provide independence and challenge
- The Board infrastructure is underpinned by a strong governance framework which enables the Board to work effectively and meet its statutory duties including achieving financial balance
- It should be supported by a well-functioning and supporting committee structure that ensures it involves and receives views and input from a wide range of stakeholders including the professionals and patients
- The Board to involve and are supported by the senior management below the Executive Directors to ensure wider professional and staff engagement
- Associate membership of Boards should address citizen representation

We are not sure that the term 'public members' is the correct name for the independent members as this could result in the public perceiving them as being their representatives on the Board and we feel their role is wider than this.

We agree with the principle that all Boards should have a Vice Chair in order to support focussed and skilled leadership.

Whilst we agree that Welsh Government should have the authority to identify and provide appropriate individuals to challenge and give support to NHS Trusts and Boards that are under-performing or under escalation procedures in accordance with the NHS Wales Escalation and Intervention arrangements, we are not sure that the appointment of additional Board members on time limited appointments is the best way to achieve this. We feel that a better way of providing support to under-performing organisations would be to identify a small team of experts to challenge and advise the Board rather than an individual additional appointment to the Board. It will be essential to provide clear guidance around Welsh Government expectations and levels of authority/accountability for such teams.

What further issues would you want us to take into account in firming up these proposals?
The therapy and health science professions have a track record of successfully working across organisational boundaries both in health and social care and with other partner organisations including the third sector. Recent developments in policy direction including the Social Services and Wellbeing (Wales) Act and the Wellbeing of Future Generations Act, together with the establishment of Public Service Boards are vehicles to facilitate the strengthening of such partnership arrangements.

Whilst the White Paper is focussed on quality and governance in health and care in Wales, the governance arrangements described specifically apply to NHS Boards and Trusts and more explicit inclusion of all public sector bodies in governance, quality and improvement matters would be welcomed.

Board Secretary
Do you agree with these proposals?
In part

Whilst we support the proposal that the role of Board Secretary should have statutory protection to allow the role to be independent with safeguards in place to challenge the Chief Executive of an NHS organisation or the Board, we feel that this is a current expectation of these post-holders and they should not require statutory protection to discharge this duty; though if compelling reasons are presented why this would be advantageous we would be supportive of that approach.

What further issues would you want us to take into account in firming up these proposals?
Identify whether other respondents have compelling reasoning to support statutory protection

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

The existing duty of quality predates the integrated model of the NHS in Wales and this has meant the quality systems and assurance have focussed on hospitals and directly provided services to individuals rather than populations.

In addition, 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. In addition 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.

The current NHS Outcomes Framework does not provide an adequate vehicle for NHS bodies to fully fulfil its duties under the Acts but also the current aspirations and directives as set out in more recent policy documents and Welsh Health Circulars (e.g. Prudent Health Care).

Therefore, we support the proposal to widen the duty of quality for NHS Wales. However, whilst doing so, it will be imperative that it dovetails with the legislation for social care and the independent sector for an integrated system to work effectively and avoid the creation of arbitrary sectoral distinctions. This will ensure that the individual truly experiences seamless quality care, with shared quality standards and outcomes.

What further issues would you want us to take into account in firming up these proposals?
It is important that the guidance underpinning the current planning process aligns with the widened duty of quality and encourages partnership working, cross-boundary working, planning on a local, regional and national level with a strong focus on quality outcomes and patient experience.

Duty of Candour
Do you support this proposal?
Yes

We support the proposal for the development of an organisational statutory duty of candour across health and social care in Wales, which would provide support and complement the duty of candour professional groups already hold through their regulatory bodies. We believe it is right that the duty of candour for individual clinicians is a matter of professional regulatory responsibility rather than statutory duty. Having an organisational duty of candour should set a clear corporate responsibility to cultivate a culture of openness, transparency and honesty as opposed to blame, which in turn enables organisations to learn from mistakes and improve the quality, safety, and patient experience of services. Openness, transparency and honesty are fundamental to a culture of learning and require permeating throughout all the levels of the organisation, starting with the corporate teams to individuals.

The statutory duty of candour should also be broadened to apply to health and social care providers including those operating independently in Wales and they should be under the same duty of candour to avoid tension between the various organisations.

All organisations holding the same duty of candour will ensure consistency, whilst ensuring that all individuals, 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.

What further issues would you want us to take into account in firming up this proposal?

It is paramount that the scope of the statutory duty of candour is carefully considered and well designed and that clear guidance is available on when such a duty would apply. It is important to consider the threshold of harm to which the duty of candour applies. The threshold of harm must be proportionate, striking a balance between providing the individual with an apology, without requiring the care professional to divulge every “near miss”. Telling the individual about every slight incident, even if there was no harm, may result in adverse effects on the individual, causing them to lose confidence in their 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.

In addition, arrangements will need to be put in place to not only ensure the implementation of the duty of candour but to also enable learning on a local, regional, and national level.

Setting and Meeting Common Standards

Do you support this proposal?

Yes

The document refers to “high level” standards, but does not explain what is meant by this. We would like to propose that this should include ALL standards as it will be through the operationalization of standards at the patient/client interface that the service user will measure the quality of care (not the high level principle).

Of equal importance is that the regulatory framework around the standards be homogenised. There should be one regulatory framework so that individuals can receive care and have it monitored through one system of regulation.

What further issues would you want us to take into account in firming up this proposal?
For this to work seamlessly, and for care to be truly patient centred, health and social care need to be managed and organised as one body, not separate organisations.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
In part

We feel the paper does not go far enough and would suggest that health and social care should not continue as different organisations. If health and social care was one organisation joint complaints management would not be necessary. However before Health and Social care could join as organisations this would require join up in government and civil service – having health and social care in different portfolios and departments impedes joined up strategy and delivery

However while they remain separate bodies it makes sense to streamline this process. It has to be questioned why there are different rules applying currently to health and social care. The term “concerns” is less accusatory than “complaints” and suggests a learning opportunity, rather than a punitive one.

Investigation within the organisation is preferable at an early stage to enable ownership and learning, rather than a culture of blame. This needs to be considered in any future changes

What further issues would you want us to take into account in firming up this proposal?
Consider whether more join up is required at higher levels.

Representing the Citizen in Health and Social Care
Do you support this proposal?
In part

We welcome the proposal to magnify the citizen’s voice to co-create services.

The proposal suggests the scrutiny function may sit solely with the regulators and there needs to be a mechanism for holding to account. As such the new body would need to have equal status to the regulators, otherwise this could in effect lead to an organisation which has no teeth and sits alongside the regulatory arm with a quasi-supportive role, and no clear function in the co-creation of services.

There needs to be clarity around the functions and roles of the new body and assurance that none of the current functions of the CHCs are lost in the transfer.

As the model appears to be based on the Scottish Health Council model we would welcome more detail on the success of this model in Scotland and how its functions compare to that currently undertaken by the Community Health Councils here in Wales.

The paper does not make reference to the National Social Services Citizen Panel for social care. The proposed body will represent the citizen voice in health and social care. Further clarification is therefore required in this area.

Can you see any practical difficulties with these suggestions?
There is a huge gap between health and social care in terms of workforce and regulation which will need to be bridged. It is often difficult to recruit citizens to this type of body and this may be further hinder its appeal and therefore effectiveness.

There needs to be a clear function identified and it may be more practical to have this panel as an equal partner with regulators taking part in inspection but bringing a patient focused perspective.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
In part

The current advisory structures do provide multi-disciplinary, semi-independent clinical advice; however, this could be strengthened with an appointment process, mandated attendance, access to external expertise and a defined work programme which is centrally driven.

To develop a co-produced social model of care rather than a medical model all service change discussions should be multi-disciplinary and include citizens. These should not be seen as separate functions and should be focused on co-creating solutions rather than being asked to comment on them retrospectively.

In addition to the patient and clinical voice, it will be key to get a range of stakeholder input including professional managers and leaders from across the sectors.

What further issues would you want us to take into account in firming up this proposal?
To guarantee that independent advice is truly independent.

Inspection and Regulation and single body

What do you think of this proposal?
To support the true integration of Health and Social Care the proposal would be strengthened if there was further consideration of a single Inspectorate covering Health and Social Care, notwithstanding the differences in the current systems.

This would work alongside a single organisation with pooled budgets. If legislative change is required it makes sense to go to an ideal system model rather than a halfway house for two co-existing regulators.

However, we (Welsh Government) also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Would you support such an idea?

Yes, but the considerations should take into account the recommendations of the Ruth Marks Review, in particular, the report advocates the need for HIW and the Care and Social Services Inspectorate Wales to work together to develop an integrated inspection framework to scrutinise the performance of health and social care organisations

Consideration also needs to be given to how these arrangements would work across Housing services for new models of care

What issues should we take into account if this idea were to be developed further?
Consideration of how this regulator could work across health, housing and social care for intermediate care and re-ablement services

WGWPMB54: Anonymous
Location: Anonymous

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
No

Board Secretary
Do you agree with these proposals?
No

Duty of Quality for the Population of Wales
Do you agree with these proposals?
No

Duty of Candour
Do you support this proposal?
No

Setting and Meeting Common Standards
Do you support this proposal?
Yes

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes

Representing the Citizen in Health and Social Care
Do you support this proposal?
Yes

Can you see any practical difficulties with these suggestions?
I would welcome the advocacy functions being repurposed to the new citizens voice to encompass health and social care. As outlined in the report the advocacy service is valuable and should be strengthened to include the social care element. Advocacy staff with the current skill base should be developed to include social care elements.

I would like there to be local offices throughout Wales and not just offices in conjunction with HIW and CSSIW. This will give local citizens assurance that they are heard have face to face contact and have a point of contact to visit locally rather than a hot desk call centre placed somewhere in Wales.

I strongly feel that the local voice of citizens will not be seen or heard if there is no office presence and you need local staff who are passionate about their work and where they live. I would welcome a new organisation but local issues need to be at the forefront with local authority and Health Boards.. Working along side HIW and

CSSIW I agree with, but it must be driven by either the CHC's or the new citizens voice locally.

The membership of the new citizens voice should have a wider scope and representation of various age groups from young adults, adults and older people with a various skill set.

In the absence of patient choice in Wales a patient voice must be well presented so a new organisation needs much more detail and planning on how this new organisation will work. I would not like CHC's to be abolished and replaced with just a new organisation this would be waste of public money.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes

Inspection and Regulation and single body
What do you think of this proposal?
No

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Would you support such an idea?
No

WGWPMB55: Ballynahinch Support Group
Location: Ballynahinch

General Comments

It is important and that service users, children, carers, volunteers and with disabilities are included and to give input and feedback on the above Services.

Also, to have ongoing, up to date, professional, personnel, training, education, care, research, resources, opportunities, other services, to continue, maintain, progress, improve and follow on, follow up services, when and where required and for the above Services, for all and the future.

WGWPMB56: Wrexham County Borough Council
Location: Wrexham

General Comments

Chapter 1: Effective Governance

We would question the worth of identifying eleven new core key principles. We are already asking bodies to work to a range of principles set out elsewhere (such as the five ways of working set out in the Well-Being of Future Generations Act, four principles set out in the Social Services and Well-Being Act, the four Bevan Commission principles, or the principles of the Welsh Language Measure) and creating more simply lessens the impact of any and all of them.

We would also suggest that the principles set out within the white paper are not all at the same level. As an example, requiring a culture of openness and transparency appears to be a much more strategic principle than calling for independent members to be referred to as 'public members'.

In terms of the specific queries raised, we would support chairs being supported by vice-chairs, and ministers having the power to appoint additional board members in specific circumstances. We would also support the approach of identifying a small number of positions that are required on Health Boards whilst allowing the flexibility of other positions being decided locally. This could reflect the 'statutory officer' approach taken in Local Authorities regarding the monitoring and section 151 officer roles. We would also support the establishment of a statutory Board Secretary role. However, alongside establishing these specific roles consideration needs to be given to ensuring that Boards are made up of members who have the skills, knowledge, support and independence to promote good governance and robust decision making.

Chapter 2: Duties to Promote Cultural Change

We support the updating of the duty of quality to reflect the new legislative framework and more integrated approaches to regional planning and delivery.

In particular the reciprocal duty with local authorities to co-operate and work in partnership is overdue. In general, whenever one party has a statutory duty to work in partnership with another body, it would make sense that a reciprocal duty is put in place. This is needed to support improved partnership working between local authorities, health boards and trusts and we would welcome it.

We also fully support improved transparency and the proposed development of a single, consistent duty across all providers but would welcome further information on how this is intended to work as this proposal develops.

Chapter 3: Person-Centred Health and Care

The Council recognises the confusion that can be caused for citizens by the different approaches and standards that they may encounter as they move between different agencies. As such we fully support the development of a single, consistent set of standards across all providers but we would highlight that this must be set at a level which, whilst setting an appropriate standard for citizens, must also be set at a level which is realistic for providers to achieve. We would welcome further work into defining what such standards could be.

Similarly, given the work that is underway locally to better integrate services we support that idea that providers of health and social care should develop a joint complaints process for cross-cutting complaints. There are clearly a number of issues which need to be addressed in developing such a process but it is in the interest of better quality, integrated services for the end user.

Chapter 4: Effective Citizen Voice, Co-production and Clear Inspection

In line with our earlier responses, we would agree that as the system becomes increasingly integrated there needs to be an appropriate mechanism to allow the citizen to engage in the planning and co-production of services at all levels, including strategic collaboration.

We support the proposed process for ensuring independent advice on both the clinical evidence for a change and the appropriateness of public engagement. However, further information needs to be given as to how this proposal would be funded and the potential impact that it could have on the timeliness of decision making.

However, we are concerned about proposals to disband the Community Health Councils and to move to a national arrangement. It seems counterintuitive that moving to a national approach should be more effective in allowing people to have a voice than retaining arrangements at a more local level. We would also suggest that the local knowledge and experience that CHCs currently have supports their role. We would ask that further, and more detailed, consideration be given to this proposal.

We would also welcome further work on the potential benefits of combining CSSIW and HIW into a single body. This would reflect, and could also support, the increased integration of services across different providers and were this to lead to efficiencies and reduced duplication could potentially reduce the cost and administrative burden of inspection and regulation.

WGWPMB57: Anonymous
Location: Anonymous

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
I agree

What further issues would you want us to take into account in firming up these proposals?
It is important that all Officers are open and transparent

Board Secretary
Do you agree with these proposals
I agree

What further issues would you want us to take into account in firming up these proposals?
The strengthening of this role provides an opportunity to safeguard the Board secretary

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
This should not be a process but working towards a world class health services ensuring that quality driven NHS

Duty of Candour
Do you support this proposal?
YES

What further issues would you want us to take into account in firming up this proposal?
This should not be a process but working towards a world class health services ensuring that quality patient driven NHS

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
YES

Representing the Citizen in Health and Social Care

Do you support this proposal?

The role of the CHC needs to strengthened into social care and bringing the organisation in to the 20th century, There needs to be a patients/ public voice for the citizens that WG serve. To challenge and seek assurances from Health and social care organisations. To answer the enquires that the public ask, to hold both organisations to account for delivering a world class organisations, citizens focused.

WGWPMB58: L Harper
Location: Flint

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
I agree with the proposal that all boards should have vice-chairs. However, there is no mention of the importance of board culture and, as demonstrated at Betsi Cadwaladr University Health Board (BCUHB), despite being in special measures, the pace of change has been slow. The title "independent" member will also cause confusion. Surely all board members should be able to understand and respond to the needs of their population? "Public member" is already in use as a title that applies to members of the public and to allocate this title to a member of the board would also be misleading and confusing.

The other 2 suggestions would need to ensure that boards are truly representative of the population they serve.

What further issues would you want us to take into account in firming up these proposals?
The above would mean developing systems that were inclusive and developing engagement strategies that included "seldom heard" groups and individuals through positive action.

Board Secretary
Do you agree with these proposals?
Yes.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
In general, yes. The structure and implementation of this would need to be outlined in more detail.

Duty of Candour
Do you support this proposal?
A duty of candour would be welcome. The aim of "consolidating existing duties of a person centred system" gives pause for thought. Much of the practice in the current system in both health and social care could not be labelled "person centred". Significant cultural change will be needed if this is to work properly. The use of sanctions for breach of the duty would need to be carefully considered.

What further issues would you want us to take into account in firming up this proposal?
Comprehensive monitoring of services against the "protected characteristics" in the Equality Act would be helpful as long as the data was utilised to inform progress.

Setting and Meeting Common Standards

Do you support this proposal?

Standards should be consistent across health and social care. Depending on how "high level" is interpreted they should apply in all locations. This is not to say that flexibility of priority cannot be applied depending on the socio-economic and population profile of an area.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Different organisations working together is obviously a good thing and something to be encouraged. However, this is easier said than done and the belief that this requirement will encourage organisations to "learn lessons" has no evidence base. Often complaints are escalated because they are initially badly handled. Advocacy and face-to-face support for the complainant is key. More transparency and quicker resolution would be a good thing.

What further issues would you want us to take into account in firming up this proposal?

Ease of access and use / a timely response / how the lesson is learnt

Representing the Citizen in Health and Social Care

Do you support this proposal?

The CHC is an independent voice that already works with health organisations to represent the views of citizens. The CHC has a different function to HIW – it represents the views and everyday experience of healthcare users. HIW inspects against specific standards. Ideally, these roles should be complementary to each other but HIW seems reluctant to engage with the CHC.

Potentially, the social care element could be an extension of the current CHC activity. More detail regarding the practicalities of integrating health and social care should be identified and bedded in before the "citizen voice" role is extended to encompass both areas.

Can you see any practical difficulties with these suggestions?

The Scottish model is not, nor does it purport to be, a "citizens voice". It has been evaluated as an expensive "toothless hamster" There is no evidence that Scottish or English systems are better at engaging the public and that the engagement leads to better outcomes. Indeed, the Scottish system cites poor engagement as an issue and the English system has been criticised for not holding health trusts to account.

That is not to say that CHCs are perfect. This is an opportunity for Wales to build on current practice and enhance provision not weaken it.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

The above sentence is extremely long and contains assumptions that are open to question.

The CHC is independent and there is scant detail in this paper regarding what the new “mechanism” would look like. The CHC does not seek to provide “clinical advice” and neither could a truly representative “citizens voice”.

The CHC seeks to inform the health board about the consequences of clinical decisions from the point of view of the lay user. A number of volunteer members do have clinical backgrounds. These are a useful counterbalance to the non-clinical members. Moving towards a more specialist approach in the design and delivery of services with inevitably narrow perspective and impact on provision.

What further issues would you want us to take into account in firming up this proposal?
Co-production is an interesting concept although it is questionable how equal participants are in reality. One partner always has the ultimate power in making the final decision and also the major resource.

Inspection and Regulation and single body
What do you think of this proposal?
As previously stated HIW’s role is not the same as the CHC’s. They carry out very few inspections and do not reflect the views of patients or carers. Closer joint working between HIW and CSSIW would be helpful. This joint working needs to be developed before the “citizen voice” role is enhanced.

Are there any specific issues you would want us to take into account in developing these proposals further?
Consideration of the “Wellbeing for Future Generations Act” would seem to be a key legislative component in any changes made.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
There is no doubt that the CHC model of operating is in need of updating. However, it would be important to objectively review and evaluate what is already in place, what needs improvement and what works well. This has not been done.

The investigation should also take account of how each individual CHC operates and what outcomes are achieved. Currently, the thrust is “Cardiff centric” with little recognition of the diversity of work that is undertaken. Current work in North Wales includes monitoring and visiting, advocacy, varied engagement activities, collaborative development work and projects with BCUHB.

What issues should we take into account if this idea were to be developed further?
There should be more flexibility at local level concerning how members are selected. In addition, the bureaucracy of the current CHC needs streamlining in both structure and application process.

Equality and human rights considerations should be at the heart of operations of any new body and be seen to be playing this role. Currently, there is not even an up to date national CHC EDHR action plan. (NWCHC has one that is regularly monitored and reviewed and is included in the annual report).

WGWPMB59: Dr S Francis
Location: North Wales

General Comments

Whilst I am in favour of combining health and social care and strengthening the citizen voice I do not see that dissolving the Community Health Council and replacing it with a new body will assist with these objectives.

I can of course only speak about the situation in North Wales. Up here the Community Health Council is an extremely active body that is responsive to local issues. One only has to look at the figures for the large number of hospital inspections and the outcome of these, the Council's active participation in consultations implemented by the Health Board, the Council's involvement in health service planning and the usage of the advocacy service by the general public.

I am fearful that any decision to form a national body will disadvantage North Wales. Doubtless this will be denied but previous experience of health service matters over the years has shown that this can happen.

In my opinion it it is vital to recognize that the North Wales Community Health Council works hard and successfully. This may or may not be the case in other parts of Wales. I suggest that the goals of the White Paper are achieved by strengthening the work of this Council in North Wales.

The Community Health Council may require some adjustment of working practice to ensure integration between health and social care but, I stress this once more, the goals of the White Paper are best achieved by strengthening its voice, and thereby that of the citizen, not by abolishing it.

WGWPMB60: South Wales Police
Location: N/A

General Comments

Whilst most aspects concern organisations and accountability within the Health Sector and not specifically policing, there are occasions when collaboration between the Health Regulators and Police is crucial in critical cases. This includes those instances where the assessment of very poor care standards may give rise to the consideration of a criminal investigation or where information coming to the police should be disclosed to, and jointly considered by, health and social care regulators. We would therefore welcome continued engagement in the process as the form and function of any merged HIW and CSSIW emerges.

WGWPMB61: Royal College of Midwives
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
We agree that having a Vice Chair will enable focussed and skilled leadership and that the Chair will have clearly defined support in their role. It seems sensible that Welsh Government should be able to appoint additional Board members in certain clearly defined circumstances.

What further issues would you want us to take into account in firming up these proposals?
These processes must be open and transparent so that it is clear as to how and why appointments have been made.

Board Secretary
Do you agree with these proposals?
We agree that the Board Secretary role should be independent and have safeguards in place to allow challenge.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes we believe that this has considerable potential in that it will encourage organisations to think about how they deliver care in a harnessed and cohesive manner throughout the life- course and not just as an episode of care. This approach will also help to underpin the 'first 1000 days' agenda.

Duty of Candour
Do you support this proposal?
Yes we believe that this will help to have an open and honest culture across health and social services in Wales. We also believe that it has the potential to make things clearer for registrants in that it could help everyone working in Wales to understand that they work under their professional duty of candour from their Codes, and then their organisation's statutory duty of candour. This could help to make things clearer.

Setting and Meeting Common Standards
Do you support this proposal?
In principle it could be good to have a clear set of common standards but there needs to be more detail as to how they would work and how other standards would fit with them.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?
Yes we support this. It would support a common approach and should provide a clearer avenue for complainants. It also has the potential for sharing of good practice as well as lessons learnt.

Representing the Citizen in Health and Social Care
Do you support this proposal?
Yes this seems to be a sensible approach. We would support more co-operation between organisations and the public when planning and providing care. There is also an opportunity to strengthen the staff voice in these arrangements.

Can you see any practical difficulties with these suggestions?
It may be difficult to maintain the independence of the new body and there is a risk that it could be seen as being a part of the existing Inspectorate bodies. This could lessen its impact and influence.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes it makes sense to do this. It is important that appropriate clinical advice is available and taken into account when taking service change decisions.

Inspection and Regulation and single body
What do you think of this proposal?
We would support a clear underpinning legislative framework.

Are there any specific issues you would want us to take into account in developing these proposals further?
However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?
We would need to see more detail but this could be worth considering.

WGWPMB62: Anonymous
Location: Anonymous

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
Previous WG initiatives have included increasing the diversity and welsh language skills of the Board and it would be positive to include this in the paper.

Please note that all of my responses are based on the Equality perspective.

Board Secretary
Do you agree with these proposals?
Yes

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
Equality considerations should be fundamental to this process.

Duty of Candour
Do you support this proposal?
Yes

Setting and Meeting Common Standards
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
Pleased to see a positive emphasis on equality issues and the need to meet individual needs taking into account people's protected characteristics. This should be strengthened as far as possible. It mentions advocates but it's also important to ensure effective communication at all times, whether in terms of addressing their sensory loss or other disability and ensuring they can communicate in their language of choice and/or need e.g. Welsh

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
To make the process as clear, straightforward and consistent as possible. To ensure attention to Equality issues.

Representing the Citizen in Health and Social Care
Do you support this proposal?
Yes

Can you see any practical difficulties with these suggestions?
It is very difficult to engage with different communities and I would like to see the development of new and innovative ways of doing this and for these resources to be available to health boards. We would all value input into our processes e.g. equality and impact assessment and any developments could benefit this.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
As above – it is so difficult to get a diverse voice and this is a real challenge. In my experience people from protected groups are often unaware of initiatives, legislation and standards relating to them. Whatever approach is taken, this needs attention – not a straightforward issue.

Inspection and Regulation and single body
What do you think of this proposal?
I agree.

Are there any specific issues you would want us to take into account in developing these proposals further?
That it should be underpinned by equality values and key staff should be fully aware of equality legislation and issues.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
Yes if all of the above were taken into account.

What issues should we take into account if this idea were to be developed further?
As above.

WGWPMB63: Royal College of General Practitioners
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
We agree with these proposals.

What further issues would you want us to take into account in firming up these proposals?
The needs of primary care do not appear to be a priority for local health boards. We feel that having a Primary Care Clinician as a Board member whose remit is the provision of primary and community care. We would like a Executive officer, who could also be a clinician from general practice care whose focus is on primary care plus the integration of care across the primary / secondary care to reduce the bias currently in towards acute hospital and secondary care. There needs to be regular inclusion of statistics about percentage of care provided locally by GP practices to strengthen the call for equivalence with secondary care. With the ageing population, and care being provided in the community for multi-morbidities, it seems vital to strengthen the role of local general practice services.

Board Secretary
Do you agree with these proposals?
We agree. It is really important that the Board Secretary should not have any other operational role to ensure the independence of the Board.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
We agree with these proposals. A clear commitment to quality improvement as core activity in all areas. Clinicians and patients must be actively involved in determining what quality looks like and on identifying outcomes that are important to all parties. This will link to the work of Health Education and Improvement Wales.

What further issues would you want us to take into account in firming up these proposals?
Improved integration needs to occur between health and social care. This must include primary as well as secondary care. Care needs to be patient focused rather than pathway focused. Management must be developed to enable a smooth transfer of care to occur between the different sectors.

Duty of Candour
Do you support this proposal?
We agree with this proposal

What further issues would you want us to take into account in firming up this proposal?
There needs to be clarity as to how this will apply and be monitored for independent contractors.

Setting and Meeting Common Standards
Do you support this proposal?
We support these proposals. We have some concerns that high level standards tend to be a bit vague and aspirational. Service providers will need help agreeing meaningful practical standards at locality and team level.

What further issues would you want us to take into account in firming up this proposal?
The standards need to apply to third sector and private services commissioned to provide health and social care. The setting of common standards should not enable the standards to be lowered to enable all to achieve. If standards are lower in one organisation than another there must be a means to raise the standards of the lower group. There needs to be a development of a common language use or understanding between health and social care as well as the lay public/ patients and carers. Some of this is being developed in groups looking at integration of care of the elderly.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Generally, we agree but acknowledge that, with increasing litigation there may be problems with achieving this.

What further issues would you want us to take into account in firming up this proposal?
Complaints can lead to litigation and as health and social care is divided up in to different organisations which are run by health boards, trusts, private organisations, local authorities, self-employed contractors and third sector organisations with different forms and types of indemnity, admitting errors may be difficult. Currently independent contractors are responsible for and fund their own indemnity so may be protective of their own risk management (and damage limitation to the business). Each organisation will want to consider the risks to itself an may be reluctant to embrace a concept of shared risk unless this is taken at a national level. This is a very complex issue and would need to be investigated and supported by Welsh Government to be achieved seamlessly and effectively. Health and social care organisations should be able to learn from errors without fear.

Representing the Citizen in Health and Social Care
Do you support this proposal?
We have concerns about this proposal and would prefer to see separate bodies working locally and nationally. The local groups need local accountability.

Can you see any practical difficulties with these suggestions?
We support the principle that all GP practices should have Patient Participation Groups but they are not as this document (paragraph 79) suggests required to have them. RCGP Wales is in the process of trying to support the development of more such groups. These work individually with their practice to enhance patient experiences. These groups are not linked to other groups but may have common members with local CHCs. As GP practices are independent contractors their patient groups must remain independent from national or regional bodies although links and transfer of information about services from the centre or locality would be beneficial. We have concerns that having groups focusing on too broad a remit as described in the document may reduce their effectiveness and think having local groups feeding into national groups might be more beneficial similar to the current CHC structure. This section make reference to “seam less” care. What patients should receive is smooth transition between sectors and greater multidisciplinary care across primary and secondary care plus social care with clear and timely transfer of clinical information. There are boundaries between teams with different remits or focus on different disease areas. Seams are needed to connect the teams but should be smooth to facilitate transfer.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
We do not support a single body subsuming citizen's organisations with HIW and CSSIW. In addition we are concerned that the process may be slow and cumbersome especially where service change is required due the changing service resources including recruitment of staff.

We are concerned that the citizen's voice should be district and that they should be able to challenge the conclusions of HIW and CSSIW or any combined future body. These bodies must also be able to challenge Welsh Government.

What further issues would you want us to take into account in firming up this proposal?
Often change occurs in the health service as a result of changing need. It often occurs gradually rather than by grand design which does not require any consultation under this new mechanism. It is important that change is enabled when it is based on evidence rather than on local emotions to retain familiar services. There needs to be an appeal mechanism. LHBs determine if the change is substantial. If they deem it not to be so, there is no requirement to go through the while process. The LHB must consult but the decision is theirs and they could choose to ignore the guidance from either the clinicians or the public so an appeal mechanism is needed after the decision is made. This should not be cumbersome but it also needs to be set up to avoid every minor disagreement or disgruntlement using the appeal process

Inspection and Regulation and single body
What do you think of this proposal?
We support these proposals

Are there any specific issues you would want us to take into account in developing these proposals further?
As services become more integrated, the inspections need to be linked and coordinated.

However, we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
We support this idea

What issues should we take into account if this idea were to be developed further?
Regulations need to have links with the relevant UK bodies and ensure that standards across the UK are similar.

WGWPMB64: Anonymous
Location: Anonymous

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

Board Secretary
Do you agree with these proposals?
Yes

Setting and Meeting Common Standards
Do you support this proposal?
Yes

Representing the Citizen in Health and Social Care
Do you support this proposal?
No. The CHC in its present form represents citizens voice by working with health organisations and is independent and statutory thereby providing assurance to the public. The current arrangement for the CHCs meets the new proposals in that there are local CHCs, regional executive and a National board. Also it currently works alongside the HIW. If the CHCs' role is to be expanded to cover the remit of Social Care then it needs to be demonstrated that Social care and Health Services are fully integrated and functioning fully as such. Following conversations with many the CHC is regarded and known as being completely independent, respected, and operating with local representatives who overall match the demographics of the area in which they serve.

Can you see any practical difficulties with these suggestions?
There appear to be 3 areas, independence, effectiveness and engagement and cost. In its present form the CHCs have a statutory right to hold the Health Boards to account, and also to carry out unannounced inspections on any Health Board services. It appears that the new body do not have these functions and may not therefore appear to the ordinary citizen as being independent. They also have the ability to raise issues with the Welsh Government if the Health Boards do not listen to the public or are not consulting effectively as the BCCHC did with a number of issues.

On the second point it appears there is no evidence up to now that the English or Scottish systems are better at engaging with the public. I believe that the first review of the Scottish system states that, following only 51 responses in its first online survey, the 'new body' needs to work harder to be seen to engage. Also the system in England has its critics and is regarded by many as not holding health authorities and hospitals to account. It is stated in the report into the Staffordshire hospital crisis

that if CHCs had still existed the problem would have been picked up sooner. The cost of setting up a new body will be massive as new staff will be appointed, rebranded paperwork will be required, new literature, advertising and inevitably will lead to redundancies with its own cost.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

No as the CHCs, which are made up of lay people, do not have the relevant specialist skills to provide 'clinical advice on substantial service changes'. If the new 'citizens voice body' is to have these skills to suggest that it comprises of experts in their field would lead most people to declare that it is not the patients' voice nor would it surely be regarded as having local input. The danger of not having patients input into substantial service change decisions on non clinical issues would inevitably lead to giving a more directive role to the Welsh Government and the Health Boards. This is not what the electorate would want to see.

Inspection and Regulation and single body

What issues should we take into account if this idea were to be developed further?

HIW inspect very few establishments at present in North Wales and tend to focus on procedures rather than outcomes. It could be proposed that merging HIW and CSSIW to look at process and procedures across Health and Social Care and expanding the role of the CHC to encompass both Health and Social Care from the patients' perspective might be a better way forward.

In my opinion the person selected to lead the public engagement events in North Wales could not be regarded as independent or appropriate to lead the discussions due to the derogatory and biased comments made about the CHC on a public social media forum.

WGWPMB65: J Pearce
Location: Cwmbran

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
No

What further issues would you want us to take into account in firming up these proposals?
I believe that the Board of health boards and NHS trusts should share some core key principles, including delivering in partnership to deliver person centred care and a strong governance framework to ensure that boards work effectively and achieve their responsibilities.

The executive officer membership should include key positions which are consistent across all health boards but I do believe that there should be flexibility built into the system which allows each local area to be more responsive to the locals needs.

Associate membership has the potential to ensure that a representative voice can be heard at board level. Ensuring a clear mandate from the wider population would be needed to ensure that any associate membership was effective in its purpose.

There is confusion regarding the aim of the proposals. The goal of the proposals appears to be to provide consistency across the health boards and it is difficult to understand how this can be achieved if proposals to allow boards a greater degree of flexibility are implemented.

I do not believe that the proposals address the issues regarding board culture, for example, those which have been identified within the governance review of Betsi Cadwaladwr University Health Board.

It is not clear from the proposals why the change in title of the 'independent members' is needed. The board is already required to respond to, and represent, the needs of the population in all board decisions. A change in the title would not automatically make any change to the perspective of those members or the publics' view of the members who sit on the board. In fact, the change from 'independent member' to 'public member' may cause confusion to the public. The change in title may give the indication that the role of these members is to represent the public, rather than that they are public appointments.

Board Secretary
Do you agree with these proposals?
No

What further issues would you want us to take into account in firming up these proposals?
I understand and recognise the importance of the role of the board secretary. I therefore welcome proposals that will ensure the role is carried out in a consistent manner and that the role is not compromised by a conflict of duties.

The role of board secretary should have sufficient status and protection to be able to advise the NHS board on governance matters and provide protection to the organisation. However, it is also important that the role has an appropriate degree of independence to allow the board secretary the ability to provide impartial scrutiny and to challenge the health board when appropriate and necessary to do so.

The proposals do not provide any clear guidance on whether the role of board secretary would remain as an NHS appointment or would become a Welsh Government appointment. The proposals include an independent process to dismiss a board secretary but no mention is made of an independent process to appoint a board secretary. It is therefore unclear where the appointment of board secretary would sit and following on from that, how much independence the role can expect.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes if assurances are given

What further issues would you want us to take into account in firming up these proposals?
The current system has duties and definitions of quality that are set out in a variety of places and so it is difficult for bodies and individuals to understand the duties and measure compliance with them.

I believe that new legislation should simplify and clarify what is expected of health and social care providers. This will allow for organisations to ensure that they meet expectation and can provide evidence that quality standards are met. Any new legislation should incorporate what quality means from a service user perspective and should not simply be based on clinical or professional standards. I would like to see engagement and consultation carried out with the public in order to ascertain what ‘quality’ means to the people who will be accessing the services.

Legislation should be the starting point for introducing new duties of quality and not the entire proposal. The introduction of legislation is unlikely to bring about any change in culture and behaviour and so more clarity is required in the proposals as to how the duty of quality will be embedded into the health and social care systems.

Duty of Candour
Do you support this proposal?
Yes if assurances are given

What further issues would you want us to take into account in firming up this proposal?
It is likely that the public already expect professionals and organisations within the health and social care setting to work in a way which is open, honest and transparent. It is currently the case that NHS bodies are expected to operate in this way and candour is promoted with the health service. However, there is no duty on an organisation to require candour and consequently there are no sanctions for organisations who fail to work in a manner which is expected.

I would support the introduction of a duty of candour for health and social care providers. However, it should be noted that simply introducing primary legislation is unlikely to bring about the cultural change that is necessary to ensure that candour is embedded at every level of an organisation.

There is a concern that is if not implemented correctly, the new legislation could focus on the wrong areas and distract from the cultural changes that are needed rather than bring them about.

Whilst I support the idea in principle, I remain sceptical about the efficacy of a duty of candour as I am unaware of any compounding evidence that the introduction of a duty in England has benefitted the patients by having a meaningful impact on the culture and behaviour of the organisation.

Setting and Meeting Common Standards
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
I believe that the public expect clear standards to be applied and enforced whenever care is provided and by whoever is providing the care. These standards should reflect what is important to the public.

There are limitations within the current regulations that specify when standards must be followed and this should be addressed by any proposals moving forward. New legislation will need to allow for flexibility and adaptability to meet future expectations.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes if assurances are given

What further issues would you want us to take into account in firming up this proposal?
It is logical that people who have concerns about their experience of health and social care should only need to raise these issues once, rather than raising the issues with separate organisations in relation of health care and social care.

Members of the public who raise an issue or concern should expect to have their concerns investigated thoroughly and in a timely manner regardless of whether their issue relates to health, social care or both and there should be a common process with a single point of contact.

Any new arrangements that are to be introduced must ensure that the public have easy access to the system to raise concerns. There should also be timely and co-ordinated investigations and responses and shared learning between the health and social care sectors.

New arrangements should also recognise the necessity of co-ordination within the health and social care organisations and not just between them.

I would propose that with the success of the advocacy service currently sitting within the remit of the Community Health Councils, any new joint complaints system should be incorporated within the new citizen's voice body.

Representing the Citizen in Health and Social Care
Do you support this proposal? No

Can you see any practical difficulties with these suggestions?

Having a stronger people's voice across health and social care is a prospect that is welcomed and I am encouraged by the apparent desire to ensure that the public are able to have their voices heard. However, the proposals set out in the White Paper do not provide any guarantees that the people's voice will be strengthened, or any detail on how the people's voice will be adequately represented.

The White Paper contains flawed evidence that demonstrates the fact that the Welsh Government is not fully aware of the current situation and I do not believe creating proposals based on inaccurate information will achieve the desired outcome. I have serious concerns that if the proposals are accepted then the people's voice will be diluted and people left without a voice.

A further concern I have is that the proposals are based to some extent on the model that is currently in operation in Scotland. While this model is under review for potentially being unfit for purpose it seems illogical to use it as a base for developing a new model for Wales.

I am aware that the introduction of new legislation could potentially allow for a new people's voice body to have a range of functions and responsibilities. However, legislation is unlikely to bring about the type of change that is required. A new body, structure and remit will not address the current challenges that the Community Health Councils face. For example, a lack of public awareness will not be solved by the introduction of a new body and legislation. Equally, the perceived lack of independence from the health board will not be addressed simply be the creation of a new organisation. The proposals do not go far enough to solve the issues that are being held up as criticisms of the current system and I have concerns that whatever

is put in place of Community Health Councils will encounter the same challenges without any mention of a resolution.

I believe that in the creation of a new body there is the opportunity to ensure that the people of Wales are represented and the new organisation is focused on the needs and wishes of the Welsh people. I would like to see a genuine desire to co-create a new organisation with the people it should be there to represent, including robust engagement with people of all ages and all groups within society. There is enough evidence from areas where Community Health Councils have been disbanded and replaced to allow for lessons to be learned and the same mistakes not made when creating something new.

The health and social care sectors should ensure that they continuously engage with the public and people should have the opportunity to have a collective voice on topics that are important to them. It is therefore important that the new organisation is independent from the health and social care sectors as well as Welsh Government so that people know that their views can be represented objectively.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

No

What further issues would you want us to take into account in firming up this proposal?

A single approach to health and social care in respect of service change is acceptable; however the proposals put forward do not provide any detail on how this would be achieved.

The communities accessing the services to be changed must be represented and their contributions valued and used in decision making. I am concerned that the proposals would leave the public with no statutory right to be consulted with when service change is being considered. The proposals refer to the new citizen's voice body providing advice after decisions have already been made. This is not an acceptable approach as there appears to be no mechanism to ensure the public are engaged with in a meaningful way.

The current proposals appear to be based on the model currently in place in Scotland which has been subject to review and recommendations made to move away from this model of practice.

I believe that all service change should be open to public scrutiny and there should be a statutory right for people to be engage with and a body to ensure this process is adhered to.

I agree with the proposal to revise the existing guidance and believe that the guidance needs to demonstrate what is required for engagement to be effective for co-production within bot the health and social care sectors. The guidance needs to address the fact that national and regional decision have an impact on local services and that engagement is required at all levels to ensure co-production is achieved.

Inspection and Regulation and single body

What do you think of this proposal?

The proposal does not provide any clear indication about how changing the underpinning legislation framework for HIW would lead to more integration and closer working between HIW and CSSIW.

Are there any specific issues you would want us to take into account in developing these proposals further?

In order for there to be more joined up working and more integration between HIW and CSSIW, the proposals need to go further than just altering the legislation framework to bring them more into line with each other.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?

No

What issues should we take into account if this idea were to be developed further?

I can accept that bringing together the two existing inspectorates and combining the resources has the potential to create a more integrated system. Housing this within a Government Sponsored Body also has the potential to bring more independence from the Welsh Assembly Government.

However, the proposals do not include any detail about how the new system will work. The practicalities of combining the existing inspectorates into a single body while retaining their independence is not addressed and I see no guarantee that this will be achieved.

It has been found in Scotland that a similar model has struggled in maintaining the independent identities of the individual bodies and there is nothing in the proposals to suggest that this can be resolved. I would therefore be concerned that the independence of the bodies would be compromised if the merging of the two organisations under one new body was not carried out effectively.

WGWPMB66: Chartered Society of Physiotherapy
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
YES

What further issues would you want us to take into account in firming up these proposals?
CSP notes that both options in the consultation paper suggest the need for some key positions.

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.

These organisations are large, complex (being integrated across primary, acute and community care) and covering a wide range of responsibilities and services. It is essential, therefore, that they draw on the full range of professional leadership and accountability for delivery of quality clinical services for citizens from across the health and social care spectrum. The expertise from the three professionally regulated executive directors (GMC, NMC and HCPC) is crucial to delivering this. The CSP considers it is essential to retain professionally regulated executive directors covering the majority of registered practitioners.

HCPC regulates 20-30% of the regulated NHS workforce and the CSP is clear that the executive leadership role for HCPC regulated professions must be considered as one of the key positions on the Board. This also needs to be consistent across Local Health Boards through the Directors of Therapies and Health Scientists (DoTHS) executive role.

The DoTHS span professions working in both health and social care. The role is crucial for leadership on the development of community service provision and progression of workforce modernisation and transformation in primary care – which are of strategic importance to Welsh Government.

Due to the nature of the work that the professions covered by DoTHS, this director brings a valuable 'psychosocial model' approach and insight to the Board. This is demonstrated by growing evidence supporting the contribution of therapists on Boards and two examples are provided:

- https://www.kingsfund.org.uk/blog/2013/08/lets-hear-it-allied-health-professionals

- https://www.kingsfund.org.uk/blog/2017/07/realising-potential-allied-health-professions?utm_source=The%20King%27s%20Fund%20newsletters&utm_medium

=email&utm_campaign=8509692_MKEVT_J785_AHPS_250717&utm_content=blog%20-%20image&dm_i=21A8,52E4C,NRUIOM,JDTIR,1

The CSP supports a set of core principles for all NHS organisations and agrees with the principles set out in the consultation paper. We have some concern, however, about the bullet point - 'It should be supported by a well-functioning and supporting committee structure that ensures it involves and receives views and input from a wide range of stakeholders including the professions and patients'. As a principle, the Board should ensure it involves stakeholders (professions and patients), but there must also be clarity on strategic leadership and service delivery from a quality perspective. It will not be acceptable for professional leadership found only at committee level and not at Board level. This is extremely important in terms of assurance on clinical quality service provision.

The CSP supports the creation of a Vice Chair role and agrees that Ministers should be able to appoint additional Board members on a time-limited basis if Boards/Trusts are underperforming or under escalation procedures.

The CSP suggests that reference to Regional Partnership Boards and Primary Care Clusters is needed in relation to policy on effective governance. Any policy or legislation arising from the White Paper will need to place appropriate requirements on these bodies/groups in keeping with the planning and delivery of services for which they will be responsible. The Executive Directors of Therapies and Health Science as a key corporate director with responsibility for professions working across boundaries will be the ideal directors in this area overseeing transformation and service modernisation.

Board Secretary
Do you agree with these proposals?
YES

What further issues would you want us to take into account in firming up these proposals?
The CSP has nothing to add. The proposals in the consultation paper provide clarity on the role.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
YES

What further issues would you want us to take into account in firming up these proposals?

The CSP considers this proposal provides the opportunity to ensure alignment across requirements in the Social Services and Well-being (Wales) Act and the Well-being of Future Generations (Wales) Act.

The CSP supports Health Boards having a duty placed upon them that addresses both their planning and provision of services. However, legislation alone will not result in collaboration and cooperation. Action will be required through performance management frameworks for Health Boards and local authorities and further consideration on the importance of clinical leadership at corporate level in order to deliver quality clinical services.

Duty of Candour

Do you support this proposal?

YES

What further issues would you want us to take into account in firming up this proposal?

The CSP welcomes the approach of including all health and social care bodies. We note that the remit is wider in Scotland, and includes independent healthcare, GPs, dentists and pharmacists. The consultation paper does not identify why this cannot also be the case for Wales. Clarification is required here.

The CSP is clear that, as regulations are developed that identify what can trigger a statutory requirement for organisational candour disclosure, it will be essential to make sure thresholds are the same between health and social care.

Care will also be required not to discriminate against the level of care a particular patient/service user group can reasonably expect to receive. All patients/service users, regardless of age or care setting should expect the same levels of candour disclosure regardless of setting.

There will need to be a clear communications strategy to ensure that all involved in the provision of health and social care in Wales understand what is required of them, and the organisation for which they work, under a Duty of Candour. In particular, an individual should not become a scapegoat for an organisation's wider failings in managing concerns and/or complaints with regard to openness and candour.

The communication strategy also needs to ensure that members of the public know what they should be able to expect.

Setting and Meeting Common Standards

Do you support this proposal?

YES

What further issues would you want us to take into account in firming up this proposal?

The CSP suggest that it would benefit the design and implementation of the high level standards if they were developed through co-production, with service users and with staff.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
YES

What further issues would you want us to take into account in firming up this proposal?
The CSP notes the point made at 67 (page 24) regarding the provision of a seamless service across health and social care. Due to the differences between health and social care in that some parts of care will be charged for and some will be free at the point of need it will not be applicable for people to have no knowledge or understanding that different organisations are responsible for different parts of their care. The situation may change over time, with the development of more integrated service provision and as decisions are made around paying for care. The current situation requires understanding in order to exercise voice and control.

Representing the Citizen in Health and Social Care
Do you support this proposal? Yes. Public services need a strong voice and effective participation.

Can you see any practical difficulties with these suggestions?

The CSP highlights that under the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009, Health Boards developed stakeholder forums. These will need to be considered within the development of more detailed proposals. It does not say in the consultation whether these will stay, go or be changed. This needs to be clarified.

It will be important to ensure that all current functions carried out by Community Health Councils are considered carefully, so that nothing is lost in transfer to the new body. As the model appears to be based on the Scottish Health Council model, the CSP would welcome more detail on the success of this model in Scotland, and how its functions compare to that currently undertaken by the Community Health Councils here in Wales.

The CSP notes that, in relation to social services, there already exists the National Social Services Citizen Panel. This is not referred to within the consultation document yet the new, proposed body will represent the citizen voice in health and social care. Further clarification is therefore required in this area.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes - the CSP supports the idea that service planning should be carried out in a co-productive way.

What further issues would you want us to take into account in firming up this proposal?

The CSP notes that the proposals in the consultation removes the requirement for an independent consultation for substantial change as is currently carried out by the Community Health Councils. The new independent citizen advice body will only be advising on whether public engagement processes undertaken by the Health Board complies with guidance. This is a substantial change.

The CSP suggests that, in figure 1, on page 34, in the Planning Stage there should be reference to co-production with service users and professionals. The CSP also suggests that the word 'clinical' (where it refers to Advice – Clinical) should be changed to 'professional' to ensure inclusivity of the wide range of clinicians and professions working across health and social care who may be required to provide advice.

Inspection and Regulation and single body

What do you think of this proposal?

The CSP supports the need for a clearer legislative framework for HIW in order to foster closer integration and joint working with CSSIW.

Are there any specific issues you would want us to take into account in developing these proposals further?

The CSP has no additional comments to make in relation to the proposal for more joint work between HIW and CSSIW.

However, we (Welsh Government) also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?

The CSP considers there could be merit in considering a new body but the proposal in the consultation is a big one and will require comprehensive planning to ensure the functions currently carried out by CSSIW, HIW and the CHC continue to be carried out appropriately and effectively.

What issues should we take into account if this idea were to be developed further?

There will be a need to ensure clarity about function and independence to act of the various parts of the new body. There will be lessons to learn from organisations that have come together to form National Resources Wales and Health Education and Improvement Wales in respect of merger of organisations.

Welsh Government will need to ensure that size of the new organisation will not create any adverse effects.

WGWPMB67: Plaid Cymru Caerphilly Constituency
Location: Caerphilly

General Comments

At its meeting on 24th August 2017, members unanimously opposed the proposal in the white paper to abolish community health councils.
Members felt that CHCs have provided a valuable service to their communities over the years as the patients' voice and watchdog.
As independent statutory organisations CHCs provide the following invaluable services:

1. advocacy for patients, their families and carers which is particularly important in disadvantaged areas such as Caerphilly County Borough

2. independent scrutiny of the NHS and the Ambulance Service, both through their visits to hospitals, doctors' surgeries and ambulance stations, through the daily reports they receive of key health statistics and through discussion with key health and ambulance officers at the CHC scrutiny, planning and executive committees
3. Involvement in consultation processes when changes to NHS and Ambulance services are planned
4. extensive contact with local communities through the volunteer members who are drawn from many of the areas covered by each CHC and who have different skills and expertise
5. a value-for-money organisation as much of the work is carried out by unpaid volunteers (supported by a small paid staff)

We do not feel that the new proposed organisation will have these essential attributes.

However, we agree that there should be greater integration between health and social care and would suggest that the existing CHCs could be expanded to cover social care matters.

WGWPMB68: M Joyce
Location: Gwynedd

General Comments

As evidence of Quality and Governance in hospital care in North Wales I enclose my latest letter to Dr Higson. The letter is self explanatory with extensive triangulated evidence relevant to your enquiry.

Thank you for your reply to my question at the Betsi AGM on 20/07/2017. As I said at the AGM my question was basically the same as I asked at the September 2013 AGM, and your reply is the same: "We are particularly mindful of the geography of North Wales and the need to balance access to services with sustainability and quality of service".
As Chair you are ultimately accountable for the quality and safety of clinical services and the performance of the Health Board, and with the Chief Executive have a statutory responsibility to provide the population with clinically effective, safe, dignified hospital care within budget.
At your first Betsi board meeting you stated "it was critical how you gathered evidence and who you went to for an opinion". The Ann Lloyd Review into board performance March 2015 reported your regrets: "He is very concerned about the lack of creativity within the organisation and considers the organisation has a rigid, overly bureaucratic and bullying culture. He appreciates and is frustrated by the fact that the 3yr plan contains no clear plan for the future..."

At the AGM September 2013 I asked the Board: "According to the National Clinical Forum, the Medical Colleges and the Postgraduate Dean, acute services could not be delivered or sustained, nor doctors trained, at three hospitals in North Wales. Why did the Health Board remain committed to keeping three major acute hospitals in North Wales, each with an A&E department"?
Interviewed in Daily Post 2014 you were asked "Can you restate your absolute commitment to retaining full consultant-led emergency services at all three district hospitals?" You replied "YES, but we as a health board do more than run a few hospitals..."
On 13th January 2015 I attended an all day meeting introduced by Geoff Lang at the Oriel Hotel, entitled 'Our 3 year Plan, Sustainable Services'. The meeting was well attended with enthusiastic engagement by many staff and local GPs. The presentations by senior clinicians showed commitment to reconfiguration of services to improve quality of care for patients with many different 'scenarios' discussed. This meeting was a sham as you had already stated in 2014 that no reconfiguration of acute hospital services would take place.
Under developing plans 2017: "Living Healthier, Staying well" the Health Board has decided: "At each of our District General Hospitals, we will continue to have the following services: a full Emergency Department; consultant-led maternity and paediatric services; direct admission for medical care for people who are unwell; direct admission for people who need operation". After seven years of endless consultation, repeated promises to publish reconfiguration plans by certain dates, the Betsi Board finally propose to continue unchanged acute hospital services. North

Wales will remain a more dangerous place to be unwell and a more difficult place to be a doctor working in three small district hospitals in geographic, professional and academic isolation, identified by Prof Bruce Keogh as a cause of high mortality rates and difficulty in recruiting doctors.

You were not at the Betsi AGM September 2013. After you took up post as Betsi Chair I sent you a letter on 9/12/2013 with 'evidence' explaining my question at the AGM. I ended that letter with a summary and conclusion: "The Board has a statutory responsibility to provide safe care within budget. Care which cannot be delivered and sustained cannot be safe. The decision to continue acute services and A&E at three hospitals means the Betsi Board have deliberately chosen to risk providing unsafe and poor quality care at increased cost from inefficient triplication of services. 'Taking forward service design in a piecemeal fashion will make it more difficult to design and plan the whole system changes that are necessary to create clinically and financially sustainable services' (HIW/WAO June 2013"). You did not acknowledge my letter.

Wales Audit Office and Health Inspectorate Wales Report on Betsi governance June 2013 "Given the challenges that are known to exist with medical recruitment, and the affordability of current service models in North Wales, the need to develop a clear strategic appraisal of options for future shape of acute services is pressing". "A number of interviewees expressed frustration and concern over the slow progress in developing a clear plan for the Health Board's acute services. Factors such as lack of executive consensus, patchy clinical engagement, and concerns over having to make decisions which may be politically difficult were all cited as reasons why more progress has not yet been made. A need to develop a more strategic and proactive approach to the challenges that exist with the recruitment of medical staff also came up as a key issue during the review".

You stress the importance of triangulating data and evidence for 'assurance' and decision making. You say in your letter 3/8/2017: "We have explored other staffing models to deliver some of these services and are establishing new ways to deliver services which balance the needs of service and training without having to compromise local access. We already have examples in place in paediatrics and obstetrics where we are maintaining services on three sites, with new staffing models that are proving robust and delivering high quality care". . Where is the triangulated evidence that other staffing models and new ways to deliver services are providing clinically effective, safe, high quality care?

I present triangulated evidence from Medical Colleges, National Clinical Forum, Postgraduate Deanery, and BCUHB Quality and Safety Committee that surgical, obstetric and paediatric acute hospital services are poor quality, clinically unsustainable and unsafe. This evidence and conclusion is supported by the Health Board's own Corporate Risk Register (CR11) which identifies: "There is a risk that patient experience and outcomes may be adversely affected due to mismatches in demand and capacity across the whole system. This could lead to patient harm and failure to meet expected standards of performance". The Risk is rated at the highest level 25 'almost certain risk of maximum impact of harm to patients'.

July 2012 The National Clinical Forum set up by the Health Minister to provide overview of safety for hospital reconfiguration wrote to the Betsi CEO. The Forum "expressed serious concern as to the deliverability and sustainability" of attempting to provide A&E, emergency surgery, obstetrics and paediatrics at three District General Hospitals across North Wales. The Forum also said "the current situation of trainees providing a large part of the on-call rotas requires major reconsideration for the future".

January 2013 The Postgraduate Dean for Wales appeared before the Assembly Health committee, and stated that doctors could not be trained to GMC or Medical College standards at three hospital sites in North Wales. He said there must be less hospital sites and better rotas, to allow improved teaching, clinical experience and increased exam pass rates. He also said that formal training rotations could be linked with Merseyside Health Authority, to allow more transparent career progression.

Dec 2014 The 'Paediatric Group' reported to the Betsi Quality and Safety Committee; difficulty sustaining rotas due to failure to recruit doctors; difficulty staffing 3 hospitals with nurses and doctors; units have to be closed when staffing levels fall; same staff work across acute, neonatal and mental care units.
Sept 2013 College of Paediatrics produced a Position Statement on Reconfiguration of Children's Health Services, quote: "The 'Facing the Future' model sees fewer, larger inpatient units which are better equipped to provide safe and sustainable care. The concentration of specialist services also provides the opportunity to be more flexible with rotas, increasing the scope to deliver 7 day 24 hour consultant led care, and provides a better environment to develop clinical skills and experience across the children's health care workforce (i.e. training)".

Dec 2014 The 'Surgical Group' reported to Betsi Quality and Safety Committee: "Work continues on developing a Sustainable, Safe Surgical Non-elective service for the population of North Wales.... The risk of continuing to deliver this service in its existing configuration remains to be significant. The 'Surgical Group' has high use of locum doctors at all grades in order to sustain safe and acceptable rotas across the three sites. There have been 2 serious incidents of note in recent months associated with Locum staff. Datix (staff concerns) reporting has increased in terms of incidents involving locum doctors and the 'Surgical Group' is seeing a growing trend in terms of patient concerns all of which highlight the risk to patients and BCU".

June 2011 College of Surgeons produced a detailed report on Reconfiguration of General Surgery Services in North Wales. They recommended emergency surgery be centralised on 1 or 2 sites to guarantee consultant cover, on call rotas, subspecialisation, and concentration of emergency admissions to maintain surgical skills and training.

I quote from the College of Obstetrics appraisal of Betsi maternity care published at Betsi Board meeting 21 July 2016: "The service provision was judged to be safe on all sites at the time of the visit. This had only been achieved by considerable short

term and unsustainable changes in the working pattern of permanent staff with an astonishingly high reliance on locum staff. On occasion up to 60% of medical staff were locums, leading at times to all three tiers of on-call medical cover being provided by temporary staff".
"For all three sites the current middle grade on-call rota is unsustainable and fragile, it is completely reliant on locum staff. There is no resilience in this tier and this may put the service at risk of failure requiring closure of any unit at short notice...."
"The service is currently being maintained by the use of locum consultants who are resident on-call. This is not seen as a sustainable option. To ensure safety the service was being managed as if it were a major incident with four times a day situation reporting".
In February 2015 every member of the Betsi Board voted to close maternity at YGC because all agreed the service was unsafe due to 25% of the obstetric rotas being provided by locum doctors. At the Betsi Quality and Safety Committee May 9th 2017 nobody raised concern that in April 2017, 25% of consultants and 46% of middle grade doctors at YGC were locums.

There are many other hospital services which do not meet fundamental standards with significant risk of harm to patients; patients treated in every hospital service by untried locum doctors which BCUHB admits is a recognised risk to patients; high rates of hospital acquired infection; least provision of critical care beds in Europe; failure to comply with NICE and College recommended treatment for stroke and heart attack; noncompliance with safeguarding standards; 50,000 patients significantly overdue outpatient assessment; 20% patients wait over 4hrs in A&E; 10% operations cancelled; waiting over 1yr for joint replacement; waiting over 1yr for routine prostatectomy with a catheter; many patients sent to England for routine eye, gynaecology, orthopaedics, urology operations to reduce waiting time targets. .

Professor Longley in his paper 'Best Configuration of Hospital Services in Wales' for the Wales NHS Confederation April 2012 made an important if obvious statement that the whole Betsi Board should note "immediate access to poor care is little use to anyone". He found worrying variation in patient outcomes, including death rates, because of the way services are arranged, and warned some services are close to collapse because of shortage of doctors.
2013,2014,2015 & June 2017 Reports every year from Health Inspectorate Wales and Wales Audit Office criticised the Betsi board for quote "Failing to reconfigure acute hospital services in spite of recognising that radical changes are necessary to create clinically and financially sustainable services. The delays in taking forward these plans are worrying, given the challenges that exist with medical recruitment and the financial sustainability of current services". The report in June 2017 raised concern that the Board failed to meet statutory responsibilities; unauthorised budget deficits rising to £100 million by 2018; no 3yr integrated medium term plan and budget.

Turning to the issue of clinical coding and mortality indicators. ‘Ensuring that board members have the right information available to them to discharge their responsibilities is a crucial role of the Chair’ (Guide to governance in NHS Wales, NHS Confederation 2009).

Unit formed at Imperial College London 2000, later known as 'Dr Foster' to analyse deathrates. Unit developed data from electronic record of every inpatient or day case episode in every NHS hospital in England. In 2007 Dr Foster started to send out monthly 'alerts' to hospital CEOs and the regulator, detecting possible problems and monitoring improvement initiatives. High mortality rate (Hospital Standardised Mortality Ratio 127) identified in Mid Staffs in 2007 led to investigation.

June 2013 Prof Keogh conducted a review into the quality of care and treatment provided by 14 hospital trusts with persistently high mortality rates and found "The review has been able to identify some common themes or barriers to delivering high quality care which are highly relevant to wider NHS....all 14 were operating in geographical, professional or academic isolation, which can lead to difficulties in recruiting enough high quality staff, and over reliance on locums and agency staff. The capability of hospital boards and leadership to use data to drive quality improvement. The complexity of using and interpreting aggregate measures of mortality".

2017 Health Minister Vaughan Gethin told BBC News that in Welsh hospitals there was a 'focus on outcomes'. "NHS Wales Outcomes Framework requires 95% of clinical coding within one month post episode and date. In February 2017, the position of clinical coding in Betsi was reported at 35%". The Board cannot gain assurance on patient outcomes including mortality without timely, accurate clinical coding.
Risk Adjusted Mortality (RAMI) is widely used across the UK as an indicator of expected hospital death rates. The average hospital RAMI is 100, Betsi RAMI quoted on the agenda for 17/8/2017 Board Meeting was 137, which suggests that patients are 37% more likely to die in North Wales hospitals.

Quality & Safety Committee, Chairs Assurance Report at Betsi Board Meeting 17/8/2017 quote: "The Committee reiterated its concerns about mortality rates in BCUHB services and noted that a paper covering the issues would be considered at its September Meeting.....The committee was concerned at the ongoing backlog in clinical coding and asked that more emphasis should be put on resolving this issue. The Committee noted that the repeated attempts to recruit and train up additional coders had not impacted on the situation. The Committee requested a response to its concerns to indicate what additional solutions to help improve performance had been considered".

Prof Stephen Palmer's 2014 'independent review of hospitals with a RAMI score greater than 100' joins many other competing reports identifying: 'The complexity of using and interpreting aggregate measures of mortality' since Dr Foster identified the scandal at Mid Staffs with 'high mortality rate measurement'.
Prof Palmer then continues: "My recommendation that RAMI should not be used as an overall summary measure of hospital performance in Wales leaves a question about how the public should be assured about deaths in hospitals. The answer is, through the case note reviews of hospital deaths in place in all acute hospitals in Wales. In this respect Wales is ahead of both England and Scotland". Some might argue with this statement. Case note reviews depend on the quality and accuracy of clinical notes, and the quality and total independence of the review team. There will

always be a bias towards 'good results'. Medical Examiners for stage 2 reviews have been delayed.
BCUHB are still using RAMI as reported to the Board every month. I can find no publically presented BCUHB ‘measure of mortality’ using ‘retrospective case record review of deaths; stage 2 review’ and it again appears from the RAMI exception reports that ‘case record reviews’ are being developed rather than established. Exception Report: Risk Adjusted Mortality Jan 2017 "Seeking to further improve Retrospective Case Record Review of all deaths, we continue to review our current system and also liaise with ABMU to introduce an electronic system. Plans are currently being developed to roll the software out in the health board over the next 12 months to support mortality work further. A date to introduce the system remains an outstanding item and we are awaiting further updates from IT".

Corporate Risk Register (CRR10) Informatics . "There is a risk that informatics infrastructure is not fit for purpose; this is due to lack of capacity and resource; increasing demand; reliance on the Wales NHS informatics system. This may lead to failures in clinical and management information systems, impacting negatively on patient safety/outcomes", Risk level 20 ('almost certain risk of major impact of harm to patients). It would appear that in 2017, there is no robust BCUHB electronic system to measure or record clinical 'outcomes' data.

As I said at the AGM there are obvious causes for increased Betsi mortality: "failure to recruit doctors; over reliance on locum doctors; trainee doctors providing a large part of the on-call rotas; inadequate medical training; high bed occupancy; lowest provision of critical care beds in Europe; unacceptable rate of hospital acquired infection; but above all Wales National Clinical Forum and Medical College concern that present configuration of acute hospital services is undeliverable and unsustainable. Put simply you can't run safe hospitals without doctors".
The Betsi Corporate Risk (CR11) identifies: "There is a risk that patient experience and outcomes may be adversely affected due to mismatches in demand and capacity across the whole system. This could lead to patient harm and failure to meet expected standards of performance", risk level 25 ('almost certain risk of maximum impact of harm to patients) in North Wales Hospitals'.

Patients have no choice where or what treatment they receive. As Keith Evans said in a 'Review of concerns handling in the Welsh NHS', the Welsh NHS is a "monopolistic organisation where you can't go anywhere else. It has to have strong regulation for its patients and users".
"Above all, the Health Board failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect, and do something effective to remedy non-compliance with acceptable standards of care. For years that did not occur...." (Francis letter to Health Minister about Mid Staffs disaster 2013)
As Chair you are ultimately accountable for the quality and safety of clinical services and with the Chief Executive have a statutory responsibility to provide the population with clinically effective, safe, dignified acute hospital care within budget. If you read

your own Corporate Risk Register particularly CR10 &11, your own Board's analysis is that patients admitted for acute hospital care in North Wales are at significant risk of harm. You have no robust systems to monitor patient outcomes and mortality.

All the hierarchy of the NHS should read the Francis Report on Mid Staffs; Keogh Report on failing hospitals; Kirkup Report on maternity at Morecambe Bay; Evans Review on concerns handling in the Welsh NHS; as a warning of the disasters for patients that follow tolerance of poor standards in hospitals. As Keith Evans recognised the Welsh NHS has to have strong regulation for its patients and users.

Robert Francis recommendations after Mid Staffs enquiry include:

A structure of fundamental standards and measures of compliance:

A list of clear fundamental standards, which any patient is entitled to expect which identify the basic standards of care which should be in place to permit any hospital service to continue.

These standards should be defined in genuine partnership with patients, the public and healthcare professionals and enshrined as duties, which healthcare providers must comply with.

Non compliance should not be tolerated and any organisation not able to consistently comply should be prevented from continuing a service which exposes a patient to risk.

Standard procedures and guidance to enable organisation and individuals to comply with these fundamental standards should be produced by the National Institute for Clinical Excellence with the help of professional and patient organisations.

These fundamental standards should be policed by the Care Quality Commission (Health Inspectorate Wales or Wales Audit office)

I am sending a copy of this letter to Health Inspectorate Wales, Wales Audit Office and the North Wales Community Health Council as the statutory 'Regulators' for standards of hospital care, to raise concern that they have produced regular reports for five years stressing the importance of 'creating clinically and financially sustainable acute hospital services' for the people of North Wales, which BCUHB under your leadership have stubbornly ignored. Why have Regulators tolerated non-compliance with fundamental standards of acute care in North Wales hospitals for five years exposing patients to risk?

WGWPMB69: Vale of Glamorgan 50+ forum
Location: Barry

General Comments

Questions on Board Membership: The 50+ Forum broadly supports these proposals, particularly that independent members should form a majority. We would like to see more detail on how independent members would be recruited(appointed? Elected?). Similarly we would like more clarity on Associate Board members and whether any changes are likely. It would have been useful to have had an example of the revised structure of a health board to compare with the current membership.

Questions on Board Secretary: We welcome proposals to clarify the role of Board Secretary. There are concerns that the closeness of personal and professional relationships within a Board may still make it difficult for a Board Secretary to raise issues of a serious nature. It is unclear whether , in the case of significant failings in care and treatment, the Board as a whole, the Chief Executive or the Board Secretary would be accountable. In our view issues of accountability are not fully dealt with and the power of the Minister to appoint additional Board members does not adequately resolve the problem.

Question of Duty of Quality for the Population of Wales: Demands on the health and social care system are generated to a substantial degree by social and environmental factors. Therefore we would support a Duty of Quality of Care which supports Health Boards and Trusts working more closely with social care services, broader local authority services (e.g. housing , environment and leisure) , the Third Sector , social security and economic development agencies. Private firms are already heavily involved in social care provision and parts of health provision , and they need to be involved in planning services as well as subject to the same expectations of quality as public services. Common standards across Wales and equality of access geographically and for all sections of the population should underpin this duty.

Duty of Candour: We support the implementation of a Duty of Candour in Wales for both health and social care and the consolidation of existing measures within health and social care legislation. In support of this we would advocate harmonising complaints procedures. Consideration should be given to making it mandatory for health boards , trusts and local authorities to publish at least six-monthly in Board and committee papers and websites details of complaints, incidents of harm and any Ombudsman reports.

Person-centred Health and Care: The proposals in this section are welcome. The phrase “the standards of care should apply regardless of the location “ is slightly ambiguous. As well as the type of care and provider it should include geographical location e.g. number of GPs per head of population in each area. Similarly a standard about about the number of IVF treatments should be uniform across Wales. Health Boards in Wales are rationing some services and it is worrying that this can lead to inequitable access to treatment. Common standards should apply to service levels of provision as well as the treatment an individual receives.

Joint Investigation of Complaints: Whilst we agree with the proposals to make it easier to complain when a complaint involves health and social care, consideration should be given to harmonising the complaints procedures. This would simplify joint investigation and less confusing to the public.

Citizen Representation: We have serious reservations about the proposals to abolish Community Health Councils and establish a new organisation “Citizens' Voice”. The arguments about being unrepresentative could be levelled at Health Boards and many public bodies. Within their limited resources CHCs have a good track record of direct contact with patients in primary and secondary care , holding public meetings , and detailed knowledge of the health services in their area. This puts them in an excellent position to provide independent views on service changes. CHCs have also demonstrated an all Wales perspective through ,for example surveying GPs services. We would prefer to support an approach which would further strengthen the work of CHCs. For example its effective advocacy service could be extended to social care and, with a change of title, its remit extended to social care.

The problem with the proposal of a “Citizens' Voice” is that it will lose most of the statutory powers possessed by CHCs and would have a very limited advisory function. Health Boards' ability to override citizen concerns would be strengthened. There is no information on the recruitment of its members, the level of professional support, or the resources it would have at its disposal. The general tone of the proposal is to streamline health board decision making with less opportunity to have a significant involvement on the part of citizens. The clinician and managerial part of the decision making process is likely to be dominant (they will decide what is a major change needing consultation) with Citizens' Voice lacking experience and expertise to challenge effectively. It is regrettable that in the desire to speed up decision making the route has been to emasculate CHCs and replace them with a much weaker consultative body of indeterminate composition and functions- hardly a model of co-production and continuous engagement.
In the absence of any detail about the proposed Citizens' Voice we suggest that the proposal is not proceeded with at present. However we suggest that any model which may emerge take into account the following points:

- build on the strengths of the present CHCs
- a single organisation to cover health and social care
- retaining some of the statutory powers of CHCs
- the advocacy service be extended to cover social care
- adequate resources to regularly get the views of citizens, patients and service users(some of the resources spent by Health Boards /social care on engagement to be transferred to any restructured body to reinforce independence)

Inspection and Regulation: We support the need for clear regulatory framework with a statutory basis. Ultimately the goal should be a unified inspectorate , using common and tested methodologies. This would be more understandable by the general public. Possibly a way forward would be to plan a merger three to five years ahead to avoid disruption and develop an integrated approach during the transition period. We would be wary of creating a new body as our systems are already complex. There is a distinction between inspection and engagement with the public

and the body entrusted with voicing the views and concerns of the public needs to be demonstrably independent. For example CHCs present powers to inspect are not essential to its role and at present CHCs liaise closely with the inspectorate to avoid overlap.

WGWPMB70: Public Health Directors Leadership Group
Location: Caerleon

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes, the Boards of Local Health Boards and NHS Trusts should share core key principles

Yes, all Boards should have a Vice Chair

What further issues would you want us to take into account in firming up these proposals?
The Executive Officer membership of Health Boards should reflect the breadth of portfolios necessary to deliver statutory, policy and performance requirements.

Health Boards have statutory responsibility for promoting and protecting the health of their populations and to discharge this population health function it is essential that an appropriately qualified Director of Public Health continues to be specified as a core Executive Officer in the membership of the Board of Health Boards

Board Secretary
Do you agree with these proposals?
Yes

Duty of Quality for the Population of Wales
Do you agree with these proposals?
We welcome the proposal to strengthen the duty to collaborate, co-operate and work in partnership to plan and deliver services that meet the needs of the population

What further issues would you want us to take into account in firming up these proposals?
Working as an integrated system is essential to deliver improvements in population health and wellbeing as well as the quality of healthcare services

Duty of Candour
Do you support this proposal?
Yes

Setting and Meeting Common Standards
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
Common outcome frameworks and common staff competency frameworks would enable common standards and a common governance system to function which would need to be consistent with NHS clinical governance processes to maintain patient safety. Currently there are separate outcome frameworks for the different parts of the system and very different competency frameworks.

Any standards developed would need to be broad enough to encompass promoting wellbeing and health as well as treatment and care services

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes

Representing the Citizen in Health and Social Care
Do you support this proposal?
We support the principle of the CHC's inspection function being brought together with HIW and SSIW to enable joint inspections that include the citizen voice.

We do not support the proposal that there will be a single national body representing the citizen voice unless there are clear arrangements for how it will function at the local level to enable local issues to be identified and resolved locally

Can you see any practical difficulties with these suggestions?
Loss of local knowledge and relationships to the detriment of the planning and delivering of local services that best meet the needs of the local population

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
No

What further issues would you want us to take into account in firming up this proposal?
The expertise lies with clinicians and public health specialists who know their local population needs and know the evidence base for their field of work. There is a need to have mechanisms to enable clinical discussion across disciplines and organisational boundaries to develop a consensus.

A 'more directive and guiding role on the part of Welsh Government' informed by clinicians who may understand the evidence base but do not have knowledge of the local population needs has the potential to lead to the wrong decisions being made and implemented.

Inspection and Regulation and single body
What do you think of this proposal?
We agree

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
No – it needs to be independent of government

WGWPMB71: Anonymous
Location: Anonymous

General Comments

This consultation document is short on detail.

The document has many leading questions and/or ideas. It seems to want binary responses i.e. yes or no.

It uses terms which may not be easily understandable without some public sector knowledge i.e. co-production.

There is no glossary.

The response time of 3 months over the summer holidays is very short time for involving the public in major and complex health and social care change.

Response by email or letter for this type of consultation has serious limitations.

Response to Specific Questions

Board Membership and Composition

Do you agree with these proposals?

No

What further issues would you want us to take into account in firming up these proposals?

The 'Public Member' posts should be clearly defined by number and by role. This will enable the public to see a diverse representation of appointees and the prospective from which the individual may speak.

Only in exceptional circumstances should an additional member be appointed to the Board and this should be a short term appointment.

Board Secretary

Do you agree with these proposals?

No

What further issues would you want us to take into account in firming up these proposals?

Firstly, this kind of post should be in no way connected by location or salary to the Board, Hospital or Welsh Government. Independence means independence.

Secondly, what are the Public Board members for? If there role was clear they should be calling-to-account proposed actions of the Chief Executive.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes.

What further issues would you want us to take into account in firming up these proposals?
New and Improved Standards must be accompanied by Resources (frequently MONEY and STAFF) to meet the new requirements.

DO NOT REPEAT THE UNDER FUNDING OF CARE HOMES AND LOW PROVISION AND OUTCOMES IN SOCIAL CARE.

Quality Assurance in Health & Social Care seems much more difficult to achieve then in industry. The idea of major reliance on QA at the development end of services and reduced attention to Quality Control at the outcomes end is sheer recklessness in human services! Speedy and effective monitoring of ongoing care and outcomes must be in place.

In designing a Quality Assurance Plan (health & social care) knowledgeable members of the public, constituted in a formal body i.e. as at the Community Health Council must be able to use their knowledge and capability to review the proposals, suggesting change or providing approval for the plan.

Duty of Candour
Do you support this proposal?
Yes, I thought it already was!

What further issues would you want us to take into account in firming up this proposal?
A duty of Candour must be delivered to someone. That 'someone' must be specified as 1) a professional body, 2) a statutory independent publically appointed body. This will ensure professional standards are upheld and public representatives able to evaluate the quality and level of service provided.

Setting and Meeting Common Standards
Do you support this proposal?
Yes.

What further issues would you want us to take into account in firming up this proposal?

Scheduled reviews by joint professional and public bodies are absolutely necessary to the formulation of High Level Standards. High level standards will change over time; again, resources must accompany standards. Both are linked.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes.

What further issues would you want us to take into account in firming up this proposal?
One 'investigatory body' to receive complaints. The citizen to be supported by professional and voluntary advocates. A local and national appeal system must be in place. The Ombudsman system to be speeded-up in order to provide for quicker complaint resolution.

Representing the Citizen in Health and Social Care
Do you support this proposal?
No.

Can you see any practical difficulties with these suggestions?
Yes, cost, organizational and credibility issues.

Citizen voices already exist within the Community Health Councils i.e. county councillors, members of voluntary organisations, publically appointed members and co-opted members with special interest or experience of human services.

The community health council should be redefined by extended the role and scope both geographically and by social diversity. This would form an immediate Health &Social Care Council, upon an experienced base, to move forward into the future. Costs would be low i.e. redundancy, new organizational start-up costs, training, office space, equipment etc.

A citizen voice body should NOT be part of any existing inspectorate, governmental department or business organisation. It should be statutory, independent and able to call all service providers to account.

As health and social care in Wales is not a free market, the new citizen body must therefore be empowered to evaluate Quality Assurance and Quality Control from the citizen prospective, in order to avoid another Mid-staffs, Winterbourne View or Ely Hospital tragedy.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
No

What further issues would you want us to take into account in firming up this proposal?
Substantial change in health and social should be made jointly by qualified practitioners e.g. doctors, para medical personnel, social workers, academics etc. AND the new citizen voice body. All substantial change must be consulted upon with the publics' views taken indisputably into account.

Co-design and co-production by ‘the public’ will need citizen awareness of related issues, some understanding of current service levels and ability to see the future of a redesigned service. Training and costs will be involved. Particular client groups who ‘shout loudest’ should not be given a disproportionate share of resources.

The issue of CONSUMER CHOICE does not appear anywhere in this document e.g. which doctor to consult, where to have treatment, how to electronically exchange information, how to be informed of any tests, reviews or com[plaint along with access to medical and social work records. This is a shortcoming in any document relating to the future.

Inspection and Regulation and single body
What do you think of this proposal?

The objective outcomes of any proposal must be stated in order to measure if the outcome has been achieved. Common performance standards are therefore necessary for these organizations.

Are there any specific issues you would want us to take into account in developing these proposals further?
The role of Public Health is absent from this document. Public health plays a large part in producing health and well-being. In any future health and social care policy this should give this greater consideration.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
No

What issues should we take into account if this idea were to be developed further?
It is too soon to take this step.

Change by evolution is better than by revolution. Large organizations are not necessarily better than smaller organizations. Establish three satisfactorily functioning bodies, HIW, CSSIW and Citizen Body. At a later date consider blending the organizations together if any care, social or well-being advantage could be achieved.

WGWPMB72: Auditor General for Wales
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
In broad terms these proposals are welcome.

However, the proposal to refer to Independent Members as "public members" (in bringing the population's perspective to NHS board discussions) downplays their other crucial functions to contribute both business acumen and knowledge of good governance to the board. It also suggests a needless overlap with the stated role of Associate Board Members to address citizen representation. We therefore suggest this title should be re-considered to provide greater role clarity.
The proposed provision for Welsh Ministers to appoint additional, time-limited, Board Members during times of poor performance is useful, but we think that such a step could more usefully be considered at an earlier stage in the process. We therefore suggest that the provision be amended to enable such appointments to be made if the NHS body is forecasting or showing early signs of weakening performance, as this could assist in addressing issues before an NHS body actually enters the escalation process.

Linked to, and underlying both of these issues, is the primary need to ensure that Board appointees (irrespective of the interests they may be representing), collectively provide a balance of the necessary skills to run complex organisations. We would caution against any increase in the total number of Board members, as the existing Boards are already large.
What further issues would you want us to take into account in firming up these proposals?
Our external audit work across NHS Wales in recent years has identified a wide range of challenges at some health bodies:

- ensuring that Independent Members with the right skill sets are selected;
- unrealistic time allocations for Independent Member roles, given the complexity of business and volume of meetings;
- the simultaneous ending of the terms of office of many Independent Members, and the de-stabilising effects that this has on Boards and NHS bodies more widely; and
- the lack of designated ICT / informatics expertise on Boards.

Actions to help alleviate these issues could include giving Boards the authority to co-opt additional members to their sub-committees (underpinned by regular board self-assessments of skill set gaps), designating a Board level Chief Information Officer and establishing an all-Wales Board training and development programme.

We would also suggest that the role and responsibilities of the Local Authority representative Independent Member are enhanced to ensure they are better equipped to bring the perspectives of all local authorities in the population area to the Board, not just those of their 'home' authority.

Board Secretary

Do you agree with these proposals?

We welcome these proposals.

What further issues would you want us to take into account in firming up these proposals?

To ensure the Board Secretary's advice is independent and receives sufficient consideration, we suggest that lines of accountability for the Board Secretary role within the organisation should be explicit, and that the Board Secretary should report directly to either the Chair or Vice Chair.

Consideration should be given to requiring a Board Secretary to hold an appropriate professional qualification or accreditation (for example, the Chartered Secretaries Qualifying Scheme from the Institute of Chartered Secretaries and Administrators (ICSA)).

We would also suggest that the skill sets and experience of the current cohort of Board Secretaries should be reviewed to ensure that they are commensurate with the role that is envisaged within the White Paper and, where necessary, appropriate personal development and support provided to the post-holder.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

Proposals intended to strengthen the current arrangements for developing regional or all-Wales solutions to service design are to be welcomed, particularly where they are applied with a focus on wider public health rather than simply 'healthcare'.

However, there is a risk that the introduction of such a duty alone could be viewed as 'gesture' legislation that will add little to existing practice without more ambitious reshaping of the health and social care systems in Wales. We expand our thoughts further below.

What further issues would you want us to take into account in firming up these proposals?

Although the duty in the 2003 Act is not itself a barrier to joint planning and delivery, and in our view there are no current legal frustrations to collaboration, we can see the benefit of updating the statutory duty in order to provide both greater focus and clarity.

Keeping in mind the inherent tensions which face NHS bodies in trying to secure best outcomes for both their 'local' and the 'wider' population, we offer the following comments:

- The proposals will need to be clear about the population area that each NHS body would be planning and delivering for under the new duty. Currently there is mention of geographic Health Board populations, regional populations, all-Wales areas and the 'wider' population. Both the 'duties' and the 'area' to which each duty applies will need to be clear.

- Potential conflicts between the new duty and current duties (such as the first and second financial duties under the 2014 Act) will need to be explored and carefully reconciled.
- Legislation alone is unlikely to change behaviours. The proposals will need to be clear about the consequences of non-compliance with the new statutory duties, and those consequences will need to have some 'bite'.
- Collaborative working will be key, although disagreements can be anticipated where there are conflicts between 'local' and 'wider' priorities. Behaviours are strongly influenced by accountabilities, and so the reshaping of the performance management system (which currently focusses mainly on an NHS body's own acute provision) will be key to ensuring that the revised quality duty has the necessary leverage to secure the desired behavioural changes.
- The careful design of an integrated strategic planning and decision-making function could be key to alleviating much of the tension that so often exists at the local level. Consideration needs to be given to the shape of such a function at both the regional and the all-Wales level.

Duty of Candour

Do you support this proposal?

We welcome this proposal in principle.

What further issues would you want us to take into account in firming up this proposal?

The current proposals are not clear about whether the approach would follow a similar route to Scotland (i.e. to include independent healthcare settings and primary care contractors). We can foresee a risk that the proposals would be weakened if applied to too narrow a range of care settings. Clarity on scope would therefore be welcomed.

Setting and Meeting Common Standards

Do you support this proposal?

We welcome the stated intent to move on from the current model of health and social care standards in Wales. However, we suggest that greater clarity on the exact nature of 'the problem to be fixed' is required before firming up on detailed proposals for new standards.

In our view, this will require a broader consideration of 'what matters' in service delivery across both health and social care, to enable the development of a more coherent approach to defining, measuring and monitoring outcomes. It cannot sensibly be tackled in isolation from a wider reshaping of health and social care.

What further issues would you want us to take into account in firming up this proposal?

We would therefore welcome consideration of the following areas:

- As noted above, a clear explanation of the current problem is required. Is it a lack of common standards or inconsistent service quality? There is

considerable merit in considering ‘what matters’ on a wider scale, to ensure a wholly coherent approach to measuring ‘what matters’ in service delivery.

- Social care is moving away from a standards-based approach to one that focuses on what matters to individuals, including outcomes measurement from the user’s perspective. Given the emphasis on this approach in recent Welsh legislation, we would suggest this approach should also be central to considerations in the healthcare context.
- The wording of any standards needs to be unambiguous, and the standards need to be widely promoted to the people who use health and social care services. This needs to form part of an engagement strategy on what people can expect from these services, and also on what service users must also do themselves (i.e. the co-production debate).
- Consideration should be given to how organisations can meaningfully consider whether they are meeting the new standards, learning lessons from the current arrangements for monitoring healthcare standards and avoiding an overly bureaucratic approach which does not truly measure quality of care.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

The proposal draws sensibly on the findings of the Evans Report and offers potentially significant benefits for those who need to make a complaint involving both health and social care services.

What further issues would you want us to take into account in firming up this proposal?

In introducing such arrangements, care must be taken to avoid making the wider complaints system overly complicated and difficult to navigate. It must be clear how the new arrangements would interface with, or supersede, the current redress mechanisms for health services.

Introduction of a new ‘system’ will only go so far in making a complaints process meaningful. For it properly to support both appropriate redress and also organisational learning, it is vital that the health and care professionals to whom complaints are directed at are involved in the complaint handling process and response. There should also be a clear and deliberate commitment to having more patient-centred communications when responding to complaints (e.g. one complaint submission should be required and a single point of contact provided).

Representing the Citizen in Health and Social Care

Do you support this proposal?

Any proposals which remove unhelpful duplication of roles between Community Health Councils (CHCs) and other bodies such as Healthcare Inspectorate Wales are to be welcomed.

However, the proposals remove a statutory function aimed at giving the patients a voice and, as such, could be seen as a retrograde step in representing the citizen,

and potentially at odds with the ambition stated in paragraph 84 of “strengthening the voice of people…”

There are clearly some challenges with the current model (those highlighted in paragraph 82 would seem to be central to this), and so there are persuasive reasons for taking some fundamental actions in this area. At present, CHCs are moving from an ‘inspection’ to an ‘engagement’ model which, at face value, could address one of the key concerns about the current arrangements. The question then is whether the remaining concerns about the CHC model could be addressed by further reform to that model, or whether an entirely fresh approach would best serve the statutory function. We would suggest that both options should be given further careful consideration.

Can you see any practical difficulties with these suggestions?
For the reasons stated above, the proposals are likely to generate political and public concerns that the voice of the citizen is being weakened, rather than strengthened. Indeed, these are already starting to be voiced. If the proposals are to be taken forward, then there will need to be clear and persuasive argument to counter this view and to provide evidence that the patient’s voice will be heard.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
The proposal to obtain independent clinical advice on proposed service change is welcomed.

However, we would note that:

- Even in the face of clear clinical evidence, obtaining public support for changes to traditional models of service delivery can be very difficult and can slow down, rather than increase, the pace of strategic change. It is not clear how the proposals would help to address that particular challenge.
- Strong political support will be required if changes aimed at creating sustainable and safe clinical services are to be implemented. It is key that a clear picture of the context in which changes are being made is provided for politicians and the public.
- The aim set out in paragraph 95 to ‘place more emphasis on the importance of regional and strategic working’ does not appear to be addressed by what is essentially a change in process which would remain focused at individual NHS bodies. It would therefore be helpful to consider how the cultural and structural barriers to true regional and all-Wales service planning could best be addressed (see also our comments under 2.1 above).

What further issues would you want us to take into account in firming up this proposal?
As the paper states, it will be important to clearly define what is meant by “a substantial proposal”. That definition should cover the key factors which could make it such (i.e. impact on finances, staff resources, service delivery, activity, patient access, other NHS bodies, etc). This should avoid the risk of individual health bodies adopting their own classifications, especially where there is an understandable desire to more quickly to step 5.

Inspection and Regulation and single body

What do you think of this proposal?

We welcome the aims of this proposal.

Are there any specific issues you would want us to take into account in developing these proposals further?

In taking forward such a proposal it would be vital to be absolutely clear about HIW's core purpose, and to ensure that 'form follows function'.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?

Any move that strengthens the independence of an inspectorate function – either in perception or reality - is to be welcomed. However, we think it is highly questionable whether Welsh Government Sponsored Body status would achieve that aim. If genuine independence is desired, then we suggest that the creation of a new statutory body along the lines of Estyn should be considered.

Independence issues aside, the proposals of a merged body along the lines suggested in paragraph 110 should also be explored further, as there are potential advantages in terms of co-ordinating programmes of work, pooling expertise and also some potential savings in back office and support functions. However, we think that such a proposal is deserving of its own consultation exercise.

What issues should we take into account if this idea were to be developed further?

Whatever structural arrangements are taken forward, would be keen to see a clear duty for co-operation with the Auditor General for Wales (given the inextricably close link between use of resources and quality of care) and a duty of collaboration with CSSIW (particularly given the proposals regards Setting and Meeting Common Standards).

In practice, we note that this is already being achieved successfully through the aegis of 'Inspection Wales', and we consider that the proposals presented here should fit seamlessly into that model.

WGWPMB73: Social Services, Flintshire County Council
Location: Mold

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
We agree with the proposals.

What further issues would you want us to take into account in firming up these proposals?
A consideration should be given to having Directors of Social Services co-opted onto the board.

Board Secretary
Do you agree with these proposals?
We agree with the proposals in order to introduce an independent nature to the role of Board Secretary.

We also agree that there should be key principles to the role which will be applicable across all Board Secretaries in Wales to ensure consistency, but these should not restrictions innovative practice and change.

What further issues would you want us to take into account in firming up these proposals?
We would suggest there needs to be clear role definition between the Board Secretaries and the existing role of Chair and the Vice Chair of the Health Board

Duty of Quality for the Population of Wales
Do you agree with these proposals?
We agree with these proposals. All parties need to be involved in the development of these new duties and effectively communicated to staff.

We feel our Third Sector partners need a greater voice in the development of the duty and should be a key part of future legislation.

The duty to co-operation is already laid down within the Social Services and Well-being (Wales) Act 2014. To improve the Duty of Quality, their co-operative duties need to be more explicit and better enforced.

What further issues would you want us to take into account in firming up these proposals?
The new duties need to be communicated to the wider public, alongside the message that they are also responsible for their own health.

Service change should be influenced by the regional Population Needs Assessments in line with the Social Services and Well-being (Wales) Act 2014.

We also need to have clear guidance and procedures on governance framework to ensure the efficacy of arrangements when there is debate (e.g. decisions regarding CHC Funding where LAs and Health Boards cannot agree).

Duty of Candour

Do you support this proposal?

Yes – this is becoming part of a number of Welsh legislation i.e. Regulation and Inspection Act of Social Care and will promote open discussion. Recipients of services should be made aware of its existence if it is to have value.

What further issues would you want us to take into account in firming up this proposal?

None

Setting and Meeting Common Standards

Do you support this proposal?

Tend to agree. People receiving a range of services should be involved in the development of these standards to ensure they are easily applicable across the sector. Staff input is also essential to develop standards that staff feel they are co-produced and not imposed.

It is important however, to support these changes with additional resources to enable the person to receive the right care for them in line with their needs and wishes, and to prevent financial factors dictating the provision of care, to the detriment of the individual.

What further issues would you want us to take into account in firming up this proposal?

Those in receipt of care need to be made aware of these standards and they should be accessible in a variety of formats.

Consideration should be given as to how staff are skilled and equipped to achieve these common standards.

Emphasis should be placed on ensuring the brining together of standards does not diminish or dilute existing good practice.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

We agree with these proposals. We hope this will prevent citizens being passed between services and that they are able to resolve their complaint in a timely way and with minimal distress.

What further issues would you want us to take into account in firming up this proposal?

In order to investigate how a system may have failed, it will be important to clearly outline the ‘best outcome’ for the system. This may be difficult given the individual nature of care, but there must be a template in place against which a process can be

measured. It may be the case that a lot of work needs to take place to ensure there are processes in place, across an integrated system, to ensure a smooth passage of care.

A good working culture must be developed to enable this to work effectively. There is still much work to be done to decide the process if the complaint is upheld and how action will be taken to make improvements over a complex and wide ranging landscape.

Those undertaking the investigations must have a good understanding of services across the health and social care sector.

There must be provision for advocacy services to support people through this process and a clear route identified to access Advocacy Services. This needs to be backed up by a clear understanding of the funding arrangements for advocacy.

Representing the Citizen in Health and Social Care

Do you support this proposal?

There are concerns that with the loss of the CHC will mean the loss of the skills and experiences of the volunteers, many of whom have been part of the Health and Social Care workforce throughout their lifetime and have a valuable role to play in scrutiny and improvement of services. There is a need for this wealth of experience of scrutiny and improvement to be retained.

The citizen's voice needs to be very local, representing towns and communities. It needs to have strong local connections and visibility within the community and is already referred to within the Social Services and Well-being (Wales) Act.

There is also concern on the links made with the Scottish Health Council, who have recently been criticised by some Members of the Scottish Parliament within the Health and Sport Committee as not being independent enough of Government and not being value for money. Lessons must be learnt from these examples to ensure any changes to the CHCs in Wales leave citizens with the opportunity for a true independent champion. It is also our understanding that the Scottish Health Council do not have the same right to access health facilities that the current Community Health Councils have, which is a further concern.

The new arrangement needs to be effective in the development of future citizen engagement for the development of regional Population Needs Assessments and area plans.

Ensure existing, well-performing, 3rd sector arrangements are considered as part of this work and not disregarded.

Can you see any practical difficulties with these suggestions?

If the new arrangements are in place, resources should be allocated equitably across regions to ensure the same level of investment across Wales and ensuring North Wales is well served, with regional office and presence.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

There is a need for local citizens to be involved at the outset of any substantial service changes decisions and not just one decisions have been made and are to be consulted upon.

We agree that there should be steps in place for planning substantial service change and to ensure that people's voices have been included in the process.

What further issues would you want us to take into account in firming up this proposal?

We must, however, not lose sight of the fact that a small change may have a substantial effect on the life of a small number of people, and that processes should also be in place to ensure that their voices are heard.

All parties must adopt and work towards an agreed set of participation standards. We suggest using the Principles of Citizens Engagement and the National Standards of Participation for Children and Young People in Wales.

We also suggest guidance and clarity be taken to agree a statement or definition on what co-production means and the difference between other levels of engagement, which should also be valued.

It is important that mapping takes place to ensure that any new citizen voice body links in with the wealth of groups who represent people locally. In North Wales, some of this mapping was achieved through the engagement process of the development of the North Wales Population Needs Assessment. Links can be made with local youth forums and looked after children's Groups to ensure they are included in the decision making processes.

Inspection and Regulation and single body

What do you think of this proposal?

We agree with the proposal to bring HIW in line with the structures put in place by the Regulation & Inspection of Social Care Act.

Does this go far enough? Should CSSIW and HIW come together?

Merging of the Inspectorates would need to be completed mindfully to ensure the highest possible standards are adopted and that the standards are not brought down to the lowest common denominator.

Consideration should also be given to how the actions and accountability following inspections is driven through. How all parties are held accountable for their actions? This could form part of the work of the Board Secretaries as an independent scrutineer.

Are there any specific issues you would want us to take into account in developing these proposals further?
None.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
Yes, in principle.

WGWPMB74: Motor Neurone Disease Association
Location: Northampton

Response to Specific Questions

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes.

Duty of Candour
Do you support this proposal?
Yes.

Setting and Meeting Common Standards
Do you support this proposal?
Yes.

What further issues would you want us to take into account in firming up this proposal?
The Association recommends that the common standards and requirements are designed to also meet the needs of those with rarer conditions. It is also important that they can be applied in instances where people living with the same condition will have different needs, as is often the case with MND. Despite being progressive and terminal in all cases it will affect people living with it differently.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes.

Representing the Citizen in Health and Social Care
Do you support this proposal?
Yes

Can you see any practical difficulties with these suggestions?
The Association welcomes the Welsh Government's intention to further strengthen the user voice in how health and social care is planned and delivered in Wales. The Association believes there are a number of considerations the Welsh Government must make when pursuing the initiative to create a new arrangement to supersede Community Health Councils (CHCs).

The Welsh Government must ensure any new process and body assigned to it represents the voices of those with rarer conditions. We have concerns that a national-level arrangement may lead to a system that dwarfs the voices of those with less common conditions.

It must also take this opportunity to identify and embed new ways of interacting with patients to obtain user voice in a meaningful and accessible way, particularly to meet the needs of those for whom existing methods are often inaccessible or who are unable to have their say without significant support. As a severely disabling and rapidly progressing condition people living with MND will struggle to participate in traditional methods of user voice engagement for a variety of reasons, including but not limited to having a significantly limited life-expectancy, having greater difficulty in getting to and participating in focus groups, and in many instances having significant communication difficulties through loss of speech. The Welsh Government should take this opportunity when establishing a new arrangement to review and amend its engagement strategies, including digital and remote engagement, to meet the needs of this group. Only considering the views of those with the ability and capacity to engage with existing engagement methods will not be representative of the wider patient voice.

The Association notes that the Welsh Government has set out an ambitious remit for a new national arrangement as detailed in paragraph 84, including for it to be nationally and locally focussed, flexible and able to look at the whole system and work jointly with partners. To realise these ambitions, the Association recommends further ongoing consultation beyond the White Paper to determine the structure of the body, how this interacts with those that already exist and that enough resource is dedicated to it to meet these expectations. To not do this runs the risk that more organisations are being created without ensuring that they and those already in existence are fit for purpose, avoid unnecessary duplication and are sufficiently resourced.

Finally, the Association believes there are a number of opportunities within the new arrangement for other agencies collecting user voice to be included. From an MND perspective, this could include formalised engagement with Neurological Service User Forums that might soon be established by the Neurological Delivery Plan for Wales. It is important that a new arrangement allows for opportunities for organisations working directly with patients to feed-up into the user voice process in conjunction with a top-down approach. The Association would like to see the Welsh Government set out further how the successor body can be accountable both to citizens and their elected representatives, ensuring it will be an effective actor in the public interest.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

Yes

What further issues would you want us to take into account in firming up this proposal?

The Association agrees with the principle that proposals for service change will likely have a greater chance of success if they are co-designed and co-created by citizens. Our issues for further consideration echo those detailed in our response to the questions in section 4.1, above all that the process is meaningful, not tokenistic and takes into account the views of people who have a rarer condition and those who

struggle to engage with traditional modes of engagement, including some people living with MND.

Of critical importance but not limited to people living with MND, is the need to make specifications going forward that all new proposals requiring patient voice are available in easy to understand language. Whilst people living with MND will be best placed to comment on their experiences and needs, it should not be assumed that they will be experts in understanding the health and social care system in Wales and understand the wider implications of proposed changes. We would recommend the Welsh Government commit to ensuring that future engagement in this area is underpinned by measures to ensure it is understandable for citizens.

In terms of the decision-making process for future proposals, the Association believes that “adequate involvement of the public” as detailed in paragraph 100 needs to be defined and agreed on. Being left open to wide interpretation runs the risk of sub-standard or tokenistic engagement becoming standard procedure. It is also unclear as to the level of weighting that advice from the proposed new citizens voice body will have. The Association would also welcome further clarity about what the accountability process is if the continuous engagement requirements are not being met.

Inspection and Regulation and single body

What do you think of this proposal?

The Association agrees with the statement made in paragraph 108 of the White Paper that there is not a strong appetite to merge the two inspectorates and make them legally independent at the moment. However, an overhaul of the legislation underpinning HIW to give it a more robust framework to work to would be welcomed.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?

As mentioned in the previous sections of the Association’s response, we would recommend the Welsh Government consider the overall effectiveness of introducing new bodies as opposed to ensuring those that already exist are fit for purpose. It is essential that patient voice is strengthened rather than diluted as a result of these proposals. Whatever the new arrangement, robust accountability and monitoring structures need to be in place.

WGWPMB75: Diverse Cymru
Location: Cardiff

General Comments

Diverse Cymru engages with diverse citizens across the protected characteristic groups and represents their views and solutions.

We ran an engagement group in August 2017 specifically related to this White Paper. At the event we gathered experiences, views and recommendations from 14 citizens. Older and disabled people were particularly well represented in the group. These views have been added to views previously gathered through a series of engagement and co-production events engaging over 40 citizens across the protected characteristic groups and service users of our direct payments support, BME mental health support, and advice services. This response is based entirely on those views and experiences. We have included some direct examples of citizen's lived experiences in yellow text boxes.

We are happy to provide the full notes of the August engagement events and health and social care papers if this would be of assistance.

We would welcome any opportunity to be further involved in the implementation of proposals from the perspective of maximising contributions to lived experiences of equality and human rights through service design and delivery.

Response to Specific Questions

Board Membership and Composition

Do you agree with these proposals?

We broadly agree with these proposals. However, we feel that it will be essential to ensure that diverse citizens and representative organisations are actively involved in health boards and NHS trusts and that the wide-range of health services are represented through clinical staff. Participants at our focus groups felt that shared principles around openness and transparency, co-production with citizens as equal partners, and fully individualised care and support should be at the heart of health boards and NHS trusts.

What further issues would you want us to take into account in firming up these proposals?

Participants felt that Boards should be required to have both third sector and citizens' representatives on them. They felt that currently the role that third sector services can play in promoting health and wellbeing is often overlooked. Having a role on health boards and NHS trusts directly would assist with this and with reaching wider and more diverse citizens. Citizens' voices are also essential to good decision-making, and should therefore be represented at all levels and on all committees and bodies.

They felt that ensuring service user experiences are taken into account within health boards is important. Those alternative perspectives of what service changes mean to service users are vital to good governance. A wide-range of professionals should be there at all levels, but also able to take decisions and implement changes. Health Boards need to work closely with the service user/citizen panels and new body. They also felt there should be representatives from all departments/services from GPs, community nurses, and pharmacists to tertiary care. There needs to be financial expertise there too at the table to explore options not discuss solutions and then have financial considerations undertaken outside the board only. They need to be able to co-opt people to help with specific issues. Every professional representative should have a deputy to ensure there is always broad clinical representation at meetings.

Participants felt that health boards and NHS trusts should focus on what can be done and co-producing solutions, including the technology to make it happen viewed through the lens of meeting the needs, wishes and outcomes of each individual. Comprehensive equality and diversity training, including the needs, wishes, outcomes and experiences of each protected characteristic group and sub-groups, is vital to ensuring that health services can maximise their contribution to delivering a fair and equal Wales and addressing health inequities.

Board Secretary

Do you agree with these proposals?

We agree with the proposals. We particularly welcome the protection to ensure that the Board Secretary is able to raise concerns. In implementing this proposal, we feel that there should be a requirement for the Board Secretary to take representations and views from citizens into account. These representations should inform concerns raised with the health organisation to embed the principle of all services being designed around the needs, outcomes and views of citizens and improving the experience of all citizens.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

We broadly agree with these proposals. In particular, we welcome the focus on collaboration across local authority and health board boundaries and working across organisations. We feel that new duties must include identifying and addressing health inequities based on protected characteristics. Given the lack of statistical evidence in relation to some groups, especially LGBT people, Gypsies, Roma and Travellers, and refugees and asylum seekers, it will be essential to ensure that improving quality can be based on qualitative evidence. Citizen experiences and stories are a vital source of evidence for improvements to services which can address inequities in services provided, access to services, and appropriateness of services. The duty should also expressly support co-production with citizens, including citizens from each protected characteristic group and sub-group, to design, develop and implement services which meet the needs, wishes and outcomes of all of the population of Wales.

What further issues would you want us to take into account in firming up these proposals?

Participants in our focus groups felt that a statutory reciprocal duty ensuring that local authorities and NHS bodies work together is only a first step. They felt there is a need to develop a new system where NHS bodies involve primary, secondary and tertiary health services together, centred around patient outcomes and wishes. They felt that the role of community pharmacies in providing health services should not be overlooked.

They also felt that multi-disciplinary teams should be established as the normal way of working. These should go beyond health and social care and involve education, transport, housing, benefits, leisure, support workers, community groups, third sector organisations, advice providers (e.g. CAB), early years and childcare services, and every service that can support people to live the life they want to live and achieve their personal outcomes. They felt that this can save money by improving people's quality of life and wellbeing.

They felt that the third sector needs to be given a voice and become part of service provision for individuals, with referral mechanisms in place and appropriate funding. Services should have a prevention focus, including preventing health conditions deteriorating.

They also expressed that service users, especially those from protected characteristic groups, should be directly involved in services working together and at all levels and stages of service design and delivery, not just through a new citizen's body. They felt that any duty of quality must recognise the range of services and the role of citizens.

They felt there should be a single point of contact for all services and active referral mechanisms between services and groups, including third sector organisations and supporting self-referral.

Participants felt that quality standards and measures should be focused on meeting an individual's outcomes and outcomes of local populations and population groups. They stated that quality for them includes the following features, which should be built into the proposed duty of quality:

- Seamless services from GP to referral to secondary and tertiary care to social services all in place and getting organised, not delays, being left without appropriate care or support or having to make appointments or find services yourself.
- Avoiding unnecessary hospital visits or admissions by linking with social care, occupational therapists looking at the environment etc.
- Avoiding criminalisation, like police involvement for mental health crises. Having links directly with specialists in mental health in A&E. Making sure A&E nurses are trained in mental health and are supportive. Links and pathways into and out of hospital and an entire package of care designed around the individual.
- Not being discharged without support being in place, ways to get home arranged, not assuming family will be carers. Not being discharged in the middle of the night with no transport and no support. This was felt to be particularly common in mental health settings. Ensuring people have a number to call if they need further support after hospital discharge, including one that is available 24 hours a day.
- Having interpreters available when needed.
- Being listened to.
- Communication needs being met.
- Diversity and mental health understanding from all staff.

- Trained receptionists – not broadcasting the details of someone's health condition from a telephone call, compassion, mental health understanding. One participant said they were in a queue at a GP surgery when the receptionist took a call and she could hear the receptionist repeating all the medical details of the condition when booking an appointment and the full name. She has gone in to book an appointment for her daughter who couldn't get through on the phone. The receptionist finished the call and she when asked by the receptionist 'can I help you?' said 'that's alright, I wanted to book an appointment for my daughter who couldn't get through on the phone, but you've just done it.' The receptionist looked shocked, but said or did nothing.
- Friendly and approachable staff at all levels who are good communicators.
- A degree of humanity and not detachment in all services.
- Explaining things to patients in plain language, next steps and reasons why etc.
- A welcoming environment, including different languages, diverse imagery, comfortable settings, inclusion, leaflets etc.
- Drop-in centres with people trained in all sorts of different issues e.g. mental health, diet, keeping active, community groups, benefits, advice, advocacy with social care and physical health.
- Accountability.

Duty of Candour

Do you support this proposal?

We support this proposal. Participants in our focus groups have repeatedly stated that a lack of openness and transparency around services and proposed developments is a significant barrier to them expressing their views and proposing solutions. This duty of candour should include publishing background information to all services and proposals in accessible formats and linking with citizen engagement to ensure that the interests of diverse citizens in Wales form the core of all health and social care improvements and service developments.

Setting and Meeting Common Standards

Do you support this proposal?

We agree with the proposal to set common standards across health and social care services and settings. We welcome the proposal that these standards should focus on supporting each person to achieve the outcomes they desire and live the life they want to live.

Given the proposed citizen focus of these standards we feel that directly engaging citizens, including specific citizen groups for people from each protected characteristic group, and co-producing standards with citizens will be essential to ensuring standards are perceived through the eyes of the person receiving care.

What further issues would you want us to take into account in firming up this proposal?

Participants felt there should be one set for both health and social care as core standards, but different clinical/service standards for each service.

They felt that core standards should be based on person-centred, individualised services and what each person wants to achieve out of life. What people want and their outcomes need to be important to what clinical options they are offered. What may best treat a condition may not fit with that person's outcomes.
Participants recommended some of the standards they feel are important to delivering person-centred services which meet the needs and outcomes of diverse citizens:

- Including equality and diversity in everything any health or social care professional or service does
- Respecting and including different experiences
- Being able to deal with people from all backgrounds and walks of life to a high standard and tailored sensitively for everyone
- Making sure they're giving the correct information
- Do no harm (duty of care)
- Do not talk in medical/social care terms, but Plain English
- Clarity of purpose
- Not assuming that certain conditions only affect certain groups of people, because they tend to (e.g. early onset dementia affects younger people, but dementia tends to be seen as older people only.)
- Consistency – same quality every time in every place
- Information sharing between services and IT systems which can support effective, person-centred service delivery
- Appropriate treatment/care for the individual, not generic
- Listening to patient views and taking active account of patient choice
- Focusing on what people what in their lives (outcomes) and how they can achieve it, not purely medical or care models of service
- Not focusing on numerical targets, but on outcomes targets. Numerical targets can be contradictory to what is best for an individual and their own wishes and outcomes
- Ensuring standards are enforced

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

We support this proposal. Participants in our focus groups stated that having the same complaints process and joint working between health and social care would help address complexity in the current systems. However, this also needs to include changing the processes to be more accessible and easy to use. Complaints processes also need to be more flexible and include verbal concerns and complaints.

What further issues would you want us to take into account in firming up this proposal?

Participants felt that both the health and social care complaints processes are hard to access and use. They felt you need to know it well to be able to use it. It takes too long. The language used 'complaints/concerns' is off-putting. Having to submit complaints in writing is inaccessible and does not help solve problems early. Some participants had experience of being told there is a complaints/concerns policy, but

not being offered a copy or having the process explained when trying to make a complaint.

A quicker resolution to verbal complaints and trying to solve problems when first mentioned would help. Staff in health and social care services need to take account of issues when first raised verbally or at the time informally, not just formal complaints/concerns. Attitudes need to change to see complaints as part of improving individual care, not a negative against them.

Complaints processes should be standards-based. People should be able to explain what went wrong for them and why their care doesn't meet standards in their own words. At the moment if feels like you need to know everything about how a service works to complain about it without being dismissed or not taken seriously.

It is important that people understand the process and the language and It must be easy to complain when needed and flexible enough to be accessible to everyone. We need to get away from the blame culture from both citizens and staff so staff can focus on improvements and resolutions and making services better.

There needs to be clear, Easy Read and Plain English information on processes, timescales, and what will happen with a complaint and scrutiny throughout. It should be an organisational process not just falling on a complaints/concerns officer or team.

The burden of proof should not be entirely on the patient and process other than in writing need to be accepted. Some participants felt that the current system makes them feel like their own experiences are being questioned by the way the process works.

Organisations should be clear about where feedback forms/surveys etc. go and what will happen with the data so people are assured it is anonymous, but will also improve services.

Participants' experiences included:
My mother passed away five years ago. I wasn't happy with the way she was treated. There was totally inadequate information. It was difficult because when she passed 6 weeks later, the doctor was not surprised and said then she had had no chance. We knew she was ill, but if we knew the time she had left we could have made the most of it and done things different. I raised a complaint, which was upheld. They committed to change the way nurses and doctors are trained and in some cases, retrained and to provide clear information and leaflets. Once I was told what they were going to do I never heard from them again, I wasn't given any information on whether they actually did it.

Representing the Citizen in Health and Social Care
Do you support this proposal?
We broadly agree with this proposal. We feel that an integrated health and social care system requires integrated citizen engagement and co-production to ensure that voices are reflected in all service developments. However, we have a number of

concerns and diverse communities at our engagement groups have expressed several recommendations for the future of co-production and citizen involvement in health and social care in Wales. These are outlined below.

Can you see any practical difficulties with these suggestions?
Participants felt that there are some issues with CHCs, especially not linking health and social care together. However, they emphasised that CHCs have been vital to their ability to make complaints and receive responses, and that a citizen-led body is important to ensuring their voices are not overlooked. They strongly felt that any new body must be citizen-led and not dominated by professionals and have the ability to raise concerns and have them acted upon.

They also felt that the role of the CHC in supporting citizens to make complaints and ensure they are acted on should be strengthened rather than lost.

One participant fed back their experience of being on a citizen's panel. They stated that every area is supposed to have a citizen's panel. It is not happening, even though it should have happened under the Social Services and Well-being (Wales) Act 2014. These are supposed to be led by citizens, including the topics for meetings, speakers to invite, information etc. being suggested by and decided by citizens from a blank sheet of paper, not just being consulted on already formulated plans or consultation documents. They need to be accessible, conducted in plain language not assuming clinical knowledge or terminology and be used for proof reading patient information etc. One area's citizen panel is only being engaged through online surveys. There must be a variety of engagement methods to involve all users and all backgrounds. People in local authorities are scared of them and the views coming out of direct citizen experiences. Some other participants had been on citizens' panels, but felt they were not heard and left. They raised issues with a lack of diversity on these panels in terms of BME people and other equality characteristics, as well as being dominated by former health professionals. Participants agreed that any new citizens' body should be fully citizen-led, accessible, in plain language, and utilise a wide-range of engagement methods.

Participants also raised concerns that the public appointments process presents a significant barrier to getting involved for many citizens with valuable experiences to share. They felt that the process is the main reason why the same people stay on CHCs for years and why there is a noticeable lack of diversity.

To address the lack of diversity they felt there should be a clear and explicit requirement to involve a wide and diverse range of service users and reach beyond the usual voices written on the face of any legislation or policy governing the new citizens' body.

To address the issues with current CHCs involving only the same people participants felt that the new citizens' voice body should be brand new, not formed out of the CHCs. It needs to be user-led not clinician led. There needs to be scope for everyone to get involved and people shouldn't be able to stay on smaller committees and groups forever. It should be broad and joined up between services. They also felt that expenses must be reimbursed, to address economic barriers to participation for some groups.

It needs to be easy for people to get there for example facilitating car sharing arrangements and linking with community transport as well as paying expenses. There also needs to be specific efforts to involve seldom heard groups, like Gypsies, Roma and Travellers, and Refugees and Asylum Seekers.

Participants felt that there needs to be power behind the involvement not just recommendations. They recommended that organisations should be required to prove they have taken citizens' views into account and justify when something has not been taken forward. The body needs to be able to stop bad practice. Results also need to be fed back to the citizens' panel so they see the difference their involvement has made and can challenge when voices have been overlooked.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

We broadly agree with this proposal. However, the new citizen voice body will only be the appropriate body to represent all citizens if our recommendations above on improving diversity and accessibility, and ensuring that all citizens who want to be involved are involved are implemented. We also feel that direct citizen engagement, including engaging people from all protected characteristic groups and sub-groups specifically, is vital to co-production and ensuring services are designed and delivered around citizen outcomes and wishes.

What further issues would you want us to take into account in firming up this proposal?

Participants felt that they generally aren't very involved in designing and delivering health and social care services. They felt that engagement meetings and co-production projects run by third sector organisations are giving them a voice now, but there is a way to go to get a direct voice in every local authority, LHB and NHS Trust. They felt they had opportunities to influence more than others, as they get invited to consultations and events and know how services work. However, they felt they are still being consulted on proposals that have been developed only by professionals, rather than involved in co-producing services.

They felt it is almost impossible for most people to get involved without first being trained. They felt that training in understanding public sector organisations and how services works should be proactively provided to diverse communities, to encourage a more diverse group of citizens to get involved. This would need to be funded. Participants felt there is a brick wall when you go to services. Professionals need to give the power to the people. Professionals are shocked when you challenge them or are articulate on important issues, throughout the system from bottom to top. Leaflets, information etc. help people to take some power back.

One participant had experience of a scrutiny committee involving the head of services and solving a complex issue by working together. This worked well as citizens were listened to. They felt good examples of co-production should be promoted more across the public sector to showcase the benefits in practice. Participants felt that involvement is changing significantly for the better now and moving more towards co-production. They felt that organisations are starting to understand and support coproduction actively. In the past they felt that co-production

was seen as just being a representative and having a say only on low-level issues and decisions and they were frightened of co-production. Now people at the top of organisations are starting to understand and embrace the idea of citizens as equal partners in designing services. Several participants had recent experiences of being on committees and panels with more of an attitude of listening and asking people what would make things better for people, their solutions as community members now. However, they felt it will take time to cascade through organisations.

Participants felt that there is an assumption that older people are not competent to understand their care and needs or how it works. They felt this is prejudice-based. One participant had experienced a doctor talking to her daughter in-front of her and not directly to her. When she challenged and said she makes her own decisions the doctor was very affronted by that.

Participants also felt that health boards, social care and other services need to work together to gather and share citizen views and experiences. They felt that each organisation asks the same people for their views on very similar topics without working together. Joined up engagement could gather richer and more in-depth experiences whilst still gathering views on specific changes, policies, or proposals. Engagement should also not rely on having to read a consultation or other document first. For some people even when Easy Read and other accessible formats are provided they still can't engage this way.

Inspection and Regulation and single body

What do you think of this proposal?

We agree that closer joint working between HIW and CSSIW is vital to implementing and regulating an integrated health and social care service in Wales.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?

We do not feel that the citizens' voice body should be part of the inspectorate system. We feel that this would misrepresent their role as one of reviewing quality and standards, rather than proactive engagement and co-production. Involving diverse citizens and ensuring that all citizens are supported to get involved and have their voice heard should be a core function of all health and social care services. The new body should support this development and act as a conduit to both diverse citizens and the wider representative third sector. We feel it should be entirely independent of health and social care services, but also feel that it should be independent from inspectorates.

Further Comments

Most of our focus group participants had experiences of different parts of the health service not communicating effectively and not working well together. They also had experiences of being discharged from hospital and not having necessary social care, or aids and adaptations in place.

They felt that a lot of information and leaflets is provided to people when they are diagnosed with health conditions, but direct links with social services or community services is often missing. They felt that being referred to an independent advocate to help navigate health and social care services is vital.

Participants felt that everyone should be seen and linked to services in the community and at GPs surgeries when they are discharged from hospital and health should connect directly with social services. They felt the biggest problem for people is being passed around and all services saying that's not our problem or not our budget. There is no direct referral to the services who can deal with an issue someone has. They have to phone around and find out for themselves. They felt that services working together and focusing on the individual's wishes and outcomes not only supports the individual to live the life they want to, but also reduces costs by preventing unnecessary hospital admissions, crises and deteriorating health and wellbeing.

An example was given of how services do not currently refer and connect well:
One participant had a neighbour who was diagnosed with cancer and needs a lot of incontinence pads and they didn't know where to go. They phoned one number, got told to phone another organisation, then another then was told they need to be assessed. They asked for the assessor to bring incontinence pads with them and were told they can't do that at the assessment. She's 85 and needs 10 pads a day, her son, who's 55 has to get them for her. Why can't all the services be together in one place?

Another participant had experiences of delayed discharge, due to adaptations not being in place. They felt this needs to be addressed as part of a seamless, integrated health and social care service.

Experiences of a lack of service integration around discharge from hospitals was particularly common amongst our participants.

One participant was in hospital and had a fractured hip pinned. The hospital were keen to discharge them as soon as possible and they were happy to go home, except they live in an old house and that was an issue so it was delayed. There was also a delay between the date of discharge and referral to physio, which delayed recovery. The ambulance almost left them at the gate to their property and they had to insist that they were taken into the house, as they couldn't do it without help. There was no discharge planning and a significant time lapse between discharge and receiving community services.

One participant had a friend whose experience of discharge was dangerous:
An elderly couple both in their 80s – the wife needed an operation which was postponed 3 times. It became an emergency and her husband was told he would get support and equipment when she came home. She came out of hospital with no assessment and no equipment, just a number she had to ring to arrange community services. She was on oxygen due to an incident in hospital and he was given just a quick instruction on how to use it at home. He had it far too high and she was getting far too much oxygen. Their daughter came round to check they were OK and found this out and adjusted it. She rang the district nurse to find out when she was coming

in, telling them about the oxygen incident, and they had a visit 4 days later. The wound also needed looking at and no-one was looking after her. They tried ringing the community team and were told there was a two week wait for an assessment. They just wanted rails so she could shower in the morning and it took 6 weeks for them to actually come out. This was not a safe discharge and should never have happened.

One participant had a really good experience of services working together and getting what they need:
Velindre took over my care and I was asked whether carers allowance would be useful. I said no, but Velindre sent me information about carers allowance and help I could get. I changed my mind after looking at the information and got all the equipment, rails etc. I needed very quickly. It seems that cancer pathways have got the right idea with everything linked up and done quickly. They [cancer care] realise that social care needs to be in place very early and easily. That way of working should be replicated elsewhere.

Other participants agreed with their experience of cancer care pathways being more effective in linking both public and third sector services and linking tertiary, secondary and primary care with social care and community services. They that the model of integration for cancer care pathways should be explored as the basis for further health and social care integration.

Some participants mentioned the new service model for the ambulance services as a model of good practice. This is where ambulances do not always take people to hospital now, but link in with advice, nurses, Occupational Therapists etc. This links well with support for falls – looking at the environment, contacting GPs, linking with other services etc. Many people fear if they fall and go to hospital they will end up in a care home and they do not want that. Options need to be available in people's homes for integrated support.

Participants felt that there should be coordinated pathways focused around the individual and their outcomes across services. They also had experiences of barriers and delays to accessing health and social care services based on who pays for what. Aids/adaptations and care and support need to be right for each individual, not available based on which organisation the funding is coming from.

Participants felt that they aren't being offered choices, especially in healthcare. They felt that treatments and even moves to care homes are forced on them, as other options are not explored. They felt that co-production will not be effective until health and social care practitioners are trained and know how to involve individuals as the experts in their own conditions, wishes and outcomes.

One participant had an example of someone being forced into a care home against their wishes, as there was no recognition of innovative models of support:
Someone I know is a double amputee and can't use an electric wheelchair or some machines, as they failed the test and don't have the strength in their arms. They were forced into a home, despite the fact they had people around them who were willing and able to be carers and support them (not family, but friends.) Their own home was sold to pay for it, without their consent. They had no voice and no choice

in this process and no options were given. They were forced into a care home because they couldn't use one piece of equipment. There was no consideration of whether friends could provide the care and support he needed.

Mental health and wellbeing

Participants felt that mental health and wellbeing are particularly left out when planning joint services. They felt that it's important to see the right people at the right time. There are service gaps, especially in mental health. Young people are becoming carers with no-one knowing and without them having any support. People with mental health conditions often won't involve social services if they have children, as they're worried their children will be taken away. It snowballs as there is an impact on the young carer. A more supportive environment that encourages young carers to find support in school is needed. The term 'social worker' still has stigma attached to it. We also need to change the language to change the concerns. having children's support officers rather than social workers would help this.

One participant gave an example of working with people with mental ill health who are discharged with no support and their language needs are not met in hospital:
I worked with a 50 year-old woman. She had financial problems and mental health problems. She had a mental health crisis while at the Citizens Advice Bureau seeking help. She went into hospital and then she was discharged with no after care or support. I was sat in a multi-disciplinary meeting about her. They couldn't put it together to even organise an ambulance. She had a 21 year-old son who became her carer. She had no care or support plan. She had comorbid conditions, and doctors were only referring her to pain management. They had no family to support them. They moved to Cardiff as refugees. There were no support structures available to them and this is when the social and health support is really important. When a crisis happens, it can all become a mess. They were isolated, spoke very little English, had no trust in the system, and were confused. Add this to the guilt of the mum about having a crisis, and the guilt of the son in being unable to help her. Where are people's choices? What options are there? How do professionals interpret people's available choices? This needs to be addressed.

Participants also raised issues with health and social care being reluctant to look at an individual's circumstances as a whole. Thy felt that this is particularly concerning in mental health services, where housing, debt, isolation, discrimination or other factors are often the underlying cause of issues. They felt that if their illness is a consequence of where they live, you're just firefighting unless you address it properly.
An example of this was given:
I was supporting a young person who tried to commit suicide because of the debts he had accrued. Citizens Advice Bureau really helped - helped him find a job, helped him with debt collectors. And he is doing better now. But if you want to prevent this person experiencing another crisis, you can't do it without looking at his circumstances. It was the debt advice and liaison which supported him to improve his mental well-being, not direct mental health services.

Recommendations

In summary, based on the views and experiences expressed above diverse communities recommended:

- Independent advocacy should be available from the point of diagnosis to support people to understand and manage their health condition and navigate health, social care and community services.
- Services should work together automatically. Once an individual is diagnosed with a health condition all relevant services (public and third sector, and including housing, advice, transport, community support, education and wider services than health and social care) should come together to maximise contributions to their health and wellbeing in a multi-agency approach.
- The success factors in the cancer care pathways should be explored as a potential model for effective multi-agency pathways in future.
- A single point of contact for all services and active referral mechanisms between services and groups, including third sector organisations and supporting self-referral needs to be established in each area of Wales.
- Diverse citizens must be actively and directly involved in service design and delivery on all committees and boards and at all levels, not only through a new citizen's representation body.
- Training in understanding public sector organisations and how services works should be proactively provided to diverse communities, to encourage a more diverse group of citizens to get involved.
- Professionals at all levels and all services need to give the power to the people. Choices need to be offered to citizens in their own health and social care services. These need to be explained in plain language. Citizens need to be respected as equal partners in their own health and wellbeing.
- Comprehensive training in the benefits of co-production, explaining choices to citizens, and each protected characteristic needs to be provided to all health and social care professionals.
- There should be a clear and explicit requirement to involve a wide and diverse range of service users and reach beyond the usual voices written on the face of any legislation and policies governing the new citizens' body.
- Appointment to citizen's panels and the new representative body must be by a simple process, not public appointments.
- The new citizens' representative body must include mechanisms for all interested citizens to get involved and present their experiences and views.
- A wide variety of engagement methods must be used by health and social care organisations to ensure they reach all interested citizens and proactively address barriers to engagement for people from different protected characteristic groups.
- Organisations should be required to prove they have taken citizens' views into account and justify when something has not been taken forward and feed back to citizens.
- Health, social care and other organisations should join up their engagement and consultation to gather more in-depth experiences and engage accessibly.
- The quality duty should also expressly support co-production with citizens, including citizens from each protected characteristic group and sub-group, to design, develop and implement services which meet the needs, wishes and outcomes of all of the population of Wales.
- Citizens, including diverse citizens, should lead the development of common service standards and the duty of quality.

- Complaints processes must be flexible, accessible, and easy to understand and use. Citizens need access to independent advocacy to support them to raise concerns and complaints.

WGWPMB76: St John Cymru-Wales
Location: Cardiff

General Comments

St John welcomes the Welsh Governments proposal to strengthen legislation around health and social care in Wales; in particular we are very pleased to note that Health Boards are to be encouraged to enhance their current partnership working.

However, we would like to highlight that new innovative ways of working, with meaningful involvement of the third sector is the key to long term improvement and legislation must help facilitate that whilst being careful not to obstruct it. This will ensure that the third sector has a strengthened role in ensuring a 'complete pathway' approach for patients across the health and social care sectors.

Response to Specific Questions

Board Membership and Composition
We agree with the proposals contained within the document, although we cannot perceive any advantage of changing the name from independent to public members.

We are aware that health boards already appoint third sector independent members but In addition to these changes we would like to see greater encouragement for third sector involvement, with all Boards required to produce a regularly updated matrix identifying the ways in which it works with the third sector to improve outcomes for the public.

Board Secretary
We agree in principal with the proposal contained within the document. There is potential that the appointment of a board secretary who is not a member of the executive may lead to concern on behalf of health boards.

Duty of Quality for the Population of Wales
We agree with the proposals contained within the document. We recognise that, as at present, it is vital that the NHS embraces partnership working. However, this should be extended if future health and social care challenges are to be successfully met. Health Boards and the Welsh Ambulance Services Trust are already under severe pressure and this is only going to increase over the next decade. New and innovative ways of working must be found especially within the area of unscheduled care and we strongly believe that partnership working with the third sector is the key to success.

Duty of Candour
We agree with the proposals contained within the document. However, there is concern that it will be difficult to legislate for introduction of candour.

Setting and Meeting Common Standards
We support this proposal.

Joint Investigation of Health and Social Care Complaints
We support this proposal. Again if this is introduced it will improve the patient pathway across health and social care. This is particularly important when you consider how the Third sector needs to work across both sectors. We also recognise that this will not be easy as, at present, the manner in which investigations in these two sections are dealt with is completely different. We also ask that the way third sector concerns are dealt with is considered fully.

Representing the Citizen in Health and Social Care
We strongly support the Welsh Governments plan to enhance the citizen's voice within Wales, however we also believe that the Community Health Councils have been an effective champion of the patients viewpoint. Navigating NHS concerns and complaints can be a confusing and daunting process, especially for people who have experienced trauma and loss. The expert support and advice provided by Community Health Councils is therefore invaluable. These organisations should be given the power to work even closer with Third sector organisations that provide healthcare services. The strength of the Community Health Councils is that its members are rooted in the communities, have local knowledge and are accountable. We fear that this may be lost with the introduction of a pan-Wales body.

We, as an organisation therefore, support the reform of Community Health Councils along the lines suggested in the White Paper. However, we fear their abolition would be a disservice for patients in Wales who are very much in need of an independent voice.

We believe that consideration should be given to the Third sector working more closely with these CHCs, who are already experienced in this area to effect the required change.

Co-producing Plans and Services with Citizens
We agree with this proposal to an extent, although the planned approach for health boards themselves to decide whether a proposal should go to the independent citizen voice body is concerning.

Inspection and Regulation and single body
Currently there are areas of health care unregulated and without inspection, consequently there is a risk of harm to the public, we have concerns particularly around the provision of first aid at events and patient transport.

We would welcome further consultation within this area.

We believe that the idea of the sponsored body is sound but would urge caution around the complexities involved in this change.

WGWPMB77: The Royal College of Psychiatrists in Wales
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
We agree with all of the above proposals.
The consultation document is correct in highlighting (paragraph 27) that in some Health Boards there is a loss in focus on mental health, which has resulted in not meeting the requirements of existing legislation. We have raised our concerns regarding this in a number of previous consultations and with senior figures in Welsh Government, the NHS Wales and Assembly Members.

In our Manifesto for the Welsh elections in 2016, and in the Green Paper Our Health, Our Health Services we called for the creation of an Executive Director of Mental Health and Intellectual Disabilities with full voting powers in each Health Board. This would address two areas of increasing importance: parity of esteem, or the provision of equal care for those experiencing poor mental health as it does those with poor physical health; and the underlying and often undetected mental health of people with a wide variety of physical health conditions.

We believe that the creation of this post would ensure proper implementation of the Mental Health (Wales) Measure 2010 so that services are designed around the needs of the patient and not of the organisation. This post could improve patient experience and service delivery and this in turn would result in a happier workforce that is currently struggling under existing pressures from increased workload and lack of resources.

Board Secretary
Do you agree with these proposals?
Yes.

What further issues would you want us to take into account in firming up these proposals?
The post should have a specific remit to include scrutinising and holding to account the quality of mental health and intellectual disabilities service delivery.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
We agree with the proposed move from individual organisations working in silos to placing a duty on organisations to collaborate in order to meet the needs of the population as a whole. Collaboration between organisations results in a shared responsibility of care. It will enable better integration between primary and secondary care and between health and social care. This is in line with what already exists for local authorities under the Social Services and Wellbeing Act (2014) Wales.

What further issues would you want us to take into account in firming up these proposals?
The proposals would require significant amendments to the NHS (Wales) Act 2006. We would insist that any changes to existing legislation (or policy) must bring about improvements to quality, and not only to process. We would urge that lessons are learned from the drafting of the Mental Health (Wales) Measure 2012. Legislating for good clinical practice will not guarantee improvement in quality of care. The Measure has resulted in an imbalance between bureaucracy and patient care, a widening gap between primary and secondary care, and a need for health professionals/Local Health Boards to meet quantifiable targets and not quality outcome measures.

Duty of Candour
Do you support this proposal?
Yes, not least as this will keep us in line with the rest of the UK.
The reporting of incidence is crucial. Errors can be corrected and used for learning and training purposes.

Doctors, nurses and midwives are already required to be open and honest with patients (GMC 2013) and must report any mistakes that compromise patient safety. If the responsibility were to lie with the organisation rather than on the individual this may encourage people to report incidents. The likelihood for dismissal, disciplinary action or clinical negligence would be greatly reduced.

There is a danger that patient and carer voices within vulnerable groups for example are not heard as they would be in other areas.

What further issues would you want us to take into account in firming up this proposal?
Welsh Government must take into account that some clinical errors are the result of individual practice but many are at least in part the responsibility of wider organisational processes. The duty of candour should be seen as an organisational, as well as an individual requirement. This should address the potential for creating a 'blame culture'.

The Andrew's report and the Ockenden report attest to this. It is important to address the culture of complacency which is often found in services treating frail elderly people with mental health conditions.

Setting and Meeting Common Standards
Do you support this proposal?
Yes, enabling positive outcomes for patients with mental health and/or learning disability is a fundamental principle of the Royal College of Psychiatrists and the College's Standards and Accreditation Programmes are designed to achieve this in a range of mental health care settings, whether in hospital, in prisons, or in the community. It is important that regardless of where a person receives support, they are treated with dignity and respect. People's needs are often complex, particularly in the elderly, making it important for organisations to work together to help

individuals recover, thrive, or die with dignity. High level standards of care must be consistently embedded across the public sector bodies providing care and treatment.

What further issues would you want us to take into account in firming up this proposal?
We would recommend that Welsh Government observe existing standards that have been set by professional bodies, including RCPsych. We would also recommend highlighting to health boards the value of signing up to the College's service quality and accreditation projects, which ensure that mental health services are supported through learning and benchmarking by a process of peer review and the provision of detailed reports.

http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects.aspx

The consultation document states that the standards of care should be focused on meeting the person's needs and helping the person to achieve
the outcome they desire. It is important to be mindful that some people may lack capacity or an ability to understand what is in their best interest. Not everyone has the ability to make a choice or indeed make the correct choice. This is correctly raised in paragraph 66. We believe that for these people, their needs must be collectively agreed and communicated to everyone involved in their care.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes because in community mental health teams (CMHTs) health and social care staff already work alongside each other. Where complaints are raised they are investigated jointly by health and social services teams. This could be held up as examples of good practice.

What further issues would you want us to take into account in firming up this proposal?
When working in a multidisciplinary team there must be one person accountable for the conduct, outcome and lessons learned. We would recommend viewing what is already being done in community mental health teams.

It is also noted that a vast amount of organisational effort is expended in the investigation process and not enough learning activity takes place to support the organisational learning process. It would be useful for the HEIW to be linked into the process to provide guidance on educational follow-up to learn from investigation findings.

Representing the Citizen in Health and Social Care
Can you see any practical difficulties with these suggestions?
It could be argued that the abolition of CHC led to a dilution of the citizen voice in health and social care. With any reorganisation the importance of the citizen's voice must be a key priority. It would be important to emphasize the 'arms length' relationship of the new body and include a link to the HEIW (Health Education Improvement Wales).

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes, we agree with this proposal. Service change should be designed by a collective group comprising both service users and service providers and it must be evidence-based.

Mental health services have changed significantly in recent years, possibly more so than any other health service. A lot can be learnt from these changes with the closure of large-scale asylums to community-based care. Some of these changes have resulted in fragmentation of patient journeys and continuity of care. There is fragmentation in physical and mental health, substance misuse and mental health, community teams and crisis teams, emergency departments and crisis teams, primary and secondary care mental health services, hospitals and social care. Fragmented services are often poorly coordinated and communication is compromised. Mental health services are very hard to navigate for both the providers and the patients.

The College believes that there are still opportunities for further improvements. Although there have been vast improvements to patient care, mental health and learning disability services are still designed to enable good clinical outcomes but has resulted in fragmentation and fails to take the patient's experience in account. There must be a voice in the Local Health Boards from mental health and intellectual disability.

Inspection and Regulation and single body
Are there any specific issues you would want us to take into account in developing these proposals further?
Joint working of health and social services in mental health is already established. This is sensible. Linking up the role of HIW with the HEIW would provide a mechanism for more systematic dissemination and implementation of learning identified by the work of HIW and CSSIW.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. What issues should we take into account if this idea were to be developed further?
Health and social care cultural values are different and these need to be addressed. We would ask, how would the interaction between the multiple independent bodies, proposed to be set up, be coherently coordinated?

WGWPMB78: Future Generations Commissioner for Wales
Location: Cardiff

General Comments

I am writing to you to respond to some of the questions set out in your consultation document 'Services fit for the future: quality and governance in health and care in Wales'. I welcome your commitment to future-proofing health and social care services for generations to come, and the references to the Well-being of Future Generations Act throughout the consultation document.

These are the five ways of working set out in the legislation which must guide your work and how you develop your proposals.

i. Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves.

ii. Long Term - The importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs.

iii. Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives.

iv. Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their other objectives, or on the objectives of other public bodies.

v. Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives.
Below I have provided comments in relation to your questions in Chapters 1 and 4, as these align most closely to the changes I expect to see across the public service.

Chapter 1: Effective Governance
I broadly agree with your proposals about Board membership and ways of working, but would like to highlight some considerations that I believe are key to helping Boards enable NHS bodies to equip themselves for the future:

- The recent Parliamentary Review interim report highlights that a key challenge for the NHS is integration, and I believe there is a particular challenge for health boards and NHS trusts to integrate their work with other sectors and organisations outside of the NHS. Board membership should help to drive this integration and collaboration and link strongly to the roles and membership of the relevant Public Services Board(s).
- Another key point highlighted in the Parliamentary Review interim report is the need for a meaningful dialogue between service providers and the public about the respective roles and responsibilities of services and individuals. As you will be aware, involvement is one of the five ways of working and it is fundamentally important that any principles for Boards enable a connection

between Board members and people's lived experience of services. I will expect to see this explored and evidenced as you develop your proposals.

Chapter 4: Effective Citizen Voice, Co-production and Clear Inspection

As I have mentioned above it is clear that a step-change in how people are involved in public services is urgently needed to ensure that the services we provide are what people want and need. I acknowledge that there are already a range of mechanisms that try to do this (as you list in para 79 of your consultation) but serious consideration needs to be given to the new arrangements that you are proposing and how they will enable this step-change.

The key considerations I am expecting you to be exploring and evidencing are:
i. Influence: it is important that people feel that they are being heard by decision-makers and not just being asked for views in order to tick boxes, and with no evidence of having had any impact. As I mentioned above there needs to be a clear line of sight between the arrangements to represent people's views and the Boards and Senior Management teams of public bodies.

ii. Diversity: it is still often the case that the types of people involved in decision making are those that have the time, energy and level of personal interest to be involved – these people are generally not the people who are the most frequent users of multiple public services. The Well-being of Future Generations Act deliberately requires public bodies to ensure that the people they involve "reflect the diversity of their population." This should be a consideration of the approach that you take to developing involvement arrangements and mechanisms going forward.

iii. Dialogue: the intention of any involvement should be to build up a conversation between people who use services and people who provide services, which is not restricted to 'service planning' or 'service delivery' – there should be dialogue about how people use services and what needs to change. This will involve public bodies thinking about how they engage: going to where people are (rather than holding one-off 'consultation events' that people are expected to attend), and enabling conversations that are as much as about preventing ill health (wellness) as they are about dealing with illness.

iv. Scrutiny: it will be important that arrangements for involvement strengthen rather than dilute access to and transparency of decision making. Consideration of the benefits of key elements of this, such as the right to visit unannounced, will be important.

v. Day-to-day intelligence: my office are working closely with Public Services Boards (PSBs) and we have recently published a report (available here) suggesting key recommendations about how PSBs and public services need to evolve and develop. A key recommendation was that PSBs are not yet making best use of experiential, qualitative data in their assessments and could do this more effectively by taking a more strategic approach to gathering the 'day-to-day intelligence' that is collected by services on the ground, including those run by the third sector. In my view this also applies to health bodies: there is potential for the 'day-to-day intelligence' about people's lived experiences to be gathered from frontline staff and used, alongside performance and other data, to inform organisational strategy and planning.

vi. Collaboration – all public bodies are facing similar challenges in relation to the meaningful involvement of people, so the more collaboration on the development of new approaches and the sharing of quantitative and qualitative information, the better the outcomes are likely to be. In my view PSBs should be the key mechanism to enable this collaboration, but it will also be important for new approaches to involvement to enable collaboration and innovation.
I hope the above comments are helpful and I look forward to seeing the next iteration of your thinking.

WGWPMB79: Carers Wales
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Broadly Carers Wales agree with these proposals with the following comments:
NHS trust boards, for consistency and additional transparency should have a vice-chair in line with LHBs to help drive forward change to improve quality.
We also agree that Ministers should have the authority to appoint additional Board members on time limited appointments, including independent public members and provide them with the information to develop the skills to scrutinise certain under-performing areas.

Carers Wales also agrees that there should be a majority of independent members over executive officers provided that they are adequately supported, trained, are treated as equals and that they are genuinely listened to. One current carer representative on a Regional Partnership Board has told us “We are heavily outnumbered and there is a distinct smell of tokenism”.

Carers Wales has a number of our volunteers who currently sit on Regional Partnership Boards across Wales and there is a mixed picture of the support they are being provided with to enable them to fully participate and contribute in the business. Feedback from them suggests that there is room for improving communication. This includes many things such as using plain language in Board papers and ensuring that papers are sent well in advance of meetings.

As an organisation we are looking to bring each carer representative from each RPB across Wales to learn from each other and share their experiences.

Given that there is a suggestion that there will be a majority of independent/public members it will be crucial that individuals are respected and receive any training or support they require to effectively contribute to the role. This should start at the outset of any involvement with a formal induction process and through regular reviews so that any concerns or issues that may arise can be addressed formally.

Board Secretary
Do you agree with these proposals?
Broadly we agree.

What further issues would you want us to take into account in firming up these proposals?
The Board Secretary should also keep Welsh Government formally informed if any challenges are made to the Chief Executive, NHS organisation or Board. There should also be a duty of public transparency if there is any issue of concern that may be in the public interest. If the public are made aware of potential failings then they

may come forward with evidence and possible suggestions on how things can be changed or improved.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

Carers Wales broadly agree with these proposals but the scope to facilitate the needs of the population of Wales should be sufficiently wide to truly realise person centred planning and care. There is no detail of how wide the scope is likely to be how people representative of the general population will be in the process or what the vision is for regional collaboration to work in practice.

Carers Wales also has some concern that if there are sub-groups/committees set up to inform the process the mechanisms that will be used to effectively feed ideas and good practice into regional or all-Wales solutions. We also feel that there is scope for possible duplicity of work as well as a possible loss of a shared purpose if ideas and opinions are lost.

There are some current reciprocal duties in place and the person must be at the heart of joint decisions. Where any dispute arises between health and social care about who organises or pays for something, the person and/or their carers must not suffer any detriment due to internal indecisions or disputes over who provides or pays for the service. The Wales Ombudsman has examples of such cases where this has happened in the past and carers and their families have been left floundering and struggling for unacceptable periods of time while internal disputes take place.

Reciprocal duties should be embedded in law and the general public need to be made aware that these duties exist, what should happen (the process) and how if the process fails they can make challenges to the system.

What further issues would you want us to take into account in firming up these proposals?

If for planning and operational reasons clinical services are provided for a patient across a different health board boundary area or indeed in a different Health Board in Wales then consideration should be given to providing family members/carers assistance with travel and accommodation costs.

Carers are currently not included under the NHS scheme for help to receive travel costs. Carers Wales has heard from carers on numerous occasions over the years where they do not meet the criteria for help and are distraught that they do not have the financial means to visit loved ones who are hospitalised. Carers Allowance is currently £62.70 per week (for those who are entitled to receive it) many carers, especially those over pension age do not receive anything. Travelling to and from hospital to visit, even within local boundaries is often costly and difficult given the current transport infrastructure and travelling further afield would exacerbate this difficulty and also cost substantially more for a lot of carers. Under the Human Rights Act, people have a right to a family life. A new Wales NHS help with travel costs scheme should possibly be considered to help alleviate the financial burden for carers and their families especially when clinical services are provided in a different Health Board in Wales that is not the persons ordinary Health Board area.

Duty of Candour

Do you support this proposal?

Carers Wales supports this proposal. Comments from carers include “It is good to see there will be no hiding behind patient confidentiality” and “This will be especially good for carers of people with mental health conditions”

What further issues would you want us to take into account in firming up this proposal?

Ensure that it is widely communicated to the general public.

Setting and Meeting Common Standards

Do you support this proposal?

Carers Wales broadly supports this proposal if it removes ambiguity. Comments received from carers include

> “Only should!!?, why not ensure”
> “What does good look like”
> “Makes sure it is not a race to the bottom in terms of standards. What does high level mean”
> “How can/will this be measured”
> “Why is it not described as a statutory duty?”

What further issues would you want us to take into account in firming up this proposal?

In our opinion and the opinion of the carers we have spoken to there should be independent assistance available and a statutory watchdog to take help individuals take forward complaints.

Any new common standards should be widely communicated with service users and carers with information about to whom and how to make a complaint including where to find independent local advocacy.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Broadly Carers Wales supports this proposal if it makes things easier when complaining about health and social services.

However, we would wish to see an independent organisation set up with statutory rights to provide independent complaint advocacy services. There is currently an inadequate amount of advocacy services across Wales and it is a postcode lottery depending where you live whether there are any services available at all.
Comments received from carers include:

> “Listen first and it would avoid complaints”
> “Timescales are important”
> “One person who continues to handle the complaint”

What further issues would you want us to take into account in firming up this proposal?

Carers continually tell us that they are put off complaining to social services for numerous reasons including the time it take to put forward a complaint and the lack of independent support to do so.

Representing the Citizen in Health and Social Care

Do you support this proposal?

Carers Wales would be happy to support this proposal with the following stipulations:

- Any new body must be independent with statutory legal rights to challenge and scrutinise. This independence may be compromised if they work alongside Health Inspectorate Wales and the Social Services Inspectorate Wales. This term "work alongside" needs to be clarified. Any new body must be truly independent of both inspectorates and have the ability to scrutinise and investigate complaints themselves.
- Any new body must provide independent complaints advocacy to enable the public to take forward complaints
- We agree that there must be a role for independent monitoring when health and social care organisations are working with the public to co-design and co-produce services
- The new body should have a role in ensuring that independent Board members are adequately supported and trained
- The new body should be involved in the recruitment process for independent Board members to ensure that there is a mix of skills and interests to represent general communities across the region and Wales
- There will need to be local level operations on health board footprints to enable the general public to access its services locally. Not everyone has the means of transport or are computer literate to deal with things at a distance.

Comments from carers include

"Good if it removes regional variation"
"Requires full commitment from all, not just token gestures"
"One experience of attending a meeting and being told 'we only want to hear positive things today' there is a need to hear about the reality, however unpalatable
"Needs to be an understanding of rurality issues, recognise 'parochial'"
"How will advocacy and support be provided?"
"Building trust is important"
"Transport is a key issue affecting everything"
"Requires active investment"

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

We do not agree. Any new body must have a scrutiny role, be independent and able to challenge. Ultimate responsibility for any substantial change if there is a dispute must rest with Ministers. We also have concerns about how robust the public engagement process would be.

Inspection and Regulation and single body
What do you think of this proposal?
Broadly agree but the devil will be in the detail.

Are there any specific issues you would want us to take into account in developing these proposals further?
How this framework is likely to work in practice, the lead in time for change, how well Welsh Government will fund the transitional process and future challenges to enable both organisations to work jointly.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
We broadly agree with this idea although it is very vague and the devil will need to be in the detail. Any organisation will need to be well funded and have be clear in its purpose, aims and objectives to achieve that is accountable to Government and the general public.

What issues should we take into account if this idea were to be developed further?
Further consultation and further detail.

WGWPMB80: Royal College of Nursing Wales
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
The Royal College of Nursing is broadly supportive of these proposals. However, there are a number of associated issues, and these are outlined below.

What further issues would you want us to take into account in firming up these proposals?
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. As such, there must be an Executive 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 Executive Nurse Director 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 in Wales.

The Royal College of Nursing also 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.

In addition the Royal College maintains that 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 membership of the Board, under the current arrangements, has been beneficial and we would be concerned if this Board position were lost in any new arrangements.

We are not convinced that changing the name of the 'independent member' to 'public member' will achieve any tangible change. Whilst it is right that the public be explicitly represented at Board level, a change in title will not in itself ensure that the necessary mechanisms are in place to enable a 'public member' to be truly representative and a voice for the local population. More detail is needed around the structures in place to make this happen.

Board Secretary
Do you agree with these proposals?
It is right that the role of the Board Secretary is strengthened and placed on a statutory basis. There must clarity around the separation and accountability of the Board Secretary role with a clear and direct line of accountability.

It is important that the Board Secretary role is able to maintain a level of independence and to be able to identify and report issues that arise.

What further issues would you want us to take into account in firming up these proposals?
Clear guidance from the Welsh Government should be issued outlining the requirements and responsibilities of the role, and this should assist in helping to avoid conflicts. There may also be merit in establishing a network of Board Secretaries, with support from Welsh Government or the Wales Audit Office, local government etc. to provide peer advice and support to those in these roles.
It is also worth considering whether, if the duty of candour being proposed applies at Board level, whether or not these measures around ensuring accountability and avoiding conflict will be applicable. If the Board are subject to a duty of candour in the same way that other employees are, then these issues should not arise because openness and transparency should be maintained at all times.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
The Royal College of Nursing agrees that the duty of quality should be updated to better reflect the increasingly integrated system in which we are working. This is largely in line with the principle behind the Nurse Staffing Levels (Wales) Act which is about having the right resources in the right place in order to ensure the quality of patient care. It is right that this duty is enhanced so that it is less provider focused, and more about meeting the needs of the population, whilst shifting the focus on promoting wellness rather than treating ill health.

We are also in agreement that services should be based on person and not organisation, particularly if this shift in approach results in an increased focus on the determinants of health such as housing, education, transport access, social support networks etc.

What further issues would you want us to take into account in firming up these proposals?
In firming up these proposals, it must be acknowledged that there is currently a very different approach to service provision taken by local authorities, compared to the approach taken by Health Boards and Trusts. Whilst the health arena tends to take a more proactive and preventative approach to health interventions, at a local authority level, it appears that the approach can be more reactive and focussed on providing services and solutions which deal with the immediate issues. To a certain extent this is largely determined by increasingly diminishing local authority budgets, and because of the differences in the way that service delivery is measured.

These differences mean that detailed consideration is needed as to how a duty of quality can be truly aligned across NHS bodies and local authorities, and in doing so, how parity can be achieved across the NHS and local authorities in terms of adopting that preventative stance.

It is also important to note that whilst an All-Wales solution to delivering quality services might be applicable in some circumstances, in others, services must be tailored to meet the needs of local populations and individuals.

Duty of Candour

Do you support this proposal?

The Royal College of Nursing supports the introduction of a statutory duty of candour across health and social services in Wales and agree that this should help set a clear corporate responsibility and tone for the organisations operating in health and social care.

A statutory duty of candour may also help raise awareness of, and provide additional strength to, whistle-blowers, and empower employees to speak-out against unacceptable practice or poor performance.

What further issues would you want us to take into account in firming up this proposal?

Registered Nurses are expected to fulfil a duty of candour at all times according to their professional code. In this way, having the duty of candour on a statutory footing would complement existing requirements on registrants. However, for non-registrants such as Healthcare Support Workers, this would be a new requirement, and this would have to be communicated to the workforce very clearly and explicitly. This is not only to ensure that there is a comprehensive understanding of what is being expected of them, but also to provide a safeguard for employees who may otherwise be at risk of not complying with the new requirements.

Setting and Meeting Common Standards

Do you support this proposal?

The Royal College of Nursing is in complete agreement with this proposal.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

The Royal College of Nursing supports these proposals and agrees that it will encourage the sharing of lessons learned. As we move to a more integrated system, it will become increasingly important and necessary to have joint investigation.

What further issues would you want us to take into account in firming up this proposal?

It is important that there are clear lines of accountability involved and to have absolute certainty around where responsibility for the investigation and any redress lies. If one organisation is leading on an investigation, a system must be in place to ensure that the lead/investigator works alongside an equivalent person from the other organisation. This is to ensure that the right skills and knowledge are available for appropriate scrutiny to take place and solutions to be found.

Representing the Citizen in Health and Social Care

Do you support this proposal?

The Royal College of Nursing supports the proposal to strengthen and enhance the citizens' voice across health and social care and to increase the level of co-design and co-creation of services. The developing health and social services integration agenda is certainly relevant when reviewing the future of CHCs and it is vital that there be a specific body for citizen engagement within social care in Wales, to build on the requirements around public engagement which are already within the Social Services & Wellbeing Act.

Can you see any practical difficulties with these suggestions?

For over 40 years, the Community Health Councils have provided a valuable role in representing the interests of the users of NHS Wales and the public. CHCs are an important mechanism which allow for the public to have a voice in their local health services, the way they are delivered and in any proposals to change service delivery. Any changes to the existing system for representing the citizen voice, must be focused on strengthening this ability to represent and advocate for the public, and on increasing public engagement with the way in which health and social care services in Wales are run.

There are several areas in which the CHCs currently work very effectively and the existing arrangements do provide a valuable service to the people of Wales. For instance, where there are good working relationships between the CHC and local health bodies, this enables any shortcomings in service provision to be brought to light in a timely and responsive manner, and individual complaints get efficient and personalised support. It also provides a mechanism by which the patient perspective is represented and incorporated into decision making.

At their best, CHCs can provide both an independent patient voice, whilst also providing local health bodies with a strategic partner in designing and delivering local services. This not only means that local communities are able to be involved in the way their local health services are run, it can also mean that the public have a greater confidence in their NHS because the CHCs have enabled them to have a voice.

The advocacy role provided by CHCs is of particular value, and it is vitally important that the public continue to have access to advocacy services as part of future arrangements, and this advocacy role must strengthened and not be diluted in any way. Providing advocacy and support during the complaints process is a specialist area of expertise and is a function that requires a great deal of resource. CHCs must therefore be appropriately resourced to carry out this function effectively, and without unreasonable waiting times for the patients involved. In addition, more needs to be done to improve the levels of public awareness of the fact that CHCs exist and to increase the levels of understanding about what they actually do. Only then can the CHCs be a truly effective and representative voice of communities.

Also important, is to ensure that the personnel appointed to any body that represents the citizen voice is informed, has currently knowledge of the system, and is able to think strategically. These attributes would enable the body to be representative and responsive in determining improvements. By the CHCs' own recognition, more

needs to be done to improve the diversity and representativeness of the CHC membership, and a different approach to the recruitment and appointments process is needed in order for this to be rectified.

It should be noted that 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” services. This aspect of their role has also been identified as a duplication of the work already carried out by inspectors, and is therefore not a good use of time or resources. The patient perspective is very important when it comes to scrutiny of services. There is an argument to be made however, that a citizen’s voice body should adopt more of a role in “enabling” the voice of the people of Wales about their health and social services, rather than in service scrutiny per se. One alternative option could be to have CHC representation in a lay/public capacity as part of future inspection regimes. This would avoid duplicating the work of inspectors, whilst also ensuring that the patient perspective remains a part of the scrutiny process.

There are important lessons that can be learnt from recent reviews of other patient voice bodies from around the UK, which could be used to inform any reforms of the existing system in Wales. For instance, it has been recommended that the Scottish Health Council change its focus on statutory bodies towards engaging with communities and increasing levels of participation, and this is certainly something which could apply in Wales. The review also contained proposals for their remit to be formally extended to include health and social care in order to reflect the increasingly integrated context of the system. Similarly, a suggestion following an examination of the Northern Ireland’s Patients and Client Council was for the Board to be reconstituted to include a higher proportion of current or former patients or clients of the health and social care system. Again, this may be worth considering for the CHCs in Wales.

In light of the fact that the proposals contained in the White Paper include replacing the CHCs with a model based on the Scottish Health Council, it is important to be mindful that Scottish arrangement was recently examined, with a number of recommendations made around how the current model could be improved. As such, the future direction of this organisation is under review and it would be worthwhile for the Welsh Government to follow these developments closely.

Overall, any changes to the existing system must enhance the patient voice and not be to the detriment of it, and the areas in which the CHCs represent the public very effectively must not be lost. It is vital that Wales has an independent patient body which can meaningfully represent and challenge on behalf of patients, which has statutory rights to hold providers of care to account, and which provides patients and the public with a body through which to raise concerns and provide effective advocacy.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?

The Royal College agrees that the more partnership working that can be encouraged in terms of co-producing plans with citizens the better, and that this will ultimately produce better patient outcomes.
We also agree that referral to Welsh Ministers for final decisions to be made should be a last resort.

What further issues would you want us to take into account in firming up this proposal?
Whilst we fully agree that service change must be based on strong clinical evidence, it should be made clear that this evidence should be the starting point of any proposals for change. Whilst we support the proposal to have an independent mechanism to provide this clinical advice, this advice should not only be sought to help inform any decisions being made, but should also be the basis for which service change is proposed in the first place.

Inspection and Regulation and single body
What do you think of this proposal?
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.

Are there any specific issues you would want us to take into account in developing these proposals further?
The Royal College of Nursing maintains that the independence and autonomy of HIW is important. A memorandum of understanding between HIW and CSSIW should be developed, particularly in the context of increased joint working.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
The Royal College maintains that this is worthy of some consideration. Being a WGSB should enable a governance structure which allows for it to be fully accountable to Welsh Ministers whilst also having a degree of agility and flexibility.
What issues should we take into account if this idea were to be developed further?
It would be important to ensure that the lines of accountability were clear, and exactly who would be in a position to challenge the new body if it were in place.

WGWPMB81: North Wales Community Health Council
Location: Wrexham

General Comments

This response represents the collected views and concerns of the 85 members of North Wales Community Health Council. It was prepared following extensive debate and discussion, not only within the CHC, but after CHC members had the opportunity to discuss the White Paper with hundreds of members of the public at many events and meetings across North Wales during the consultation period.

The content of this document was finally agreed at a special meeting of the North Wales CHC Executive Committee on 26 September and we confirm that it is a true and correct representation of the views of North Wales CHC members and its six Local Committees.

Mrs Jackie Allen Chair, North Wales CHC
Mr Mark Thornton
Vice Chair North Wales CHC
Mr Roger Williams
Chair Conwy Local Committee NWCHC
Dr Garth Higginbotham
Vice Chair Conwy Local Committee NWCHC
Dr Tak Matsuda
Chair Denbighshire Local Committee NWCHC
Mrs Roma Goffett
Chair Denbighshire Local Committee NWCHC
Ms Linda Harper
Chair Flintshire Local Committee NWCHC
Mrs Stella Howard
Vice Chair Flintshire Local Committee NWCHC
Mrs Menna Williams
Chair Gwynedd Local Committee NWCHC
Mrs Vera Wilson
Vice Chair Gwynedd Local Committee NWCHC
Ms Eleanor Burnham
Chair Wrexham Local Committee North NWCHC
Mrs Nerys Jones
Vice Chair Wrexham Local Committee NWCHC
Mr Alan Dixon
Chair Ynys Môn Local Committee NWCHC
Mr Brace Griffiths
Vice Chair Ynys Môn Local Committee NWCHC

The North Wales Community Health Council welcomes the opportunity to respond to the Welsh Government's White Paper: Services fit for the future. North Wales CHC has been closely involved in the preparation of the national response prepared by the Board of CHCs in Wales and fully supports the content of that document. This

response represents our opportunity to be heard on these proposals and to highlight local concerns and place emphasis on issues unique to North Wales.

North Wales CHC is the independent watch-dog of NHS services within North Wales and we seek to encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities.

The CHC movement seeks to work with the NHS and inspection and regulatory bodies to provide the crucial link between those who plan and deliver the National Health Service in Wales, those who inspect and regulate it, and those who use it. North Wales CHC maintains a continuous dialogue with the public through a wide range of community networks, direct contact with patients, families and carers through our enquiries service, complaints advocacy service, visiting activities and through public and patient engagement. By this means we are able to provide a highly integrated and coordinated service to patients, their families and carers. Over the summer North Wales CHC has asked people what is important to them about the proposals and in partnership with the Board of CHCs and the other six CHCs in Wales we have looked at the different arrangements across the UK and beyond. We have considered in detail what others have said about the strengths and weaknesses of related arrangements in other UK countries.

North Wales CHC collected over 250 responses directly from individual members of the public which have been forwarded separately to the Welsh Government. People have told us that they want any future body to:

- be independent,
- be able to hear directly from people including hearing directly from people whilst accessing care,
- be responsive to what matters most to people locally, regionally and nationally and,
- have the necessary powers to hold service providers to account.

Few people we talked to felt that the White Paper would provide them with the above. In our SMS survey on the White Paper proposals, 96% of respondents rejected the Welsh Government proposals.

Members of North Wales CHC are disappointed that the White Paper consultation failed to meet the standards of either the Gunning principles or Welsh Government's own consultation guidelines. The timing of the consultation over the recess/summer holiday period gave it a low profile.

North Wales CHC has concerns about the eight "Engagement Workshops" that were hastily arranged (18th to 28th September) following criticism by the Consultation Institute. These sessions also had a low profile in North Wales. Information on the sessions was only available on the Welsh Government's consultation website. Details of venues and times were provided on email request with a follow up phone call to confirm attendance; all fairly onerous on anyone wanting to attend an event arranged at short notice. The event at Caia Park, Wrexham was very poorly attended

with 4 or 5 members of the public. We understand this reflects the experience across Wales.
The lack of any detail in the impact assessment regarding potential impact on the protected groups listed in the Equality Act is a serious cause for concern.

North Wales CHC believes the manner in which this consultation has been carried out risks bringing Welsh Government consultation methods into disrepute and that a review should be undertaken in order to learn lessons that must be applied in future. Whilst North Wales CHC members support the creation of a citizens' voice body, it was felt that the proposed changes are back to front i.e. changes to social care and health care should be made prior to any other changes with a successor body to CHCs being modelled at a later date.

What others have said
The White Paper suggests that a number of reports have made a case to replace Community Health Councils and they are listed as Footnotes 29, 30 and 31.

Footnote 29 refers to Marcus Longley's review of CHCs. That review was conducted specifically on the premise that CHCs were needed in Wales, where the Government had implemented a Welsh healthcare model which rejected the "purchaser- provider split" and denied patients the right to choose their provider. At no point in his report did Marcus Longley challenge the continuation of CHCs.

Footnotes 30 & 31 reference the personal views of Ann Lloyd and Ruth Marks but fail to mention the many expressions of support for CHCs in response to the Welsh Government Green Paper, Our Health Our Services, consultation in November 2015.
The most serious error of fact in the White Paper is the misrepresentation of the OECD conclusions and recommendations. The OECD did not suggest that the CHCs should be replaced, as is implied in paragraph 14. The OECD did not recommend an alternative "Patient Voice".

The proposal to abolish, rather than strengthen, the CHC movement does not appear in the OECD report. On the contrary, the OECD said;
"Community Health Councils are a key feature in the architecture of Wales, with a clear role to engage with and ensure that the patient voice is heard (Page 225)".
The OECD's overall recommendation was one of evolution of existing institutions, not abolition. There was no recommendation to close down CHCs.

OVERVIEW
North Wales CHC strongly supports the Welsh Government's aspirations for a health and social care system that enshrines good governance, candour and the delivery of high quality services which are independently checked by an effective inspection and regulation regime.

We particularly welcome the aspiration to strengthen the people's voice across health and social care, and embedding the key principles of co-design and co-production. During the consultation period we have made substantial efforts to engage with the public and listen to what they have to say about the Welsh

Government's proposal. We used a wide variety of methods to engage: face to face discussion, email, social media, SMS, telephone and land mail.

North Wales CHC recognises that primary legislation can play an important role in achieving Welsh Government aspirations for a stronger citizen voice. However, there is little evidence to suggest that primary legislation alone would provide the catalyst to deliver real and longlasting change.

The entire CHC movement has concerns that the White Paper places an over-reliance on legislation to deliver its policy aspirations rather than looking at other ways of doing so. There is a real risk in overusing legislation in terms of the ability and flexibility of health and care services to deliver real cultural change and respond flexibly to future needs.

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 (former Chief Secretary to the Treasury, Health Minister from 5th June 2009 – 11th May 2010 and currently Mayor Greater Manchester) 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".

The hands-on experience of those 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) on each occasion there was a reorganization. There have been three iterations since the abolition of CHCs in 2003; Patient Forums, LiNks and HealthWatch.

The greatest criticism of CHCs arises from within the NHS and from politicians when CHCs do not support plans for significant alteration to the provision of local healthcare (such as hospital closures) or when they use their powers to refer controversial plans to the Minister. 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 increasingly prepared to challenge policy makers over their decisions on health and social services provision and to resort to the law to pursue their rights. Politicians and NHS leaders can no longer decide what they consider to be in the public interest based on only token consultation and expect their decisions to remain unchallenged.

Such perfunctory and minimal consultation is the reason for the increasing trend towards the challenging of decisions by the use of Judicial Review.

In the 2015 Green Paper Welsh Government said:
"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 National Social Services Citizen Panel is a strange example to use. Although it was announced enthusiastically by Ministers in 2012, it still has no website, no record of proceedings 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. If this is an example of how the new Citizen Voice will operate it is clearly a massive step backwards.

We set out below our detailed response to each of the proposals.

Response to Specific Questions

Board Membership and Composition
We agree that the boards of both health boards and NHS trusts should share some core key principles including delivering in partnership to deliver person-centred care and a strong governance framework to enable boards to work effectively and meet their responsibilities. We also agree that all boards should have vice chairs, and that executive officer membership should include some key positions which are consistent across local health boards but also allow some flexibility in appointments. In more detail:

- the proposals in the White Paper individually or collectively do not appear to address the issues about board culture identified in earlier governance reviews. The difficulties of changing Board culture are illustrated by the successive HIW/WAO annual reports setting out the shortcomings of the Betsi Cadwaladr University Health Board and the unacceptably slow pace of change (despite being in Special Measures with considerable Welsh Government support). The White Paper gives the impression that legislation alone will change Board culture – this is simply not the case.
- We do not agree with all the core key principles identified. Specifically, we cannot see that a re-titling of the role of 'independent' members would bring about a change in the perspective these members will bring – nor why such a change is needed. There is already a clear need for the whole board (and not just a re-titled public member) to understand and respond to the perspectives of the population in all board discussions and decisions. A system of rigorous selection against a person specification and skill set rather than political appointment would be a good starting point.
- We consider that a re-titling of the current 'independent members' to 'public members' may cause confusion and give an impression that their role is to represent the public. It is our view that the public currently recognise and accept the governance and leadership role of all voting NHS board members.

We agree that a representative voice should be heard at NHS board level. Associate membership of boards could contribute to achieving this. However, care would be

needed to ensure that any such associate member has a clear mandate from the wider population, e.g. a representative from a new, stronger, people's voice body.

Board Secretary

We recognise the important role that Board Secretaries have within NHS organisations and welcome proposals to ensure this role is carried out consistently and not compromised through conflicting duties and responsibilities. We believe that the solution to the problems outlined in paragraphs 33 – 35 of the White Paper is to monitor and enforce compliance with existing regulation.

In order that board secretaries are able to carry out their role as principal advisors to their NHS boards on governance matters, and so that they can properly protect the organisation they serve, it is important that the role has sufficient status and protection. We believe that, on a practical day-to-day basis, it will be impossible to ensure the independence of the Board Secretary. Whistleblowers in the NHS rarely fare well, even when protected by the Public Interest Disclosure Act, and we foresee that the role of Board Secretary could become untenable in certain situations.

Duty of Quality for the Population of Wales

We consider that as the current duties and definitions of quality are set out differently in a variety of places, it is complex for both bodies and individuals to understand and measure.

We would want any new legislation to genuinely simplify and clarify what is expected of service providers and what quality means from a service user's perspective.
We believe that the actions needed to deliver services that meet public expectations on quality must extend beyond introducing primary legislation. Legislation in itself will not bring about a shift in culture and behaviours.

Duty of Candour

In general terms, the public should and do expect that those responsible for providing their health and social care (both individuals and organisations) do so in a manner that is open, honest and frank.

We recognise that the current duty for NHS bodies to promote rather than require candour means that there is currently no sanction on bodies who fail to do so.
On this basis, we support in principle the introduction of a duty of candour for health and social care providers.

However, primary legislation in itself cannot bring about the cultural change necessary to embed this at every level in every organisation. We are concerned that the introduction of new legislation – if not done properly – could focus on the wrong things and distract from, rather than bring about, the change needed.

To date, we are unaware of any real evidence that the introduction of a duty of candour in England is benefitting patients by having a meaningful impact on organisational behaviour. Such progress as has been made is dependent on a system of fines and penalties that would not work well in the Welsh context.

Setting and Meeting Common Standards
The public expects clear and meaningful standards that apply wherever and whoever provides their care. Any such standards should be informed by and reflect what is important to people.

We recognise that there may be a need to address the limitations within current regulations that specify what standards must be followed. In doing so, it is important that any new legislation is framed in a way that allows flexibility and adaptability to meet future expectations.

Joint Investigation of Health and Social Care Complaints
We consider that people who have concerns about their health and social care should only need to raise these concerns once in order for them to be investigated thoroughly and in a timely manner. We agree that there should be a common complaints process across health and social care accessed through a single point. We consider that a single complaints advocacy service should form part of a new people's voice body.

The focus of any new arrangements must be to ensure:
- easy access for people to raise concerns
- timely and co-ordinated investigation and response
- shared learning.

Any new arrangements must recognise the need to ensure co- ordination within health and care organisations/sectors and not just between them.

Based on our own advocacy caseload and on discussions with colleagues in Local Authority Social Services, North Wales CHC believes that the number of complaints that are about the interface between NHS and Social Services are currently very low. We recognise, however, that this may rise in future as the delivery of services changes but caution on introducing new systems and procedures that might further affect the ability of NHS Concerns Teams to provide timely responses.

The valuable role of the complaints advocacy service, as provided by CHCs, must not be diminished. In England the service has become one of leaflets and call centre advice rather than the hands on, personalized service currently available in Wales. North Wales CHC has been working with other organisations to promote its independent advocacy service. Meetings with CADMHAS and Stroke Services to consider the independent complaints service have been held and have been positive.

Advocacy is a key element of the work undertaken by CHCs and should not be looked at in isolation. The proposals need to consider every aspect of work done by CHCs as a coherent whole, as the loss of any one aspect of work would weaken the others.
It is vital that a new representative body should offer a truly independent Complaints Advocacy Service. This must be completely independent of the health care provider with whom the patient has an issue. It is undeniable that health care providers have

not been adequately responsive to concerns raised by families and patients about the quality of care provided.

Representing the Citizen in Health and Social Care

We welcome the Welsh Government's intention to create a stronger people's voice across health and social care. The White Paper provides a once in a generation opportunity to do this in a way that best serves the people of Wales in health and social care.

We are not convinced however that the proposals as outlined will achieve this and are concerned they will dilute rather than strengthen this voice in the NHS. Further, we are concerned that the evidence presented in support of the proposals is flawed in some key aspects.

Over the summer the CHC movement asked people and bodies who represent them what is important to them and looked at the different arrangements across the UK and beyond. CHCs considered in detail what others have said about the strengths and weaknesses of the different models. We have reflected on what works well in our current arrangements.

Given that the Welsh Government's proposals are drawn, in large part, from the arrangements in place in Scotland, we paid particular attention to the role and remit of the Scottish Health Council. Rather than make a brief telephone call, the Board of CHCs visited the Scottish Health Council to hear from them directly about the current arrangements; the recent review which identified a clear case for change in their role and remit; and the on-going consultation about their future direction.

We are concerned that the White Paper proposals for a stronger citizens' voice body in Wales are predicated on a model that is not, and does not, currently describe or consider itself to be a citizens' voice body.

The CHC movement has jointly agreed what we consider should be the key functions and principles underpinning the detailed design of a new people's voice body for health and social care in Wales.

We recognise that legislation can provide for the introduction of a new people's voice body with a range of functions and responsibilities. A change in structure and remit itself, however, cannot address all the challenges identified. Evidence suggests that some of these challenges, for example the level of public awareness and perceived independence of bodies set up to represent the interests of people in health and social care, are common across the UK.

We believe a new, strong and meaningful people's voice body should be designed and developed with others in Wales, for Wales. We should learn from others' approaches and experiences and build on what is valued within our own current arrangements.

We should grasp the opportunity to co-create a new and exciting people's voice body with the capacity and capability to work with others to drive flexible and innovative

ways of engaging and involving people of all ages - on the things that matter most to them and using their preferred ways of communicating.

Why do we need a people's voice body at all?
We agree with the aspiration set out in the White Paper that health and social care bodies should get things right for themselves by continuously engaging with their communities. We also know that these bodies do not yet get this right every time – and we do not believe that new legislation alone will make this happen.

In Wales, by and large we don't have a market-driven health and care system. It is therefore important that our services are created with and for the people that use them. Not only do those planning and delivering health and social care need to engage on the matters they are contemplating, but people must have the opportunity to have a collective voice on the things that matter most to them.

Health and care organisations have the responsibility to respond appropriately when concerns are raised with them. However, those people in the most vulnerable situations may not be in a position to raise their concerns without independent support.

We believe therefore that people in Wales deserve an independent, effective voice. This voice should be:
- working hard every day to make sure people's views and experiences influence how their health and care services are designed and delivered
- encouraging and valuing the diverse range of voices across Wales
- capable of making sure service providers across health and social care are held to account for the services they provide to people and communities in Wales.

What should a people's voice body do?
We consider the purpose of a new people's voice body in Wales should be to: "reflect the views and represent the interests of people in their health and social care services".

We believe a new people's voice body in Wales should have the following functions: To encourage and support the involvement of people of all ages as individuals and communities in the design and delivery of services by:
- Engaging directly with individuals and communities on the things that matter most to them about their health and care services and engaging directly with people while they are accessing services.
- Supporting, encouraging and facilitating engagement and involvement through a formal alliance with others to promote co-production and co- design (building on the Scottish Health Council's model Our Voice).
- Working collaboratively and across-boundaries to develop a creative, bilingual and accessible platform for individuals, communities, regions and the wider population to share their views and experiences and influence health and social care design and delivery on a local, regional and national level.
- Informing the development of national standards and guidance for engagement and consultation.
- Advising and supporting providers on involving people, including on engagement and consultation activity.

- Monitoring and evaluating the effectiveness of involvement, engagement and consultation. Checking that people have had the opportunity to be heard and that their views are properly considered and responded to.

Whilst we do not consider a new people's voice body should be checking compliance against standards (this sits better with others) it could and should refer concerns to responsible bodies if it appears standards for engagement and consultation have been breached.

To represent the interests of people in health and social care by:
- Scrutinising health and care policy, plans and performance locally, regionally and nationally
- Challenging service providers and policy makers where improvement is needed
- Scrutinising the work of health and care regulators and inspectors
- Sharing ideas, information and concerns about health and social care to support service improvement
- Involvement in the co-design and development of services (including service change proposals)
- Providing independent advocacy support and assistance to individuals raising a concern about health and care services

Currently all CHCs have a joint Services Planning Committee with their local health board. Any successor body must have a similar arrangement that also includes social care changes.

Services Planning Committees have oversight of a vast range of local healthcare issues at a very early stage. They are a forum where experienced and knowledgeable volunteers can debate with NHS professionals and help form forthcoming service developments. North Wales CHC members are seriously concerned that this power would not be held by any successor body.
It should have the following rights:
- Right to visit unannounced wherever health and social care is delivered (NB this would not extend to the homes of individuals)
- Right to co-operation from care providers in contacting people on their behalf for the purpose of collecting independent feedback about care services
- Right to be heard in health and social care (including on service change) by:
- Policy makers
- Service providers
- Scrutiny bodies
- Regulators
- Right to a full, public and timely response from the above on concerns raised.

We do not consider a new people's voice body should take on the following existing CHC functions, duties or powers:
- Provide advice and information on health and social care services

We believe the responsibility for this should be with health and social care bodies. The new people's voice body must have the right to challenge services where the advice and information are not sufficient, clear, accessible or accurate.

- Inspect premises

We believe that the responsibility for formal inspections should sit with relevant regulators/inspectorates. However, the new body must have the current CHC right to visit, to report on its findings from the patient's perspective and to have those reports acted upon.

Monitoring and scrutiny work undertaken by North Wales CHC has been developed collaboratively with BCUHB, meaning that real lessons can be learnt from CHC reports, which are received and considered at Director level. The development work has included setting out how BCUHB will act upon the recommendations and evidence where improvements have been made.

It is unfortunate that no Welsh Government representative has spoken to the North Wales CHC about CHC visiting and monitoring when preparing the White Paper (although they seem to have spoken to others at length). Without having had such discussions it is difficult to understand how they felt able to make the statements about CHC visiting practices and their value. CHCs already have many years of experience in effecting real change at ground level and the Government should be looking to take this skill, knowledge and experience into any new arrangements - not diluting and eventually eradicating this important safeguard.

We have attached evidence of the regard in which North Wales Visiting and Monitoring is held by NHS professionals. This includes:

- Our work around hospital hygiene and infection prevention - a letter of support from the Infection Prevention Team stating that the work of North Wales CHC has been key to changing staff culture
- Support from the Director of Nursing for our "Lonely in Hospital" report
- Support from the Mental Health Director for our "One Simple Thing" on improving NHS dementia care
- Our report on urinary catheterization, revealing the pain, risk of infection and reduced quality of life arising from long waiting times for prostate care. The BCUHB Board were unaware of this situation until it was highlighted by the CHC.

All of this work is patient focused and outside the remit and capability of professional regulators who mainly focus on procedure, policy and statistics and whose presence in local NHS establishments is not as frequent as that of CHC visiting teams. It is wrong to view the roles of CHC visiting teams and HIW inspectors as duplication – they are different but very complementary activities.

Earlier in this submission we have quoted Lord Justice Francis on the impact of the loss of CHCs in relation to the Mid-Staffs NHS Trust. We remind the Minister that, at the time, the Mid-Staff Trust was regarded as an exemplar by all the professional regulators.

In other areas of scrutiny, North Wales CHC has considerable influence. Members attend various high level committees i.e. Quality Safety & Experience as 'observers with speaking rights'.

Additionally, CHC members participate in workshops to consider service delivery e.g. Hyper Acute Stroke Unit, Orthopaedic Services. The CHC also meets regularly at

Chair to Chair level and has an open and transparent relationship with BCUHB, who value the contributions of the CHC.

Authors of the White Paper do not seem to understand the already close working between CHCs and HIW – with sharing of reports and information on a weekly basis PLUS the bi-annual Healthcare Summits to which CHCs make an invaluable contribution.

- Responsibility to develop alternative models to service change proposals where agreement cannot be reached

We believe any lay organisation would not be equipped to meet this responsibility.

- Right of referral to Ministers on service change proposals

We believe a new people's voice body should not be the decision making body for a proposed service change. All service change proposals should be open to public scrutiny. Where decisions are not considered to be in the public interest, the appropriate challenge is through judicial review. There is a discussion to be had about whether the new body should have funding to initiate judicial review in appropriate cases.

What should a new people's voice body look like?

So that a new people's voice body is, and is seen to be, independent, it should be established as a single legal entity on a stand-alone basis. So that it is accessible and can respond quickly to what matters most to people and communities about their local services, it should have a strong local presence and focus. The organisational design of a new people's voice body must:

- enshrine the principle of decisions being taken as close as possible to the people impacted We do not accept the White Paper claim that involving local people in decision making is "cumbersome"
- provide for local determination of priorities according to evidence of local needs
- provide for the agility to take decisions that impact locally, regionally and nationally
- provide for clear lines of accountability within a strong standards & governance framework

Volunteers should be representative of the communities they serve and:

- be the lifeblood of a new people's voice body
- have the opportunity to contribute in different ways according to their skills and interests underpinned by a strong framework of modular and competency-based learning and development.
- A new people's voice body must be free to determine how it recruits its volunteers. Welsh Government, not CHCs, have had the power to recruit CHC members and they have steadfastly ignored advice from the CHC movement on how to improve the process of recruitment and make the movement better reflect local communities.

In summary, we believe our outline proposals for a new people's voice body provide a strong framework on which to base future arrangements in Wales. However, the success of any future model will depend on the detailed arrangements being co-produced with partners and stakeholders. We ask that the Welsh Government looks to facilitate this approach over the 6-12 months following the consultation period.

Co-producing Plans and Services with Citizens
We consider that there should be a single approach across health and social care to handle service change proposals and are concerned that the detail in the White Paper proposals around a new service change process does not provide for this. Integrated service developments should be driven by communities whose contribution must be valued and utilised by decision makers in both health and social care. It makes no sense to develop a detailed service change process centred on NHS decision making alone.

We also have concerns that the detailed process described in the proposals is based upon current practice in the NHS in Scotland which has been subject to a recent review that recommends a move away from this approach in light of experience. Specifically, the review recommends a shift from defining service change as significant or otherwise. The review states “decisions as to whether something should be seen as ‘major’ or ‘minor’……. have become divisive, confrontational and detrimental to public confidence in the NHS”.

Our experience is that, where service change has been successful, the level and nature of involvement, engagement and consultation were proportionate and responsive to the needs of those affected. We consider that all service change should be open to public scrutiny.

We agree with the proposals to revise existing guidance. We believe that the guidance needs to illustrate what effective engagement, based on co-production principles, looks like in health and social care. In revising and extending this guidance to social care, the Welsh Government should work with NHS bodies, social care providers, the people’s voice body and others with a role in helping communities to be heard.

The revised guidance should explicitly recognise that decisions taken nationally and regionally have a direct impact on how health and care services are designed and delivered locally and should provide greater clarity as to how co-production principles will be used to ensure people are engaged at all levels.

Inspection and Regulation and single body
We are not clear how the proposals to overhaul HIWs underpinning legislation would inevitably lead to more integration and common methodologies between the two existing inspectorates (CSSIW and HIW).

We recognise that removing the existing inspectorates from within Welsh Government and housing them within a Welsh Government Sponsored Body would bring more independence from government.

However, it is difficult to see how the governance and accountability arrangements would work in a model that seeks to preserve the independence of three separate bodies within one Welsh Government Sponsored Body. The experience in Scotland, with its Healthcare Improvement Scotland model (which houses within it a range of distinctive groupings, including its inspectorate and the Scottish Health Council),

illustrates the challenges of maintaining an individual and independent identity for each.

WGWPMB82: Anonymous
Location: Anonymous

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Ok, but…

What further issues would you want us to take into account in firming up these proposals?
Ok: Health Boards and Trust Boards should share and agree on what principles they share and be consistent, say doctors or therapists doing preventative health education program for the next 50-75 years, so the next generation could be healthier.

But: Remember EU? Some one appoints into positions and at the end we do not want EU, as it becomes not what expected, as public have no voice or control over appointed ones…

Board Secretary
Do you agree with these proposals?
Yes.

What further issues would you want us to take into account in firming up these proposals?
Should also be representing the public and give account to independent Health Councils.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Hmmm. No. You should think out of the box. Why not to try to make it more simple instead of further complicating?

What further issues would you want us to take into account in firming up these proposals?
What a nurse or doctor working in North Wales hospital could facilitate needs of Cardiff? Regions and Boards should collaborate to get the best of Government funds and share information on effectively achieved results.

Duty of Candour
Do you support this proposal?
See above.

What further issues would you want us to take into account in firming up this proposal?

See above.

Setting and Meeting Common Standards
Do you support this proposal?
Ok. But…

What further issues would you want us to take into account in firming up this proposal?
How would this apply to metropolis hospital and small village GP surgery? Or should the doctors rotate and do some work in metropolis? Ask CHC's what they think.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
Did you know, that whenever patient complaints he could be refused further appointments or to be treated fairly with same organisation? That is why most complaints never get escalated.

Representing the Citizen in Health and Social Care
Do you support this proposal?
No!

Can you see any practical difficulties with these suggestions?
Voluntary independent CHC do function way much better and represent citizen voice. The proposed changes did not work in England and do not work in Scotland. Who will monitor HIW??

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
NO

What further issues would you want us to take into account in firming up this proposal?
Why not to consult CHC's??

Inspection and Regulation and single body
What do you think of this proposal?
Not clear at all.

Are there any specific issues you would want us to take into account in developing these proposals further?
See above.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
No

What issues should we take into account if this idea were to be developed further?
Unless there is a way WG sponsored body will be independent from WG. Otherwise will not work and be another bureaucracy institution. Think about this and consult CHC's.

WGWPMB83: Anonymous
Location: Anonymous

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
In general, I support the Core Key Principles described but have concerns about:
1. Referring to independent members as "public members" is a meaningless change, given the difficulties identified by HIW/WAO in the current role of independent members in BCUHB. In addition, the title "public member" may give the impression that this member has been chosen/elected by the general public or acts as a specific conduit for community views.
2. It is not clear how "Associate membership of Boards should address citizen representation."

Board Secretary
Do you agree with these proposals?
I agree with proposals to give statutory independence to Board Secretaries.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
I agree with these proposals.

Duty of Candour
Do you support this proposal?
I support this proposal for a Duty of Candour.

What further issues would you want us to take into account in firming up this proposal?
1. This duty of candour must include the relevant Secretaries of State and their officials.
2. This duty should be conducted in a genuinely open spirit and not in a ritualistic manner merely to meet regulations. For example, current Health Board Equality Impact Assessments are frequently anodyne, bureaucratic exercises of duty that subvert the original intention of that process.
3. An assessment of the exercise of this duty of candour should be included in future standards/inspection frameworks.

Setting and Meeting Common Standards
Do you support this proposal?
In general, I support the proposal. However, although formulating these 'high level' standards shouldn't be difficult, they may be seen as little more than the health and social care iterations of 'motherhood and apple pie'. What difference would they make in practice?

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
I do not have enough current knowledge or experience – particularly of social care - to judge these proposals fully. However, I do know that the Ombudsman has judged current Health Board handling of complaints to be lamentable. Citizens Advice and CHC's receive numerous concerns about unresolved complaints concerning health or social care provision.

Representing the Citizen in Health and Social Care
Do you support this proposal?

Not in its present form:

Inspections and visits
HIW co-opt high quality external Peer Reviewers and Lay Reviewers to form teams that inspect against the framework of the Health Standards.

Peer Reviewers inspect processes and procedures such as care plans, medicines management, aspects of patient capacity, prevention of abuse and so on, using a level of expertise that CHC's could not and should not attempt to duplicate.

Lay Reviewers talk to patients and relatives or carers and complete questionnaires on patient experience. Perhaps because HIW is headed by a statistician, there is a preference for standardised, comparable data rather than capturing individual richness of experience, resulting in anodyne HIW reports along the lines of '8 out of 10 patients liked the food'. In addition, it is well known that asking patients for their views whilst still in the hospital ward is not the best way to elicit candour or reflection.

Furthermore, the lack of parity of esteem between categories of HIW reviewers is symbolised by the decision to cease paying Lay Reviewers (the patient experience reviewers) a fee from April 2016 but to continue to pay Peer Reviewers (the procedures and regulations reviewers).

Despite the nomenclature, CHC visits are not 'inspections' in the sense that CSSIW or HIW would recognise and are of a different quality. Checklists are used as 'aide memoires' for the volunteers to look at areas of care, cleanliness and food service and concerns are regularly fed back to the Health Board. The general tenor of a CHC visit is to ask a lay person's more general, holistic question: 'Would I want my relative or partner to be a patient here?' Unlike occasional HIW snapshots, CHC's keep a watching brief on local health facilities and have an ongoing dialogue with patients and the local community.

Therefore, despite claims of 'overlap' or 'duplication', HIW and CHC's serve patients in different but complementary ways.

Patient pathways

As the White Paper indicates, there is no one health or care provider, no single inspectorate and few meaningful metrics for patient pathways of care. There are individual examples of good practice such as the joint WG/Macmillan/Picker annual surveys of cancer patients. North Wales CHC has tracked Stroke patient pathways from 999 call through acute care to rehabilitation and social care services.

If the envisaged new patient's voice/champion is to be an advancement on current practice, it must be centred on the patient rather than on provider 'silos' and predicated on close, regular, local monitoring of care pathways across service providers.

Quality assurance
Despite their generally high quality, the paucity and infrequency of HIW inspections mean that service providers have to utilise other quality assurance mechanisms for day-to-day operations. For example, in addition to its internal systems, Betsi Cadwaladr University Health Board relies on feedback from and dialogue with North Wales CHC as part of its quality assurances.

Examples from the past few weeks:
a. the current BCUHB Risk Register includes:

"CRR09 Risk: Primary Care Sustainability:
There is a risk that the Health Board is unable to meet its statutory responsibilities to provide a primary care service to the population of North Wales.

"Assurances:
1. Oversight by Board and WG as part of Special Measures.
2. CHC visits to Primary Care.
3. GP council Wales Reviews.
4. Progress reporting to Community Health Council Joint Services Planning Committee." (my emboldening of text).

b. A comprehensive report on "Service Developments within Mental Health" to BCUHB's Quality committee on 12 September outlined how its External Assurance focussed on "divisional compliance to Healthcare Inspectorate Wales and Community Health Council inspections."

c. An unsolicited letter sent in July from the Senior Nurse in charge of the Infection Prevention Team at BCUHB states:

"We are grateful to the Community Health Council (CHC) for their continued support with the Bugwatch Survey across our acute hospitals. The survey provides an extremely helpful independent view of our infection prevention and cleanliness standards. We are equally delighted that our commitment to continuing improvement is visible to the CHC."

Co-design/co-creation

North Wales CHC is currently working in partnership with BCUHB on the redesign/reconfiguration of the provision of Stroke, Orthopaedic, Vascular and Renal services. It is also collaborating with WAST on enhancing patient retrieval services.

Membership
The CHC's have a membership structure which is unduly cumbersome and has too many committees. Like many Cardiff-based bodies, the overarching Board of CHCs seems a long way from the concerns of North Wales.

In common with many other voluntary organisations, CHCs are not wholly representative of all community groups (underrepresentation of the young, the employed, young mothers, people with protected characteristics, etc.). However, they currently have no control over their recruitment. Apart from a few co-opted members, half the members are appointed by the Minister, a quarter nominated by voluntary organisations and a quarter nominated by county councils.

Nor are HIW's Lay Reviewers typically 'lay' persons since the majority are people with current or previous experience of health and social care policy and practice.

Can you see any practical difficulties with these suggestions?
The lack of specificity makes it difficult to comment on practical application.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
It is unclear how this would work or why it would be an improvement. The Royal Colleges have been used with some success to provide clinical advice on reconfigurations. External independent reports (e.g. the Ockenden Report on mental health provision in North Wales) have also highlighted the need for service delivery change. Stakeholder groups, voluntary organisations and CHC's already are involved in service change discussions.

There is the danger of creating a system that is more bureaucratic and more remote without any gains in efficacy.

What further issues would you want us to take into account in firming up this proposal?
Clarity of thought, purpose and design.

Inspection and Regulation and single body
What do you think of this proposal?
I agree with many of the points made in the White Paper about the HIW's underpinning framework.

HIW should not be inspecting suntan and tattoo parlours.

The constraints of inspecting against the Health Standards limits HIW's ability to comment (formally) on non-regulatory but important issues that come to light during inspections.

HIW's involvement in the Escalation framework with a number of Health Boards suggests further avenues in governance, corporate culture ('ward to Board'), workforce issues and so on. For example, while there are already workforce assessment systems in place (Investors in People, Corporate Health Standard, etc.), appropriate HIW Peer Reviewers could ascertain the efficacy of HR policies and plans at ward level. Staff questionnaires are part of current HIW inspections but the results are not contextualised within broader Board strategies.

In other words, there is little linkage currently between HIW's 'macro' work at Board level and its 'micro' inspections of that Board's hospital wards.

Given HIW's model of an administrative core that co-opts different expert reviewers according to the nature of the inspection, an expansion of its palette would require a wider pool of expertise to call upon.

However, before HIW is given a wider remit or more powers, it needs to improve its management and administration and to become more receptive to suggestions for service improvement and collaboration.

Are there any specific issues you would want us to take into account in developing these proposals further?
There are significant differences in organisational culture between CSSIW (assertive), HIW (defensive, self-righteous) and CHCs (parochial). Unless there is greater harmony between the three, an overarching body will not lead to greater synthesis/symbiosis but merely paper over the cracks.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Having worked for a Government Sponsored Body, the former Disability Rights Commission, I am not convinced that an arms length bureaucracy will be much of an improvement.

Would you support such an idea?
No.

WGWPMB84: Hefin David AM
Location: Caerphilly

General Comments

I have met with both constituents and representatives of Aneurin Bevan Community Health Council (ABCHC) since the publication of the attached White Paper Consultation Document.

A common theme emerging from the concerns that they have raised is that any patient representative (or 'voice') body resulting from the proposed changes must have real teeth and statutory clout, and that the White Paper Consultation Document's proposals do not give sufficient assurances of that. I must say that I share these concerns.

Community Health Councils (CHCs) play a crucial role in giving local people a voice when it comes to the provision and standard of NHS services provided by their Local Health Board (LHBs). They are an extremely valuable way in which LHBs, and NHS Wales more widely, can be held to account in the interests of local people.

My constituents and I fear that the proposed changes could result in a lack of independent scrutiny of Aneurin Bevan University Health Board (ABUHB), which the ABCHC does effectively through its visits to hospitals, GP surgeries and ambulance stations as well as its various working committees. CHCs do not duplicate the work of Healthcare Inspectorate Wales (HIW) – the inspection work that both organisations carry out is necessarily of a different nature. My constituents and I feel that this is not recognised in the White Paper Consultation Document.

My constituents and I are also concerned that the White Paper Consultation Document appears to give little or no consideration of retaining the existing CHC structure; but with improvements that could include extending its remit to include social care, more flexibility in recruitment, retention of volunteer members, and a concerted effort on awareness-raising of their work among the local population.

Finally, my constituents and I believe that any new arrangements resulting from the White Paper Consultation Document must ensure that the voice of local people is both heard and listened to; must be independent, non-political, open and transparent, and have the statutory clout to hold both ABUHB and NHS Wales to account; and also be cost-neutral.

I would be grateful if the Welsh Government could take the above concerns into account when taking forward any future proposals that result from this consultation.

WGWPMB85: Information Commissioner's Office
Location: Cardiff

General Comments

The Information Commissioner has responsibility in the UK for promoting and enforcing the Data Protection Act 1998 (DPA) and the Freedom of Information Act 2000 (FOIA), the Environmental Information Regulations (EIR) and the Privacy and Electronic Communications Regulations. She upholds information rights in the public interest, promotes openness by public bodies and data privacy for individuals. She does this by providing guidance to individuals and organisations, solving problems where she can, and taking appropriate action where the law is broken. The opportunity to respond to this consultation is therefore welcomed but comments will only be made in respect of issues relevant to the scope of her responsibilities – in this case the Commissioner's interest is in the extent to which the coming into force of the General Data Protection Regulation (GDPR) on 25 May 2018, is being taken into account in the proposals to improve quality and governance in health and care. GDPR will make data protection an issue for the boardroom.

A) Chapter 1: Effective Governance
One of the aims behind the GDPR is to help make organisations more transparent in how they handle personal data, and to improve standards by raising the strategic profile the range of activities that contribute to successful data protection practices, particularly in complex organisations such as the NHS.

As public bodies, and particularly public bodies that are responsible for large quantities of special category data, all NHS Wales Health Boards and Trusts will be required under GDPR to formally appoint a Data Protection Officer (DPO) no later than 25 May 2018. Whilst the DPO is very unlikely to be a be a Board Member, Article 38.3 specifies that "the data protection officer shall report directly to the highest management level..", so clearly this is a legal responsibility that will require significant attention from at least one member of the board. GDPR allows for the DPO to be either an employee or a contractor, and sets out in some detail the position and its key tasks. Article 38 states (in summary):

- The DPO should be involved, properly and in a timely manner, in all issues which relate to the processing of personal data.
- The board shall support the DPO in performing their statutory tasks by providing necessary resources, access to data processing operations and support to maintain his / her expert knowledge.
- The DPO cannot be instructed in their statutory tasks by the board, neither can they be penalised or dismissed for performing those tasks.
- Data subjects may contact the DPO about anything to do with the processing of their data or the exercise of their rights under GDPR.
- The DPO shall be bound by secrecy or confidentiality concerning the performance of their tasks, in accordance with the laws in force in that country.

- The DPO may fulfil other tasks and duties; however these must not result in a conflict of interest.

Article 39 sets out the statutory tasks for the DPO. In summary these are:

- To inform and advise the board and employees of their data protection obligations.
- To monitor compliance with all data protection law and the relevant organisational policies including the assignment of responsibilities, staff training and awareness and audits.
- To advise on and monitor performance of data protection impact assessments.
- To co-operate with the supervisory authority (ICO), providing a point of contact and engaging in prior consultation as required by Article 36.

I attach a link to the European Union's Article 29 Working Party Guidelines on Data Protection Officers.

B) 3.1: Setting and Meeting Common Standards

In order to support delivery of high quality person centred care, whether by different parts of the NHS or social care, it is vital that organisations are able to share patient information legally and safely. Important steps have already been made in Wales towards this goal, but the issue of common standards for information governance between health and social care have not yet been addressed. A set of common standards supporting the management of personal information wherever it is being used within the health and care system would enable all organisations within that system to have confidence that when they agree to share a patient's data in order to support provision of care it will be managed in any part of the system with equivalent standards of security and confidentiality.

Whilst all organisations within health and social care are of course subject to the Data Protection Act and will be subject to the GDPR, there is a significant level of detail in how they approach these laws that remains incompatible, for example access to secure e-mail systems so that data can be safely transferred between health and social care and agreed and implemented standards and frequency of data protection training for front line staff. Currently these issues are addressed on a project by project basis, for example through Wales Accord for Sharing Personal Information agreements, or the developing Wales Community Care Information System. As Wales moves towards person centred care with different parts of the health / care package provided by different organisations, it would be beneficial for there to be compatibility of standards as the norm, as sharing personal data appropriately will need to underpin the smooth running of the health and care system. From our position as regulator, we encourage sharing personal data to support provision of safe and effective care, but that must be done in compliance with data protection laws and must be clearly explained to service users. A compatible approach to the Duty of Confidence is also an issue for consideration, although this is not within ICO's remit.

GDPR includes a new "principle of accountability" which will require all data controllers to be able to demonstrate how they comply with data protection law both in their internal processing of data and in any partnership working or other data

disclosure that they may be involved in. It will also require that health and social care organisation undertake statutory privacy impact assessments on all large scale projects using personal data, so that a “privacy by design and default” approach can be adopted throughout the development of projects and programmes involving personal data. A common standard for information governance across the NHS and social care pathway would be a key step towards meeting this new legal duty as well as making the day to day processes of sharing information to support care less complex and time consuming for frontline staff and the information managers trying to support them.

C) 4.3: Inspection and Regulation
Currently NHS Wales relies on the Caldicott Principles in Practice assessment toolkit to monitor and report on information governance compliance. It is now agreed between NHS Wales, Welsh Government and ICO that C-PiP does not adequately address this task as it does not require organisations to evidence their answers, nor is there any robust external scrutiny of the annual reports. This has also been a problem with regard to getting Section 251 clearance for Welsh health research projects.

NHS Wales are in the process of developing a new Information Governance toolkit that aims to be more robust and therefore more useful to organisations in identifying potential problems before they occur. This toolkit will cover the NHS parts of the health and care system, but as set out above, there is as yet no agreement to a joint set of standards between health and social care. In addition, the lack of evidence based assessment of each other’s’ data protection standards creates considerable risk and tension for organisations as they need to share the data to support provision of care, but struggle to be properly assured that the receiving organisation will manage the data with an appropriate standard of data protection.

External scrutiny of each organisation’s toolkit report is essential to ensure due diligence in completion. Currently there is no Welsh provision for this as it is not a topic directly covered by Wales Audit Office, Health Inspectorate Wales or the Care and Social Services Inspectorate. The only external scrutiny of information governance in NHS Wales or Welsh Local Authorities is when an organisation is selected for audit by the ICO.

We strongly recommend that Wales introduces its own national approach to routine information governance evidence based scrutiny, in order to support high standards of data protection in a partnership based care system.

D) 3.2: Joint investigation of health and social care complaints
We welcome a joined up approach to investigation of complaints, and agree that it is important that the various organisations involved in delivery of health and care services work together to put things right. Where any complaint involves a data protection matter – for example a concern may be about, or include, problems with the accuracy, availability or disclosure of someone’s health or care records – then the complainant has a legal right to refer the matter to the Information Commissioner. Freedom of Information complaints are also a matter for the Information Commissioner, but are less likely to form part of a wider service provision issue than data protection matters. The Information Commissioner has a

good working relationship with the Public Services Ombudsman for Wales, and is keen to build similarly productive links with Health Inspectorate Wales, Care and Social Services Inspectorate Wales and any new organisation with similar remit.
In our complaints and concerns referral process, our normal procedure is to ask the complainant to raise the matter in the first instance with the data controller (ie: the organisation responsible for their personal data). In this type of complaint the data controller may be an NHS organisation, a Local Authority, a third or private sector service provider, or there could be shared data controllership between two or more organisations. We expect the data controller to investigate the matter, co-ordinating local investigation with any partner organisations if necessary, and if that does not resolve the concern then the complainant may refer to matter to the Information Commissioner.

We will be happy to contribute to any future guidance for the health and care sectors the Welsh Government may wish to develop to ensure that any complaints involving information law issues are correctly handled.

WGWPMB86: Cartrefi Cymru Co-operative
Location: Unknown

General Comments

Cartrefi Cymru Co-op provides social care and housing related supported to over 650 people across Wales, mainly people with learning disabilities and older people, and others as well. We work in 15 local authority areas and employ 1200 staff, making us the largest Wales-based non-statutory provider of social care.

Our comments on the White Paper are as follows:

1. Effective Governance

We are concerned that the interests of people with learning disabilities (and of those professions which focus upon their health and social care) are not separately represented at Board level. We see the White Paper as an opportunity to separate Learning Disability from Mental Health, to the benefit of both interests but especially of Learning Disabilities.

We recommend that this is done through the appointment to Boards of an additional Director with a specific remit to include leading on Learning Disabilities. One of the Independent Members should also have a 'champion' role for Learning Disability.

2. Duties to Promote Cultural Change

We welcome the Duty of Candour, but would point out the issue of language. Unless accessible, plain language is used, the supposed candour will still amount to obfuscation.

Changing culture, and particularly on the scale required for the achievement of both health and social care integration AND the adoption of Co-productive attitudes and practices, will take time and needs to tackled in multiple ways. Simply placing a duty on Boards and authorities to promote Co-production will not be sufficient, not least because there is much evidence to show that, without an effective induction into the concept and practice of Co-production, it is all too easy for professionals to misunderstand what it is and is not. It is NOT inter-agency collaboration (good though that is), nor is it one-off consultations or tokenist inclusion of citizens on Boards etc.

We therefore recommend that statutory instruction and guidance goes further than the current proposal, as follows:

- Co-production needs to be built into the training and accreditation of all health and social care professionals. This will involve instructions for Social Care Wales and any relevant health training and accreditation devolved to Wales. We would urge Welsh Government to embed Co-production into all professional training within its scope, as the wider it is adopted as basic good practice (that is, valuing your client's opinion helps you both get what you want) the more it will be reinforced by inter-professional contact.
- There needs to be a clear role for the Regional Partnership Boards in relation to promoting collaboration and culture change. These are the principal statutory vehicle for achieving health and social care integration, but they are

at risk of being marginal to the “business as usual” going on at LHBs and LAs (and possibly even WG).

3. Person-Centred Health and Care

No comments

4. Effective Citizen Voice, Co-production and Clear Inspection

The first point to stress is that the White Paper appears to be seeking to adopt a model for “citizen voice” from Scotland at a time when Scotland is known to be having second thoughts about its effectiveness. It surely makes sense to pause, engage with Scotland in an up-to-date exchange, and even more importantly, not rush into the design and delivery of a vehicle for “citizen voice” and co-production which has not been co-designed with citizens. We have no particular flag to wave for CHCs, but on the face of it, a national voice body could be worse.

We therefore recommend that an inclusive process of co-design and co-delivery in relation to the future of a citizen voice vehicle (or vehicles) in relation to health is adopted and is one which ensures local voices remain relevant.

We would also recommend that the design and delivery of any such vehicle gives particular attention to the need to ensure that the voice of the disadvantaged and marginalised is heard. There is a need to avoid the dominance of such vehicles by white, middle class, “usual suspects”.

Finally, we would like to take this opportunity to point out to Welsh Government that the creation of new legislation arising from this White Paper creates an opportunity to address an error in the Registration and Inspection Act. The R and I Act has created a primary legislative requirement for charitable trustees of social care providers (such as Cartrefi Cymru Co-op) to become Responsible Persons and visit every service location every month. This is generally acknowledged to be a drafting error, and much effort is going into trying to find a way around it, so that trustees do not resign in droves rather than face such onerous responsibilities. As we understand it, it would be entirely legal and relatively straight forward for a correction to this R and I Act to be included as a clause in the legislation arising from this White Paper. We hope this idea is helpful and an opportunity for inter-department collaboration.

WGWPMB87: Cardiff and Vale Community Health Council
Location: Cardiff

General Comments

Members of the Cardiff and Vale of Glamorgan Community Health Council (CAVOG CHC) welcome the opportunity to respond to the recent Welsh Government White Paper 'Services fit for the future' consultation.

CAVOG CHC oversees on behalf of the local population NHS services provided by:

- Cardiff and Vale University Health Board,
- Velindre NHS Trust,
- Welsh Ambulance Services NHS Trust (Cardiff and Vale of Glamorgan).

CAVOG CHC maintains a continuous dialogue with the public through a wide range of community networks, direct contact with patients, families and carers through our engagement activities, complaints advocacy service, visiting activities by speaking to users of NHS services at the point of receipt of care and through public and Patient surveys. Following our visits we were able to highlight issues raised by patients in relation to:

- Health Board Estates
- Accessibility
- Discharge and Repatriation

During the past 12 months CAVOG CHC had undertaken 86 visits to health care services to engage with patients. Our advocacy service supported 152 people with concerns, we received 370 enquires. Members undertook some key engagement events such as Pride Cymru, Dementia Care and we also raised awareness of the CHC in the Vale of Glamorgan on the community radio station Bro Radio.

We have built up good working relationships and routinely share our reports and NHS responses with the inspection and regulatory bodies to provide the crucial link between those who plan and deliver the National Health Service in Wales, those who inspect and regulate it, and those who use it.

CAVOG CHC is made up 24 voluntary unpaid members who are appointed either through the Welsh Government Public Appointment Branch (12), Local Authorities (6) and Third Sector (6).These members are supported by eight staff.

Overview
CAVOG CHC agrees with the Welsh Government's aspirations for a truly integrated health and social care system that enshrines good governance, telling the truth, and

delivering high quality services which are independently checked by an effective inspection and regulation regime.

We recognise that primary legislation can play an important role in achieving these aspirations. However, there is little evidence to suggest that primary legislation alone would provide the catalyst to deliver real and long lasting change

We particularly welcome the aspiration to strengthen the people's voice across health and social care, and embedding the key principles of co-design and co-production. Members were concerned that the proposals were actually diluting the voice of the public by abolishing CHCs in their current form.

Over the summer CHCs have asked people what is important to them about the proposals contained in the White Paper; in addition we considered in detail what others have said about the strengths and weaknesses of related arrangements in other UK countries.

We collected over 245 responses from individual members of the public which have been forwarded separately to the Welsh Government. A clear message from the public from our engagement activities was to ensure the population of Cardiff and Vale of Glamorgan do not lose what is already provided by the CHC. However, they supported the view held by the CHC of the need to evolve into a new peoples' voice body for Wales. Members fully endorse the comments received from the public.

Chapter 1: Effective Governance
Board Membership and Composition
The White Paper rightly raises concerns about the membership of Local Health Boards whilst acknowledging that the current NHS trusts have different structures. We are of the view that having a core structure across Health Boards / NHS Trusts and Social care would be of benefit and ensure consistency.

Members raised concerns that when Local Health Boards were established (2009) their regulations did indicate a clear executive structure however, over time this has changed and we believe the voice of Community, Primary & Mental Health at Board level has diminished. We need to see a strengthened Board being led by Primary Care as more services transfer from hospitals closer to people's homes.

We would also question the change within the principles from Independent Member to 'Public Member'. This in our view will give an impression that their role is to represent the public at Board level, whilst acknowledging these individuals are appointed through the public appointments process and receive an honorarium. Members were of the view that the requirement currently to have independent members appointed with specific skills i.e. finance, IT, community is very prescriptive and does not allow the Board to have the flexibility to meet local needs. Members

would wish to see this requirement removed to allow flexibility of appointment across a wide range of skills required to sit at Board level.

The CHC welcomes the proposal of a Vice Chair to NHS trusts and a continued enhanced role on Local Health Boards.

Members were of the view that a representative voice is required to be heard at NHS Board level to feed in a cross section of views from the communities it serves. CAVOG CHC is of the view this should be from a stronger peoples' voice body. Members commented that until 2010 CHC volunteer members were associate members of the NHS Board and this provided a platform for the views of the public to be heard. Members are of the view that this status should be re-established which would secure a seat for the public voice at NHS Board level.

Members were supportive of the proposals for Ministers to appoint where necessary to Boards and they were of the view that it is essential that an appropriate mechanism is in place to support Boards who are experiencing various challenges. Members commented that a clear process should be established to ensure transparency where Ministers appoint to Boards. Members commented that this should go further by clearly authorising Ministers to remove Board members as appropriate.

The CHC raised concerns regarding the NHS escalation process, as currently they provide invaluable information on the patient experience at the Healthcare Summits with other key partners which helps inform the discussions between the Wales Audit Office, Healthcare Inspectorate Wales and Welsh Government when determining if escalation is required. It is believed this will cease if the proposals in Chapter 4 of the White Paper are implemented and CHCs are abolished.

The Role of the Board Secretary
Members recognise the important role played by the Board Secretary within NHS organisations. However, members commented that this terminology was outdated and could be perceived by many that this person took the minutes of Board Meetings. Members were of the view that this important governance role should be re-designated as Head of Corporate Governance and Compliance. Members believed this would truly elevate the status of this role as a key advisor on all governance and compliance issues in relation to Board activities.

The proposal contained in the White Paper could lead to the Board Secretary becoming isolated from key discussions. There were additional concerns on how this post holder will be supported if these proposals are implemented.

Members were of the view that this role should not be excluded from the proposals which allow Welsh Government to appoint to NHS Boards. They were of the view that any appointment to this post may be considered a political one.

Chapter 2: Duties to Promote Cultural Change

Duty of Quality

When Local Health Boards were established, their remit was to see themselves as organisations responsible for the health of their population. This would be achieved by putting the person at the centre of the care they receive. This section appears to be changing that premise by moving this responsibility to regional and possible national level and removing the “requirement of focussing on the quality of services provided to an individual rather than at a wider population level”.

Members commented that any new legislation would need to simplify and clarify what is expected from service providers and what quality means from a user perspective.

Members believe that this new duty would be a driver to raise the quality of services. However, they did have concerns that this legislation itself would not bring about a shift in culture and behaviours.

Duty of Candour

The CHC fully supports an integrated Duty of Candour across all providers of Health and Social Care in Wales to include private and contracted services. Members were of the view this was already in place and it will be essential that Health and Social Care providers are seen to be fulfilling this duty. In addition, it needs to be clear about what enforcement action will be taken for non-compliance, as this is not evident in the White Paper. Clarification is also required on the mechanism for monitoring this Duty of Candour and to whom it will report?

The CHC are unaware of any real evidence from other areas of the UK where this duty has been implemented where meaningful changes to organisational behaviour have impacted on service users.

Chapter 3: Person-Centered Health and Care

Setting and meeting common standards

Members commented that setting standards across a number of organisational boundaries would present some significant challenges which would need to be resolved. They were of the view that the public would expect meaningful standards that apply to everyone who provides their health and social care.

Members were of the view that any standards should be developed and influenced by the public voice. In addition, failure to meet the standards should be dealt with in a transparent way.

Joint Investigation of Health and Social Care Complaints
Members welcome the proposal to establish a joint investigation process for complaints across health and social care. They believed it was essential that any process was the same across all organisations, as this would reduce confusion which is currently the case for complainants.

**Concerns were raised to the current independent complaints advocacy service and where this would sit in future. Members echoed the views of the public we engaged with during this consultation that the advocacy service should be retained by the new peoples' voice organisation and supported the role extending it into social care. In addition they were of the view that Wales needed a standardised complaints system across Health and Social Care. Members were very concerned that there may be a downgrading of the 'Putting things Right' system as they are aware that social service complaints processes are not standardised across Local Authorities and therefore appear fragmented.

Members highlighted concerns raised in the Francis Report by Peter Walsh of AvMA, in comparing the functions of CHCs and what ICAS provided now in England .
Where I think there is potential for ICAS to do much more is in being more proactive about looking at learning from complaints and things that need to happen. When I was referring to community health councils I said that they were more joined-up, that the two functions were combined, which meant that directly data from complaints could feed into the monitoring and the intervention by the CHC. We've lost that in the fragmented system. It's almost as if ICAS is seen as in a side as being advocacy in a purer sense. And what we would like to see more of is the ability to translate that learning into actual action to improve things and make them safer for patients.
(Francis Report Chapter 3 Complaints, process and support. p277)
Chapter 4: Representing the Citizen in Health and Social Care
Members acknowledged and welcomed the intention to create a stronger voice across health and social care. However, they were of the view that the abolition of CHCs raised serious concerns. They commented that they supported a re-focus of the current CHC model to meet the needs of the public. This re-focusing of the functions should be based upon a detailed analysis of the systems and frameworks currently in operation across the UK.

Members were of the view that there is an opportunity to co-design and co-produce an alternative model that ensures the current infrastructure and networks already in existence are enhanced, and learn from the mistakes made previously in England. Members welcomed an opportunity to move away from the current prescriptive statutory legislative framework to one of focusing on improving outcomes for the public who access health and social care, which will in their view lead to having an organisation which represents and amplifies the voice of the population of Wales either at local, regional or national level. Members were of the view that the current

CHCs can evolve into a new peoples' voice body for Wales and this would result in the retention of the existing networks, and infrastructure which has built up over time Upon analysis of the proposals contained in the White Paper, members believe this will in effect dilute the publics' voice and focuses its only remit to areas of significant service change, and removes a route for constructive challenge to be made.

Members felt strongly that the Welsh Government proposals are drawn, largely in part, from the arrangements in place in Scotland. We have heard directly from the Scottish Health Council following a recent review and subsequent public consultation launched in July 2017 which identifies a clear case for change for their future direction. CHC members were concerned that the White Paper proposals for a stronger citizens' voice in Wales are predicated on a model that is not, and does not currently describe or consider it to be a citizens' voice body.

It may be helpful to reflect on why Community Health Councils were initially established. CHCs were set up following the 1974 NHS Act which moved health functions e.g. community nursing and public health and the role of Medical Officer of Health out of local authorities to district Health Authorities. CHCs were established in part to compensate for the democratic deficit in the NHS.

CHCs were in existence long before the current regulators in Wales were established such as Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales. Despite several changes to the CHC Statutory Instruments over the years which set the framework for CHCs, some language in relation to use of the term 'Inspection' has not changed despite CHCs requesting changes to make them more relevant. Despite this not being actioned CHCs have maintained a patient experience focus as part of its visiting process.

Members commented that a number of patients receive care from NHS England and therefore, we could learn lessons from areas where CHCs were abolished in 2002. These concerns were highlighted in the Francis Report into the issues concerning Mid Staffordshire NHS Trust.

"The Francis report is the result of a public inquiry into the role of commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust between January 2005 and March 2009. It follows on from two previous inquiries into events at the Trust which uncovered a lack of basic care in many of its wards and departments. This previous report brought to light many distressing personal accounts of appalling care, such as patients being left in excrement in soiled bed clothes for lengthy periods, assistance not being provided with feeding for patients who could not eat without help, and staff treating patients and their families with indifference and a lack of basic kindness.'

This report considers why these serious problems at the Trust were not identified and acted on sooner, and what should be done to prevent it happening again in future. Its findings are highly critical of the Trust's Board at the time highlighting "an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities".

However, the report ultimately concludes that responsibility is not confined to the Board of the Trust alone, but runs right through the health service. It states that events at the Trust are "not… of such rarity or improbability that it would be safe to assume that it has not been and will not be repeated".

The report calls for a "fundamental change" in culture whereby patients are put first and makes 290 recommendations covering a broad range of issues relating to patient care and safety in the NHS".
(RCGP Review of Francis)

It was noted by Members that the White Paper proposals do not give any peoples' voice body the ability to visit where care is being delivered, although acknowledge that the advocacy service was being considered a function of this new Citizen Voice body. Members' reiterated the statement from Peter Walsh AvMA in the Francis Report. "When I was referring to community health councils I said that they were more joined-up, that the two functions were combined, which meant that directly data from complaints could feed into the monitoring and the intervention by the CHC. We've lost that in the fragmented system". Members therefore consider it essential that these two functions are retained. (Francis Report Chapter 3 Complaints, process and support. p277)

"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." (Francis Report Chapter 6 - Patient & Public Local Involvement and Scrutiny p 581)

CHCs have worked together on developing their own ideas on how best to fulfil the Welsh Government's stated aspirations – outlining what CHCs consider should be the key functions and principles underpinning the detailed design of a new public voice body for health and social care in Wales.

CHCs recognise that legislation can provide for the introduction of a new peoples' voice body with a range of functions and responsibilities. A change in structure and remit itself however, cannot address all the challenges identified. Evidence suggests that some of these challenges, for example, the level of public awareness and perceived independence of bodies set up to represent the interests of people in health and social care, are common across the UK (The Right Time, the Right Place (2014) https://www.health-ni.gov.uk/topics/health-policy/donaldson-report) Kings Fund, Local Healthwatch: progress and promise (2015).

CHCs believe a new, strong and meaningful peoples' voice body should be designed and developed with others in Wales, for Wales. Wales should learn from others' approaches and experiences and build on what is valued within Wales' own current arrangements.

CHCs have taken the opportunity of this consultation to co-create a new and exciting peoples' voice body with the capacity and capability to work with others to drive flexible and innovative ways of engaging and involving people of all ages - on the things that matter most to them about health and social care and using their preferred ways of communicating.

CHCs agree with the aspiration set out in the White Paper that health and social care bodies should get things right by continuously engaging with their communities. CHCs also know that these bodies do not yet get this right every time – and do not believe that new legislation alone will make this happen.

In Wales, by and large we don't have a market driven health and care system. It is therefore important that our services are created with and for the people that use them. Not only do services need to engage on the service matters they are thinking about, but people must have the opportunity to have a collective voice on the things that matter most to them about the services they receive.

Health and Social Care organisations have the responsibility to respond appropriately when concerns are raised with them. However, people in the most vulnerable situations may not be in a position to raise their concerns without independent support.

CHCs believe that people in Wales deserve an independent effective voice that is working hard every day, to make sure public views and experiences influence how their health and social care services are designed, and delivered whilst encouraging. and valuing the diverse range of voices across Wales. The population of Cardiff and Vale of Glamorgan told us they need a voice that is capable of making sure service providers across health and social care are held to account for the services they provide to people and communities in Wales.

CHCs consider the purpose of a new peoples' voice body in Wales should be to: "reflect the views and represent the interests of people in their health and social care services". Volunteer members are the lifeblood of an organisation. They also act as the eyes and ears for their local communities in relation to Health and Social Care. The CHC has raised concerns over the years surrounding the membership appointments process. Comments received indicate this is a tiresome and confusing process and acts as a deterrent to becoming a volunteer. Members were of the view that the membership appointment system needs to be reformed, ideally allowing the organisation to recruit its own volunteers as appropriate.

CHCs believe a new peoples' voice body in Wales should have the following functions:
To encourage and support the involvement of people of all ages as individuals and communities in the design and delivery of services by:

- Engaging directly with individuals and communities on the things that matter most to them about their health and care services, including engaging directly with people accessing services through a mechanism to enter, view, listen and feedback.
- Supporting, encouraging and facilitating engagement and involvement through a formal alliance with others to promote co-production and co-design. Working collaboratively and across-boundaries to develop a creative, bilingual and accessible platform for individuals, communities, regions and the wider population to share their views and experiences and influence health and social care design and delivery on a local, regional and national level,
- Informing the development of national standards and guidance for engagement and consultation,
- Advising and supporting providers on involving people, including on engagement and consultation activity,
- Monitoring and evaluating the effectiveness of involvement, engagement and consultation.

Checking that people have had the opportunity to be heard and that their views are properly considered and responded to, Whilst CHCs do not consider a new peoples' voice body should be checking compliance against standards (this sits better with others) it could and should refer concerns to responsible bodies if it appears standards for engagement and consultation have been breached, To represent the interests of people in health and social care by:

- Scrutinising health and social care policy, plans and performance locally, regionally and nationally. Challenging service providers and policy makers where improvement is needed,
- Sharing the views / experiences gathered with the regulators and local authority scrutiny panels,
- Scrutinising the work of health and social care regulators and inspectors

- Sharing ideas, information and concerns about health and social care to support service improvement,
- Involvement in the co-design and development of services (including service change proposals),
- Providing independent advocacy support and assistance to individuals raising a concern about health and social care services,

It should have the following rights:
- Right to visit unannounced wherever health and social care is delivered to hear the views and experiences of service users / patients and replay these to the service providers,
- Right to co-operation from care providers in contacting people on their behalf for the purpose of collecting independent feedback about care services,
- Right to be heard in health and social care (including on service change) by:
  - Policy makers
  - Service providers
  - Scrutiny bodies (i.e. local authority scrutiny panels)
  - Regulators
- Right to a full, public and timely response from the above on concerns raised,

Members do NOT consider a new public voice body should take on the following existing CHC functions, duties or powers:

- Provide advice and information on health and social care services.

We believe the responsibility for this should be with health and social care bodies. The new people's voice body must have the right to challenge services where the advice and information is not sufficient, clear, accessible or accurate.

- Inspect premises.

We believe this responsibility should sit with relevant regulators/inspectorates

- Responsibility to develop alternative models to service change proposals where agreement cannot be reached

We believe any lay organisation would not be equipped to meet this responsibility.

- Right of referral to Ministers on service change proposals

We believe a new people's voice body should not be the decision making body for a proposed service change. All service change proposals should be open to public scrutiny.

Where decisions are not considered to be in the public interest, the appropriate challenge is through judicial review.

So that a new peoples' voice body is, and is seen to be independent, it should be established as a single legal entity on a stand-alone basis.

So that it is accessible and can respond quickly to what matters most to people and communities about their local services, it should have a strong local presence and focus. The organisational design of a new public voice body must:

- Enshrine the principle of decisions being taken as close as possible to the people impacted
- Provide for local determination of priorities according to evidence of local needs
- Provide for the agility to take decisions that impact locally, regionally and nationally
- Provide for clear lines of accountability within a strong standards & governance framework

Volunteers should be representative of the communities they serve and:

- Be the lifeblood of a new public voice body
- Have the opportunity to contribute in different ways according to their skills and interests underpinned by a strong framework of modular and competency based learning and development.
- A new public voice body must be free to determine how it recruits its volunteers.

In summary, CHCs believe their outline proposals for a new peoples' voice body provides a strong framework on which to base future arrangements in Wales.

However, the success of any future model will depend on the detailed arrangements being co-produced with partners and stakeholders. CHCs ask that the Welsh Government look to facilitate this approach over the 6-12 months following the consultation period.

It should be stated clearly that CHCs welcome the opportunity to change as being a real opportunity to get an effective legislation framework in place in order to strengthen the peoples' voice across Health & Social Care.

Service Change

Members commented that currently the CHC has the right to be consulted on service changes within Health and these are fully understood and complied with by health boards. We co-produced a service change flow chart with the Cardiff and Vale Health Board which provides a clear process to follow. Concerns were raised that there appears to be no such requirement in social care and CAVOG CHC would wish to see the current process expanded to encompass health and social care.

Members have expressed concerns that the proposals within the White Paper do not provide the local population with an independent mechanism and opportunity to be engaged or be able to hold the relevant organisations to account on the decisions made.

They also have concerns that the detailed process described in the proposals are based upon current practice in the NHS in Scotland which has been subject to a recent review that recommends a move away from this approach in light of experience. Specifically, the review recommends a shift from defining service change as significant or otherwise. The review states “decisions as to whether something should be seen as ‘major’ or ‘minor’……. have become divisive, confrontational and detrimental to public confidence in the NHS”. This is illustrated in the diagram (figure 1 p34 White Paper). Members were of the view that every change affects patients / carers etc. and strongly felt they should be engaged throughout the process.

Integrated service developments should be driven by communities whose contribution must be valued and utilised by decision makers in both health and social care. An integrated service change process centred on NHS decision making alone is not acceptable.

CAVOG CHC’s experience is that where service change has been successful, the level and nature of involvement, engagement and consultation was proportionate and responsive to the needs of those affected. We consider that all service change should be open to public scrutiny.

We have included two examples of the impact of CHC activity which will be lost should the White Paper proposals be implemented.

Example of Regional Collaboration / Consultation
CAVOG CHC has a number of experiences of service change with some requiring a formal consultation process such as the South Wales Programme. This consultation covered four Health Board areas and proposed changes to a number of key services. CHCs worked together with the NHS to ensure a comprehensive programme of events were held across the region, within Cardiff and Vale of Glamorgan we held 11 public meetings mostly focused upon the areas which were most likely to be affected by the proposals.

Members of the CHC chaired these events to ensure assurances to the public that their voices were heard. This afforded them to hear directly the questions and answers provided which provided them the ability to form a view when responding to the consultation. Members were very concerned that under the proposals this would not be the role of the new citizens’ voice body to directly engage with the public.

The CHC believes that it is essential for local people to have information in order to feed in their observations and views regarding service change. Members commented that even small service changes cannot be underestimated as they can affect a large number of the population within a community or locality. We have detailed below an example of a local service change which affected in excess of 2,000 patients. It should be acknowledged this would be excluded from any public engagement under the White Paper proposals.

Example of local Branch Surgery Retention (Service Change)
Following notification that a General Practice had applied to close its Branch Surgery, a surgery which provided the only GMS service in one of the most deprived areas in Cardiff, the CHC undertook meetings with patients and local residents; liaised with both the Health Board and local Assembly Members and, following all this, made the decision not to support the Practice's proposal to close its Branch Surgery.

In addition to forwarding the decision to the Health Board, the CHC also identified a number of alternative arrangements that had not previously been considered by the Practice. Following consideration, the Health Board formed the decision to not approve the closure of the Branch but instead agreed to work through the options put forward by the CHC to ensure GMS provision continued in this deprived area.

Example of Cross Border work
The CHC has also been involved in resolving issues regarding cross border services, and attended with the local Assembly Member to hear the concerns of local people. Following this the CHC raised the issues with the Health Boards and held a tri-partied meeting where a resolution was found. We returned to the area and fed this back to the local population and the Assembly Member. Members reiterated that under the proposals no organisation would be available to support the Assembly Member or local population.

CAVOG CHC agrees with the proposals to revise existing guidance on service change. Members stated that the guidance needs to illustrate what effective engagement based on co-production principles looks like in health and social care. In revising and extending this guidance to social care, the Welsh Government should work with NHS bodies, social care providers, the peoples' voice body and others with a role in helping communities to be heard.

The revised guidance should explicitly recognise that decisions taken nationally and regionally have a direct impact on how health and social care services are designed and delivered locally and should provide greater clarity as to how co-production principles will be used to ensure people are engaged at all levels.

Inspection and Regulation
Members of the CHC welcome the intention to overhaul HIWs underpinning legislative framework. However, from the proposals it is unclear what this means. Members commented and this was reaffirmed by the public who fed in their views that they want to see a closer integration with Care & Social Services Inspectorate Wales and would wish to see the merger of these two inspectorates into one organisation this was echoed by the public who responded to the consultation. Members recognise that removing the existing inspectorates from within Welsh Government and housing them within a Welsh Government Sponsored Body would bring more independence from government.

However, it is difficult to see how the governance and accountability arrangements would work in a model that seeks to preserve the independence of three separate bodies within one Welsh Government Sponsored Body. The experience in Scotland with its Healthcare Improvement Scotland model (which houses within it a range of distinctive groupings, including its inspectorate and the Scottish Health Council) illustrates the challenges of maintaining an individual and independent identity for each.

Conclusion
Members of Cardiff and Vale of Glamorgan CHC would wish to place on record their appreciation to the members of the Public, Assembly Members, Members of Parliament, Elected Leaders of Local Authorities and the Third Sector who took the time to meet with the CHC and respond to this consultation. We collected and submitted over 245 formal responses on behalf of the public, and provided in excess of 200 additional copies of the White Paper during this consultation.
Members commented that the process followed during this consultation called into question whether this process followed the “Gunning Principles for consultation”.

1: When proposals are still at a formative stage:
Public bodies need to have an open mind during a consultation and not already made the decision, but have some ideas about the proposals

2: Sufficient reasons for proposals to permit ‘intelligent consideration’ People involved in the consultation need to have enough information to make an intelligent choice and input in the process. Equality Assessments should take place at the beginning of the consultation and published alongside the document.

3: Adequate time for consideration and response
Timing is crucial – is it an appropriate time and environment, was enough time given for people to make an informed decision and then provide that feedback, and is there enough time to analyse those results and make the final decision?

4: Must be conscientiously taken into account

Think about how to prove decision-makers have taken consultation responses into account.

The risk of not following these principles could result in a Judicial Review. A number of public bodies across the UK have been taken to Judicial Review and deemed to have acted unlawfully in their Public Sector Equality Duty – usually linked to the four Gunning Principles.

Members commented that the Welsh Government's Easy Read and Youth Consultation documents may have failed to articulate the role of CHCs in Wales. Therefore, any response from these routes may be based on an illinformed point of view.

We would wish to reiterate that the CHC is supportive of a stronger voice for the people of Wales and feel the alternative proposals outlined by CHCs are a model that would work for Wales; these proposals have been supported by the people we engaged with during this consultation period.

Members Cardiff & Vale of Glamorgan CHC would encourage the Cabinet Secretary for Health, Wellbeing and Sport, to consider our response and make a commitment to work with all CHCs in Wales in developing these high level principles into a model to put the individual at the centre of Health & Social Care in Wales.

WGWPMB88: Aneurin Bevan Community Health Council
Location: Cwmbran

General Comments

It gives me great pleasure in presenting Aneurin Bevan Community Health Council's response to the white paper, Services fit for the future.

Aneurin Bevan Community Health Council understands that as an organisation, changes are needed to future proof the patient's voice in Wales. We welcome many of the changes proposed within the white paper, such as bringing health and social care together in order to ensure a seamless process and in developing an organisation that will strengthen the citizen's voice in Wales.

As an organisation we are concerned that the white paper is suggesting an over reliance on legislation to deliver its policy aspirations and is also looking at aspects of the Scottish Council in developing a new organisation whilst being criticised by its own parliament.

Aneurin Bevan Community Health Council believes that a new organisation is needed, but feels that it is imperative that it has the appropriate key functions in order to provide the citizens of Wales with a stronger voice.

Aneurin Bevan Community Health Council would welcome the opportunity to work with Welsh Government in the future on developing a new organisation.

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
NO

What further issues would you want us to take into account in firming up these proposals?
The White Paper's proposals claim that there are two options for the appointment of Board members 1) core membership set out in regulations for "elements of consistency" and "elements of flexibility" for the appointment of executive members and 2) "Allow Boards to decide on almost all the executive members themselves, apart from one or two". Option one's conclusion states that "this could be unpopular" and the second option concluding that "consistency across health boards would inevitably be sacrificed". From these statements it is unclear whether the proposals offer enough detail to evidence the benefit of either option for us to make an informed decision. Furthermore, the questions for these proposals do not directly ask for feedback on these options but state that Board membership should "probably include some key positions" and should be "consistent" "but also allow some flexibility". These statements again do not give sufficient assurances that Board membership will be consistent as the words "probably" and "flexibility" give rise to

Board's each having different variations in the Board membership in line with their differing priorities. It is therefore difficult to understand how consistency, which appears to be the ultimate goal, will be achieved through the implementation of these proposals.

Whilst we agree with the ethos of the proposed 11 core principles, we have concerns around how the independence of the "public members" will be any different from the current "independent members", and how a change in their title will achieve greater "perspective of the population" than already exists. Until clarity is offered on the benefits of either option 1 or option 2 plus the clarity around how the public member will be any different to the existing independent members, we cannot agree to these proposals.

Board Secretary

Do you agree with these proposals?

NO

What further issues would you want us to take into account in firming up these proposals?

The Aneurin Bevan CHC holds the role of Board Secretary in the highest of regard as we believe they currently uphold the high standards of strong governance within the Aneurin Bevan University Health Board.

The White Paper's proposals are unclear around whether this position would, in the future, remain an NHS appointment or a Welsh Government appointment, given that the White Paper states an independent process should be put into place to dismiss a Board Secretary, it does not state at all whether their appointment would also be subject to the same independent process. If it remains an NHS appointment, how will these proposals and potential statutory protection offer adequate assurances of independent scrutiny of the Health Board or NHS? If it is to be a Welsh Government appointment, then this avenue suggests a Welsh Government officer will be working within an NHS remit which may give rise to accusations that the NHS will not be sufficiently independent from the operational scrutiny of Welsh Government.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

Yes but we require some assurances

What further issues would you want us to take into account in firming up these proposals?

We agree that the Duty of Quality (and Planning) should indeed be updated to reflect the proposed integrated shape of Health & Care Services and population expectations. There should be reciprocal duty placed on Health and Care Services to co-operate and work in partnership to improve quality. If agreed following the outcome of this White Paper, we require the assurance that as a measure to meet public expectation, consultation and engagement with the public will be undertaken to ensure that their perspective on quality and planning is fed directly into the updated duties placed on Health and Care organisations. This would ensure that the

public are truly involved in the co-design and co-production of services and those services truly understand their realistic expectations. Also, the updated duties should clearly set out processes for (the unlikely events) that the Health and Care organisations fail to work collaboratively and fail to agree on reasonable project goals.

Furthermore, avenues for the public to challenge Health and Care Services during the decision making processes needs to be clear and accessible. As the White Paper stands, it is unclear how Health Boards and Local Authorities will balance national or regional priorities and needs against conflicting local views and wishes. We recognise that during times of national or regional service reconfiguration or development, difficult decisions will need to be made and those decisions will be unpopular with different areas in some way or another. At present, Community Health Councils are involved in local, regional and national processes to ensure that the public's voice and view on the quality and planning of Health Services is taken into consideration (example being the CHCs involvement in the South Wales Programme), CHCs also ensure that communication with the public on service options is clear so the public are adequately informed on the reasons for regional and national focus. We believe the proposed new Citizen's Voice body (Chapter 4) should hold statutory rights to be involved with Health and Care Services to represent the public on matters around the quality and planning of Health and Care services.

Duty of Candour

Do you support this proposal?

YES but assurances and clarity are required on some aspects

What further issues would you want us to take into account in firming up this proposal?

The White Paper rightly refers to the NHS's Putting Things Right Procedure which places a duty on the NHS in Wales to be open, transparent and honest when health incidents occur, whether they are identified through the submission of complaints or identified by members of staff when undertaking their duties. Extending this duty to social services is a clear necessity. Lessons can be drawn from the implementation of the Duties of Candour in England and Scotland to learn from good and bad experiences when attempting to encourage a culture change in multiple public service organisations.

It should be clear who the responsible body will be to ensure that a culture of openness, transparency and honesty is being achieved and how it will be monitored; will it be Healthcare Inspectorate Wales, Care and Social Services Inspectorate Wales, both or neither?

We recognise that culture changes are not achieved straightway and there should be one monitoring body in place to be responsible for assessing Health and Care organisation's commitments to the Duty of Candour.

It's imperative that any Duty of Candour being developed (or being built upon) in Wales should itself be clear and accessible for public and staff understanding and

the requirements should (as far as possible) be jargon free and be in plain language. Training days for staff should be developed to encourage the open and honest reporting of incidents. It should also be clear that a duty of candour not only covers the reporting of incidents but also encourages openness and transparency on all levels, including Executive/Board decision making.

The ethos of the Duty of Candour should encourage learning and improvement to better staff and service user experiences, rather than harbour any negative connotations that are perceived to be attached to Whistle-blowing.

Setting and Meeting Common Standards

Do you support this proposal?

Yes

What further issues would you want us to take into account in firming up this proposal?

We believe that the public expects clear and meaningful standards that apply wherever and whoever provides their care. Any such standard should be informed by and reflect what is important to the public.

We recognise that there may be a need to address the imitations within current regulations that specify what standards must be followed. We feel it is important that any new legislation is framed in a way that allows flexibility and adaptability to meet the future expectations.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

YES but assurances are required

What further issues would you want us to take into account in firming up this proposal?

Joint investigations between Health and Social Care to ensure a seamless complaints investigation makes clear sense and the Aneurin Bevan CHC welcomes this proposal but we require clarification/reassurance on a few points.

This proposal is in line with the Social Services & Wellbeing (Wales) Act 2014 – part 10 – Complaints, representations about Social Services. However, we query if the Social Care aspects of any complaint submitted would be subject to the same principles of the NHS's Putting Things Right Procedure 2011 and whether proven social care failings or breach of duties in care where harm has been caused will be subject to the same investigation/panel review for assessing whether a qualifying liability in tort exists. We believe that this level of investigation and legal responsibility should be transferred to the Local Authority complaints procedures so that complainant outcomes are not negativity impacted upon when the organisation at fault (whether NHS or Local Authority) has been identified.

Currently, the Community Health Councils in Wales offer a free and professional Independent Complaints Advocacy service for NHS complaints. The Aneurin Bevan

University Health Board have stated that complaints where a CHC Advocate is involved, is a smoother and less stressful process for clients and staff, as the CHC Advocates assist and guide patients/relatives through the correct processes to ensure their complaint is addressed fairly and through the correct channels. If in the future, joint investigations between Health and Social Care are realised, we believe that the new Citizen's Voice body should take on the existing Complaints Advocacy Service and support it to integrate Health and Social Care complaints. This will ensure the public feel greater reassurance that the advice and support they receive will be through a truly independent, citizen focused body.

Representing the Citizen in Health and Social Care

Do you support this proposal?

NO

Can you see any practical difficulties with these suggestions?

Aneurin Bevan Community Health Council supports the development of a new Citizen's Voice body. However we feel that the White Paper's proposals do not give sufficient detail or information on the plans, expectations or role for the new Citizen's Voice body which is intended to replace Community Health Councils and have concerns that the proposals set out in the white paper have the potential to significantly weaken the citizen's voice rather than strengthen it.

We believe that the White Paper lacks assurances around the ability of a new "Citizen's Voice" to be able to represent the public with any form of legal strength that would ensure services are held to account and service standards are kept under review from the public's point of view.

We set out our concerns below:

1. The White Paper states that currently CHCs are limited in cross-boundary working due to "their attachment to a particular geographical area and population" and this presents "challenges". The White Paper therefore wishes to "strengthen the voice of people in the way that health and social care is planned and delivered by setting up a new arrangement which will have national and local focus". We feel the first statement is inaccurate and can evidence a number of cross-boundary working initiatives to address local, regional and national issues, the principles of which should underpin the new Citizen's Voice body:

- The Consultation for the South Wales Programme 2013 – this looked at options for the future of consultant-led Maternity Services, Neonatal Care, Inpatient Children's Service and Emergency Medicine (A&E) at hospitals in South Wales. It spanned the regional areas of Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff and Vale, Cwm Taf and Powys – also working with the Welsh Ambulance Service to create safe and sustainable hospital services for people living in South Wales and South Powys. All CHC's across South Wales and the South of Powys were involved in this consultation event between May – July 2013 and worked with the Health Board's to gather the public's view and wishes for the future of these Services across South Wales. Each event was represented or chaired by paid CHC officers or volunteer

members to assist in the public engagement. http://www.wales.nhs.uk/sitesplus/documents/1077/SWP%20update%2034%2015-04-14.pdf

- Welsh Government's Planned Care Board – The Aneurin Bevan CHC was approached in 2015 by the Clinical Lead for the WG's Planned Care Board and asked to develop a national patient survey that would be used to gather the patient experience through the whole for a clinical pathway from referral to follow-up treatment for Ophthalmology, ENT, Urology, Radiology and Orthopaedics. Aneurin Bevan CHC developed and piloted the whole patient pathway survey in Aneurin Bevan University Health Board's Ophthalmology Service. The surveys referred to as PREMS (Patient Recorded Experience Measures) were designed to ask patients the same questions across Wales at certain trigger points throughout their care and treatment. These standard surveys were developed by the Aneurin Bevan CHC for the Planned Care Programme Board and piloted for national use in order to measure patient experiences across the whole of Wales. This project was set up and directly worked towards the principles of the Prudent Healthcare Programme to move services toward patient centred care and involvement in the co-production and co-design of service improvement.

- The Board of CHCs then set, as part of their annual plan, 5 national projects for 2016/2017 for each of the 7 CHCs to participate in: Ophthalmology Patient Experience Review, Care of the Elderly, Dementia, Child and Adolescent Mental Health Services and Adult Mental Health Services. The Aneurin Bevan CHC led on the national Ophthalmology Patient Experience Review. The Wales-wide survey (using the PREMS surveys) was conducted by all CHCs in Wales, and gathered national feedback. The report then fed directly into HIW's National Ophthalmology Thematic Review, whilst they looked at clinical experiences and standards, the CHC's patient experience review informed their review at Stage 1 to offer patient-led guidance for their stage 2 review going forward. Not only does this demonstrate national scope but also collaborative working with HIW.

2. The Citizen's Voice should be independent in order to gain the trust of the public and to ensure that the public are able to voice their concerns regarding Health and Social Care services. The White Paper proposes an "independent body", however, it then states the body will "work alongside Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales and the Care and Social Services Inspectorate Wales and work closely with them. We want these bodies to be organised in such a fashion that they can take a unified approach when required, for example, through joint planning or advisory structures, but similarly can continue to operate independently of each other when necessary". This proposal is a contradiction to the White Paper's intention to develop an independent body, as an independent body should work in 'collaboration' with other organisations, not work 'alongside' them. Furthermore, the independence of the Citizen's Voice body should not be set up under the premise of a "Welsh Government Sponsored Body" as this too diminishes the Body's integrity and credibility as this proposal also infers a lack of independence.

3. The White Paper states that CHCs currently "duplicate" the work of Healthcare Inspectorate Wales (HIW) and therefore the CHCs statutory right to enter and inspect should be removed when developing the new Citizen's Voice. We believe the public and the NHS in Gwent feel reassured that the Community Health Council can enter NHS areas to 'visit' not 'inspect' services to ensure that the patient voice is heard and acted upon. HIW as the regulators inspect NHS services from a clinical perspective, when they inspect a ward they look at patient notes, ensure that risk assessments, fluid charts, medication charts are all in order and complete to their fullest. They look at clinical adherence to national and local policies and also look at staffing resources and pressures etc. For example, recent GP inspections, HIW may only survey around 8-10 patients on the day of the visit as clinical focus is their priority. However, when the CHCs conduct GP visits, they send the surveys out two weeks prior to visiting day (approx. 100+ surveys) and surveys on the day to enable a greater snapshot of the patient experience, which is the CHC's primary focus. Last year HIW undertook 32 "inspections" within the Gwent area, Aneurin Bevan CHC undertook 119 "visits", all the reports of which generated an in-depth reply or action plan from the Health Board (whom welcome our reports) to improve the patient experience. These reports and action plans are all shared with HIW inspection manager at the time for intelligence sharing and for the specific purpose of not duplicating work on specific topics.

In the current model of Community Health Councils, we do visit the same hospital wards as HIW (not on the same day) but again from a holistic and patient experience point of view. Currently, CHCs looks at the environment in which the patient resides, support at mealtimes, linen availability to ensure there are appropriate levels of towels, gowns, bedding and blankets etc. Staff attitudes towards patients and the level of communication offered to patients to be able to understand their conditions, treatment plans and ability to ask questions. This is a person centred visit.

Some tangible examples of Aneurin Bevan CHC's interventions includes:

- The movement of the GP Alternative Treatment Centre (ATC) for excluded Primary Care patients based previously in Maindee Police Station in Newport, to a dedicated clinical room within St Woolos Hospital Newport, whilst still maintaining a police chaperone. The previous room provided at Maindee Police Station was simply equipped with a desk and two chairs, there was no clinical examination couch or hand wash basin in the room. Should a patient require further medical review they would simply be referred to the hospital and face waits and delays for medical attention. The clinic there ran every Friday throughout the day and had poor attendance levels. Following the Aneurin Bevan CHC's visit to the site (coverage given in the South Wales Argus) the clinic was moved to St Woolos Hospital to improve both the patient experience and clinician experience. Since its movement, attendance and use of the service has increased because patients no longer feel criminalised by the need to attend a police station for medical attention. This demonstrates that; when undertaking our statutory duties, the Community Health Council fought for a fair service to people who had been excluded, despite patients' negative behaviours, everyone deserves and is entitled to medical services that are delivered in an environment that is fit for purpose. HIW do not represent the patients' interests to this extent. If the new Citizen's Voice body

is unable to visit sites and look at these issues, their purpose will quickly diminish and little faith will be placed in them to be able to fight for equitable services.

- On wards the Aneurin Bevan CHC's impact can be demonstrated further via the outcomes they achieved on Annwylfan Ward in Ysbyty Ystrad Fawr. This ward is a dedicated Dementia unit. When it first opened, little consideration had been made around it being a Dementia Friendly Environment (DFE) e.g. The day room floor was blue with white speckled stripes. The patients therefore believed that the floor was wet and avoided using the day room, some patients had been witnessed attempting to dry the floor with tissues. There were no hand rail supports in corridors for patients to hold on to should they be at risk of falling. These are just two examples of many issues we highlighted on this ward. Because the CHC were able to mobilise their volunteer membership quickly, and visit so frequently the Health Board produced a comprehensive action plan to address all issues we had raised and then consulted with dementia experts to improve the environment, like colour coding doors to differentiate between toilets and bedrooms etc. Levelling off the garden area to remove any trip hazards. HIW do not look at these aspects and do not follow up on visits as frequently as the CHC does to monitor progress.

HIW and CHCs may visit the same wards/GP sites, but they focus on completely different aspects of care. The White Paper wishes to strengthen the "citizen's voice" by removing the Citizen's Voice statutory power to visit patient and public services. This will only weaken their position and ability to represent the citizens of Wales. Therefore, there is no duplication of work, simply a different focus, which both Bodies conduct well, one as the Welsh Government's regulator and one as the independent patient voice. This separation instils the much required credibility that patients seek from a Body set up to represent their needs and should be adopted into the new Citizen's voice. It is paramount that the Citizen's voice retains this statutory function as we believe that statutory powers and rights will give the future model the strong citizen's voice that is required to hold NHS and Social Care services to account.

4. The White Paper has proposed to make the new Citizen's Voice an "advisory body" with regards to service changes and base them in some respects around the Scottish Health Council (SHC) model. During research the CHC has found that the SHC does not have any statutory powers to protect the citizen's voice with regards to NHS service changes and it is currently under review by the Scottish Government as it is deemed "unfit for purpose". During the Consultation Institute's conference in Cardiff, which focused on the proposals set out within this White Paper, the Chief Executive of the Scottish Health Council gave a presentation on their role and remit to give a better understanding of what their structure and purpose could mean for the public in Wales. The Chief Executive explained that they do not currently speak for (or protect) the patients or public in Scotland with regards to Healthcare service change proposals, their purpose is to "quality assure the [consultation] process as it develops", they do not voice or consider the feedback received from the public on any proposed changes. The SHC does not hold a view or opinion on the proposed changes or the decisions made but simply ensures the NHS follow a specific service change consultation pathway. Community Health Councils in Wales also do this, but

we also focus very heavily on the patient/public voice and the potential impact on them and their wishes. The Scottish Health Council monitor processes for adherence only and do not follow-up on agreed service changes to ensure that what was proposed and agreed, is eventually delivered for the benefit of patients, which Community Health Councils in Wales do via their Scrutiny Committees and annual visiting schedules. The Chief Executive of the SHC stated that he believes their inability to represent the patients' voice is a "gap in their process" and they want more of a role in expressing what the public think. The SHC therefore holds more of a governance role in service change proposals and don't speak for patients. In conclusion to this point, we are deeply concerned by Welsh Government's intentions to "strengthen the voice of the people" by shaping some aspects of the Citizen's Voice body for Wales on the model currently in place in Scotland, who themselves have stated, they do not currently represent the interests of the public in health or social care.

The White Paper is proposing that the NHS itself will determine whether a service change is "substantial" or not and therefore will be able to set its own course of action to implement a service change. Whilst approaching the newly developed Citizen's Voice body afterwards and deciding, without any obligation, whether or not to take the Citizen's Voice body's advice into consideration. Again this will only weaken the Citizen's Voice body's position and ability to protect the public voice and ensure it is heard and listened to.

5. Scrutiny of Services – Currently, Aneurin Bevan CHC analyse daily NHS performance data from Ambulance response times, A&E handover times, A&E waits and delayed transfers of care and referral to treatment times. At the moment the NHS is obligated under the CHCs statutory powers to answer and address any concerns brought to their attention about patient waits.

For example:

- On a daily basis the Aneurin Bevan CHC's senior management team receive and review Stroke patient waits in the Royal Gwent Hospital and Nevill Hall Hospital A&E depts. to ensure timely transfer and medical intervention (within 15 minutes). The Aneurin Bevan CHC challenges the Health Board on any long waits or trends/peaks in delayed waiting times. This data also feeds directly into any complaint trends dealt with via the CHC Advocacy Service and will highlight areas of concern via this route also. This again demonstrates the need for the new Citizen's voice body to retain remit over the scrutiny of services and the Citizen's Complaints Advocacy Service.

We are concerned that the White Paper does not cover or explain this aspect of the CHC's current work but describes it as a new function of the Board Secretary who is based within the Executive Team of the Health Board itself. This proposal therefore takes independent analysis of patient waits away from the Citizen and intends to place it within the remit of an NHS employee. We believe that when developing the new model for the Citizen's Voice, this analysis and statutory remit must be done by an independent citizen focused body. If this is removed, it will again weaken the

Citizen's Body's ability to challenge the NHS and Social Care services on the citizen's behalf.

We hope that any proposals going forward take deep note of our response set out above and protect the strength of the citizen's voice in Wales and ensure that the new Citizen's Voice body has statutory powers and rights. If statutory functions are not placed within the new citizen's voice body, there will be no obligation on any Health or Social Care body to engage with the new organisation on any meaningful level and will only weaken their position in the Community that they serve. The public will also feel that the Citizen's body lacks the "clout" to be able to represent them and hold the service providers to account if they are simply an "advisory" body.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

NO

What further issues would you want us to take into account in firming up this proposal?

The White Paper's proposals to create an independent mechanism to provide clinical advice on substantial service decisions, with advice from the proposed new citizen's voice body suggests that the public will no longer have a statutory right to be consulted with on NHS service changes as set out in the NHS (Wales) Act 2006 section 183, which states that; the public or their representatives have the right to be involved in; the planning of provisions, the development of proposals and the decisions being made around service changes.

The White Paper suggests that the new citizen's voice body will be approached for advice after "substantial" service change decisions have already been made. The White Paper does not explicitly state whether an amendment to the NHS (Wales) Act 2006 will be made in order to remove these rights from the public. Currently, Community Health Councils do receive clinical analysis and advice on service change proposals very early on the proposal development stages. We believe that these statutory rights should continue into the new citizen's voice body.

Inspection and Regulation and single body

What do you think of this proposal?

Whilst the proposal of creating a clearer underpinning legislative framework for HIW is acceptable, there is no clear indication within the proposals of how this will lead to more integration and closer working between HIW and CSSIW.

Are there any specific issues you would want us to take into account in developing these proposals further?

The White Paper appears to suggest that simply working to a similar framework will promote more integration between HIW and CSSIW. This ideal is simplistic and the way in which the two inspectorates are required to work jointly requires greater exploration before the proposals can be developed further.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?
NO

What issues should we take into account if this idea were to be developed further?
It is accepted that housing the existing inspectorates within a new Welsh Government Sponsored Body has the potential of bringing more independence from the Welsh Assembly Government. The pooling of resources and creation of an integrated system are notions which the Aneurin Bevan Community Health Council would certainly agree with.

However, the proposals provide no clear explanation of how the new system would work. The difficulties of incorporating the existing inspectorates into a single new body whilst retaining the independence of each inspectorate body are complex. Ensuring governance and accountability arrangements are adequate and robust, while allowing for each individual body to retain its independence is essential and there is no guarantee within the proposals that this is achievable.

This model of incorporating the inspectorate within an overarching and independent body is currently found in Scotland with the Healthcare Improvement Scotland model where it has been found that it is difficult to maintain the independent identity of each inspectorate.

Therefore, we are concerned that by pursuing independence from the Welsh Government, the proposals will in fact decrease the independence of each inspectorate contained within the new body.

WGWPMB89: G Owens
Location: Swansea

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
As a renal patient I know that hospital transport for dialysis patients is one of the main issues that haemodialysis patients have. Whilst hospital transport to and from dialyis units for HD patients living in close proximity to their unit is reasonable, for a substantial percentage of HD patients who live in one Local Health board area yet dialyse in another, travelling to and from their unit is not adequately provided. I am aware that steps are being taking to address this inequality for HD patients, cancer patients and end of life care. However one of the problems is lack of cooperation between LHBs and Trusts. Patients who use their own transport have different mileage allowances. How on earth can't LHBs make arrangements that all HD patients receive the same expenses? That is a simple task compared to organising hospital transport. There must be other areas where LHBs and Trusts are not working together. I agree that working together would benefit patient care

Board Secretary
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
There should be a process that enables CEs of NHS organisations accountable. The use of the word "Trust" is a misnomer, there is a lack of trust in these unaccountable bodies

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
Hospitals and Social Services need to have reciprocal duty to care for patients. However, unless more funding is given to both, I doubt that this will be feasible by legislation alone.

To often elderly people are discharged with inadequate care into the community. The Social Services are already stretched to the limit and staff have "unreasonable" demands made of them to accomplish tasks in the time allotted to individual patients.

I have always thought it wrong that staff who care for people in the community have no special parking badges enabling them to park close to the patient's residence. Has any survey been taken that shows how much time is taken by staff to park legally? If the staff member has just 15 or 20 mins with a patient, taking even 10 minutes to find a parking place, makes the smooth running of a shift impossible. The Welsh government could facilitate this by issuing "universal " parking badges to care workers. The remuneration of care workers in private homes should be adequate to attract good quality staff to work in the private sector.

Duty of Candour

Do you support this proposal?

Yes

What further issues would you want us to take into account in firming up this proposal?

Whistle blowers should have full protection. Whilst I know this is a subject that has been raised often. However, it is a personal belief that staff are still wary to speak out for fear of losing their job and damaging their chances of promotion or securing another position

Setting and Meeting Common Standards

Do you support this proposal?

Yes

What further issues would you want us to take into account in firming up this proposal?

It is essential that adequate funding and sufficient staff numbers are in place to ensure this is possible. Currently the NHS staff are working under tremendous pressure. It is a credit to the goodwill of the staff that patients across Wales receive good quality care in most cases. Long waits for appointments, surgery, treatment are the result of lack of resources.

In addition,I do not agree with centralisation of key services too far away from the patients' homes. I feel that, currently there is too much centralisation at Cardiff. The two proposals currently being considered regarding the Major Trauma Unit for Wales is a case in question. Morriston has a first class trauma unit and supporting services. Neurosurgery was transferred to UHW some years back against the wishes of people living in South West Wales. Resulting patients from the whole of South West Wales having to travel further. Cardiff is close to Bristol that would mean that those living in South East Wales will have closer access to two major trauma units. Those in the South West will not equity of access!

Care needs to be taken with the current thinking "all in one place centre of excellence etc" With the NHS in financial difficulties this could create an "unworkable" model of care for patients across South Wales.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
There should be clear lines of responsibilities between different organisations. This will ensure that there would be no “passing the buck”

Representing the Citizen in Health and Social Care
Do you support this proposal?
No

Can you see any practical difficulties with these suggestions?
I was pleased that Wales kept its CHCs when England dropped their equivalent bodies. I have only dealt with the CHCs once, on behalf of renal paediatric patients, when I was a volunteer WKPA trustee. That was at the time (in 2002?) when proposals were made to transfer three paediatric services from Wales to Bristol. T he Neath/Port Talbot CHC placed a proviso on its agreement to transfer renal paediatrics to Bristol. The CHC requested an audit after one year which subsequently showed a much bigger cost to Wales than envisaged. This simple act secured the provision of paediatric nephrology in Wales. I would like to see the CHCs keeping the right to be consulted and informed by relevant health bodies. The right to enter premises funded by NHS, hold meetings with the boards and keep its Independent Complaints Advocacy Services. I believe it would be better to add Social Service Care to the CHC’s remit that merge it with HIW and CSSI Wales. To merge would make CHC’s “invisible” and create a bureaucratic monster.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
However, it must be independent and listen more to the citizen voice body than those involved in the proposals for service change. The voice of the service user is too often pushed aside for economic reasons

Inspection and Regulation and single body
What do you think of this proposal?
I am not sure that this would create the desired result

Are there any specific issues you would want us to take into account in developing these proposals further?
I do not agree with the above two bodies incorporating the role of the CHCs. CHCs’ remit should be maintained and enlarged

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
I am not sure about these two proposals - for the reason given below

What issues should we take into account if this idea were to be developed further?
As a lay person reading this makes me immediately think of a new body needing more funding. I believe that the only way to maintain the standards the public need from the NHS is to increase funding at the front line for better facilities and more staff on the wards and in the community.

WGWPMB90: Multiple Sclerosis Society Cymru
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
MS Society Cymru would like to see that service users and / or representatives are given a greater role in a strong governance framework to enable Local Health Boards to work effectively and meet its responsibilities.

Board Secretary
Do you agree with these proposals?
Yes

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
In addition to strengthening the existing planning duty, MS Cymru would like to see a greater understanding of population needs.

One of the key actions in the recently revised Welsh Government's Neurological Delivery Plan is for Health Boards and Welsh Government to publish information on NHS performance. However, MS Specialists do not have access to the right information from the whole of Wales to support service development.

Whilst MS Cymru welcomes the Welsh Government's funding of a Wales Neurological Alliance project to develop a Patient Reported Experience Measure (PREM) for all neurological conditions in Wales, Health Boards must also provide the necessary baseline data which would afford a better understanding of MS treatments and services across Wales and enable the effective commissioning of services.

Furthermore, prior to making any substantive changes in service delivery, in addition to complying with their duty under the Social Services and Well-being (Wales) Act 2014 to jointly prepare and publish an assessment of the care and support needs of the population, Local Authorities and Local Health Boards must also undertake an equality impact assessment.

Setting and Meeting Common Standards
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
There are a number of existing standards pertaining to treatments and services for people living with and affected by MS in Wales. For example, the recently revised Welsh Government's Neurological Delivery Plan acknowledges that National Guidelines set out the Welsh Government's 'expectation of effective care for people with a neurological condition'.

On 14 January 2016, NICE published a set of recommendations for the NHS in England and Wales which will allow Local Health Boards and healthcare professionals to clearly see what level of service they are expected to provide for people living with Multiple Sclerosis (MS).

There are currently 12 disease-modifying therapies (DMTs) for MS, each with different support and safety monitoring requirements.

The Association of British Neurologists (ABN) guidelines for prescribing disease modifying treatments in Multiple Sclerosis recommends that given the significant impact of Disease Modifying treatments on MS that treatment should start as early as possible in eligible patients.

NICE guidelines, multiple sclerosis: management of multiple sclerosis in primary and secondary care (CG186) recommends that all people with MS have a comprehensive review of all aspects of their care at least once a year, and that this review is carried out by healthcare professionals with expertise in MS and its complications. The guidelines also state that people living with MS should have access to a single point of contact who acts as a care and treatment coordinator and that care and treatment should be made available through multi-disciplinary teams.

During a statement to the Senedd on the revised Welsh Government's Neurological Delivery Plan (26th September 2017), the Cabinet Secretary for Health, Well-being and Sport acknowledged that whilst improvements had been made, there is a need for 'further improvement' in meeting standards for conditions like MS.

As the findings of the MS Society's 2016 MY MS My Needs survey showed, the NICE MS Standard and Guidelines are not being met and consequently this is having a significant impact for people living with and affected by MS;

- Access to effective treatments to reduce relapses and slow disease progression is patchy across Wales.

- People living with MS are experiencing lengthy delays in accessing vital treatments and services.

- A lack of infrastructure is leading to people living with MS making unnecessary visits to Accident and Emergency Departments.

- People living with MS are not able to access the most appropriate health and social care professionals at the right time.

- People living with progressive forms of the condition feel like they are on the 'scrap heap'.

Access to treatments and services helps people living with MS manage their condition, and to identify early signs of complications and put in place prevention and treatment strategies to avoid unscheduled hospital admissions.

By preventing relapses and disability progression, people living with the condition should be able to take greater control of their condition and their lives, directly and indirectly improving physical, economic, emotional and social outcomes.

With the increasing number of treatments options, it is more important than ever that people living with MS are supported to make choices about their treatment, and can access the best treatment for them, regardless of where in Wales they live.

Findings from the My MS My Needs survey conducted in 2013 revealed that access to DMTs in the UK was low (40% across the UK) with Wales having the lowest rate - just 30% of people with relapsing forms of MS taking a DMT.

Results from the survey in 2016 showed that; 49% of respondents from Wales who identified that they could potentially benefit from taking a disease modifying therapy (DMT) are doing so.

Whilst it is encouraging to see that the number of people receiving DMTs in Wales has risen, this increase in DMT uptake demonstrates a significant positive improvement in MS healthcare in Wales. This is likely to be linked to the newer treatments that have become available on the NHS, which are judged to be more effective and easier to take.

The NICE Quality Standard for MS recommends that people with MS have access to care from a multidisciplinary team with expertise in MS, and access to a comprehensive review of their treatment and care annually. This team should consist of a range of professionals including neurologists, MS specialist nurses, physiotherapists and occupational therapists, speech and language therapists, psychologists, dieticians, social care, continence specialists and GPs.

With an increasing number of treatments available, each with different support and monitoring requirements, it is vital that people with MS are fully supported to make an informed choice about their treatment. Conversations about treatment options, including DMTs, should begin close to diagnosis, with follow-up after diagnosis with a specialist within six weeks and again within six months.

However, MS specialists in Wales say that timely follow-up is becoming more difficult resulting in less time to assess people effectively, discuss treatment options and manage risks. Consequently, they feel as though they are 'always behind the curve in providing appropriate treatments'.

For example, Wales was the first UK nation to approve the symptom management treatment Sativex in 2014, yet it is only recently that all LHBs in Wales have been able to prescribe it. Furthermore, there is a waiting list in one LHB for Tysabri because staff are unable to manage the ongoing monitoring and follow up needed. Another LHB is developing business case to manage infusion clinics but still has an issue with 'follow up'.

With this added pressure on MS Neurologist and Specialist Nurse case-loads, people living with progressive MS feel they are being pushed further down the waiting lists with little or no support.

MS Specialists in Wales are concerned about the lack of infrastructure that is currently in place to cope with existing treatments. There are presently a number of new treatments in the pipeline for more progressive forms of MS however any new treatment will inevitably mean increased monitoring and this will place further demand on a service which is already working to full capacity.

The NICE Quality Standard and Guidelines for MS can play a significant role in ensuring better quality care for people living with MS however they must be implemented consistently across Wales.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes

Representing the Citizen in Health and Social Care
Can you see any practical difficulties with these suggestions?
MS Society Cymru supports proposals that ensure that there is greater involvement of the public in the design and creation of health and social care services.

Whatever structure is put in place to achieve this must have a visible presence within our communities so that local service users know what they do and where they can access them should they need them.

Any body must be representative of the community and not only seeks to involve the public but listens to them. Properly engaging with citizens in the coproduction and co-design of services requires significant resource and time and we hope that this is reflected in Welsh Governments plans.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?

Findings from the MS Society's 2016 MY MS My Needs survey showed that people living with MS in Wales do not feel that their views are taken into consideration when services are being designed for them.

For example, as the following demonstrates, far from being involved in the decision making process, people living with the condition have reported incidences where their views have been ignored;

'There was no understanding of Multiple Sclerosis on the ward and no input from the Multiple Sclerosis team. They did not keep up to date records and there was little or no communication. We occasionally would see the doctor and he would speak to us but they just didn't give her the care that she needed' (Bob).

Prior to being placed on a trial when Silver coated catheters were introduced by the NHS, Jonathan experienced continual severe UTIs, several hospital admissions a year and a deterioration of his MS symptoms. This regime has worked extremely well for Jonathan and the number of occurrences and severity of UTIs has diminished considerably. However, without any discussion, Jonathan's Mother was told this year that the catheters were being withdrawn.

'I've sat for hours at his bedside, useless to help him, knowing this infection could be the fatal one. Yet, being fully aware that these patients are "prone" to UTI's, these decision makers come up with recommendation to revert to latex products that inevitably will lead to more frequent and more severe UTI's that will need IV antibiotics during hospital admission'.

'How can they possibly justify the cost of 13 Silver Coated Catheters per year, compared to the cost of 3 or 4 yearly hospital admissions? I am concerned that an unknown person can walk into a severely ill patient's home and change treatments that have been diligently tried and tested by Consultants and relevant professionals without any consultation with either Jonathan or with family members' (Dawn).

Whilst a new citizen voice body is welcome, we must be cognisant that it will not be representative of all conditions. There are around 4,900 people living with MS in Wales and there is no guarantee that there will be a representative from the MS community on the new body.

We must therefore ensure that prior to any substantial service change, in addition to seeking the advice from the citizen voice body the proposed independent mechanism undertakes a process of public consultation so that all service users are afforded the opportunity to have their voices heard.

WGWPMB91: The Royal College of Paediatrics and Child Health
Location: London

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
The proposals should take into account the rurality of Wales. In many rural areas, Board Executive Officers have little knowledge of local services, infrastructure, geography, public services and culture – specifically within Western Wales. The Board Executive Officers should be supported to learn about the areas that the Health Boards serve, i.e. local transportation issues, to enable patients and families to better access services.

Board Secretary
Do you agree with these proposals?
Yes - this would be a good model

What further issues would you want us to take into account in firming up these proposals?
It is recommended to define the role of the Board Secretary and necessary responsibilities, in a way that encourages working together with the Chief Executive, rather than opposition and difference.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
Currently, these proposals appear quite simplistic. Some variation needs to be possible, and resourced. The population is varied in health, deprivation, language and culture – the provision of services needs to appropriately reflect these differences. I.e. what suits urban populations may not suit rural models and access to care for individuals in remote areas is highly important.

Duty of Candour
Do you support this proposal?
Yes

Setting and Meeting Common Standards
Do you support this proposal?

Partially. Standards should reflect differences among people, they should all be delivered to a high-standard but this may mean a different path in different areas.

What further issues would you want us to take into account in firming up this proposal?

In order to uphold this proposal:
- The standards should be meaningful and measurable, with the potential for more detailed standards to be mapped to them.

- It is recommended to place the standards into broad categories such as, quality, safety, leadership, kindness, governance, involvement, value for money / efficiency, effectiveness.

- The standards should emphasise that partnership working applies across all public (and independent) services and age groups.

- The standards should holistically represent all aspects of public sector services which contribute to health and wellbeing. Education services should be recognised and stated as significantly related to health and social care.

- The standards should include the voice of citizens, children and young people.

- The standards should identify implementation barriers at the outset and provide guidance for overcoming them - State of Child Health (2017, p.14) recommends creating an 'action plan'.

- All standards should be inclusive of children's needs, as it is recognised that challenges within child health cut across multiple sectors and areas. State of Child Health: 2017 Recommendations for Wales (2017, p.4) outlines that all decision-making, policy development and service design should promote 'child health in all policies'.

- Standards should promote the establishment of managed clinical networks to assist in the delivery of high-quality services (Bringing Networks to Life, 2012). It is recommended to consult the BSPGHAN standards for gastroenterology, hepatology and nutrition (2017) as a best practice example resource.

- Standards should support an appropriate workforce and recruitment strategy. In order to meet the RCPCH Facing the Future and specialist service standards, it is estimated that an extra 84-91 WTE consultants are required within Wales (2015 Workforce Census).

It is recommended that the proposal should consult the following documents for advice and guidance:

BSPGHAN & RCPCH (2017) *Quality Standards for Paediatric Gastroenterology, Hepatology & Nutrition*. London: British Society of Paediatric Gastroenterology Hepatology and Nutrition. – Available here.

RCPCH (2012) *Bringing Networks to Life – An RCPCH guide to implementing Clinical Networks*. London: Royal College of Paediatrics and Child Health. – Available here.

RCPCH (2017) *RCPCH Medical Workforce Census 2015*. London: Royal College of Paediatrics and Child Health. – Available here.

RCPCH (2017) *State of Child Health: Report 2017*. London: Royal College of Paediatrics and Child Health. – Available here.

RCPCH (2017) *State of Child Health: 2017 Recommendations for Wales*. London: Royal College of Paediatrics and Child Health. – Available here.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?

In principle.

What further issues would you want us to take into account in firming up this proposal?

This proposal needs to effectively plan and provide guidance for how best organisations will work together, regarding the responsibility and duty of each organisation and how they communicate and share understanding.

This proposal should overcome issues of lack of integration between health and social services and provide clear instruction regarding who will be responsible for managing and responding to complaints. Currently, the proposal suggests that health providers are mainly responsible. The reports 'Putting Things Right' and 'Social Services Complaints Procedure Regulations' are suggested for considering how these organisations can contribute to working together.

The proposal should provide details (or practice examples) of how organisations can effectively work together in reality. The collaborating organisations should ensure a shared focus on the individual throughout their work. The proposal should outline potentially arising issues when organisations work together, then offer suitable suggestions of solutions. For example, possibility of 'working together' becoming a tick-box exercise or an opportunity for organisations to place blame onto others or creating delays in providing meaningful responses to the complaint. Additionally, the proposal should provide a definition of "social care" and should state whether children's services (i.e. education) are included.

It is suggested that organisations should meet on a quarterly basis to review, discuss and improve services. Standard 11 from Facing the Future (2015, p.40) outlines that there should be regular meetings between health care professionals from different

settings alongside patient representatives. It is suggested that a higher body oversees the cooperation between organisations in order to create trust, ensure quality improvement, and make contract / commissioning decisions. Through this, joint recommendations could be agreed. Furthermore, there must be a fair and agreed process in place for appointing the lead investigator.

It is recommended that the proposal should consult the following document for advice and guidance:
RCPCH, RCGP & RCN (2015) *Facing the Future: Together for child health*. London: Royal College of Paediatrics and Child Health. – Available here.

Representing the Citizen in Health and Social Care
Do you support this proposal?

Partially.

Can you see any practical difficulties with these suggestions?

Numerous practical difficulties are associated with this suggestion, notably the transition between the two systems and appropriately designing an effective CYP engagement strategy in the new system.

Practical difficulties in transitioning systems:

The proposal should appropriately design, plan and manage the process of changing an established service. This should include planning staffing and resources required to effectively migrate from one system to another. This is particularly important given the involvement of the public. In transitioning away from the CHCs, the new arrangement should attempt to preserve and retain the existing base of support and engagement, which CHCs have built up. For example, ensuring correct telephone numbers and email addresses are stored for advocacy and advice services.

It is recommended to consult the experience of the English system, which witnessed a process of repeatedly changing between systems. CHCs were replaced with PPI Forums which were abolished before formal establishment to be replaced by LInKs, which was then subsumed into Healthwatch and Health Scrutiny Committees. Important lessons can be learned from this period of continued change, notably diminishing citizen and staff confidence in the system.

Practicalities to consider in setting up a new, effective system:

The new system should ensure that it is inclusive of children and young people from all backgrounds, experiences and support needs. The new body should ensure diverse voices are recognised within the forum. This includes representation across different ages, backgrounds, experiences, additional support needs and localities. To assist in achieving this, it is recommended that information provided to CYP should be highly accessible at all stages of their involvement (promotion, recruitment, information for comment, response and feedback) – a variety of formats is required when engaging different ages and support needs. Additionally, it is recommended

that CYP gatekeeper (i.e. parent or carer) role is appropriately and sensitively managed. This involves promoting positive attitudes and environment towards the benefits of CYP involvement amongst internal staff members.

The new body should be adequately resourced in order to provide meaningful CYP involvement. It is suggested that guidelines for the system include reference to: skilled participation workers, individual support workers dependent on additional support needs (e.g. personal care worker), interpreters, advocates, travel arrangements, appropriate venue and facilities, dedicated project budget, and appropriate timescales for recruiting CYP involvement.

The new body should set clear goals for CYP engagement; outlining specific parameters to co-design and co-create services with citizens will achieve meaningful engagement. Furthermore, the system should create evaluation and impact frameworks to regularly assess the development and achievements of CYP, community impact and strategic outcomes.

It is recommended that the proposal should consult the RCPCH & Us network as a resource or best practice example for how to effectively engage children, young people and families. The network has successfully produced standards, guidelines and training which are informed by CYP voices and experiences. Furthermore, a range of products, resources and materials have been co-designed by CYP to support future engagement activities.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

In principle.

What further issues would you want us to take into account in firming up this proposal?

This proposal poses similar challenges for implementation as outlined for 4.1.; notably around the practical issues of involving CYP within engagement activities.

The proposal should ensure a diversity of opinion is sough, with representation from different ages, backgrounds, experiences, localities and additional support needs. There should be a range of entry points for involvement within the citizen voice body, in order to represent a range of voices then there should be various commitment levels of participation. For example, engagement activities could range from consultation, tasters/challenges, to ongoing engagement. Furthermore, accessibility of engagement events should take into the accounts of CYP – they should not take place during school hours and the information / language utilised should be clear and understandable. In order to achieve CYP engagement to a high quality, there should be adequate resources in place, such as; skilled participation workers, skilled support workers, interpreters, travel arrangements, appropriate venue, and time. CYP involvement should be monitored, with achievements, outputs and outcomes articulated.

It is recommended that CYP are involved before Step 1, so that citizens are influencing service design and production from the outset. Involvement of citizens is

of paramount importance in order to co-design and co-create services. CYP represent 20% of present citizens but 100% of the future – thus, their opinions should be appropriately and proportionately represented.

The proposal should state that the involvement of CYP should be audited and mandated to identify and highlight specific CYP voices. This strategy may require innovative approaches, but it is recommended to consult RCPCH experience in developing appropriate schemes.

Inspection and Regulation and single body
The Welsh Government believes that ensuring a clearer underpinning legislative framework for HIW will help to foster closer integration and joint working with CSSIW and at the very least this should be taken forward.

What do you think of this proposal?
Agree.

Are there any specific issues you would want us to take into account in developing these proposals further?
The underpinning legislative framework should include ESTYN (the education and training inspectorate for Wales). This would enable a unified arrangement of inspection and regulation between education and social care, which is specifically important for vulnerable children, those with long-term conditions and special educational needs.

It is recommended that the quality of services is monitored regularly, with regulatory guidance set out in the legislative framework. Medical Royal Colleges provide services which support the regulation of quality improvement - it is recommended that these are taken into account during the design of new mechanisms for joint working, to maximise efficiency and minimise duplicate submissions. For example, National Audits provide robust data on service provision while Clinical and Service Standards define criteria for delivery of care. It is recommended to incorporate programmes of peer review and bespoke invited reviews to offer independent oversight into the running of services – these should feed into regulatory and inspection activities.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?
Partially.

What issues should we take into account if this idea were to be developed further?
The proposed reconfiguration should be carefully considered and justified as credible, efficient and able to add value. Benefits should be demonstrated as able to outweigh the resulting costs of financial pressure, upheaval and loss of expertise. Furthermore, it should be proven that these benefits cannot be achieved by fostering greater collaboration and information sharing between existing agencies. It is

recommended to consult the experience of the merger of CSCI and the Healthcare Commission in England, which saw confusion and lack of credibility within new organisations.

Should a new body be introduced, however, it should include education (ESTYN). Education provision and support for CYP are closely linked to ensuring the highest possible health and social care outcomes.

WGWPMB92: Aneurin Bevan University Health Board
Location: Newport

General Comments

Thank you for the invitation to provide a response from Aneurin Bevan University Health Board to the White Paper Consultation Document – 'Services Fit for the Future – Quality and Governance in Health and Care in Wales'. This response has been developed and approved by the Board of the Health Board. We would also like to thank colleagues from Welsh Government who engaged with the Health Board through the process of development at one of our briefing sessions to outline the thinking and principles that underpin the White Paper proposals.

Introduction:

Since the reorganisation of the NHS in Wales in 2009, Aneurin Bevan University Health Board considers that it has realised in many ways the potential of the benefits of integrated organisations as envisioned at the time of the reorganisation. The 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. It is suggested that some of the proposals within the White Paper could enable Health Boards and wider care systems to further deliver for the populations we serve, which we would welcome.

However, the Health Board does not consider that it is the time to use the White Paper to prompt further fundamental structural change in the NHS in Wales. Instead it considers that the White Paper offers 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, whilst also furthering our ability to respond to a changing environment and an increased need to work in partnership to deliver care.

Stability and certainty 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, are being understood and implemented. It will also be important that the NHS in Wales takes into consideration the recommendations to be made by the Parliamentary Review into Health and Social Care in Wales. Proposals in the White Paper therefore, need to consider and align with further proposals to come from the Parliamentary Review.

The Social Services and Well-Being (Wales) Act and the Well-Being of Future Generations (Wales) Act offer the potential to transform the way health and care systems operate. However, there are also other system changes such as the development of GP clusters, which will aid progress. Legislation proposed by the White Paper should be developed in ways which take into consideration and respond to these changes and the further opportunities that such developments present for the future of our local care systems.

The role of Welsh Government (in its broadest sense) in leading and managing transformational change is pivotal to the success of the system. Any new legislation should positively encourage the co-ordinated governance and delivery of an integrated health and care system across Wales, which better meets the needs of the population of Wales rather than complicating it further. There needs also to be a review of the supporting structures for the NHS in Wales which appear unco-ordinated and on occasion unaccountable.

In terms of the legislative frameworks and governance structures in NHS Wales, the current statutory instruments for Health Boards are seen to be too prescriptive in respect of issues such as Board membership, Board Committees and Advisory Groups and appointments of associate members.

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.

The White Paper is welcomed in terms of the proposals to review, simplify and streamline the complex and complicated governance and reporting arrangements within NHS Wales. The proposals, if they can streamline arrangements, have the potential to make accountability clearer within organisations, between NHS organisations and between Welsh Government and the NHS in Wales.

It is also important to consider the governance arrangements when service change is increasingly being considered on a pan-Wales or regional basis e.g. the Wales Collaborative and the newly establishing Regional Planning and Delivery Fora. Statutory obligations of Boards are to their resident populations and not to the overall population of Wales or a region. This has led to governance issues in the past, for instance within the South Wales Programme, and has the potential to be replicated through the newly developing Regional Planning and Delivery Committees/Fora, if the role and authority of these bodies are not made clear and are not fully understood.

In respect of the current integration agenda the White Paper could be seen as an important mechanism through which the current legislative and regulatory landscape in health and social care in Wales could be tidied up and clarified to improve quality and the delivery of high standards.

A key theme of the White Paper is in respect of ongoing engagement with the public, patients and partners. Aneurin Bevan University Health Board has put in place a range of developments in this field over recent years and any further clarity of arrangements and opportunities to expand this work would be welcomed. It is suggested that much of this clarity and focus can be achieved without the need to consider further legislation.

The requirements to consult should be consistent across health and social care to reflect the increasing interconnected and integrated nature of services. 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 and local government.

Furthermore, while there is increased integration between Health Boards and Local Authorities, it is important that measures are put in place to ensure that Health Boards also work together. However, a sound mechanism should be devised to adjudicate between health bodies in the event of a dispute.

It is vital that any legislation that is developed as a result of this White Paper is understood by the public and that they are engaged in any changes. While Health Boards are continuously engaging with the public through their own mechanisms and increasingly in partnership with Public Service Boards, 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 embrace the very different ways of working required in the future.

A key aspect of the White Paper is 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.

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 up-skilling public sector staff to work with people and communities in ways which recognises that the community is an asset to build on, rather than being seen as creating problems to be solved. Similarly, there is a major cultural shift required to move away from the view of public service organisation as delivery agents for services to passive populations, to a greater focus on communities in which everyone contributes to maintain and improve services and maintain their own health and well-being, where possible.

The future success of the NHS relies on us all taking a proactive approach to health and health services and ensuring that we create the right conditions to enable people in Wales to live active and healthy lifestyles. It is important to work 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 actively 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 and what the factors are that have framed and driven those decisions.

Response to Specific Questions

Board Membership and Composition

Do you agree with these proposals?

What further issues would you want us to take into account in firming up these proposals?

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. A narrower membership could provide a more streamlined focus so that the Board

could adapt to more strategic decision making. It is the quality, commitment and understanding of the people involved that is important in delivering sound evidence based and rounded decisions.

If the size of the Board is reduced, careful consideration will need to be given to the ability of the Board, particularly its Independent Membership, to fully support the requirements placed upon them. Independent Members need to concentrate their energies on duties that best use their skills and time. To date Independent Members have been engaged in a plethora of responsibilities, not all of which use their skills effectively. Consideration needs to be given to the current capacity of Independent Members to be able to fulfil appropriately all the requirements placed upon them within a nominal 4 days per month.

It is important that Boards have the right skills, expertise and knowledge to be able to make the required decisions and effectively scrutinise the organisation's plans and activity, whilst also making the right judgements about future strategy. It is also important that the Board roles are attractive to key individuals who have appropriate skills and backgrounds. Further work

will be required to look at the workloads and expectations placed on Board Members, particularly Independent Members and also the remuneration and support packages offered to ensure that we continue to attract the right people.

The appointment of additional time limited Board Members in the event of an organisation being placed in special measures or where very specific skills are required for the programme of work of the Board is appreciated and understood. Whether or not the individuals appointed would have personal authority on behalf of Welsh Government and how this impacts on the decision making of the Board needs to be determined.

When considering the Executive membership of the Board it is necessary to consider the breadth of portfolios required by health organisations to deliver against the current policy and performance requirements. Board membership needs to have adequate Board level resource to enable it to appropriately delivery required obligations and accountabilities. The Board should be able to vary the regulations and to decide the executive structure in terms of numbers and roles required to deliver against its objectives rather than being prescribed by regulations. In the case of executive membership at the very minimum this must include an accountable officer and an accountable finance officer.

Health organisations should be given more flexibility to appoint Independent Members when required and that appointment periods also have flexibility. When organisations are working in highly pressured environments of constant challenge and expectation for continuous change and development this flexibility, particularly for short term appointments to respond to changing requirements for expertise over time would provide Boards with the agility they need.

Board Secretary
Do you agree with these proposals?

What further issues would you want us to take into account in firming up these proposals?

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 not fully understood. Since that time the role, including its responsibilities, has varied to a greater or lesser extent across NHS Wales organisations. The proposal to provide greater clarity is welcomed, to assist in ensuring the role is seen as a trusted position providing independent advice to the Chair, Chief Executive and Board. This will enable the role to be in a position to effectively challenge and advise Boards, as necessary.

The role of Board Secretaries is stipulated in Standing Orders, and a model Job Description has been produced by the Welsh Government. The Board Secretary must be appropriately qualified and this needs to be made clear in the role description. It is also important that operational management is not allowed to encroach on the stipulated accountabilities of the Board Secretary to ensure potential internal conflicts are avoided.

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 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 orders etc.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

What further issues would you want us to take into account in firming up these proposals?

It is proposed that no further changes to the law are required to strengthen local collaboration in planning and meeting people's health and well-being needs closer to home. It is our contention that the current legislation is adequate to ensure these requirements are facilitated and delivered. However, governance arrangements are becoming more complicated. More could be done to streamline rather than 'add to' current requirements and also ensure that adequate resources are provided to support effective implementation.

We recognise the significance of the new legislation recently introduced, including 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 new legislation introduces 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 embedded before consideration is given to any 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.

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 a specified single public sector service budget (not just attempts at pooled budgets), to measure such outcomes and collective responsibility for a single needs assessment with all parties bringing their data and expertise to the table.

We would also recommend the potential to impose sanctions, such as escalated measures, 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, so long as this task of co-operation is clearly evidenced.

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 White Paper can again look at this to clarify these arrangements, especially community based accountabilities, we believe it could be powerful, especially if it focuses on clear alignment with the new Social Services and Well-being (Wales) Act and also the Well-being of Future Generation Act.

While there is a risk that the introduction of further legislation may only serve to make the position more complicated, the White 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 White Paper should not be developed in isolation and will need to be drawn up to complement and be consistent with the emerging legal frameworks.

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 advice on how to facilitate engagement which will help to shape and build the joint plans which are being built up from GP cluster and community network levels through organisations to the Public Service Boards.

Quality

We need to continue to build on the existing systems and apply the tools which already exist, which have quality and safety of care at their heart. In light of the Francis Report and the Andrews Review, there needs to be a continuing focus both on quality and safety.

However, we need to be clear what we mean by quality, especially in an integrated health and social care environment. 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 these priorities and standards. 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 and this could be better utilised. Nationally and locally we need to further encourage and realise the benefits of collaborative governance.

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.

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 professional and geographical boundaries. The framework would need to encompass specific measures to enable monitoring and evaluation of "real time" performance indicators through a dashboard and develop an integrated outcomes framework. This would be heavily dependent on sophisticated IT structures which were interoperable across NHS and other partners. To monitor the delivery of quality in NHS Wales will require investment in data capturing facilities to gain timely performance information across all health (and social care) organisations.

In relation to quality it is vital that there is a culture of continuous improvement across the NHS; more emphasis needs to be placed on this. 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.

Duty of Candour

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

We are supportive of the introduction of a statutory duty of candour. However this involves more than considering a legislative approach but the consideration of 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 and how organisations enable and support them to do this.

The definition of candour used will need to be clear. While professional groups already hold a duty of candour, it would be powerful if this is extended across the whole of 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 and are key features already in many organisations across Wales and were reinforced by the Evans Review.

These principles of openness and candour need to also apply from to the design and agreement of plans and care plans for patients.

Setting and Meeting Common Standards

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

We support the creation of consistent healthcare standards across the NHS and wider care system to be set in legislation and include standards for health, social care, third sector provision and the independent sector.

A common standards framework will provide certainty and clarity for patients and service users and it will be important that there are a small number of clear and specific outcomes against which progress can be measured and judged. The introduction of a common standards framework would have implications for the function and role of the regulators which need to be considered. There also needs to be clarity with regard to competencies required and a training programme to underpin and consolidate these standards.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

There are already well established good practices in place for the joint investigation of complaints. The complaints process should be an integrated process which ensures that the same principles, processes and timelines are followed across organisations. It would be helpful to identify a lead organisation or individual lead for each complaint to avoid uncertainty, duplication and issues falling between organisations.

It is also important to consider whether or not the NHS redress 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.

Representing the Citizen in Health and Social Care

Do you support this proposal?

Can you see any practical difficulties with these suggestions?

Aneurin Bevan UHB has a very constructive and positive working relationship with Aneurin Bevan Community Health Council. Locally the CHC's members and officers are a valued source of advice, guidance and constructive challenge for the Health Board and provide important insights into the views of patients, their families and

carers about the Health Board's services and the quality of our care. There is a lot of time invested in the engagement and joint arrangements between the CHC and the Health Board; it is clear that this can and does add value to the ways in which local health services are planned and delivered and the time invested means that the relationship works.

In addition to the many meetings held between the CHC and UHB, the CHC has also established a very productive relationship with Aneurin Bevan UHB through a Joint Planning Committee. This committee discusses a range of proposed service developments and changes along with any pertinent or associated issues often raised directly by patients or their carers. These are sometimes robust and challenging sessions but are extremely welcome. The CHC's early view and advice and continuing involvement in discussions are 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.

Therefore, in relation to the Health Board's experience of our local Community Health Council this is positive and constructive and for us the current local CHC governance structure and approach works well.

However, more generally in Wales concerns have been expressed in terms of how reflective CHCs are of the communities they serve and whether or not their membership is diverse enough to understand and comment on the range of issues and interests that are present in local communities.

The Health Board agrees with the aspiration set out in the White Paper that health and social care bodies should get things right for themselves by continuously engaging with their communities and that CHCs and any all-Wales body will not be able to replace this. As more work is undertaken jointly with primary care services, social care providers and third and independent sectors, a view on the principles and expectation for community and public engagement would be welcomed. Recognising the requirement for the increasing integration of service delivery, a new body nationally, linked locally might enable a response to this expanded requirement, whereas CHCs as currently configured focus in the main on NHS services only.

It is particularly important that our services are created with and for the people that use them. Not only do services need to engage on the matters they are concerned about and interested in, people must have the opportunity to have a collective voice on the things that matter most to them.

If a new people's voice body is taken forward, it must be independent and be seen to be independent and be separate from the NHS and other care services, but with clear lines of accountability and responsibility for its work, actions and judgements. Further consideration could be given to the developing model of the regional citizen panels, which have been developed in response to the Social Services and Well Being Act.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

What further issues would you want us to take into account in firming up this proposal?

The proposal to introduce an independent mechanism to provide clinical and specialist advice on substantial service change decisions is questioned. Health bodies usually commission and seek such advice as part of our planning arrangements and through the development of service plans.

However, it is considered important that if such a panel is established it will be important that the Minister should appoint such a panel when required and only in exceptional circumstances rather than having a permanent panel.

It is considered that a process of referral to the Minister should remain in place, but only be used infrequently since this ensures that referrals are not made lightly and that referrals to the Minister are made in exceptional circumstances only.

Consideration should be given to the concept of an Independent Review Panel arrangement for considering contested service changes, which could provide advice to the Minister. It is anticipated that this could be with regard to more national and regional arrangements where there is disagreement. However, given the required scale and pace of change required, local mechanisms need to be robust to enable required changes to take place with suitable advice and scrutiny.

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. It is considered that legislation would not lead to further strengthening of 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.

Citizen's voice

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 consultation and engagement requirements are likely to increase. Related to this is the increasing way that change is being considered on a pan-Wales and also regional basis e.g. the Wales Collaborative and Regional Planning and Delivery Fora.

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.

It is suggested that the requirements to consult become 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.

This may be an opportunity for a review, with the provision of one Stakeholder/Citizen Reference model for Public Service Boards to utilise this for integrated planning and engagement.

Inspection and Regulation and single body

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Would you support such an idea?
What issues should we take into account if this idea were to be developed further?

The NHS needs a strong and effective regulator and it should be independent (not arm's length) from Welsh Government.

WGWPMB93: Lieutenant Colonel (Retd) J Skipper
Location: Carmarthen

General Comments

I am grateful for the opportunity to comment on this vey important White Paper consultation. The Paper coalesces extremely well the main thrust of the corresponding Green Paper consultation: the Welsh Government's Healthcare Quality Division have done well to focus on the areas of real importance. Progress on the areas below are key to ensuring long overdue development of the vital relationship between NHS Healthcare and Social Care, to bridge the wasteful resource and inefficient/inconsistent governance gap between the two. The ultimate aim is to establish a clear and continuous patient pathway, with the citizen at its heart, consistent across the whole of Wales.

Unnecessary delay is not an option if scarce resources are to cope with the increasing demands of an ageing population. The remedy must be supported by all political parties and be achieved on a consensual cross-party basis. The unnecessary political footballing surrounding such a key public service is of no benefit to the citizen. So many excellent Reviews have been written over recent years (Sir Paul Williams, Andrews, Evans, Marks, Llloyd, Longley et al), but so little traction and tangible progress with the recommendations made. The background work is done, the task has been identified so let's get on with it.

The questions below link very closely to each other, so the opinion expressed in one will naturally apply to another. Similarly, failure to adequately address one topic will adversely affect another. It is also worth bearing in mind a number of important factors that present serious challenges to achieving 'Services fit for the Future. For example:

a. Consistency. This objective underpins just about everything in this White Paper. If we are to avoid an unfair post code lottery of support across Wales then there has to be, inter alia, common high level standards in place, the same core structures within LHBs and Local Authorities, common methodologies in handing complaints and concerns and harvesting the intelligence that results, plus the application of appropriate and unambiguous legislation to ensure that partners work together.

b. Top Down Governance, Bottom Up Assurance. Whilst it is vital that the Service understands and harnesses the needs of citizens within the diverse communities within Wales, consistency will never be achieved unless there is robust but sensitive national governance structure in place – top down. For example, the CHC currently espouses a 'bottom up' approach but largely ignores and confuses the need for the CHC Board to exercise national cohesion and harmony between the seven 'autonomous' regional CHCs. Similarly, the seven LHB, in spite of common Standing Orders, are too differently constituted: the many differences hindering the increasing need for partnership working. Many wonder what the job the Chief Executive of NHS Wales actually is. It is suggested that consideration be given to establishing a body along the lines of the National Advisory Board (NAB), which was set up following the 2009 NHS Wales reorganisation.

c. Seven LHB, 22 Local Authorities (LA). I consider it a great shame that the Williams report recommendation to reduce the number of LA in Wales failed to materialise. If their individual sovereignty is to continue, could thought be given to 'regionalising' the social care function for all LA within each of the LHB, in order that the local partnership development is not frustrated by too many inconsistencies. In other words, the three LA in HD LHB and the five LA in AB LHB work together and share resources/common procedures. This might well address the very serious systemic issues that DToC presents. On a final note, can seven LHB be justified? Maintaining local sensitivity could still be achieved by seeing if some LHB could be combined. There must be a cost saving in terms of non-clinical management staff etc?

d. Function First not Organisation. It is vital that the organisation achieves the required function. If it doesn't, then change it – don't preserve something that's broken and doesn't get the best from scarce public treasure. For example, the Senedd White Paper Debate on 20 Sep 17 generally aired political angst about the proposal to abolish the CHC, albeit recognising the need for CHC reform. It will never do that with the Council structure it has now. My experience as a senior CHC officer (2008-16) is that the CHC fails miserably to adequately achieve its statutory NHS functions – let alone trying to embrace Social Care as well.(see section 4 below). In the case of HIW, it is a professionally led body trying to do too much with scarce resources – some duplicated (badly) by CHC. Similarly, CSSIW focuses just on Social Care - MOU umbilical's with HIW failing to bridge the gap to health adequately Answer? – in stages, bring the three bodies above together to allow scarce resources to achieve effective function.

e. Qualities of Leadership. I drafted the Board of CHCs Green Paper consultation response in Nov 2015. I included a number of comments that extolled the importance of key appointments within Health and Social Care (CEO of LHB for example) being selected on the basis of proven leadership qualities. Failures in some LHB recently, where Special Measures have been imposed, point to a catastrophic failure in leadership at the very top. Another example is a Director of Nursing in a LHB who does not see the importance of walking the wards and seeing what it's like on the front line. I suggest that the Job Descriptions for key posts across the landscape categorise 'Proven Leadership Qualities' as an Essential quality, not something that's subject to chance.

f. Get the Public onside. Political squabbling aside, if the aim of 'Services Fit for the Future' is to succeed, then the public must see the benefits of the changes proposed. They should see, in clear terms, that the abolishment of CHC, for example, will lead to the development of a stronger citizen voice, that a strengthening of a complaints system across Health and Social care will be of timely assurance to them and a learning process for the organisation, help them understand what co-production/Prudent Healthcare/Choosing Wisely mean. The public have a strange apathy to healthcare issues until it affects them directly. The whole process to achieve the White Paper objective requires sensible investment in continuous engagement with those it will benefit.

g. Be Bold. Tinkering around the edges of this serious challenge is not going to achieve the outcome the White Paper seeks. Numerous MOU and Service Agreements linking organisations like CHC, HIW, CSSIW, OPCW, PSOW probably suggest that there are two many organisations doing the same tor similar things. The need to change secondary or primary legislation should not be seen as an impediment for change. For example, changes to CHC Regulations in 2010 and 2015 did not address the real problems in an organisation failing to achieve it's function, when the real reason was arguably that an inefficient Council structure prevented consistent and robust support for citizens across Wales.

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?

Agree.
a. It is vital that the CEO and Chair especially have proven leadership qualities. You can have all the legislation and standing orders in the world but they count for nothing if key personnel do not know what leadership is or the definition of it (A RMA Sandhurst definition is "Someone who can get the very best out of those he/she is responsible for when things are at their worst". One could argue that the stresses within the LHB present an enormous challenge to any leader. When leadership fails we have a situation such as, for example, Betsi Cadwaladr LHB, placed in Special Measures for dire governance and the CEO not registering/accepting things going severely wrong.

b. There have been instances where there has been a massive disconnect between the 'Board and Ward". The application of the military idiom of 'Front Line First" has been a foreign concept: the Board has to directly relate to what is happening when nurse meets patient. I have visited some wards where senior nursing staff have never met the Director of Nursing, let alone the CEO or Chair.

c. Consistent Membership. Given the need for healthcare to be delivered and organised across LHB boundaries, there MUST be a level of consistent core membership commonality, with sensible flexibility only permissible to support local imperatives. All Board members should receive appropriate training.

d. Complaint Handling. I have seen lip service given to this subject at some LHB meetings and a reluctance to deal with reality. The same Board officer member in every LHB should have this responsibility to ensure consistency of approach across Wales. LHB should regard complaints as a source of vital intelligence that should inform and focus their work. The Evans report provides all that is required to address this – yet I detect little uptake of the key recommendations.

e. This leads to the requirement to establish a legal duty of Candour – dealt with later. Without this public confidence fails.

f. Citizen Involvement. When employed in HIW I read several LHB self-assessments that paid scant regard to continuous public engagement and also

reflected inconsistent ways of handling it and insufficient resources to discharge it. An independent member of the Board should have that task as a specific responsibility.

g. Planning Change. The LHB must involve citizens at the earliest stages of any change, and be prepared to make these intentions public. Failure here results in loss of public confidence and in HD LHB for example, resulted in large demonstrations outside the Senedd and three very costly Judicial Reviews. It did not help that the local CHC became something of an antagonistic action group working against the LHB rather than with it (see section 4).

Board Secretary

Do you support this proposal?

Absolutely.

What further issues would you want us to take into account in firming up this proposal?

a. The excellent Evans Review should be re-opened and viewed afresh. The report found that a culture of openness across the NHS was far from optimal, with many LHB described as 'in lockdown' when it came to handling patient concerns/complaints effectively and expeditiously. Even a simple apology at the outset was considered anathema by some LHB, seen as an admission of guilt rather than a human reaction to defuse an invariably upsetting and painful episode. Too many complaints have unnecessarily escalated to the PSOW through this simple action.

b. Training. All NHS staff should understand what their duty is regarding candour. Often due to poor ward personnel management and poor LHB leadership, staff do feel that punishment and disciplinary action will follow should they make a mistake. Mistakes are made – sometimes the consequence of wards with 100% occupancy being staffed to a 'quota' that simply does not fit the numbers or the patient acuity. Training must embody the principle that mistakes do happen and the whole NHS culture develop the appropriate pathway to handle them – not in an environment where staff are simply frightened to come forward – nurses, management everyone. Are all staff familiar with 'Putting Things Right'? I doubt it.

c. The proposal is right in saying that openness and transparency should be written into the culture of BOTH the NHS and Social Care. The principles should be consistent. This will be important when Advocacy Services and Complaints Handling straddles both NHS and Social Care.

d. As Keith Evans stated, complaints are a gift and a rich source of learning and service improvement. A citizen-centred service demands it.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

Yes – absolutely key to success.

What further issues would you want us to take into account in firming up these proposals?

a. As mentioned in my General Comments above, seven LHB and 22 LA are lack coterminosity and this is a real challenge to effective (and CONSISTENT) partnership working. If the sovereignty of 22 LA cannot be reduced to creating just seven, then the LA in each LHB area of responsibility should be regionalised insofar as the NHS-Social Care function is concerned.

b. Radical as it might be, given the level of cross LHB boundary working at the moment (ARCH in West Wales), why not consider reducing the number of LHB. I have heard some senior clinicians voicing the requirement for just one for two for Wales, with a reworked sub-structure ensuring that local reach and sensitivity is maintained. Once set up there may be significant cost savings, allowing more money to be applied to clinical - staff and equipment.

c. Healthcare Planning – a holistic approach. Whilst there may be local differences to cater for, planning to achieve the best for a patient group/specific illnesses must be done on a Wales-wide basis. Where and when should centres of specialisation be established. Ensuring that we avoid the creation of very different LHB (consistency again) is key. Citizen engagement is even more important and the views of different LHB populations should be looked at together (a key role for the proposed Citizen Engagement group in Section 4).

d. There has to be legislation in place to ensure that LHB and LA work in partnership consistently across Wales. Why not budget share? Then the term 'discharge from hospital' might not mean that the patient falls into the expensive gap of DToC or is indeed forgotten by the lack of a pathway with big gaps in it.

e. Can we clarify what we mean by 'integration'. It was not clear in the Green Paper. For NHS it is the integration of Primary/Community, Secondary and Tertiary care. Here, shouldn't we be clear that it is the integration of Health and Social Care to create to uninterrupted patient pathway from cradle to grave.

Duty of Candour

Do you support this proposal?

Absolutely.

What further issues would you want us to take into account in firming up this proposal?

a. The excellent Evans Review should be re-opened and viewed afresh. The report found that a culture of openness across the NHS was far from optimal, with many LHB described as 'in lockdown' when it came to handling patient concerns/complaints effectively and expeditiously. Even a simple apology at the outset was considered anathema by some LHB, seen as an admission of guilt rather than a human reaction to defuse an invariably upsetting and painful episode. Too many complaints have unnecessarily escalated to the PSOW through this simple action.

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d. As Keith Evans stated, complaints are a gift and a rich source of learning and service improvement. A citizen-centred service demands it.

Setting and Meeting Common Standards

Do you support this proposal?

Yes – especially to make sense of a series of separate legislation that is different to interpret and apply by health/social care providers working on the front line.

What further issues would you want us to take into account in firming up this proposal?

a. Standards must be clear, understandable and achievable – not just sound good and sit on a shelf gathering dust.

b. They must apply consistently to a single care pathway as the proposal outlines well. There must be a mechanism to REGULARLY review standards to ensure they are being met and are pertinent – across health and social care. Paragraph 66 of the White Paper won't be achievable if this isn't in place. We know it, but management often forgets it in the frantic drive to balance the books and meet targets.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Absolutely – all embraced by Williams, Andrews and especially Evans, et al.

What further issues would you want us to take into account in firming up this proposal?

a. In 2014 I carried out a review of the Independent Advocacy Service (IAS) currently driven by the CHC. (I have enclosed tis report for your ease of reference – it might help).There were an increasing number of complaints that spanned more than one LHB and also the Social Care spectrum – a spectrum that the IAS could not enter. Only part of the complaint could be pursued when a time resolution for the complainant required a joint approach. This fracture extended the process and

pushed the issue onto the PSOW path. The proposal is right and the solution is well described.

b. The IAS that currently sits with CHC should form the basis for the creation of this Joint organisation for Health and Social care, ensuing all-Wales consistency of approach. The IAS, formed under the 2006 NHS Act, should obviously be expanded, with those advocates currently employed by CHC bolstered by similarly trained LA personnel. The Service must develop cohesive links with the individual LHB complaints handling teams (all working to the same model!) as well as those teams looking at, for examples, issues in care homes. Strong links to the OPCW are also essential, given the ageing population.

c. However, we must be careful to understand the difference between the advocacy function and the investigation function. The same person doesn't carry out both, but the synergy between the two functions is obvious and both should have independence of action and decision from the facility/individual/organisation that is the focus of the complaint.

d. Learn Lessons and Intelligence. The reoccurrence of mistakes/the same complaint repeating time after time mean we havn't got the system right now. We currently 'identify lessons' but don't actually 'learn lessons'. Joint Advocacy and Investigation is a vital source of INTELLIGENCE that may well identify serious issues before they develop and this intelligence must be available to those inspecting facilities, such as HIW. Serious consideration must be given to establishing robust conduits to achieve this lest the value of complaints be lost an forgotten.

Representing the Citizen in Health and Social Care

Do you support this proposal?

Certainly. In saying that it gives me no pleasure to see the CHC abolished, but it has simply not fulfilled any of its NHS statutory functions in either a consistent or effective way across Wales. In its current form, based on a Council constitution, it has failed in its NHS function and this is not the basis upon which to establish the additional Social care functions envisaged in the proposal. All parties must accept that the CHC is not fit for future intent and that it's functions must be embodied in a new, professionally led organisation, whilst ensuring that the best practice and experience of the CHC staff cohort and the local strength of some excellent members be fully utilised elsewhere. We must look at the effective discharge of function not the preservation of an organisation that has demonstrably lost its way.

Can you see any practical difficulties with these suggestions?

a. The chief difficulty will be the opposition to change, from within CHC, the political arena and the general public, who will wrongly see the abolition of CHC as stifling the citizen voice in the NHS. Therefore it is vital that all parties are reassured that this change will not only see an enhancement of the CHCs current NHS functions of Public Patient Engagement/ Continuous Engagement (PPE/CE), an IAS and the right of entry to NHS premises, but an extension of these functions into Social Care within a professionally led body.

b. A CHC's chief weakness has been adherence to a Council structure that has failed to work in harmony and consistency across Wales. The seven CHCs are still considered to be 'independent' of the CHC Board in Cardiff, with this status often regarded as 'autonomy', fighting against the need for Wales-wide consistency. This was a clear intention of the 'light touch' CHC Regulation changes that came into force in April 2015. At the time the then Minister for Health served notice on CHC that improvement, based on comment in a number of reviews – notably the 'Longley Review of 2012, as well as poor performance in some areas, was essential if the CHC was to be retained. I have personal experience that these improvements have not been forthcoming, in spite of the enormous efforts of three CHC Directors and one CEO since 2008.

c. Chief weaknesses have been the so-called 'Member-led constitution', where largely unqualified volunteers have been given decisions they are unqualified to make, as well as the wrongly interpreted 'bottom up' philosophy which has frustrated all efforts to achieve Wales-wide consistency through the adoption of best practice. The 'bottom-up' philosophy more correctly describes the many excellent volunteer members who join CHC for no other purpose than to reflect and improve the experiences of the citizens within the communities they are familiar with. If tapped into properly they constitute an invaluable source of local intelligence, without which the whole Citizen-facing White Paper proposal will fail. I am aware that many of these members currently feel disenfranchised and, when I left CHC in mid 2016, there was no all-Wales training programme available to them. This was painfully evident during a series of joint GP inspections led by HIW, when the inconsistences in CHC member training were clear. Basic stuff.

d. One other point is that several NHS Reviews – including the Longley Review of CHCs – described the CHC movement as Wales' 'best kept secret'. Whilst the name itself is a poor descriptor, the PPE/CE function has tailed off considerable over the past three years or so. A CHC hosted public debate in Cardiff City Hall in early 2014, as part of the Evans Review, revealed that very few of the 70 strong audience had heard of it. Only as recently as early September this year, two of the biggest GP practices in Carmarthen had nil literature advertising the CHC, in spite of the HD CHC office being located just 800 yards away. Media too. For example, over the past 18 months there has been little visibility of CHC on BBC Wales Radio/TV on some vital NHS issues.

e. In saying this I must register the excellent performance of some of the seven CHCs, notably AB CHC, but regrettably such good practice here and elsewhere by dedicated staff and members, has not been embraced nationally. Attempts by Directors/CEO to strengthen the CHC Board office in Cardiff, and thus strengthen national consistency, have crashed on impact with the 'member-led Board' and the preservation of local autonomies at regional level.

f. The Way Forward. No delight is taken in documenting the above but its important to recognise some of the weaknesses that now demand reform. CHC costs c£3.8million annually – exceeding HIW's annual budget. One suggestion is to look at how the current CHC functions can be 'lifted', along with the solid experience and good practice accrued since 1974, into the proposed new 'national

arrangement'. This would utilise and re-role many of the existing staff and some of the volunteer membership. It is suggested that these assets are managed by HIW.

(1) The PPE/CE function. This is vital in order to capture the citizen voice – now to embrace social care. Currently CHC has the people in place in LHB areas. A designated CHC staff member should coordinate this PPE function. Management, training and direction should be from the Headquarters of the new Citizen Voice body – I would suggest that forms up under HIW, optimising current operational linkages with CSSIW.

(2) The CHC 'Inspection' function. CHC members can only provide the lay aspect so the current right to enter NHS premises should be extended to enter Social Care premises along with LA staff (and OPCW staff?) in the same team. This is really 'PPE', but also looking at the physical environment in which the patient/individual resides. This current CHC function should move quickly to HIW control, under similar terms to the HIW-led GP inspections where CHC have provided the lay element working concurrently with the peer element provided by HIW. This is then the 'inspection' package. Again, the role of CSSIW/HIW is inextricably linked if the citizens voice is to embrace Health and Social care (see 4.3)

(3) The Independent Advocacy Service. This is the one function 'hosted' by CHC that works exceptionally well. Some detail has already been discussed at 3.2 above. As a function it can relatively easily be 'lifted' from the CHC, but the hosting for it will require careful consideration. The Wales-wide dispersion of Advocacy teams within LHB areas is important and should continue, but expensive CHC real estate may not be appropriate, given the service will need to be expanded to cover Social Care – with appropriate staff from the 'regionalised' LA in the LHB areas. It is important that the intelligence naturally produced from the advocacy process reaches, currently, both HIW and CSSIW, possibly triggering a PPE/inspection focus once aggregated with other sources.

g. There should be minimal delay in now developing the legal process around creating a new structure to absorb the CHC functions. Arrangements for the employment of CHC members to undertake increased joint work with HIW could be progressed quite quickly, within the existing CHC-HIW I developed when in the CHC.

h. However, the first steps above cannot avoid seeing the need for HIW and CSSIW to not only work closer together and embrace CHC functions resources, but to use the first steps as the progression to the new independent body suggested at para 110, where a single, professionally NOT member-led national independent body, with robust local 'reach', naturally embraces health and social in an effective, visible and consistent way. Health and Social Care Inspectorate Wales perhaps?

i. Final point. When considering the future for CHC I'm not sure that we should be following the Scottish model, nor should we consider Healthwatch England, the poor replacement for English CHCs.

Co-producing Plans and Services with Citizens

What do you think of this proposal?

Fully agree, but a fostering of 'closer integration and joint working' should represent just Phase 1 , where Phase 2 sees the creation of just one body for Wales (see above at 4.1 item h). Why not embrace the best practice within CQC and see if that

could be applied here. CQC has learned and applied a great deal following the Mid Staffs NHS Trust debacle and the resulting Francis Report.
Are there any specific issues you would want us to take into account in developing these proposals further?

Mainly addressed in the paras above. The re-role of CHC members to HIW soonest will certainly address the issue of two organisations doing the same thing, although CHC lay visits into a hospital are not strictly 'inspections', other than reporting on the environment the patient exists in (that was a core function of the now defunct CHC Hospital Patient Environment (HPE) programme for WG. This environment 'inspection', however, is certainly relevant to care homes, where the access to NHS care is good, but the fabric of the building is awful and not conducive to good spiritual welfare and recovery.
However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?
Certainly – this has to be the objective. Legislation will take time as will getting agreement from all sides, but if we are serious in addressing the challenges that lie before Health and Social Care NOW and in the future, we must aim for this option.
What issues should we take into account if this idea were to be developed further?

Already outlined above. There is a tremendous amount of work here for WG. It is suggested that an appropriately experienced citizen body be involved as this work progresses.

Inspection and Regulation and single body

What do you think of this proposal?
Fully agree, but a fostering of 'closer integration and joint working' should represent just Phase 1 , where Phase 2 sees the creation of just one body for Wales (see above at 4.1 item h). Why not embrace the best practice within CQC and see if that could be applied here. CQC has learned and applied a great deal following the Mid Staffs NHS Trust debacle and the resulting Francis Report.

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What issues should we take into account if this idea were to be developed further?

Already outlined above. There is a tremendous amount of work here for WG. It is suggested that an appropriately experienced citizen body be involved as this work progresses.

WGWPMB94: J Pritchard
Location: Hengoed

General Comments

I have read this document with great interest and would offer the following comments.

Welsh Government is clearly keen to promote the patient's and citizen's voices in health matters and proposes abolishing the existing Community Health Councils, which currently undertake this task, replacing them with a new organisation. However the white paper does not guarantee the independence of this new organisation, which should be an essential principle.

It does not provide adequate scrutiny of the NHS or Ambulance Service but appears to leave this to the Board Secretary who is a Health Board employee!
Scrutiny by knowledgeable, independent people is key to maintaining and monitoring standards and pressing for improvements. This function should be built into the new organisation.

The white paper does not guarantee the provision of an independent advocacy service which is especially important in disadvantaged areas and the lack of which would undermine Welsh Government policies to reduce inequalities in health.
There needs to be a body which ensures that patients and citizens are consulted when changes to health provision are proposed. The white paper does not specify this.
There is no point in abolishing the existing system, centred on CHCs, unless it is replaced by something better.

The integration of health and social care would seem to be a desirable objective, but far more comprehensive proposals need to be brought forward before spending time and effort dismantling a system that, on the whole, works well.

WGWPMB95: Cytûn (Churches Together in Wales)
Location: Cardiff

General Comments

Cytûn (Churches Together in Wales) brings together the main Christian denominations of Wales, and a number of other Christian organisations, to work together on matters of common concern. The 16 member churches have around 165,000 adult members in every community across Wales, and regular contact with many more adults, children and young people. A full list of member churches and organisations can be found at: http://www.cytun.cymru/us.html

The vast majority of health care chaplains across Wales are clergy trained and supported by Cytûn member churches. Local congregations contain many other health care workers, and are often involved in the informal provision of social care through play groups, lunch clubs, tea dances, carers' support groups and many other activities of this kind. A growing number of churches are aiming to be 'dementia-friendly' and many work in partnership with social care providers to care for this and other vulnerable groups. A few churches engage in formal social care provisions through service level agreements with local authorities.

This response has been compiled by the church and society officers of member churches following consultation with church members with relevant experience. We are responding only to the latter part of the consultation, regarding complaints, inspection, patient advocacy and support.

We wish to note our regret at the timing of this consultation, over the summer holidays, making wider consultation within our constituency difficult. We also regret that neither the title nor the brief description of the consultation on the Consultations website made it clear that it included a proposal to abolish Community Health Councils – this is obvious only on looking at the full document. We would urge a greater transparency in future.

Response to Specific Questions

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
What further issues would you want us to take into account in firming up this proposal?

We support an integrated and accessible arrangement for investigating complaints regarding health and social care. We are, however, concerned at the possible loss of the patient advocacy role played by CHCs in this process in the NHS.
We regret that this section does not contain any guiding principles regarding a complaints procedure and we suggest that any complaints process should be:

- Independent of health or social care providers.
- Visible and accessible to the public
- Aim to empower the individual to put his/her case rather than 'take over' the complaint

- Be based on a philosophy of journeying with both complainant(s) and provider(s) to achieve better outcomes in the future
- Be able to offer, or have access to, mediation services to avoid the need for litigation
- Be able to see and report on patterns of complaints which might indicate deeper problems in a provider or sector.

The current practice of Health Boards employing a 'Complaints Officer' who is part of the Health Board hierarchy is not compatible with providing assurance of independence. This is currently partly ameliorated by the patient advocacy role of CHCs, but this is also questioned in this document (para 88). We would suggest, therefore, that an independent complaints handling procedure be established for those complaints which cannot be dealt with satisfactorily by an entirely internal process. We would suggest that this process be co-located with the Inspectorates, thereby having access to appropriate independent expertise, and meaning that perceived patterns of problems could lead to focussed inspections by the inspectorate.

Representing the Citizen in Health and Social Care

Do you agree with this proposal?

What further issues would you want us to take into account in firming up this proposal?

We recognise the difficulty faced by Health Boards in particular in engaging in service change, when so much public emotion attaches to local hospitals, doctors' surgeries, etc. We support the proposed procedure in Figure 1 as a first step. However, we do not believe that this process can be regarded as "co-production" – it is a streamlined consultation mechanism. Co-production would involve citizens' and third sector input at a much earlier stage, long before service changes become concrete proposals. We would therefore encourage further thinking in this field by Health Bodies and the new Citizen Voice organisation.

Inspection and Regulation and single body

What do you think of this proposal?

Are there any specific issues you would want us to take into account in developing these proposals further?

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?

What issues should we take into account if this idea were to be developed further?

We would support the proposal in para 110 to create a single body, independent of Welsh Government (but publicly funded) to act as an inspectorate for all health and social care settings and providers in Wales. We are aware that CSSIW is a new body and that further reorganisation – by merger with HIW – would have a considerable disruptive effect. Therefore, close co-operation and aligning of operations might be a more appropriate way forward.

As noted above, we are keen to see close working between the Patient Voice and inspectorate bodies, but we are not convinced that incorporating the patient voice in

the same body makes sense, as the function of professional inspection against statutory standards is a very different one from expressing the citizen's voice – and on occasions these two bodies may need to come to different conclusions on the same matter.

WGWPMB96: Anonymous
Location: Anonymous

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
The core principles which are set out are things I thought were already in place e.g openness and transparency. It is somewhat disappointing to see what should be active principles at the present, being revamped as something new for the future. There are no real dynamic and revolutionary changes afoot here. And this is what we need.

What further issues would you want us to take into account in firming up these proposals?
The governance of the Board is of great importance, however there is little meaningful change proposed here. One of the key difficulties in the present structure is the lack of clinical and operational expertise at Board level and the inability of the Board to scrutinise clinical decision making in relation to provision of clinical services and changes to these services. The Board is reliant upon others to tell them and will only have one perspective of this. This became very apparent with the Tawel Fan scandal in BCUHB. On the ground there were huge concerns and yet the Board was supposedly oblivious to these. Simply adding more and more people to the Board and renaming Independent Members 'Public Members' will not make any real difference. I would like to see the following;

- More engagement from ALL Board members with the front line services.
- Board members to engage with patients and visitors on a regular basis.
- Board members to do 'walk arounds' and interview staff about the situation and to engage with staff about Board proposals etc.
- Regular 'drop –in' sessions across the Health Boards in order for Board members to 'get a feel' for how things are.

There is an 'ivory tower' approach to management and these proposals do little to change this. Good governance comes from having operational knowledge combined with a strategic framework. Tawel Fan happened because nobody visited the unit to talk to relatives and to see for themselves how things were. If you walk around enough times you can soon see when things are not right. These proposals are not enough. If you want to know what the weather is like then you need to go outside occasionally.

In relation to Boards and NHS Trusts being allowed to appoint members to the Board for specific situations needs to be viewed with great care. These will be appointments from the public purse and if current members of a Board are not fully skilled and equipped to carry out their role then questions need to be asked regarding their suitability. Simply employing more people to do other people's jobs is not a good use of public money. And this proposal will be open to potential conflicts of interest and may not follow an open and transparent appointment system. If such appointments are to be made then an open application system needs to be in place to safeguard against political influences and nepotism.

Board Secretary
Do you agree with these proposals?
I agree with the proposals

What further issues would you want us to take into account in firming up these proposals?
The role is to ensure HB business is conducted in a fit and proper way and to ensure there is no local interpretations of key principles.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
I agree with the need for change, however what is proposed needs detail and Health Boards need to be given clear prescriptive guidelines about expectations.

What further issues would you want us to take into account in firming up these proposals?
There does need to be a more prescriptive approach from Welsh Government in language the public understand. For example a standard needs to be set that if a person needs a fasting blood test stating that this will be done by appointment before 10.00am. This does not happen now. The reality for many elderly [people is doing battle to get an appointment and being offered a midday appointment that is a bus ride away. People need access to physiotherapy near to their homes and will be seen within a specific time frame. People attending A&E with an eye injury will assessed and triaged by suitably trained practitioner within 1 hour. Tell the public what the Health Boards will be doing and focus on the everyday issues which matter and which make life difficult. Again this should not need to be said.

There does of course need to be high standard care and nobody will dispute this. However the proposals do not give clear indications of how this will happen. The biggest threat to poor care is lack of knowledge and skill and inappropriate staffing skill-mix. I would suggest the Health Boards work in partnership with the educational providers to ensure there are proper fit for purpose post-basic clinical courses for front line staff to attend. High standards come with high skills and knowledge.

Duty of Candour
Do you support this proposal?
I agree with the proposal

Setting and Meeting Common Standards
Do you support this proposal?
There needs to be changes in the way Health Boards plan and deliver services. Not convinced these proposals are radical enough to effectuate proper meaningful changes for the local population

What further issues would you want us to take into account in firming up this proposal?

The HBs have failed to engage with innovation and advancing medical care and expertise. Wales lags behind England in so many ways. The HBs appear to be acting in a defensive and reactionary way and the main focus is to answer the numerous complaints in a timely manner but do nothing to stop complaints being made. This is a completely back to front approach. But sadly is now the normal way of business and the Welsh Government needs to address this. And it should not take a public consultation to address these issues.

The clinical advancements in other parts of the country make patient safety more effective. The HBs need to look at what is happening and be more dynamic. There is evidence that access to physiotherapy on a self referral and drop-in basis reduces admissions to A&E and to GP. Yet BCUHB took a decision to move the physio from Glan Clwyd to Royal Alex in Rhyl. RAH is not on a main bus route and the car park is difficult to walk on, making it unsafe for elderly or poor mobility people. Nobody thought about the impact on the service user and nobody had clear knowledge of available evidence. How can this be? Who took this decision? This is just one example of things which happen without any thought to those people who will need to use the service. This decision was made without using an evidence base and without asking people who use the service. Services appear to be designed for the convenience of BCUHB. Same applies to the Ophthalmology services in Glan Clwyd. This service was moved up to Abergele and is difficult to access. All emergencies attend Glan Clwyd and the person has to wait hours to be referred to the Eye dept. Who decided this? Where is the focus? There does need to be a radical changes but these proposals are not enough. Proper accountability needs to happen and the Community Health Council simply leaving leaflets asking for 'feedback' is woefully inappropriate and ineffectual.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Anything which helps with the issue of complaints are to be welcomed. However this feels like empty rhetoric and more needs to be done to prevent complaints

What further issues would you want us to take into account in firming up this proposal?

There needs to be proper accountability and a designated person within the Health Board who will ensure that any lesson learnt is not soon forgotten. Too many complaints have a recurring theme which does not appear to be addressed. There is too much 'learning lessons' and not enough action to prevent a repeat. There perhaps needs to be more accountability for non-clinical staff. Professional groups are answerable to their respective professional regulators, but managers have no such sanction. Maybe this can change here in Wales.

Representing the Citizen in Health and Social Care

Do you support this proposal?

I broadly agree with the new proposals but they need to be prescriptive in regards to public engagement. For example they should be visible within the hospital/clinic etc and perhaps in pubic libraries on designated days. Visibility is key to the success of

these bodies . There is also a role for these bodies to educate the public. For example when major trauma services was moved from Liverpool to Stoke, some people thought this was about saving money etc, but it was a clinical decision and the public will always support such decisions when they understand the reason for changes. Proper engagement will help with this and the public are great channels for cascading information to their families and friends. Such a change will help with the decision making in relation to service change.

Can you see any practical difficulties with these suggestions?
Effective Citizen Voice
On the point of more engagement with the public, I agree this needs to improve. However care is needed to ensure this engagement is meaningful for everybody. There will always be self-interest groups and those who shout the loudest will get the best services. There are massive health inequalities within Wales and some people will find it difficult to engage. It is those without transport and financial means who suffer the most when services are moved away to remote locations. And there is always the issue of patient service groups being over represented by white, middle class, middle aged men and women, who can no doubt advocate for themselves but who cannot speak for others. The NHS needs to be for everybody. Whatever the format of the new proposed body there needs to be meaningful engagement

On the point about changing the format of the CHC. It does not really matter what format you adopt because it is how the CHC/new body operates. There is a clear need for such a body but they must to engage properly and have a clearly defined role to play. At present the CHC can be seen walking around the hospital asking staff questions but what is the point of this? They should be out in the community asking people about their experiences and engaging in open focus groups with all age groups. The CHC needs to be a channel for change and reform. Continuous engagement and feedback is needed. Simply changing the name will not suffice there needs to be proper training of staff and an open recruitment process. There is a whiff of nepotism and cronyism with the present structure and it is sometimes a case of 'who you know'. This needs to stop if there is to be an effective voice for ordinary citizens.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
I agree with the proposals in relation to strategic service changes. Proper review of evidence and benchmarking is important

What further issues would you want us to take into account in firming up this proposal?
I feel there needs to be more work done to prevent Health Boards changing services without notifying the public. These changes are not major strategic changes but the small changes which impact on the everyday lives of service users. For example a change to phlebotomy services and moving physiotherapy services as I have detailed earlier. There is publicity about the major changes but other changes happen by stealth and there is no mechanism to influence these once the change has happened.

Inspection and Regulation and single body
What do you think of this proposal?
Are there any specific issues you would want us to take into account in developing these proposals further?

Inspections are necessary however there is a danger that they create a false sense of security and high standards need to be maintains at all times and ways for each Health Board to reassure itself on this is important.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Another publicly funded body needs careful thought. What difference will this new body make? This is public money and proper scrutiny of the value of a new body must be considered.

Would you support such an idea?
Undecided about this as I feel there needs to be more detail about how such inspections are carried out and how the findings will be made public.

What issues should we take into account if this idea were to be developed further?
I agree with the proposals. However I believe there needs to be more scrutiny about clinical standards of care and this does not always happen. I am sure each health Board has an internal mechanism to reassure itself about standards of care and perhaps these need to be made public. This will reassure the public that standards are being maintained and poor standards of care will not have to wait for a formal inspection to be uncovered. There should also perhaps be a monthly public notification by each Health Board about the number of complaints it has received.

My personal view is that HIW inspections are not enough on their own. An inspection is as good as the day and the scandal in Tawel Fan needs to be a guiding influence in all future proposals. Public confidence has been severely dented by this. Each Health Board should be required to benchmark itself on a monthly basis and a designated person should be accountable for this.

WGWPMB97: Neath Port Talbot Older Person's Council
Location: Port Talbot

General Comments

NPTOPC considers that merging the Health and Social Care standards and principles are important. Also that it is vital that there is a commonality in the inspection regime in these services. This unification will support a modern health and social care system where collaboration between services is now common place.

However, we are concerned that considering that this consultation is on a 'White Paper' that it contains little detail on how this is to be delivered. There appears to be reliance upon an example of practice in another area, without validation of the success of that project.

We note that there is reference to an increased emphasis upon referral to Independent Advocacy Services. These services are usually supported by the Third Sector, which currently struggles to provide support for existing demand, with the meagre funding provided. We are aware that improved Independent Advocacy forms a part of the Social Services and Wellbeing (Wales) Act, but neither that Act, nor this proposed legislation, are offering a solution to support the existing and increased demand.
NPTOPC has also seen the Caerphilly 50 Plus Forum's response to this consultation, and agree with, endorse and wish to include with our comments above, their response to this Section.

"Common Standards for Person-Centred Care
Common standards for person-centred health and care across NHS, independent health sector and social care (where appropriate) which organisations are required to comply with are in principle laudable. However, when this has been attempted in previous years it has proved very difficult to shape in practice. The aim of "high level standards" that have meaning across such large and diverse sectors, with different service areas which often having little in common with each other, can lead to superficial results that citizens cannot make any sense of or utilise if they are wanting to access services or have complaints to make. Additionally, to fairly reflect the quality standards needed in the "medical model" of the NHS and the "Social Model" of Social Services seems an impossible task. Even the academic literature on what constitutes Person-Centred Care differs between the two sectors. Instead of investing in the proposed complex and difficult approach, we would want to see strong quality standards for each sector that are regulated and inspected robustly but with high level common standards at the inter-section of health and social care where they could drive up the quality of services provided jointly and provide transparency for the public in the way they are written. Another issue needs to be addressed before Common Standards can be implemented – Paying for Care. Whilst progress in Wales with raising the capital limit is very welcome, until the broader issues highlighted by the Dilnot Report are substantively addressed, the disparity between "free at the point of delivery" NHS and chargeable and means tested Social Services cannot be addressed or at least improved in the increasingly integrated manner that the legislation and policy statements want to see services delivered.

Unless a solution is found, the concept of Common Standards is seriously undermined."
(Quotation from part of Caerphilly's 50 Plus Forum's response)

3.2 Joint Investigation of Health and Social Care Complaints
The NPTOPC would urge that whatever system is put in place that it should operate quickly and efficiently, with adequate built in capacity to cope with possible future demand. Here again the NPTOPC would like to include in their response the considered opinion of the Caerphilly 50+ Forum as this echoes many of our concerns.
"Joint Health and Social Services Complaints System
We would support the proposals set out in the consultation which have already been addressed in England. It is essential that the investigating team comprises investigators from both organisations. These individuals must have been trained to deal with complaints into both health and social care provision, rather than specialising in only one of these areas. If not, the system will become fractured and impact on the public adversely. It is also important that the different aspects of a complaint are investigated in a timely manner and that they are taken forward as a whole case rather than separately. The new arrangements need to be properly resourced as delays or failures in getting access to services or their grievances resolved can have a significant impact on the lives of older people. Good information and advice about how the new system will operate is an essential requirement with access to advocacy on an even and joint H&SC basis where that is needed."
(Extract from the Caerphilly 50 Plus Forum's response)

Chapter 4 – Effective Citizen Voice, Co-production and Clear Inspection
This Chapter refers to a vision of strong citizen engagement in co-production. Whilst the NPTOPC are strong advocates for public engagement and representing a strong voice for the older population or others with protected characteristics, there is concern that the proposals within this consultation document are just too ambitious to be effective.

Within this document there is also much criticism of the Community Health Councils (CHC). The NPTOPC has listened to the local Community Health Council's messages regarding this consultation, agreeing with them that the loss of local scrutiny will be lost if these proposals go ahead. It is that local 'nipping in the bud' element which can often stop a small issue escalating into a big problem. CHCs to some extent already co-produce services, but this role could be strengthened.

The assurance provided by local CHCs provides reassurance of a standard and a resource to refer to, or act as an advocate if standards fail. You would in effect be taking away a local voice for patients.

The NPTOPC here will reiterate the response that was sent off for the Green Paper consultation in 2015 when we commented that we were:
"*not sure how their advocacy services could be strengthened, but should be".*
"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'.
(extracts from the NPTOPC response to the Green Paper in 2015)

We note that there are no proposals to strengthen CHCs , here again the comments from the Caerphilly 50+ Forum are endorsed by the NPTOPC:
"Representing the Citizen in Health and Social Care
Whilst a reasonable evidence base is provided to highlight the deficiencies with the current CHC Model, there is no argument put forward about how that model could be changed and improved. CHCs have a long history and many achievements and should not be dismissed so readily. Instead, a new approach based on the Scottish Health Council is proposed but without sufficient detail to know whether it will add value or whether it will work in Wales. What evaluation of the Scottish model has been undertaken? What has it improved since it was established? A visit to the SHC website shows it is largely dominated by health care with little information relevant to Social Care. Paragraph 4.3 provides more details about how the new model might work but that is all about health care and clinical governance – how will Social Care fit into the new approach? In summary, therefore we believe that a lot more work on the new proposed model is needed, its responsibilities and how they relate to other bodies, especially Social Care Wales and CSSIW and in particular, far more detail about how it will operate in respect of social services and social care more generally. A separate engagement with citizens about the detail of this and a consultation exercise is needed when that work is completed."
(Extract from the Caerphilly 50 Plus Forum's response)

4.3 – Inspection and Regulation
Here again the response from the Caerphilly 50 Plus Forum encapsulates the feelings of the OPC. We would like to add that we also feel that whatever inspection regime is decided upon, that it is vital that there is an independent scrutiny of that body.
"Inspection and Regulation and a Single Body
Whilst closer integration and joint working between CSSIW and HIW is essential in the short term, we believe that the case for a single body for regulation and inspection of health hand social care outside of Welsh Government is undeniable. Wales is the only country in the UK where both inspection bodies are directly within Government and separate. Despite their operational independence, the overall Ministerial responsibility for them and potential or perception of political interference cannot be ignored. The Inspectorates are also fettered in the strength and transparency of their professional advice they can give about new policy proposals. With new legislation and strong policy drivers to integration of health and social care, it makes no sense to continue with separate health and social care regulators – other parts of the UK have long since taken this step. Any structural change is problematic and needs resources but that should not be used an excuse for the status quo. A clear commitment and timetable to create and introduce a single regulator should be given as soon as possible. Jointly provided services for older people can only be improved if they are regulated on a joint basis too."
(Extract from Caerphilly 50 Plus response)

General Comment

The NPTOPC received a presentation from Welsh Government Officers at their monthly meeting in September 2017, on the Welsh Government's Parliamentary Review on Health & Social Care Services in Wales. The Review Panel is considering the future of health and social care in Wales. The NPTOPC is at a loss to understand how this identifies with this White Paper, which effectively outlines a vision for aligning future Health and Social Care Services in Wales? The NPTOPC wonders which of these is potentially a duplication of the approach, effort and resources from the Welsh Government?

WGWPMB98: B Campbell
Location: Swansea

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

Board Secretary
Do you agree with these proposals?
Yes

Duty of Candour
Do you support this proposal?
Yes

Setting and Meeting Common Standards
Do you support this proposal?
Yes

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes

Representing the Citizen in Health and Social Care
Do you support this proposal?
Yes

Can you see any practical difficulties with these suggestions?

There must be more effort in getting any body to represent the diversity of the population if they are truly to be a citizen voice, a big problem with the existing CHCs which are anything but diverse.
It is appreciated that there are inspecting bodies in place but the new body should, on visits to premises, be able to identify minor but obvious failings e.g. disabled toilets full of unnecessary clutter. Again a failing of the procedure of existing CHCs.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes

Inspection and Regulation and single body
What do you think of this proposal?
Yes

Are there any specific issues you would want us to take into account in developing these proposals further?

Obviously the inspecting body should be the "experts" but as I have said before there should be lower level input from those who represent the citizens voice.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
Would like to know about this idea

WGWPMB99: C Harris
Location: Unknown

General Comments

I would like to register my extreme concern about some of the contents of the above white paper, particularly in relation to the proposed abolition of Community Health Councils (CHCs) in Wales.

Welsh Ministers only have to look at what has happened in England since CHCs were abolished in 2003 and it appears that they are following suit without providing any clear explanation for this decision, but just cherry-picking, albeit inaccurately, negative or unclear passages from reports/papers produced by others, i.e. Longley review, OECD, etc.

In the white paper it clearly states that CHCS duplicate inspection duties that are carried out by Healthcare Inspectorate Wales (HIW). CHCs do not "inspect"; that is down to the professional clinicians employed by HIW or CSSIW. CHCs carry out monitoring visits by voluntary members and are carried out from a "patient's" perspective. These members are a vital part of CHCs and the recruitment process for these members has been increasingly stifled by both Welsh government bureaucracy and hampered by its elected members. For example, CHCs are not permitted to advertise vacancies within their organisation in local media.

Ultimately, if Welsh government remove the function of visiting premises by CHC members, then they will totally remove the option of obtaining an independent way of gathering the patients views, perspectives and opinions. Currently, when voluntary members carry out visits, they will also engage with patients, relatives and careers whom they come into contact with during the visit.

Another serious worry is the uncertainty behind how patients would seek help in raising an NHS concern or complaint should the white paper be successful in its recommendation of abolishing CHCs. How will patients voice be heard then? In England, advocacy has been pushed from pillar to post and have to research whether a particular organisation can offer assistance; NHS Advocacy Service (ceased April 2013), SEAP, POhWER, GMC, ICAS, etc. CHCs in Wales offer a free, independent advocacy service which is totally client led. Remove this service and the patients voice is silenced once again.

Whilst the current set-up of CHCs is not perfect, guidance and support should be provided to them, rather than carte blanche abolition and flippant, half hearted suggestion of amalgamation with other health organisations.

The White paper also suggests, maybe naively, that by setting up a separate body with roles appointed through the public appointment process. There needs to be a very clear process in place to ensure the transparency of these appointments by ministers. If they are paid, how are they going to be independent?

Also, any service change put forward by any Health Board, no matter how small, should be passed through CHCs to ensure that the patients perspective is at the

forefront of any such change. The White paper currently devalues this , by indicating that any new body would only review whether a health board has carried out the service change pathway in a correct manner and not whether the actual change is of benefit and reasonable and engaged with patients, relatives and carers in the locality.

I do believe, however, and agree that I and every other person in Wales should have a stronger voice, but this should be achieved by supporting and enhancing the current role that CHCs have within Wales.

WGWPMB100: Ynys Mon Citizens Advice
Location: Holyhead

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes. Agree with these proposals

Board Secretary
Do you agree with these proposals?
Yes. Agree.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes. Agree.

Duty of Candour
Do you support this proposal?
Yes. Agree.

What further issues would you want us to take into account in firming up this proposal?
A statutory duty of candour across all public bodies and persons operating within them, including Ministers, would considerably further Welsh Assembly's published aim in the Well-being of Future Generations Act of 'getting closer to the public we serve.'

Setting and Meeting Common Standards
Do you support this proposal?
Yes . Agree that a common set of high level standards should apply

What further issues would you want us to take into account in firming up this proposal?
There would be a danger of such a set of proposals being anodyne and unusable by frontline service operators unless the language and aims were carefully fashioned to be clear, appropriate and brief. This would be a good opportunity for co-production.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes. Agree with this proposal.

What further issues would you want us to take into account in firming up this proposal?

It would help if a single standard process was created. The various UK Ombudsman complaints processes that we often have recourse to in our work at Ynys Mon Citizens Advice are clear, accessible, brief and flexible. A good model.

Representing the Citizen in Health and Social Care

Do you agree with this proposal?

In general agree that an independent mechanism to provide clinical advice would be useful. Although this is a field beyond our expertise some of the same points as above would apply. Clinical expertise is already drawn on by Health Boards to assist their decisions. What would be different in this proposal?

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

In general agree that an independent mechanism to provide clinical advice would be useful. Although this is a field beyond our expertise some of the same points as above would apply. Clinical expertise is already drawn on by Health Boards to assist their decisions. What would be different in this proposal?

Inspection and Regulation and single body

What do you think of this proposal?

In general agree

Are there any specific issues you would want us to take into account in developing these proposals further?

Creating an underpinning legislative framework would only provide a basis for working closer together. To change the cultures of two separate organisations into one would need far more than just legislation.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?

Do not agree. Cannot see in the White Paper any substantive reason why this would be a good idea.

What issues should we take into account if this idea were to be developed further?

We would support a new body if it were to affect peoples' lives for the better in major ways. But if it didn't it would be seen as an unnecessary expense.

WGWPMB101: B Woodward
Location: Cardiff

General Comments

We are writing to respond “No” to proposals to abolish Community Health Councils(CHCs) as set out in the White Paper "Services Fit for the Future".

We recognise and welcome the discussion in the White Paper about the need to
- promote the integration of service delivery
-work across boundaries
-represent local communities, strengthen the voice of the public and secure public engagement
-achieve visibility

It is unlikely that anyone is going to disagree with these aims but they seem to make the case for strengthening CHCs rather than abolishing them. Experience across the UK and elsewhere suggests that abolishing CHCs has failed to secure these goals. Indeed the proposal to follow the current model in Scotland overlooks the fact that this model is under review because of its failings and is likely to be replaced. The Francis report (2013) into the failings in Mid-Staffordshire referred to the important role CHCs had played in England before their abolition (We include below a relevant extract from the Executive Summary Annex A).

We are aware of the challenges faced by CHCs, some of us having worked in the Health and Social Services since the 1960s before joining the CHC. But the aims set out in the White Paper were those which we strived to deliver throughout our time in the CHC. We give below practical examples of how this was done at Annex B. As the White Paper sets out, there is a need always to improve delivery in these areas but that is not always easy and there are real challenges to be faced. But in our experience, CHCs are fully subscribed to trying their best to meet these challenges. It is clear alternative models have been less successful.

The proposals in the White Paper do not make clear how the goals set are to be achieved. Neither has it given any indication of the costs both in terms of finance, loss of knowledge and expertise or potential damage to safeguarding the quality of service through independent scrutiny. The proposed role of Board Secretary seems very confused as being both to support the Board in delivering its agenda and securing independent challenge.

We fully recognise the need to modernise and keep pace with developments for which a name change may help promote, but it would make much more sense if this is done in partnership with CHCs. The need for an effective independent voice for the public in the NHS as currently provided by CHCs remains as important as ever both at national and local level.

Annex A
Extract from Francis Report Executive Summary Paragraph 1.19: 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.

Annex B
Examples In support of keeping the CHC in Wales
As past (CHC) Community Health Council members between 2003 and 2014, appointed by the Welsh Government, we are outlining some, but by no means all of the instances of poor management and disregard for the patient/client found by CHC members made both during announced and unannounced visits during this period. We can speak personally about these concerns which were documented in publicly available reports at the time. They also illustrate how we worked across boundaries and collaborated with others in ways that the White Paper seeks to promote.
Hafod Newydd Children's Mental Health Unit at Bridgend: Visited 15th April 2008 and Follow Up 20th April 2009.Joint visits by Freda Webster and Bob Woodward Cardiff CHC and colleagues from Bridgend and Rhondda Cynon Taff CHCs to the newly opened regional mental health unit for children from South Wales.

These visits followed concerns about children being accommodated on adult mental health wards. By the time of the follow up, this was not the case. During the visits we discovered from the children and staff that education was not being provided to some children because of the failure of local authorities to agree joint funding of teaching posts. We supported the Health Board in seeking to address the problem-there were some children not receiving education when they were due to be taking GCSEs. Children with mental health needs should not be further disadvantaged. This demonstrates how we worked collaboratively to address a wide range of services and needs.

Bed Closures at Whitchurch Hospital and other Hospitals 2003-16
While we supported the development of community care, we were concerned that hospital bed closures were being pushed through without appropriate alternatives being developed with the necessary capacity.

The CHC were unable to obtain confirmation of the bed numbers at Whitchurch Hospital it was necessary to visit and undertake a bed count
This was undertaken on a Saturday morning and we were able to confirm that we had been given incorrect information by the Trust.

Similarly in 2011, in St David’s Hospital, promises made to long term patients and their relatives transferred from Lansdowne Hospital were broken and bed numbers cut.

In 2017, a 16 bed Unit (New Facility) was closed in Llandough Hospital, despite a shortage of Mental Health Beds. Why close the beds when The Iorwerth Jones Unit was due to move there in the next few months?

We remain very concerned that Care in the Community as currently provided lacks the capacity as an alternative, as care is only available for 12 hours a day. Much of the care for the other 12 hours falls back to the family, who have to manage the best they can.
Hospital beds are still vital and closures should not happen until the services in the community are comparable to the hospital admission.

Outliers
On a visit by the CHC members to Whitchurch Hospital and in conversation with one of the patients it was revealed that a number of patients were being transported to Llandough Hospital every night to sleep and then returning to Whitchurch in the morning to spend the day. The patients' carried their possessions in plastic carrier bags and apparently sat around all day with nowhere to lie down or participate in any activities.
As a result of this information, the CHC members met with the Hospital Managers and the local MP, Julie Morgan chaired the meetings. Our report was also covered in front page headlines in the South Wales Echo.

Following discussions, the situation was improved for the patients by the installation of lockers on the wards for the patients' possessions and the practice of the patients having to sleep in Llandough stopped.

This unsatisfactory practice was brought to the attention of the Hospital Managers by vigilance of the CHC.

Out of Hours (OOH) GP Service at UHW
When CHC members visited the Out of Hours GP Service at UHW late at night they were horrified to find patients with ill children and babies sitting on the floor outside the OOH Consulting Rooms as only 4 chairs had been provided.
As a result, the CHC met with the hospital managers and eventually more chairs were provided, improved lighting in the corridor and more adequate toilet facilities.

The Iorwerth Jones Unit
We identify below a number of concerns identified over several years at this unit, some of which we pursued jointly with Health Inspectorate Wales.
Following refurbishment at Iorweth Jones, new showers were installed as there were very poor facilities for the patients at Whitchurch Hospital. When the CHC made an unannounced visit it was discovered that the new showers were used to store bed linen and towels. The very expensive and specialist bath was constantly reported to be out of order.

The Laundry service was constantly being brought to the attention of the visiting CHC members by the patients' relatives as the clothes they brought into the Unit either disappeared or were ruined in the laundry. New items of clothing regularly

went missing and it was it was regularly an item for discussion at the relatives/carers /staff and CHC meeting with very little effect even when the Laundry Manager and Executive Nurse for the Trust was present.

Another issue raised to the CHC Members was that the money given by relatives to the Unit to buy new clothes etc for patients. Apparently the money was spent and no receipts were given to the relatives or records kept on the Unit.
The mini bus was available to take the patients out but it was reported that it was rarely used
One of the issues identified at the Unit at this time was that there was not a Manager in charge of the Unit in post, only Acting up staff.

Llanfair Ward: Llandough Hospital
The CHC members were invited to the opening of this Unit which had great facilities for the patients which included Arts and Craft room, Kitchen and Gym
On a subsequent visit it was ascertained by the CHC members that the facilities were not being used to their full potential as the wards were upstairs and the facilities downstairs.

In practice this meant if any of the patients wanted to use the facilities, a nurse had to accompany them therefore reducing the number of staff on the ward

Patients reported that they felt isolated and complained that they were made to feel unwelcome when they tried to use the main hospital facilities, such as the Bank , shop and café. Unfortunately the patients did not even enjoy the facilities the main hospital patients received which was the trolley service with newspapers, sweets etc. They had to rely on a member of staff to bring in a newspaper for them.

The CHC brought these issues to the attention of the hospital managers at the time. The Unit has now been closed as being considered not fit for purpose after 6 years

Subsequently members of the CHC discussed these issues with the members of the Planning Committee when the new Mental Health Unit was being planned.

Conclusion
If CHC members had not been monitoring many of these issues relating to patient care, they would not have been identified and the appropriate action taken for the benefit of the patients.

The CHC is the only organisation that is in regular contact with the patient and users of the NHS. Without the unfettered opinion of the CHC members who are volunteers, the patient will in future, if changes occur, have to rely on members employed by the NHS to represent them. It could be difficult for them to be unbiased as they have their jobs to consider and could be easily influenced by their employer.

The CHC's in England were abolished and now newspapers are campaigning to be "the voice of the patient ".Please do not allow this to happen in Wales, the people of Wales deserve an independent voice and that is the CHC.

WGWPMB102: Hospice UK and Hospices Cymru
Location: Cardiff

General Comments

About Hospices Cymru
Hospices Cymru is the collective voice of Hospice UK members in Wales. The group seeks to advance hospice care and enable better care for more people in Wales.

About Hospice UK
Hospice UK was founded in 1984 and is the leading charity supporting hospice care throughout the UK. Our vision is hospice care for every person in need and our mission is to enable hospice care to transform the way society cares for the dying and those around them.

About this response
Hospice UK and Hospices Cymru welcome the opportunity to respond to this White Paper Consultation Document. This response draws on the experience of hospices in Wales supporting and caring for people with terminal or lifeshortening conditions, and from the knowledge and experience of Hospice UK working at a national level for people with palliative care needs. We have limited our comments to those issues affecting people who need hospice and palliative care.

Context
It is estimated that 24,000 people in Wales have palliative care needs each year. This care is provided across a range of settings – in hospitals, hospices, in the community, in care homes and in the person's home. Palliative care takes an holistic approach to meeting a person's needs, drawing on a truly Multi-Disciplinary Team working across and within health and social care, and delivered by statutory, independent and voluntary agencies. This ranges from meeting the person's clinical needs, to providing specialist counselling, to offering complementary therapies – all in the pursuit of the best wellbeing outcomes for the person.

Duty of Quality for the population of Wales
We agree that the existing planning duty should be strengthened to require Health Boards to plan for the provision of quality services at a regional and all-Wales population level. Whilst every local health board required Paediatric Palliative Care provision to meet the needs of its population, this provision is currently planned for at a regional/all-Wales basis. The nature of this provision is specialist and the number of children, young people and families requiring this service is low, at around 15 per 10,000 population aged 0-19. Clinical delivery remains as local as possible with consultant led teams based in Swansea and Cardiff supporting the consultant leads in each of the health boards. Ty Hafan children's hospice is the specialist provider covering South and West Wales and the south of Powys, with Cardiff & Vale University Health Board taking the lead for the region, whilst Ty Gobaith/Hope House supports children, young people and clinicians in North Wales and north Powys, with Betsi Cadwaladr University Health Board leading on provision. Whilst the populations of all seven health boards access the services of these providers, not all health boards engage with the children's hospices in a strategic or sustainable way, such as through commissioning and contracting. Requiring health boards to cooperate by

planning for quality provision at an all-Wales level will facilitate in this arrangement and will work towards greater equality of access to this service for children and young people across Wales.

The current requirements to produce Integrated Medium Term Plans are not explicit enough in directing Health Boards to collaborate with their external partners across health and social care settings in planning to improve population wellbeing outcomes. Third sector palliative care providers, such as hospices, must be included as partners in planning services to meet population palliative care needs. Hospices can provide a range of data about extant provision and local population need that will support future service planning. A new planning duty on health boards to deliver quality healthcare services should replicate the requirement on local authorities in the Social Services and Well-being Act 2014 to cooperate with both statutory and voluntary agencies in assessing and meeting population needs in an integrated way.

Current planning duties, specifically in relation to the Integrated Medium Term Plans, do not support health boards to demonstrate in sufficient detail the population level data required for planning. The lack of a Wales-wide needs assessment for expert palliative and end of life care is a huge gap and its absence will make planning for quality provision at a population level impossible. Developing a needs assessment was not included in the recently published Palliative and End of Life Care Delivery Plan. This means that we do not know who is being reached, and who lacks access to appropriate care. There is urgent need to identify those who need palliative care and thus work towards greater consistency in provision of care across Wales.

Common standards and a joint complaints procedure
We agree with the proposal to introduce Common Standards and a joint complaints procedure across all health and social care organisations. Palliative care must be Person Centred and individualised, regardless of where or by which organisation(s) that care is delivered. The delivery of that care must accommodate the person and not the organisations delivering it. With that in mind, people must have the right to the same standards of care regardless of where they receive it.

Delivering against common standards will go some way towards ensuring equally high standards of care for people with palliative care needs, despite differences in local provision where some areas are well-served by NHS provision, others by the voluntary sector and where there are local differences in the availability of either inpatient or hospice at home provision. Common standards should include delivering on agreed outcomes for people.

Commissioners must be able to commission services with the individual in mind rather than being limited by the differing frameworks of the institutions that may provide that care. A common standards framework will go some way towards supporting the commissioning of truly integrated palliative care.

A person or carer must not face the challenge of navigating parallel complaints systems when they have an issue that needs to be addressed about their care, especially at a time of heightened emotion or bereavement. People must be able to present their concern once with the onus on the organisations providing care to jointly investigate and address the issue and report back to the person together.

Inspection and regulation

Independent hospices represent a challenge to the current inspection and regulation regimes, being regulated by either or both Health Inspectorate Wales (HIW) and the Care and Social Services Inspectorate Wales (CSSIW). As it stands, hospices with inpatient facilities are regulated by HIW under the category of an 'Independent Hospital'. Hospices providing outpatient support – such as day care – or where they employ specialist palliative care nurses (Clinical Nurse Specialists) are regulated by CSSIW as 'Nursing Agencies'. Hospices providing direct care provision in people's homes, including support with personal care and administration of medicines, are regulated as 'Domiciliary Care Providers' with CSSIW. A single hospice organisation may provide all, a combination, or only one of these services and likewise people may access a combination of these regulated services throughout their journey, making the system tricky to navigate for all.

From a hospice perspective, as well as for the people accessing this support, it is prudent to take forward the proposal to bring the legislation underpinning HIW in line with the Regulation and Inspection of Social Care (Wales) Act 2016 to facilitate joint working and inspection where appropriate. In particular, this should reflect the move to inspecting based on outcomes.

We would also welcome further detail on proposals to fully integrate the two inspectorates where it can be demonstrated that this leads to better outcomes for people.

WGWPMB103: Hawliau
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Whilst there have been some efforts to broaden the skill and background experience of Board Members. This should be continued and further enhanced and developed. The turgid way in which some boards seem to operate make it less attractive in attracting board members committed to transformational thinking. Also those board members with no experience of serving on Boards. One Health Board I am aware of for example meets between 8 and 6 for a full day . This hardly uses the most recent approaches of effective decision making and attention from positive psychology and neuroscience perspectives such as the work of John Medina.

In terms of governance it has been seen recently that a Chair of a Health Board was not made aware of governance issues as identified by WAO until relatively late in the governance process. One suggestion would be to audit overall governance process more thoroughly perhaps on an annual basis as accounts are. This would ensure that governance is audited using effective ethical tools and that this is published and benchmarked.

Welsh Government should publicise the positive stories from Public organisations. Celebrating meaningful success using Appreciative Inquiry principles will support change on the more challenging issues facing public services. By focussing on what works and impact we can explore the challenges in a more creative and successful way. Whereas much of the focus of the change energy is on financial resources a focus on softer areas such as low aspirations , lack of joined up services and an absolute focus upon outcomes may achieve quicker and more sustainable change .

What further issues would you want us to take into account in firming up these proposals?
Mandatory training should be insisted upon for all Board Members. This should focus as well as on the relevant technical issues but also upon cultural change and transformation. There should be an exploration as to the increased involvement of staff as observers within the Board process.

An audit of the service user experience within the development of the organisations activities should be independently evaluated on an annual basis. From my experience, most ‘service user involvement ‘is tokenistic and fragmented in organisations with little evidence of change in practice in procedure.

Using any exploration of models of user involvement such as Arnstein or Hart or the Welsh Government principles for user involvement are broadly being ignored. I can find no evidence for example that services are commissioned using these principles. As suggested already this needs to be independently monitored if we are to see real evidence of effective service user voice at any level within public service organisations. My expectation would be that any commissioned service which is

provided by third sector or private organisations also demonstrates meaningful participation. This is of significant importance when working with those groups broadly identified as seldom heard in terms of voice and influence.

Board Secretary

Do you agree with these proposals?

Yes

What further issues would you want us to take into account in firming up these proposals?

This needs to be monitored on an annual basis by the relevant inspectorate or the Wales Audit Office.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

Yes

What further issues would you want us to take into account in firming up these proposals?

We need to find a mechanism to ban silo working – whilst we have some statutory levers within recent legislation this needs to be monitored in terms of its effectiveness. It would also be helpful if Welsh Government could begin to demonstrate how it did not work in silos as this exacerbates the current challenges within public services where organisations have competing priorities which are not resourced. This results in little action or commitment as it can be judged as being 'too difficult ' to achieve any change.

Duty of Candour

Do you support this proposal?

In part as members of regulated professions already have this duty.

What further issues would you want us to take into account in firming up this proposal?

Where possible managers who work in health and social care should be able to demonstrate an understanding of the customer facing role. One of the reasons that we need a duty of candour is because some managers have become focussed upon the wrong things. I am for example aware of managers who are only focussed upon costs and not outcomes. Meaningful engagement with service users as part of managers role could have a positive impact upon service design ,redesign and delivery.

Setting and Meeting Common Standards

Do you support this proposal?

No – we have principles in a number of laws and in prudent healthcare. Any understanding of change suggests time is needed to embed principles. As Welsh

Government has developed principles and values for delivery these should be tested out before we develop a further level of process.

If Welsh Government was serious about improving standards it would under the Regulation Act for example not have delayed the registration of key staff. A whole system approach across public services would ensure that there was a common direction of travel for all public services rather than more piecemeal and at times contradictory developments which currently are taking place.

We need to develop basement standards for all public services.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

It depends on the relationship between organisations.

What further issues would you want us to take into account in firming up this proposal?

Organisations

1 demonstrating how they have changed as a result of a complaint

2 Introducing a feedback process based upon continuous improvement so issues can be resolved without the need to make complaints

3 Supporting effective advocacy services so that it is available easily. Independent commissioning of advocacy services would be helpful. The short-term nature of advocacy services e.g. retendering every 3 years builds some perverse incentives into the system.

4 All 4 commissioners (Children , Older People , Welsh Language & Sustainability) should explore advocacy as part of their monitoring role.

Representing the Citizen in Health and Social Care

Do you support this proposal?

No, you have provided no evidence for this – I assume it is driven by political whim. It might be more helpful to align all the inspectorates around a common framework. Whilst not as politically attractive it makes more evidential sense to have a common framework used by different sectors to evaluate progress and outcomes delivered. As you have had different parts of Welsh Government design evaluation frameworks, this is a good example of where Welsh Government needs to address its silo thinking.

Can you see any practical difficulties with these suggestions?

A focus on stopping and thinking before doing would be helpful. Supporting services to be more proactive and preventative would be helpful. The use of KPI's should be rationed and commissioning should be smart and not only focussed on process.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

No as again there is no evidence that is thought through. As an example of poor policy making by Welsh Government you had Funky Dragon which after losing political influence was ended. I am not convinced that the proposed current structure will make any difference and it could be argued will be harmful in the short term whilst it beds in. Surely some clarity for inspectorates and commissioners on monitoring using shared and agreed principles would be the most beneficial way to move forward.

What further issues would you want us to take into account in firming up this proposal?

Welsh Government is very good at issuing strategic change documental without providing resources to deliver. If it were to stop this then the public service system could recalibrate and focus on where it needs to be. A strategy for everything is not helpful and ignores the complexity of delivering public services at a time of complexity.

Inspection and Regulation and single body

What do you think of this proposal?

Go further and do it once for all inspectorates. Where there are particular aspects of equality e.g. refugees or for social groups e.g. looked after children and young people. It would be helpful to ensure that progress against all domains is measured for groups at particular disadvantage. It would also be helpful to measure the due regard duty ((Section 7 of the Social Services and Well Being (Wales) Act 2014)) was being monitored and implemented. This due regard duty for the 3 key conventions is a positive way forward if it is effectively monitored.

However, we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?

No – use what you have – the levers are there if you become strategic in your thinking and start to practice the principles of the Future Generations Act 2015.

What issues should we take into account if this idea were to be developed further?

No new structures or planning mechanisms – develop what you have.

WGWPMB104: M Davies
Location: Cardiff

General Comments

We are writing to respond “No” to proposals to abolish Community Health Councils(CHCs) as set out in the White Paper "Services Fit for the Future".

We recognise and welcome the discussion in the White Paper about the need to
- promote the integration of service delivery
-work across boundaries
-represent local communities, strengthen the voice of the public and secure public engagement
-achieve visibility

It is unlikely that anyone is going to disagree with these aims but they seem to make the case for strengthening CHCs rather than abolishing them. Experience across the UK and elsewhere suggests that abolishing CHCs has failed to secure these goals. Indeed the proposal to follow the current model in Scotland overlooks the fact that this model is under review because of its failings and is likely to be replaced. The Francis report (2013) into the failings in Mid-Staffordshire referred to the important role CHCs had played in England before their abolition (We include below a relevant extract from the Executive Summary Annex A).

We are aware of the challenges faced by CHCs, some of us having worked in the Health and Social Services since the 1960s before joining the CHC. But the aims set out in the White Paper were those which we strived to deliver throughout our time in the CHC. We give below practical examples of how this was done at Annex B. As the White Paper sets out, there is a need always to improve delivery in these areas but that is not always easy and there are real challenges to be faced. But in our experience, CHCs are fully subscribed to trying their best to meet these challenges. It is clear alternative models have been less successful.

The proposals in the White Paper do not make clear how the goals set are to be achieved. Neither has it given any indication of the costs both in terms of finance, loss of knowledge and expertise or potential damage to safeguarding the quality of service through independent scrutiny. The proposed role of Board Secretary seems very confused as being both to support the Board in delivering its agenda and securing independent challenge.

We fully recognise the need to modernise and keep pace with developments for which a name change may help promote, but it would make much more sense if this is done in partnership with CHCs. The need for an effective independent voice for the public in the NHS as currently provided by CHCs remains as important as ever both at national and local level.

Annex A
Extract from Francis Report Executive Summary Paragraph 1.19: 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.

Annex B
Examples In support of keeping the CHC in Wales
As past (CHC) Community Health Council members between 2003 and 2014, appointed by the Welsh Government, we are outlining some, but by no means all of the instances of poor management and disregard for the patient/client found by CHC members made both during announced and unannounced visits during this period. We can speak personally about these concerns which were documented in publicly available reports at the time. They also illustrate how we worked across boundaries and collaborated with others in ways that the White Paper seeks to promote.
Hafod Newydd Children's Mental Health Unit at Bridgend: Visited 15th April 2008 and Follow Up 20th April 2009.Joint visits by Freda Webster and Bob Woodward Cardiff CHC and colleagues from Bridgend and Rhondda Cynon Taff CHCs to the newly opened regional mental health unit for children from South Wales.

These visits followed concerns about children being accommodated on adult mental health wards. By the time of the follow up, this was not the case. During the visits we discovered from the children and staff that education was not being provided to some children because of the failure of local authorities to agree joint funding of teaching posts. We supported the Health Board in seeking to address the problem-there were some children not receiving education when they were due to be taking GCSEs. Children with mental health needs should not be further disadvantaged. This demonstrates how we worked collaboratively to address a wide range of services and needs.

Bed Closures at Whitchurch Hospital and other Hospitals 2003-16
While we supported the development of community care, we were concerned that hospital bed closures were being pushed through without appropriate alternatives being developed with the necessary capacity.

The CHC were unable to obtain confirmation of the bed numbers at Whitchurch Hospital it was necessary to visit and undertake a bed count
This was undertaken on a Saturday morning and we were able to confirm that we had been given incorrect information by the Trust.

Similarly in 2011, in St David’s Hospital, promises made to long term patients and their relatives transferred from Lansdowne Hospital were broken and bed numbers cut.

In 2017, a 16 bed Unit (New Facility) was closed in Llandough Hospital, despite a shortage of Mental Health Beds. Why close the beds when The Iorwerth Jones Unit was due to move there in the next few months?

We remain very concerned that Care in the Community as currently provided lacks the capacity as an alternative, as care is only available for 12 hours a day. Much of the care for the other 12 hours falls back to the family, who have to manage the best they can.
Hospital beds are still vital and closures should not happen until the services in the community are comparable to the hospital admission.

Outliers
On a visit by the CHC members to Whitchurch Hospital and in conversation with one of the patients it was revealed that a number of patients were being transported to Llandough Hospital every night to sleep and then returning to Whitchurch in the morning to spend the day. The patients' carried their possessions in plastic carrier bags and apparently sat around all day with nowhere to lie down or participate in any activities.
As a result of this information, the CHC members met with the Hospital Managers and the local MP, Julie Morgan chaired the meetings. Our report was also covered in front page headlines in the South Wales Echo.

Following discussions, the situation was improved for the patients by the installation of lockers on the wards for the patients' possessions and the practice of the patients having to sleep in Llandough stopped.

This unsatisfactory practice was brought to the attention of the Hospital Managers by vigilance of the CHC.

Out of Hours (OOH) GP Service at UHW
When CHC members visited the Out of Hours GP Service at UHW late at night they were horrified to find patients with ill children and babies sitting on the floor outside the OOH Consulting Rooms as only 4 chairs had been provided.
As a result, the CHC met with the hospital managers and eventually more chairs were provided, improved lighting in the corridor and more adequate toilet facilities.

The Iorwerth Jones Unit
We identify below a number of concerns identified over several years at this unit, some of which we pursued jointly with Health Inspectorate Wales.
Following refurbishment at Iorweth Jones, new showers were installed as there were very poor facilities for the patients at Whitchurch Hospital. When the CHC made an unannounced visit it was discovered that the new showers were used to store bed linen and towels. The very expensive and specialist bath was constantly reported to be out of order.

The Laundry service was constantly being brought to the attention of the visiting CHC members by the patients' relatives as the clothes they brought into the Unit either disappeared or were ruined in the laundry. New items of clothing regularly

went missing and it was it was regularly an item for discussion at the relatives/carers /staff and CHC meeting with very little effect even when the Laundry Manager and Executive Nurse for the Trust was present.

Another issue raised to the CHC Members was that the money given by relatives to the Unit to buy new clothes etc for patients. Apparently the money was spent and no receipts were given to the relatives or records kept on the Unit.
The mini bus was available to take the patients out but it was reported that it was rarely used
One of the issues identified at the Unit at this time was that there was not a Manager in charge of the Unit in post, only Acting up staff.

Llanfair Ward: Llandough Hospital
The CHC members were invited to the opening of this Unit which had great facilities for the patients which included Arts and Craft room, Kitchen and Gym
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In practice this meant if any of the patients wanted to use the facilities, a nurse had to accompany them therefore reducing the number of staff on the ward

Patients reported that they felt isolated and complained that they were made to feel unwelcome when they tried to use the main hospital facilities, such as the Bank , shop and café. Unfortunately the patients did not even enjoy the facilities the main hospital patients received which was the trolley service with newspapers, sweets etc. They had to rely on a member of staff to bring in a newspaper for them.

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WGWPMB105: F Webster
Location: Cardiff

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On a subsequent visit it was ascertained by the CHC members that the facilities were not being used to their full potential as the wards were upstairs and the facilities downstairs.

In practice this meant if any of the patients wanted to use the facilities, a nurse had to accompany them therefore reducing the number of staff on the ward

Patients reported that they felt isolated and complained that they were made to feel unwelcome when they tried to use the main hospital facilities, such as the Bank , shop and café. Unfortunately the patients did not even enjoy the facilities the main hospital patients received which was the trolley service with newspapers, sweets etc. They had to rely on a member of staff to bring in a newspaper for them.

The CHC brought these issues to the attention of the hospital managers at the time. The Unit has now been closed as being considered not fit for purpose after 6 years

Subsequently members of the CHC discussed these issues with the members of the Planning Committee when the new Mental Health Unit was being planned.

Conclusion
If CHC members had not been monitoring many of these issues relating to patient care, they would not have been identified and the appropriate action taken for the benefit of the patients.

The CHC is the only organisation that is in regular contact with the patient and users of the NHS. Without the unfettered opinion of the CHC members who are volunteers, the patient will in future, if changes occur, have to rely on members employed by the NHS to represent them. It could be difficult for them to be unbiased as they have their jobs to consider and could be easily influenced by their employer.

The CHC's in England were abolished and now newspapers are campaigning to be "the voice of the patient ".Please do not allow this to happen in Wales, the people of Wales deserve an independent voice and that is the CHC.

WGWPMB106: The Co-production Network for Wales
Location: Cardiff

Response to Specific Questions

Duty of Quality for the Population of Wales
Do you agree with these proposals? Yes
What further issues would you want us to take into account in firming up these proposals?
Pt. 43 refers to 'individuals ..... being directly involved in the co-designing and co-producing of solutions. The introduction of the Prudent Healthcare principles provides a universal framework...'. The first Prudent Healthcare principle is about a co-production approach.

However, we feel that many health and social care staff do not have the knowledge, training or support to implement these principles in practice. We would like to see an encouragement to staff to join the Co-production Network, whereupon they will be able to access training, information and communities of practice to help them in applying the principles into everyday practice. Workforce Development & Training personnel should also be encouraged to make links with us, to look more closely at Training & Learning frameworks which include Co-production at the centre.

Setting and Meeting Common Standards
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
Under Pt. 57 there is a reference to 'All health and social care service providers need to demonstrate that they are doing the right thing.....Their care should be 'person centred'.
If 'person centred' is the ambition we wonder whether training on person centred approaches is a priority, particularly in the NHS. We would recommend that such Training should be part of the Induction process for all staff and can recommend Trainers who can help deliver.

Representing the Citizen in Health and Social Care
Noreen Blanluet, independent co-production consultant, and one of the founders of Co-production Wales which has now become the funded Co-production Network for Wales has written a Response to you regards this. We wholeheartedly support her response, in particular these quoted passages:
"Instead of replacing the CHCs which already have a regional structure as well as a national coordination through the Board of CHCs, they could be retained while reviewing and adjusting their role. There is a wealth of experience and capacity there which it would be shameful to discount, though some skills building in terms of co-productive ways of working would no doubt be required. Ideally CHCs could morph into an on the ground, hands-on organisation, deeply connected to their communities

and versed in and committed to co-production, with the breadth of diversity to work across both health and social care.

However - while I am imagining what the future might look like, I am not seeking to offer a prescriptive solution, merely a vision of what an effective citizen-engagement body could be. The possibilities are rich but what matters is how a solution is arrived at, and I don't think we are anywhere near this goal through the White Paper proposals. Welsh Government needs to take a truly co-productive approach at this early stage and convene an entirely different conversation. This may result in CHCs remaining, or it could mean the creation of a new body - one does not enter a co-productive conversation with a fixed idea of what the end result will look like.

I would like to urge Welsh Government to take a courageous, and yet obvious, position: to take a more innovative approach to designing citizen-centred health and social care services. This will mean putting on hold the proposed plans presented in the White Paper for a new national body, and convening a conversation with key stakeholders who must include "ordinary" citizens as well as engaged citizen activists and advocates, and a range of organisations who have an interest in this work from various angles - including the CHCs themselves and may I also recommend the Co-production Network for Wales.

Only then will Welsh Government - and this collective - be able to develop a proposal for a service that acknowledges and leverages the wealth of experiences and assets present throughout our communities and organisations, and create a solution that is truly co-produced. This will not be simple and fast, but it will be effective and sustainable. We can keep tweaking the system through successive Green and White Papers, or we can bring our collective wisdom to design something world-leading. Let's co-produce co-production. What do you say?"
We think that this is an opportunity to genuinely apply the co-production principles to a hugely important area. An opportunity to go beyond tokenistic or partial engagement, to a situation where citizens and professionals genuinely share power.

Co-producing Plans and Services with Citizens
Do you agree with this proposal? We believe that this needs re-visiting, in light of our response in 4.1

What further issues want us to take into account in firming up this proposal?

In Pt. 93 it says 'plans will have a greater chance of success if citizens are in involved in co-designing and co-creating them.' Then, in Pt. 95 there is a reference to 'inclusive continuous engagement....so we can co-create improved patient outcomes.....we will be revising existing guidance to illustrate what effective engagement based on co-production principles looks like'. Our response in 4.1 (and our support for Noreen's articulation of this) is just as relevant to this area.

WGWPMB107: Royal College of Pathologists
Location: London

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Board leadership is clearly important, however, the additional benefit of having a vice chair is not clear from this consultation document.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes, it makes sense to update the duty of quality to reflect the current organisation arrangements. We would welcome the focus on partnership working and cross boundary working. Pathology services in Wales already work across Health Board boundaries in many areas to provide high quality pathology services for the population making best use of resources, eg. in screening services or specialist services such as genetics, and there is more potential in other services which are currently hampered by cross boundary politics.

Duty of Candour
Do you support this proposal?
We support this, bringing Wales in line with England and Scotland.

Setting and Meeting Common Standards
Do you support this proposal?
Broadly, yes.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes, we support this, although there will be significant challenges in achieving this.
What further issues would you want us to take into account in firming up this proposal?

The way that health and social service will need to work together will need to be well resourced and realistic about the time taken to respond. Whilst a commitment to a quick response (currently 30 days in health) is clearly good for the complainant, the reality of healthcare means that this is impractical in many cases, and the additional complexity of cross sector investigation will inevitably require appropriate time to address concerns and learn from errors.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?

Yes, we support the principle that Health Boards should be able to make service change decisions, taking into account independent views including clinical where necessary. Welsh Government must remain open to decision making, informed by independent clinical advise. The Royal College of Pathologists' "RCPath Consulting" offers such independent advise.

What further issues would you want us to take into account in firming up this proposal?

The definition of "substantial" needs to be clear and not left to individual interpretation. The mechanism for service change where it is being considered across Health Board boundaries also needs to be clear (it is not in this paper). For example, in pathology services there have been past and present projects proposing significant service changes across Wales. As these services are often not patient facing the level of scrutiny tends to be less. In addition, in the absence of a single national accountability progress tends to be slow, limiting innovation and service development. Welsh Government should be clear on where it draws the line between service level autonomy vs. the proposed directed role envisaged in this paper.

WGWPMB108: Anonymous
Location: Anonymous

General Comments

Although I am offering my personal views on this White Paper I cannot ignore the perspectives I have developed from the various voluntary and paid roles I have taken over the past 28 years.:-

a previous Community Health Councillor,

an appointed Non Executive Director of a Welsh Government Sponsored Body (WNB – becoming Health Professions Wales).

an existing Board member and Chair of a UK charity as well as previous charities.

A Board member of a Registered Social Landlord (a traditional housing association) and a previous Board member of Care and Repair Cymru – now a Health Advisor to the Board.

A social gerontologist and nurse academic as well as a registered manager and matron of nursing homes.

A present lay appointed advisor on ageing to government.

An Associate Health Board member.

As an educationalist I remind people that in order to perform as a high quality health and social care practitioner you need to have, as well as the core values and behaviours that should always underpin your practice, a well developed bank of knowledge appropriate to the persons whom you provide a nursing service. For any individual service knowledge about the cohort group as well as the individual and their life course is crucial. For gerontological practice there are clear core demands which are clearly set out in WHO guidelines :

http://www.euro.who.int/en/health-topics/Health-systems/nursing-and-midwifery/publications/2003/who-europe-gerontological-nursing-curriculum

http://apps.who.int/iris/handle/10665/252671

Within The Social Services National Outcomes Framework statement it includes the NHS. However, I am unsure that most nurses working in the NHS would know about this Framework or indeed adhere their continuing education and nursing practice to the key indicators of this Framework.

Whilst I realise that this work is developing it is important to realise that one of the most important activities in the integration of care is that all people involved in implementing the new Health and Social Care Integration policies understand each other's perspective AND the individual citizen whom they are assessing and then designing, developing, implementing and evaluating a service for.

Response to Specific Questions

Board Membership and Composition

Do you agree with these proposals?

Yes generally and I hope that my explanation below explains what else should happen.

What further issues would you want us to take into account in firming up these proposals?

At present I am the elected Chair of the Stakeholder Reference group (SRG) – my membership being as the Carer representative. This group represents some of the external environment for the Board including representation from each local authority, third sector CVCs, CHC, Care Forum Wales, RSLs and Health and Social Care Co-ordinators for each LA plus a Carers rep.

There are, as an Associate Board member – which the Chair then becomes - approximately a minimum of 30 days per year that are spent undertaking meeting attendances, reading of papers and writing specific reports for Board and yet I do not think that Associate Board Members from the SRG and who are voluntary, are treated equally against the role of paid Independent Board Members. This I feel, is similar to my comment below about having paid Community Health Councillors – valued for their particular expertise and a payment attached to that value and contribution to the Health services.

Board Secretary

Do you agree with these proposals?

YES.

What further issues would you want us to take into account in firming up these proposals?

In order to scrutinise and challenge the CEO effectively this person will need to be highly knowledgeable and skilled.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

YES. I see this within the role of the Regional Partnership Boards. However in the light of the fact that there is now a Health, Housing and Social Care All Wales Committee why is there no formal representation of Housing on these Regional Boards. I see this as a serious anomaly/omission and have already raised this several times. At present this omission just does not illustrate an integrated system strategy – in the light of the evidence of housing linking strongly with health outcomes and also Housing now providing residential type supported housing and care homes in Wales as well as domiciliary care services.

Strengthening the existing planning duty should help to bring together Local Authority, Health board and Housing RSLs to properly work together to achieve solutions now, not in another 5 years. Talk must now stop and integrated action take its place.

Duty of Candour
Do you support this proposal?
Yes – absolutely.

What further issues would you want us to take into account in firming up this proposal? At present in order for the NHS to be assisted in developing evidence based practice it takes advice from its local representatives from Royal Colleges and other professional bodies. However, it constantly disturbs me that the Royal College of Nursing cannot solely focus on this clear advice as it always has its trade union functions to affect its judgement and advice despite its reassurance that it can do this without influence.

I really do not think that this duty of candour is understood by NHS and LA managers – there is still a focus by some staff on risk avoidance and staff are still very reluctant to report poor practice/abuse. Some staff will need further training in this area of knowledge and practice.

Setting and Meeting Common Standards
Do you support this proposal?
Definitely Yes.

What further issues would you want us to take into account in firming up this proposal?
It is important that any new Standards are mapped against existing standards (i.e. National Outcomes Framework) as care is now firmly about well being. I would expect to see that these Standards are based on evidence and values and consider that the NOF is ideal.

However, how can we develop Standards when there is evidence of little understanding of nursing practice in, for instance, the care home sector, with no Leader in Care Home Nursing Practice based in government, no government nurse representation on the Care Home Good practice workstream, and an absence of clear guidance in nursing practice and the older person.

The dominance of the medical model of health and care still exists particularly by the nursing profession (other than some enlightened nurses who strive to work with social care colleagues effectively) and ageism firmly exists within nurse education curriculum (i.e. no mandatory requirement to learn about ageing and the life course in nursing – but it is required in social work). Despite NHS Continuing Care funding in the community and in care homes I find it concerning and disappointing that we still have this situation.
This is despite a Strategy for Older people Phase 3, a Welsh Nursing Academy Position Statement on Ageing, Nursing practice and the older person, and a clear fact that at least 70% of people who use NHS services are over 65.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
It will need clear leadership and understanding of how to map the impact of health and social care practice outcomes. Evidence based practice should be key to this. As I have said in 3.1 sadly some practices in health (I include nursing practice in care homes) is still not evidence based as there is still little national leadership in gerontological nursing practice in care homes and or indeed NHS Wales. Up to date research into the roles of nurses in care homes and the skills and competencies required has already been provided by myself to WLGA Care Home market analysis recently.

Representing the Citizen in Health and Social Care
Do you support this proposal?
Yes – The WIHSC Longley Report was most useful and I would support that in order to value the expertise that exists within the public already, all appointed officers (previous Councillors) should receive a payment. I say this as a previous Councillor who became a lay appointed member with a health background, whilst working full time. Whilst my employer supported my appointment and would have been happy to reduce my hours in order for me to dedicate some more effective time to my CHC role I could not afford the loss of salary, as being a CHC lay appointed councillor was (and still is) unremunerated.

Can you see any practical difficulties with these suggestions?
There is obviously a cost to paying Councillors (or whatever title is chosen for this new Body). However, the cost will be outweighed by the benefit of having more specialist and expert councillors devoting more time and arguably more objectivity and quality to their role. Having recently read a CHC report at a public Health Board meeting this week I was extremely disappointed at the quality of content and how it did not reflect the tracking of complaints and the learning shown to improve practice. With more experienced and appointed members I feel that this would be less likely to happen.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
YES – Please see my comment about the conflict of interest of taking advice from a nursing professional body which is also a trade union body. This is a clear conflict of interest. Thus the role of the citizen is crucial and the emerging activities of the regional citizen panels are essential.

What further issues would you want us to take into account in firming up this proposal?
I would like to see that the new regional citizen panels are provided with the clear evidence based research which shows what works well and that good practice is clearly shared – with no further reinventions of the wheel or holding on to good practice for just one area. There are some wonderful good practices which receive

awards yearly at the NHS Awards and it amazes and disappoints me that the public does not see the affect of these Awards – that this good practice is then shared throughout Wales. I raised and tweeted this point at a recent 1000 Lives conference 6 months ago. For instance the Burtzog model from Netherlands was presented and the conference agreed to begin a pilot in Wales with Public Health Wales leading on this – I have not heard that this has been taken forward. Neither have I heard that the ABUHB C.H.A.a.T model with which I was involved has been taken up by any other Health Board after it won the overall NHS Wales award in 2015.

Inspection and Regulation and single body

What do you think of this proposal?

I agree.

Are there any specific issues you would want us to take into account in developing these proposals further?

All Inspection agencies should be independent and able to scrutinise effectively. I have been very disappointed with the work of HIW where many local health professionals undertake work for the body. Anecdotally - I have noted in HIW reports of poor practice and seen a year later that nothing has changed in that particular ward. How is conflict of interest managed – it is not.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?

YES – I was an appointed Board member (lead for adult nursing – independent sector and older people) of the Welsh Nursing and Midwifery Board (WNB) which then became Health Professions Wales. I was a member of the Board when we took the decision to be the first nation to have a qualifying degree in nursing and very proud of the indepth work we undertook to reach this decision. I was very disappointed when this body was closed down and very worried for the quality of nurse education and the monitoring of education and practice for the future. I would welcome this body to return for Wales which would remove to a certain extent the influence that the RCN as the only nursing body to go to for advice – see my comments above about conflict of interests.

So – my comments on the WNB offer an example as to how a care professional WGSB can work very well – just as Care Council for Wales has done and has been a real pioneer for social work and social care practice.

What issues should we take into account if this idea were to be developed further?

There should be clear evidence in the archives as to how previous professional bodies have worked. CSSIW is now working much better in terms of inspecting, using a good evidence based tool (SOFI) and then undertaking enforcements more effectively. This is good example of how HIW should be working. Great care should be taken with any new WGSB that there are new faces joining this body. Wales is a small place and many senior roles are often recycled elsewhere. We must take great care that Inspection stays fresh and strong at all times and that the public can see this working well.

WGWPMB109: General Medical Council
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?

We recognise the desire to enable and encourage more effective governance of NHS organisations, and welcome the inclusion of a range of core principles committing to a culture of openness, quality improvement, and co-production.

We would seek assurances that our core functions, carried out by organisations on our behalf, are not affected by any changes to health board governance. This includes health boards providing, and assuring the quality of, training places.

Board Secretary
Do you agree with these proposals?
Yes

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
The GMC welcomes the ambition to achieve a systematic approach towards quality improvement within the health service. Quality improvement is part of doctor's responsibilities, as made clear in our core guidance stating both that doctors "must regularly take part in activities that maintain and develop your competence and performance", and that they "must take steps to monitor and improve the quality of your work". Regular engagement in quality improvement activities is a requirement of our 'Supporting Information for Appraisal and Revalidation'.

The responsibility to maintain and improve quality is a prerequisite to meeting the White Paper's ambition to establish a person-centred health service. As part of this, we welcome the specific proposal for a Duty of Quality to reinforce existing commitments to delivering high quality care.

The GMC's National Training Survey (NTS) is an important tool allowing NHS organisations to identify firstly areas of good practice, as well as those areas of concern in terms of quality of training, which are addressed through our comprehensive quality management framework. This could be a useful indicator of particular areas where a duty of quality would be most useful in engendering

improvements to particular services. This would also support our aspiration to be more proactive as a regulator to ensure that doctors are supported to comply with GMC guidance and standards.

Regarding the implications of the proposed duty on cross-border working between health boards, we welcome the opportunities this represents in terms of the management of training and the provision of training places. The GMC is committed to ensuring that such opportunities to improve education and training are valued and built on, evident in the focus on the importance of these within organisational culture in our guidance 'Promoting excellence: standards for medical education and training'.

Duty of Candour

Do you support this proposal?

Yes

What further issues would you want us to take into account in firming up this proposal?

The GMC welcomes the intention to strengthen the legal duty of candour, and aligning with both England and Scotland on this. We have taken an active role in encouraging doctors to embed honesty within their practice and relationships with patients. GMC guidance makes clear the importance for doctors to be transparent in their communications with patients, and their responsibility to raise concerns where patient care may be compromised.

We would anticipate that a legal duty of candour would be in line with our core guidance 'Good Medical Practice', which stresses the requirement for doctors to "be open and honest with patients if things go wrong" , and that they "must be honest and trustworthy in all of your communication with patients and colleagues". Furthermore, GMC guidance 'Raising and acting on concerns about patient safety' states that "All doctors have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisations in which they work."

Openness is an important part of delivering on the White Paper's objective of a person-centred health service. This was recognised by the Francis Inquiry report, which recommended introducing a statutory duty of candour in order to strengthen both transparency within the health service, and patient safety. As part of our response to this report, the GMC issued joint guidance with the NMC 'Openness and honesty when things go wrong: the professional duty of candour'. This stressed that, in the event where something has gone wrong with a patients care, healthcare professionals are required to tell the patient when this has happened, offer an apology, provide an appropriate remedy or support if this is possible, and explain fully to the patient both the short and long term effects as a result of what has happened.

We would seek assurances that a statutory duty of candour would not conflict with this professional duty of candour. Additionally, we would seek an assurance that

training and support would be provided for staff involved in the process of implementing and maintaining the duty.

Introducing a legal duty of candour would support existing GMC guidance to strengthen both patient safety and transparency within the health service. It would also help to engender moves towards a culture of quality improvement within the sector.

Setting and Meeting Common Standards

Do you support this proposal?

Yes

What further issues would you want us to take into account in firming up this proposal?

As described previously, it is absolutely fundamental to the GMC that 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 do this by setting standards and providing guidance for all doctors regardless of their location or role. We would welcome seeing this enhanced with consistent standards across health and social care provided they align with our existing guidance.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Yes

What further issues would you want us to take into account in firming up this proposal?

The GMC recognises the benefits this would bring, simplifying the complaints process for patients in relevant cases, while also improving the ability of health and social care organisations to learn lessons when things go wrong with an individual's care. The GMC recognises the importance of learning lessons from such situations, with our core guidance stating that doctors "must be open and honest with patients if things go wrong". Additionally, 'What to expect from your doctor: a guide for patients' states that "doctors have to report when things go wrong for patients…so lessons can be learned."

The White Paper includes the proposal for health and social care organisations and independent providers of health and social care to collaborate on an agreed joint complaints process. We would seek assurances that this collaborative effort will be completed within an agreed timescale, so as to ensure that doctors and patients are able to enjoy the benefits this process would bring in a timely manner.

Representing the Citizen in Health and Social Care

Do you support this proposal?

Yes

Can you see any practical difficulties with these suggestions?
The GMC welcomes the aspiration to make the platform for patient views in healthcare more visible. The move towards a national body is also in keeping with the aim to encourage greater cross-border working, a necessary move in light of financial and workforce pressures facing health boards. This also reflects the reality of health boards needing to collaborate to address patient needs where particular health boards do not have adequate capacity to provide certain treatments.

The principle of collaboration within the health service is recognised as part of a doctor's responsibility on our core guidance 'Good Medical Practice', stating that doctors "must work collaboratively with colleagues, respecting their skills and contributions."

The White Paper's assertion that this proposal would improve the issue of visibility of the patient voice is welcomed. Ensuring the public is aware that their concerns and experiences are consistently included in scrutiny of the health service is integral to achieving the White Paper's ambition of a person-centred service.

The GMC recognises the importance of ensuring patient views are aired and responded to, with our core guidance stating that doctors "must listen to patients, take account of their views, and respond honestly to their questions." Additionally regular patient feedback on the services individual doctors provide is a requirement of our 'Supporting Information for Appraisal and Revalidation' reflecting the importance we place on the views of patients.

The GMC would want to be assured that, as well as fulfilling a representative role, any new patient voice body ensures that the citizen voice is heard and that this is at an individual and local level as well as regional and local. We seek assurances that the arrangements for the proposed body would not weaken the patient voice as it currently stands within the health and social care sectors. We would like to see examples of good practice of CHCs and others already being involved in the planning and review of services being recognised and built upon.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
The GMC welcomes the White Paper's support for ensuring patient views and experiences are consistently included and influential on the design and creation of health services. Alongside an explicit statement that patients must be treated as individuals, our core guidance states that doctors "must listen to patients, take account of their views, and respond honestly to their questions" and that they "must work in partnership with patients, sharing with them the information they will need to make decisions about their care".

The White Paper notes that one of the first steps that the Welsh Government will take is to revise existing guidance "to illustrate what effective engagement based on co-production principles looks like and to provide greater clarity on what is meant by substantial service change."

We welcome the White Paper making clear that any proposals for service change need to be based on clinical evidence to provide the right health outcomes for patients. We would want assurances that what is understood as substantial service change is not just an arbitrary categorisation determined on a financial basis, but also in terms of the impact it has on the ability of doctors to act as professionals and maintain GMC standards. Crucially, as the White Paper proposals are designed to strengthen a person-centred health and social care sector, substantial service change should also be understood in terms of the impact on patient care.

Inspection and Regulation and single body

What do you think of this proposal?

The GMC welcomes the White Paper's aim to clarify responsibility for the inspection process in regards to the duplication of these functions by CHCs. Addressing this would provide patients with greater assurances over when premises have been effectively inspected.

Are there any specific issues you would want us to take into account in developing these proposals further?

The GMC has a strong working relationship with HIW through various agreements. The GMC and HIW are joint members of the Wales Concordat, and have in place a Memorandum of Understanding, as well as an Information Sharing Agreement. This Agreement is currently being updated to allow the live sharing of data from the GMC to HIW. The GMC's aim is for this relationship to be maintained throughout any legislative changes being made to the working arrangements of HIW. We would seek assurances that the boundaries of both HIW's and the GMC's remit, as a system regulator and a professional regulator respectively, are recognised. This would ensure a continuation in the clear separation of functions between HIW and the GMC.

We recognise the benefits of a closer working relationship between HIW and CSSIW, providing a consistent approach to inspection of services which overlap between the health and social care sector. We would seek greater detail regarding how complaints and concerns would be managed, and how these processes would interface with our role as a regulator.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?

What issues should we take into account if this idea were to be developed further?

Multi-disciplinary team working is an existing reality within the health service, and is anticipated to become much more widespread in the future. Taking this into account, we would want to see the new arrangements be future proofed to facilitate the need

for closer working between professional regulators, particularly if there is regulatory reform in the future.

WGWPMB110: All Wales Directors of Nursing Peer Group and Assistant Directors of Nursing
Location: N/A

Response to Specific Questions

Board Membership and Composition
There was agreement that:

- there should be a set of core principles across NHS Wales.
- there should be a strong independent members composition, in order to provide challenge and the title "Public Members" is fully endorsed.
- every chair should be supported by a vice-chair.
- the concept that WG can co-opt additional Board members at times of poor performance was supported, although it was felt that Health Boards should be able to co-opt additional board members to address local Health Board specific issues (which are not just related to poor performance).
- There is a need to address citizen representation in a balanced manner.
- Statutory Board roles should not be merged e.g. COO with Director of Nursing, as this can lose focus. The COO role should not be an executive role on the Board.
- There was a strong view about the role and contribution of the Director of Nursing/Midwifery and Patient Experience, which must be included in the "Core Composition" of board members. This is due to the size of the nursing and midwifery profession, the direct contribution to patient experience but also, importantly, in light of the Nurse Staffing Act. It is essential boards have clinical representation in order to drive the modernisation agenda, ensure clinical leadership and secure/assure a patient focus.
- There was concern that complete flexibility to decide on executive membership could possibly see Health Boards being managed and led very differently. Whilst it is accepted that some local variation should be enabled, core & majority composition is vital for a one-Wales approach.
- Ways of increasing diversity amongst Independent Board Members in particular, those with protected characteristics, would be welcomed. The Independent Member appointment process needs to be more efficient and better designed to engage individuals from different backgrounds, age groups and ethnic backgrounds. The current appointment process is onerous and deters many suitable candidates from applying. It also needs to be sharpened as the recruitment timetable is far too long.

Board Secretary
The promotion of openness and transparency is essential in upholding public confidence and integrity. Standardisation and formalisation of the board secretary role would further enhance and facilitate this objective.

There is a wide variation in the role of Board Secretary across NHS Wales in terms of responsibility, portfolio, reporting lines and resource which needs to be addressed. There should be a standardised Job Description and Personal Specification. For due

diligence the Board Secretary role should be 'independent' of executive board members, with line management via the Chair as opposed to the CEO.

Duty of Quality for the Population of Wales
As care is provided across boundaries and pathways, patients and the public do not always understand or expect organisationally created barriers to hinder high quality care. This is particularly the case when things go wrong and acting efficiently and effectively to put things right, learn and improve systems should be expedited. A duty of quality would improve patient safety and quality care, by aligning focus with RTT & Finance.

A duty of quality needs to align with SSWBA and Well Being of Future Generations Act to ensure that health and social care plans are integrated.

There was agreement that NHS bodies should be placed under a reciprocal duty with local authorities to co-operate and work in partnership to improve quality and responsiveness of services.

Joint planning of services is essential to deliver the SSWB Act and provide sustainable, high quality services and that the directive for joint board posts would enhance this agenda. If a Finance Director had responsibility for health and social care financial resource we may see some real change.

Further illumination should be given to the pooling of budgets between Health & Social Care, which would facilitate the vision of a seamless pathway for citizens.

Duty of Candour
This is in line with regulatory bodies' expectations and responsibilities of registrants and the Duty of Candour needs to be across all health and social care bodies.

In investigating and answering concerns and complaints it is absolutely vital that all services, including independent health care, have the same level of candour, responsiveness and duty to the public.

It would also be beneficial for Wales to have an NHS Constitution, like that in NHS England, that establishes the principles and values of the NHS in Wales, sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

Setting and Meeting Common Standards
This will enable organisational benchmarking to drive service improvement, public scrutiny, transparency and promotion of informed choice for patients.

There was support for the development of a high level of standards for health and social care. Again this is an essential component of the SSWB Act. These standards need to incorporate the principles of the Care Aims (Kate Malcomess) and

Prudent Health Care principles in joint standards. These standards should be applied to statutory bodies, the independent sector and third sector providers.

The standards need to be cognisant of professional standards and codes.
A fundamental review of the role and function of CHC's is required, especially in terms of monitoring NHS provision. It would be far more efficient to have a joined up approach to independence and scrutiny with 'Advocacy' managed separately (see chapter 5 response).

Joint Investigation of Health and Social Care Complaints
This supports the objective of 'investigate once investigate well' as patients expect one response and not disjointed and not be subjected to a disconnected approach. It supports the achievement of more timely responses, reduces duplication and increases efficiency.

Rather than just 'joint' investigation, there should be an appetite to transform complaints, as progressing via the Keith Evans review, but with a focus on Health & Social Care.

Representing the Citizen in Health and Social Care
The CHCs have had a vital role in advocacy and citizen engagement but their scrutiny and monitoring role is historic and outmoded. A transformed approach is required and this is fully supported. There is a great opportunity for a focus on Health & Social Care. The CHC current inspection role is fragmented and often very subjective.

It is acknowledged that Independent bodies, such as the CHC, play an important role in providing a voice and support for local people but they need to be representative and modernised.
Further clarity on role and function, particularly at a local and regional level, is required and greater detail is necessary to inform views on the future of the CHC's/their replacement.

There is not enough detail re: the Scottish Model to comment on its effectiveness and whether this model would fit for Wales.

Co-producing Plans and Services with Citizens
There is agreement with the broad ethos, but there is a need for further clarity and understanding of what the independent mechanism for clinical advice would look like. There are existing bodies of independent clinical advice currently available?

There is a need to modernise approaches to engagement and inclusivity.

More detail is required on the establishment of an Independent Clinical Panel in order to provide an informed view about this proposal.

It is acknowledged that co-production (irrespective of terminology) is essential to transform services.

Inspection and Regulation and single body
This is fully supported.

There is wholesale support for a single inspection and regulation body, however this must not be a merger of two existing bodies, but the creation of a new single body, which is current, resourced and independent.

Inspectorate transformation is required and essential to protect the public.

WGWPMB111: Care and Social Services Inspectorate Wales
Location: Cardiff

Response to Specific Questions

Duty of Quality for the Population of Wales
Do you agree with these proposals?
YES

Duty of Candour
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
This needs to align with RISCA regulations and guidance
We think it should extend to primary care

Setting and Meeting Common Standards
Do you support this proposal?
We support this in principle yes but have identified below areas to be taken in to consideration

What further issues would you want us to take into account in firming up this proposal?

- It is important to be clear where current regulations such as SSWB Act and RISC Act sit with these. An additional set of standards could be confusing for people.
- It will be important for any standards to be outcome focused and person centred.
- It will be interesting to consider the work Care Inspectorate Scotland are doing to integrate their work with newly published standards in Scotland.
- For CSSIW, consideration of applicability to childcare services is also important.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes if the issues outlined below are addressed

What further issues would you want us to take into account in firming up this proposal?

- If including providers of regulated services, it will be important to ensure clear links with RISC Act
- It will be important processes are clear about who should lead or there will be a risk of confusion.

- Where a regulated service is part of the complaint, it may not be appropriate for them to 'lead' any investigation.
- There may also be issues regarding final sign off/disagreement which may potentially lead to delays in complaints being responded. Timescales will need to be aligned across agencies
- There is also potential for disagreement if independent investigation is required (which has a cost attached)
- Timescale of 30 days is too long if the complaint is about care still being provided
- Links with safeguarding and serious untoward incident processes must be clear

Representing the Citizen in Health and Social Care

Do you support this proposal?

We need to understand more about what is being proposed.
CSSIW, through our use of SOFI methodology as well as direct discussion with people and use of feedback questionnaires already embed the voice of people in receipt of care and support in our work. This is supported by our National Advisory Board and regional advisory forums.

We would support the principle of avoiding any duplication with the core functions of CSSIW / HIW

Can you see any practical difficulties with these suggestions?

- Yes – given the volume of health and social care services together, this is a huge remit.
- Will it extend to local authority social services?
- Will it include childcare services?
- Where will the existing National Advisory Boards of HIW and CSSIW sit with this?
- How will appointments be made?
- How will the voice of children and young people be represented?
- How will the arrangements be supported / coordinated / resourced?
- We would not want to see a huge infrastructure created
- It is also important to consider the link with regional citizens panels as required by SSWB Act
- Consideration of the links with advocacy / advocacy organisations is also important
- Consideration of links with Children's and Older People's commissioners is also important

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

Yes

What further issues would you want us to take into account in firming up this proposal?

- Need to clearly define ‘substantial’ service change
- If the remit of proposed new citizen body is across social care and health services, it is of concern that considerable capacity could be taken by involvement in service change within the NHS

Inspection and Regulation and single body

What do you think of this proposal?

This would be very helpful, provided this is based on the principles underpinning the Social Services Wellbeing Wales Act and Regulation and Inspection of Social Care Act as a further change would be very destabilising for the social care sector.

Are there any specific issues you would want us to take into account in developing these proposals further?

- Align with RISCA as far as possible including provider level registration of independent providers
- Consider approach to independent providers who have both healthcare and social care services

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?

- A joint inspectorate for an integrated service would be prudent, however, a joint inspectorate operating in a landscape where health and social care services are not integrated could create a new set of challenges. In particular, the scope of healthcare services is significantly larger than social care and the actual interface small; therefore there is a danger that the demands of the very visible health agenda could lead to a reduced focus on social care issues.
- CSSIW and HIW already work closely together where there is a clear rationale for doing so.
- Our view is that our independence is already adequately safeguarding under current arrangements formalised in a memorandum of understanding between CSSIW, HIW and Welsh Ministers. However we recognise citizens may not be aware of this and there may be a perceived lack of independence
- Alignment of legislation would support further development of joint working.
- The work of Inspection Wales also contributes to more integrated working between audit, inspection and review bodies without the need for structural integration

What issues should we take into account if this idea were to be developed further?

- Of the 6133 services regulated by CSSIW, 4321 are in relation to childcare and play. It would be important to ensure these remain appropriately prioritised.
- The cost of change and the development of a WGSB – estate, IT, HR advice etc.

WGWPMB112: Owen Smith MP
Location: Pontypridd

General Comments

The Welsh Government is currently consulting on the future of Community Health Councils and I would be grateful if you could accept this as my submission on the subject.

I am fully supportive of an independent patients' voice and the benefits offered by Community Health Councils across Wales – particularly the service offered by Cwm Taf Community Health Council.

Navigating NHS complaints can be a confusing and daunting process, especially for people who have experienced trauma or loss. The expert support and advice provided by Community Health Councils is invaluable.

I agree that the inspection role may touch upon the work of other organisations, however it should be key feature of Community Health Councils that members have up-to-date knowledge across the whole of the NHS.

The overwhelming strength of Community Health Councils is that members are rooted in their communities, have local knowledge and are accountable. I fear that this would be lost with the introduction of a pan-Wales body.

One of the clear messages elected representatives get from the public is the desire for local, citizen-focused services that are accountable.

I support reform of Community Health Councils along the lines suggested above. However, their abolition would be a disservice for patients in Wales who are very much in need of an independent patient voice.

Whilst I am, of course, supportive of measures that would increase diversity amongst Community Health Councils, I believe the current system could be reformed along the lines I have outlined.

Thank you for taking the time to consider these points and I would be grateful if you could ensure that these comments are fed into the consultation process.

WGWPMB113: Welsh Health Specialised Services Committee
Location: Caerphilly

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
The establishment of core principles as outlined is supported.
The inclusion of a Vice Chair for all Boards is supported; this will help to ensure continuity of service and consistency across all NHS Wales Organisations.
We support the proposals for Welsh Government Ministers to have authority to appoint additional Board members and for individual Boards to have some flexibility to appoint based on remit and priorities.

What further issues would you want us to take into account in firming up these proposals?
There are currently different arrangements across the Joint Committees such as NWSSP, WHSSC and EASC; it would be helpful and clearer if there was a consistent approach to this.

Specifically in relation to WHSSC
Consideration as to whether the Managing Director of WHSSC should be an Accountable Officer as is the case, for example, with NHS Wales Shared Services.
Clarification that the Managing Director of WHSSC is principally responsible to the Chair of WHSSC with a secondary statutory responsibility to the Chief Executive of Cwm Taf UHB in their capacity of accountable officer; clear lines have been established but these are sometimes not understood by those not close to either organisation.
The Independent Members of the WHSSC Joint Committee occupy their positions by virtue of being independent members of a health board. This presents a potential conflict of interest at times which could be avoided if totally independent members were appointed to WHSSC.

The structure of WHSSC is set down in the Directions and Regulations which include the Chief Executives of the NHS Trusts as Associate Members. It would be more appropriate if the Joint Committee was authorised to appoint its Associate Members to meet the commissioning needs of Wales in the same way it is being suggested for Health Boards and NHS Wales organisations.

Board Secretary
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
Consideration should also be given to the application of this across the various Joint Committees, such as NWSSP, WHSSC and EASC; it would be helpful and clearer if there was a consistent approach to this.

It is felt that there is not a requirement for statutory protection, rather a clear escalation process for occasions where concerns relating to the Chair or Chief Executive need to be raised.

It is also suggested that there be provision of an overarching paragraph, or similar, outlining the core responsibilities of the role, which cannot be diverted from, and that individuals must have the necessary knowledge and experience to discharge the functions of a Board Secretary.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes, this seems, in principle, to be of value. However, it is unclear as to what this means in day to day practice.

Duty of Candour
Do you support this proposal?
Yes

Setting and Meeting Common Standards
Do you support this proposal?
Yes, in principle.
What further issues would you want us to take into account in firming up this proposal?
Care should be taken not to set such standards to such a high level that they are only regarded as aspirational rather than meaningful.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes.

Representing the Citizen in Health and Social Care
Do you support this proposal?
Yes

Can you see any practical difficulties with these suggestions?
It would be necessary to make sure the appropriate calibre of individuals are recruited to the new body, and those individuals would require suitable training and development to ensure their effectiveness.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
Engagement should be focussed on the process for deciding on service change rather than the anticipated outcome. We suggest that a robust process would support a positive outcome.

However, engagement on outcome rather than process may result in a polarisation of views related to vested interest.

Inspection and Regulation and single body
What do you think of this proposal?
We support a more integrated approach to Inspection and Regulation. However, the current very disparate portfolio of responsibilities covered by HIW requires review and would be well served with a more systematic approach to quality monitoring.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Would you support such an idea?
The proposal to establish a new body would be a positive step. It would facilitate a review of the existing portfolio of work carried out by HIW and the introduction of a more systematic approach to quality monitoring.

WGWPMB114: Velindre NHS Trust
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
We strongly support the notion of all Trusts having a Vice Chair to support organisational leadership, but we believe this should be an additional post to the existing 7 Independent Board Members, increasing IM membership to 8.

We have on many occasions, raised the request to consider an increase to the number of Executive Directors for Trusts from 5 to 6. With the introduction of a Vice Chair, an additional Executive Director would not affect the balance of the Board. Given the strategic and operational breadth of challenge and potential opportunity the Trust is facing, a small Executive Team is potentially fragile in managing and delivering the core functions of the Trust, despite the desire to explore developmental opportunities for the NHS in Wales. The ability to increase the number of Executive Directors and Independent Members would assist Trusts to increase the level of capacity and capability at officer/independent member level to deal with the broad agenda set out across health, well-being, health /public services in the future.

The proposals to allow some flexibility for Welsh Ministers to make time-limited particular appointments is supported, assuming this would apply to IMs and Executives. We suggest this flexibility is afforded not only for situations cited in the consultation (i.e. special measures), but to also include opportunities for additional Board appointments during times of new ventures/significant change programmes. In these circumstances, consideration would also need to be given to maintaining the balance and composition of the Board. One solution could be that any such appointments are made as Associate Board Members, to ensure the effective working of the substantive Board.

The proposal to refer/rename Independent Members as Public Members should be approached with caution. It is vital to ensure it is clear that Boards have independence in their accountability and scrutiny, therefore we support retaining ‘Independent’ in the title of Non-Officer members, but note an option for renaming to ‘Independent Public Member’.

We also support the introduction for Trusts to appoint Associate Board members to reflect citizen representation, whilst recognising the challenge of securing membership that is truly reflective of the diverse population served.

What further issues would you want us to take into account in firming up these proposals?

We would also support an increase in the notional commitment expected from IMs in their role, from 4 to a minimum 6 days per month. In practice, this still may be far

from reflecting the current commitment required from Trust IMs, who are expected to deliver the same breadth of involvement as the larger cohort of IMs in Health Boards.

Board Secretary

Do you agree with these proposals?

The proposal to provide greater profile and clarity is welcomed, to assist in ensuring the role is perceived at an appropriately senior level and be seen as a trusted position providing independent advice to the Chair, Chief Executive and Board. This will also enable the role to be in a position to effectively challenge and advise Boards, and individual members (Executive and Independent), as necessary.

Although the role of Board Secretaries was outlined in a model Job Description produced by the Welsh Government, local variation has resulted in some roles deviating from the core requirements, including Velindre's post holder.

We recognise and support the importance of ensuring there is no deviation from an agreed model Job Description, as this protects the independence of the role and eliminates any conflicts of interest as highlighted by the review into Governance at Betsi Cadwaladr Health Board. We support a clear, corporate portfolio of responsibilities is not deviated from, ensuring an absence of operational responsibility which could compromise the independence of the role. By addressing this however, and removing the operational responsibilities currently within the portfolio of the Velindre Board Secretary, there would be an increased burden on the current Executive Directors with professional and operational portfolios to whom these responsibilities would transfer. We believe this also supports the case to increase the number of Executive Directors for Trusts, to ensure appropriate balance of operational responsibilities is effectively and appropriately distributed, protecting the focus on the core responsibilities of the model Job Description for the role of the Board Secretary.

A step Velindre Trust (and other NHS bodies in Wales) has taken to strengthen the role and award a greater understanding of the seniority and responsibilities has been to rename the 'Board Secretary' as 'Director of Corporate Governance'. Although this has gone a long way in clarifying the status and role being undertaken in the organisation, it is also important that in order to undertake the role appropriately, the role should be given adequate resources and staff to be able to execute the requirements of the office and run the governance and assurance arrangements of the organisation.

The proposal to provide statutory protection for the role is still not clear. There is a risk that awarding such protection may result in the role being seen as Chief Whistleblower for the organisation, and may impact on effective working relationships, particularly with the Executives. We do recognise potential benefits of providing such protection, particularly in circumstances when relationships and/or culture do not reflect healthy challenge but a greater understanding of what legal duties would be placed upon the individual and what qualifications and experience would be essential to deliver these duties.

We support the principle of ensuring an independent process for dismissal of the post holder.

What further issues would you want us to take into account in firming up these proposals?
Consideration should be given to ensuring an independent aspect in the appointment process for the role, noting the post should remain accountable to the Chair and indirectly to the Chief Executive.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
We support the principle of a duty of quality. However, this can only be truly achieved through cultural change. A duty on bodies to co-operate and work in partnership would need to take into account the existing NHS organisational structure in Wales. Individual accountabilities of statutory bodies, corporate Boards as decision-making bodies and the necessary governance required to ensure joint planning and joint decision-making would need to be reviewed to ensure clear practical arrangements are in place to support an improvement in quality across the system.

Legislation alone is not sufficient to achieve these highly generalised aims.

Duty of Candour
Do you support this proposal?
Yes.

What further issues would you want us to take into account in firming up this proposal?
A shared understanding of what this actually means in practice is essential. A definition would be helpful. Clarity will be essential in ensuring what this means. Will Wales adopt the model in place in England and Scotland?

Setting and Meeting Common Standards
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
This is increasingly essential as new treatment methods, technologies and ways of working allow high quality, safe, care to be delivered in the location that best suits the patient.

A shared understanding is needed, therefore a definition in the white paper would be helpful. If a primary purpose of both health and social care is to prevent ill-health, then families and communities need to be captured in the definition. For best

outcomes, work needs to be with context families/communities, as well as individuals. This does not come through the consultation paper, in any section.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Yes.

What further issues would you want us to take into account in firming up this proposal?

This is increasingly essential as new treatment methods, technologies and ways of working allow high quality, safe, care to be delivered in the location that best suits the patient.

It will be vital to ensure the current high quality of health organisations responses to concerns are not diluted by the inclusion of social services issues.

It should also be noted that by co-operation between health and social care formulating joint consideration of concerns, timescales for finalising responses will inevitably increase.

Representing the Citizen in Health and Social Care

Do you support this proposal?

In part. More detail is needed on what the "new national arrangement" would look like.

Velindre Trust values the contribution CHCs have made to the improvement of services, especially over recent years. We welcome the removal of an inspection role of CHCs (or incumbent body) and strengthen the engagement and cooperative working arrangements that support citizen involvement in planning and service improvement. The value CHCs have added should not be lost in any new arrangements, and we welcome a regional and national approach to ensure citizen voice in health and social care.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

Yes.

What further issues would you want us to take into account in firming up this proposal?

There is a lot of emphasis on organisations working together and across traditional boundaries. In principle, we support this. However, firstly, family and community seem to be absent in this dialogue about cross boundary work. Secondly, the purpose of cross boundary work needs clarification. It opens up the possibility of an infinite scope of work for a Health Board/Trust, along with confusion and conflict.

As part of any such arrangement, the "citizen voice body" will have to agree/understand that once independent advice has been received, it is not their role

to then challenge that if they do not agree with the outcome (there are other mechanisms for doing that).

Inspection and Regulation and single body

What do you think of this proposal?

We don't believe legislation will be necessary to affect this change.

Are there any specific issues you would want us to take into account in developing these proposals further?

We believe there could be merit in considering a new body, for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection across health and social care.

Would you support such an idea?

In principle, yes, noting comments above.

WGWPMB115: Mid Wales Healthcare Collaborative
Location: Aberystwyth

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
YES. All health bodies should be governed by the same over-arching principles, including those stated. All are fundamental to healthcare services and in reality, ought to go without saying. These principles need to be instilled and reinforced through all training and development programmes.

Having Vice Chairs should strengthen and focus leadership; in our experience the model of 'co-Chairs' is also worth considering, bringing a wider range of skills and networks, capacity and availability.

Additional fixed-term Board members where skills need strengthening seems entirely sensible on the assumption this would normally be undertaken in discussion with the Board's Chair. In addition, steps to enhance each/all existing Board members' performance in underperforming circumstances, would merit attention.

Board Executive membership needs first to fit local circumstances not some general blue print - however it is inevitable that there will be consistency between Boards in relation to several key functions such as finance and performance. A guide list might be helpful laying out general expectations but there must be room for flexibility especially when innovation and collaboration are so crucially needed.

What further issues would you want us to take into account in firming up these proposals?
The above questions are based on an assumption of continuing the current organisational system. Within these structures LHBs must provide greater local accountability plus bespoke solutions for their populations. NHS processes seem to prevent small scale successes becoming widespread. Any new system must streamline management and preserve what works well at moment.

Based on our experience, the following would make a major difference in NHS Wales' ability to deliver the fundamental principles outlined above:

- A single national, strategic body to co-ordinate planning, drive performance, promote consistency and equity, provide unifying focus and national identity
- Devolving operational function to local level.
- Empowering Staff to innovate: a. Risk Management needs to be on a different level to ensure quality whilst allowing new ideas b. culture of the NHS needs to welcome, rather than resist, challenge and change
- Replacing CHCs with citizen health panels
- Appointing local facilitators to convene and represent public/patient views both in delivery of service (local) and strategic (national).(See answer to 4 below)

- Employing Performance Management proactively to encourage innovation and working across boundaries.

Board Secretary

Do you agree with these proposals?

NO. This will deliver little more than at present and could become divisive, creating antagonism, putting the Board Secretary in an difficult position and disrupting necessarily trusting relationships: it conflicts with the principle of trusting, collaborative working which the system depends on.

The independent Board Members should be providing challenge and may need training to do this effectively. Welsh Government, Ministers and Officials have key roles too.

Furthermore the public and patients need to be enabled, through new systems and process, to make a constructively-challenging 'non-executive' contribution. We have found a model of 'light-touch' scrutiny through a joint panel of representatives of Local Authorities both challenging and helpful.

What further issues would you want us to take into account in firming up these proposals?

The issue of challenge links with the whole approach to performance management which needs overhauling in line with governance (see answer to 1 above).

Duty of Quality for the Population of Wales

Do you agree with these proposals?

YES. Enhancement of duty of quality is fully supported and on a broad integrated platform. The public's and patients' views about quality must be incorporated in an updated interpretation of 'quality'.

The NHS/LA reciprocal duty is sensible: to consolidate and provide for consistency across what's currently happening, and to fit for the future.

Strengthening the planning duty is supported. How this intended collaboration works at the NHS/ LA interface and also geographically, will need clarifying.

Duty of Candour

Do you support this proposal?

YES. Making this a consolidated statutory duty is a pragmatic suggestion, although the necessity is a sad reflection. This should be a component of the core principles of question1.

Complete honesty is the only way to engender trust. Traditionally, 'engagement' has been based on giving 'good news' and avoiding difficult issues. For example, dressing-up decisions that are clearly financially-driven as 'safety 'issues is deceptive and patronising and is no basis for constructive interaction.

How to monitor, maintain and enhance candour is an interesting question.

Setting and Meeting Common Standards
Do you support this proposal?
YES. These should flow from and embody the principles of question 1.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
YES, absolutely. The CHC Complaints Advocates/Mental Health Advocates/LA Complaints Officers should be one organisation across Wales to ensure consistency and independence.

Representing the Citizen in Health and Social Care
Do you support this proposal?
Suggested model for citizen voice:
CHCs have always found it hard to be "representative" due in large part to their formal and statutory status. Recently CHCs have seen their role as one of ensuring that Health Boards engage and consult appropriately rather than finding out what the public feel independently of the Health Boards.

We have found very different public audiences for different subjects and the catchment area for interested audiences can vary according to the care pathway being discussed. As a result it may be self-defeating to try to establish a formal arrangement for citizen voice.

With our green health initiative, a critical role is that of "community connector" with strong local knowledge and community identity to facilitate interactions between health and the providers of activities. Maybe this role could be enlarged to be the convener for citizen voice: ideally placed to gather appropriate audiences to comment on or co-produce services.

So perhaps it is better to establish a network of "community connectors" with clear roles rather than try to establish a mosaic of regional bodies, constrained by their constitution and boundaries. Any institutional or geographical boundary is constantly confounded by the realities of people's lives.

CHCs have always spent time "inspecting" health premises in order to improve the patient experience. This lay inspection role could sit with HIW/CSSIW. Furthermore local communities could influence the inspection cycle through the suggested network of "community connectors".

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
YES. It is crucial that difficult and conflicting issues are openly debated. It will be important to have an independent and broad representation. (For example we invited the RCS from Scotland to give a different clinical perspective on the safety of surgery

in small rural hospitals). There is a danger of “group-think” if the body is selected from too small a pool.

Inspection and Regulation and single body

Do you agree with these proposals?

YES. We support the further development of this proposal and the idea of an independent national sponsored body. It is essential that citizens, rural and urban, are appropriately represented.

WGWPMB117: Royal College of Occupational Therapists
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
The College welcomes the intention to focus on the governance, quality and accountability issues raised by the transformation of our health and social care services. The policy and legislative direction will enable people to exercise stronger participation in the type and form of services that will best help them to maintain their independence and live their lives their way. The focus on 'what matters' to the individual is already delivering change. Prudent, person centred, community services are essential to enable people to achieve their wellbeing outcomes and make best use of resources.

Core Principles for Health Boards.
The profession agrees the need for core key principles. Including the need for a Vice Chair. Highly complex decision making requires an agile, skilled and committed board membership. We note that the Integrated Health Boards in Wales are large, complex organisations with extremely wide ranging responsibilities and services. This is different to other nations' services, which are often separate, more specific organisations. For example, English Foundation or Acute Trusts or Primary care commissioning groups which lead only on one part or type of service that Health Boards in Wales manage. The complexity and breadth of an Integrated Health Board remit requires a wide range of expertise, knowledge and leadership skills in the Executive Body. The College would not wish to see a return to a restricted 'medical model' nor a financial 'bottom line' model on the Boards.

Throughout the document references are made only, and specifically, to Health Boards and Trusts. The developing Primary Care Clusters and Regional Partnership Boards, while not separate legal entities will be responsible for services on behalf of the Boards and Trusts. There is no reference to these bodies, nor any explicit expectation that core principles, governance and quality expectations would also apply to these new systems/ structures within NHS Wales. We feel that needs to be redressed in any subsequent stage to this white Paper if coherence of vision and approach, and integrated delivery is sought.

As a result of the policy direction of Welsh Government, the therapy workforce, including occupational therapists, are now able to work in very different ways. The Social Services and Wellbeing (Wales) Act (SSWB Act); Wellbeing of Future Generations Act, Primary Care Plan, Prudent Care principles and the development of Clusters and Regional Partnership Boards; with the Integrated Care Fund and other pooled budgets are all driving improved integration and person-directed interventions close to peoples home. This will be better supported by a more explicit inclusion of all public sector health and social care bodies in governance, quality and improvement matters.

Executive Officer Membership

The College is not convinced that a supporting committee structure will assist effective decision-making. The suggestion at paragraph 27 of identifying only 'core' membership of the Board and allowing variation of other Executive roles will need careful consideration to prevent the inadvertent exclusion of important areas of expertise, perspective and skill from key decision making. A subordinate committee is likely to struggle to provide timely, effective advice and options if key personnel are outside the discussion and contributing with only part of the whole picture. We believe it probable that this subordinate committee would become advisory, or operational and delivery focussed. That loss of perspective and expertise on the Board may reduce the effectiveness the decision-making.

Point 28/ p11 identifies it will be 'unpopular' to take certain Executives off the Board. Whether something is unpopular is not important: the key issue is that it could reduce effectiveness of the Board in making decisions about complex matters by excluding those with skills and expertise in transformed services, thus reducing outcomes for the population and sustainability of future services.

The therapy workforce has an unique and core role to play in prevention, place based care and co-production: The very type of transformed services that NHS Wales has identified are needed to make it sustainable. The creation of the posts of Executive Director in Therapies in Health Sciences has driven change and ensured that Local Health Boards have access to the unique perspective, skills and knowledge to make different decisions to meet that transformation. The posts have brought the skills of Allied Health Professionals, experience of inter-agency and community working and an understanding of the social model of care to Health Board decision making. Their different perspectives have added value to Board membership discussions, raising different ideas, knowledge and solutions and will become ever more relevant as NHS Wales seeks to move from hospital based to community services.

The Executive Directors for Therapies and Health Sciences bring accountability for the Health and Care Professions Council (HCPC) registrant workforce. These professions make up over a third of the workforce and there is growing evidence that having the 'different' voice of therapists on the Board delivers 'different' solutions. For example:

- https://www.kingsfund.org.uk/blog/2013/08/lets-hear-it-allied-health-professionals
- https://www.kingsfund.org.uk/blog/2017/07/realising-potential-allied-health-professions?utm_source=The%20King%27s%20Fund%20newsletters&utm_medium=email&utm_campaign=8509692_MKEVT_J785_AHPS_250717&utm_content=blog%20-%20image&dm_i=21A8,52E4C,NRUIOM,JDTIR,1

Early on the White Paper stated that the intention of the proposals is to make processes for LHBs and Trusts the same. Point 30 appears to contradict this and assume continued difference.

What further issues would you want us to take into account in firming up these proposals?

Explicitly include Regional Partnership Boards and Primary Care Clusters in these changes. Good governance and high quality, with a requirement to give voice and

control to citizens is essential. Policy or legislation arising from this White Paper needs to place the same requirements on Regional Partnership Boards and Clusters as are placed on Health Boards and Trusts. Indeed it is even more critical that they are explicitly included in this because they will lead planning and delivery of integrated and community based services, including joint teams, Integrated Care Fund projects and Community Resource Teams, and they will particularly need to be aligned with Local Authority duties under the SSWB (Wales) Act 2014.

The Executive Directors of Therapies and Health Sciences provide a logical link between the Executive Board and the developing integrated bodies to drive transformation, quality and good governance. This is an advantage that should be used to the fullest. This requires those posts to remain as core members of the Health Board.

Board Secretary

Do you agree with these proposals?

Yes

What further issues would you want us to take into account in firming up these proposals?

We have nothing further to add at present.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

Yes, Quality should be at the forefront of every action. The profession welcomes the intention to align the duties of Local Authorities and Health Boards for quality and require the same focus on the person, their outcomes and experience, control as is in place under the SSWB Act. There are strong quality measures in the Social Services and Wellbeing (Wales) Act and in the Regulation and Inspection of Social Care Act which could be applied to Health services, such as Responsible Individuals and Annual Reports. Introducing similar measures would strengthen accountability for quality in the NHS and facilitate integration.

What further issues would you want us to take into account in firming up these proposals?

The College reiterates that the reciprocal duties should clearly include Regional Partnership Boards and Clusters and any other future mechanism in service planning. We also note that the relationships between Clusters and Regional Partnerships will need to develop in order to avoid duplication and gaps in provision over the longer term.

Duty of Candour

Do you support this proposal?

Yes, the profession would expect that to extend to all bodies including contractor professions, Clusters and Regional Partnership Boards.

What further issues would you want us to take into account in firming up this proposal?
There is also a need to consider extending this to critical preventative and enabling services such as adaptations, funding for which is usually in Housing Departments in Local Authorities, and which may be perceived to be excluded from this, as they are from the SSWB Act.

The duty of candour should look as much like the SSWB Act duty as possible in order to help reinforce the commonality. Indeed, an amendment to the SSWB Act instead of a separate Act for Health, potentially offers a strong message about integration.

Housing is a vital element of creating wellbeing and strong communities. Services provided by occupational therapists, such as adaptation services, often straddle housing, health and social care. This White Paper provides an opportunity to consider the issue of quality and integration of housing services where they intersect with social care and health. Citizens should be able to expect the same duties of quality, candour, service improvement, focus on outcomes and co-production across all services.

Setting and Meeting Common Standards
Do you support this proposal?
Yes, Again this needs to explicitly refer to all parts of health and care services, not simply 'Health Boards'. Clusters and Regional Partnership Boards and other developments need to be explicitly included if standards are to be raised and citizens to understand their rights. Clarity will also support effective implementation.

What further issues would you want us to take into account in firming up this proposal?
This also needs to apply across housing services as more and more services transect housing, health and social care. This point is also raised in 3.2 and 4.3. For example, if a housing provider provides residential reablement (step down/ step up or Intermediate Care) processes of standards, quality and complaint investigation, and possibly Inspection should also follow the pattern of service provision.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?
This raises the question about how complaints might include work planned or delivered via Clusters and Regional Partnership Boards and wider contractor professions and housing services.

Occupational therapy services frequently straddle organisational and sector boundaries in the provision of person centred and well integrated care and support. For example, adaptation services which may be provided by housing, health, social

care or any combination of the three. This will need to be taken into account when considering how to investigate complaints effectively. As more intervention is delegated to and delivered via independent, third sector or social enterprises (for example social prescribing) complaint investigation may also need to include these organisations as well.

Point 67 says “people receiving health and social care may not, and should not need to, understand that different organisations are responsible for different parts of their care” (p24/25). The College believes that people do need to understand this. They will be charged for some parts of their care provided by some organisations. Unless they understand that they will not be able to participate fully in determining or accessing their own care. Stating that people should passively receive care from ‘organisations [who] are responsible’ also contradicts the philosophy of co-production and the intention to place citizens at the centre of, and ensure they can exercise voice and control over, their own care and support.

One of the key issues in transforming and making more sustainable our health and social care services, is tackling the lack of public understanding and transparency of those services. The move to greater duties of candour, clarity and quality will require the public to understand much more clearly how services are provided and what they are responsible for paying for.

Representing the Citizen in Health and Social Care

Do you support this proposal?

Yes, there is a need for a strong citizen voice and participation in the provision of all public services.

Can you see any practical difficulties with these suggestions?

It is important to be clear what function is missing and what needs to be met before deciding whether a national organisation is to be created. A relationship with, or use of, the National Citizen Panel under the SSWB Act could be considered. Practical difficulties will arise if too many disparate organisations all do overlapping things and speak with different voices. However, one national body may struggle to speak to all things and for all people. The practical issues will need to be weighed very carefully against a clear understanding of what outcome is sought from having a citizen voice. This may determine different solutions for different functions.

There should be a strong citizen voice alongside professional and expert service voices in inspections. There, it may be most practical and effective to have equal status for each of those voices as an integral part of an Inspection team rather than a stand-alone, separate citizen voice from national, or local, bodies

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

The College agrees that the best solutions will be made if all perspectives have an equal voice in co-creating decisions. That includes professionals, leaders and managers and citizens: individually and collectively.

What further issues would you want us to take into account in firming up this proposal?
Figure 1 on p34 needs to add a first step where citizens, professionals and other relevant voices are involved, as equals in the development of the plans for service change. It is not acceptable to simply enable citizens to comment on plans that have already been developed. Co-production means citizens should co-produce the plans: together. The Partnership Forum model is used effectively around Wales and may offer insights for developing this proposal.

Step 4 uses the word 'clinical'. We suggest what is being sought here is professional advice, and suggest that is a more appropriate word. A range of 'professional', in the sense of expert, voices are needed. This includes clinical professions as well as recognising that professional management and leadership voices are also essential. Clinical also precludes other professional groups who would not see themselves as 'clinicians' yet are essential, for example social work or housing professionals.

Inspection and Regulation and single body
What do you think of this proposal?
If legislation is needed to achieve any change, then it seems a missed opportunity not to use that legislation to move straight to the ideal/ preferred position to integrate fully into one organisation picking up on the recommendations of Ruth Marks' Review.

Are there any specific issues you would want us to take into account in developing these proposals further?
Consideration needs to be given to new service patterns where housing services and indeed housing providers are part of care and support services and are providing care and support services as well as acting as a Landlord. For example, residential Reablement/ Intermediate Care Services; Extra-Care and adaptation services across housing, social care and health.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
Yes, Especially if legislation is required to change the current working of HIW, then Welsh Government should seek to ensure the resulting new body is fit for the long term and incorporate the recommendations of the Marks' Review.

What issues should we take into account if this idea were to be developed further?
Consideration needs to be given to new service patterns where housing services and indeed housing providers are part of care and support services and are providing care and support services as well as acting as Landlord. For example, residential Reablement/ Intermediate Care services; Extra-Care and adaptation services from Housing providers) across housing, social care and health.

WGWPMB118: Torfaen County Borough Council
Location: Pontypool

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes, consistency of approach is important and this part of the White Paper rightly focuses on this. We would hope that Ministerial intervention rarely needs to become a consideration, but recognise that there needs to be some power of intervention if local governance falls short and leaves citizens and NHS staff in potential jeopardy.

We agree that there should be some consistent key positions common to all LHB's – such as around Director of Finance, Clinical Director roles, and Board Secretary – but welcome also the flexibility to appoint key positions as determined by particular circumstance and area need.

TCBC – Nothing further to add

What further issues would you want us to take into account in firming up these proposals?
For those Executive Officer roles that are determined to be common across LHBs – and we suggest that there should be no more than four or five of these – then some broad outline of role responsibility should be outlined so it is clear as to their accountability and reporting responsibility.
It would also be useful to be clear as to numbers of associate members (minima and maxima) and that this should include at least two citizens resident in the LHB area.

TCBC – We would like to see increased transparency in Board decisions with greater accountability. Clear reporting and publication mechanisms should be employed to promote this.

Board Secretary
Do you agree with these proposals?
Broadly yes – the white paper highlights the variation in range of responsibility, portfolio and reporting that currently exists – so a clear and consistent role description, and a clear statutory protection level, would be sensible and helpful for LHBs and for the individuals discharging this role. Our expectation is that the independent challenge element should rarely need to be exercised, and that there is also scope for issues/areas of concern to also be highlighted to regional partnership boards so that these can be a 'sounding board' to look at testing ideas and proposals that require wider scrutiny.

TCBC: Nothing further to add

What further issues would you want us to take into account in firming up these proposals?

There will need to be a balance in terms of setting out clear role responsibilities yet not over defining a role that needs a level of flexibility depending on Board composition and size. There may well be some merit in setting out requirement for an Audit and Scrutiny Committee for each LHB, which includes Board members, Associate Members and partners, to which the Board Secretary reports and which can also take some of the responsibility for appropriate challenge to the Board as a whole or the Chair Executive.

TCBC – Should the Board Secretary be employed by Welsh Government rather than the LHB? This may alleviate a possible conflict of interests and encourage greater freedom to challenge.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

Broadly yes – we do agree that there should be a co-equal duty of cooperation and working in partnership placed on LHB's as with local authorities – and this is implicit in the Social Services and Wellbeing Act, and in Public Service Board working under the Wellbeing of Future Generations Act. We also see the relevance and importance of having a quality focus that means regional and national planning has to considered for more specialist services. In some respects this already exists, but clearer parameters around this will be helpful – learning the lessons from both good and bad examples of consultation and engagement in the recent past.

The caveat is that this can often run counter to public expectation – to have services accessible both in terms of distance and hours of availability – which can often be unrealistic considering the nature of some specialist services. We would expect Welsh Government to share the public engagement and response requirements that are likely to fall on LHB's as some unpopular decisions may need to be taken. Whilst culture change has been emphasised for public sector bodies, there is also a need to address culture change for the wider public

TCBC: We agree with the proposals but think this would need to be enforced by WG as LHB and LA's are unlikely to instigate this on their own. Co-location would be a good introduction. Look at some examples where this is already in place and working well e.g. Adult Mental Health Care or Joint Adult and Children's Safeguarding Teams.
Guidance would be required for data sharing where there are still areas of reluctance and uncertainty regarding data protection issues e.g. some information from GP's not being shared with other health and care professionals.

How do we as an authority, challenge decisions made by LHB that have a significant impact on us e.g. ward closures? There is a lack of consultation that needs to be addressed.

What further issues would you want us to take into account in firming up these proposals?

We would expect there to be a clear and specific consultation on this duty once drafted so that sensible aspirations here set out can be checked against the detail. Responsibilities also need to be clear if – as is likely to be the case – more than one

organisation is involved, making clear who is the lead partner, which organisations are involved, and where decision making rests.

The Public Services Board requires 4 bodies to take equal responsibility and the arrangements set out in this White Paper will strengthen the expectations on LHBs to see beyond their own organisation and fully contribute to the PSB agenda making this a two-way reciprocal arrangement.

Duty of Candour

Do you support this proposal?

Yes – a culture of openness and transparency is important for health and care, and statutory organisations should take a lead here. This approach is a broader and one than simply complaints resolution – but does require a culture shift from all levels which will take time to develop. We welcome the proposed approach to be comprehensive across health and social care – but recognise the need for a full involvement of bodies such as the GMC and Royal College of Nursing so that staff bodies can fully implement to the cultural change that is aspired to. We also are pleased to note the willingness not to 're-invent the wheel' but to draw on what already exists and how it is working.

TCBC: Agree with points made above but would suggest there is still some way to go for openness and transparency from some organisations. There is a discrepancy between what Health would consider "clinical issues" and what Social Care would classify as a "safeguarding issue". Failure to respond to abuse and poor practice in respect of safeguarding concerns. This lack of accountability needs to be addressed.

What further issues would you want us to take into account in firming up this proposal?

It will be useful to ensure congruence with staff codes of practice – for doctors, nurses, therapists, etc. – and also appropriate alignment with Public Information Disclosure Act (PIDA) as the line between candour and whistleblowing can be a fairly fine one.

Setting and Meeting Common Standards

Do you support this proposal?

It would be hard to argue against this proposal – the principles have already been set out – as noted – in many other pieces of legislation, and there should be congruence as to standards for professionals working across health and social care, whether in the public or independent sector. We would urge that standards are kept clear, simple and understandable for both staff and citizens – and it will be very important to make clear the avenues that exist for citizens to raise their concerns if they feel that standards are not being met. This should include routes within an organisation (such as complaints procedures, access to independent advocacy) and external routes (such as inspectorates or staff standards bodies)

TCBC: Agree with above

What further issues would you want us to take into account in firming up this proposal?
As noted earlier, there should be congruence with professional standards set out in professional bodies codes of practice. There is also a clear link between standards and regulation/inspection – as this is the process whereby standards are assessed and shortfalls identified. What will be important is to make full use of work that has been done – with CSSIW on Regulation & Inspection, for instance and with Social Care Wales, around standards and registration. A sensible approach would be an iterative one – getting some first standards ready, agreed and out – and then building on this over a planned period rather than try and cover everything and all at once.

TCBC: Agree but need to pay close attention to standards already in place eg Criminal Law and Regulations, Health & Safety (HSE) and standards of care (CSSIW) as well as specific areas e.g. Mental Health.

There are areas where it could be argued that existing procedures are not being followed as well as they should e.g. with regards to safeguarding, there is not much interaction with HIW.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
This is another proposal that it would be difficult to argue against, and this kind of approach has already been taken forward in some recent legislation. The 'duty to report' in relation to Social Services & Wellbeing Act, Part 7 linked to the 'duty to enquire' makes clear that all care providers must report adult at risk concerns, and local authorities must inquire into these. We would suggest there needs to be a similar level of clarity as to which organisation reports complaints, and to who – as well as which organisation enquires into complaints, with a clear common process for escalation should complainants not be satisfied with initial complaint handling.

The point in relation to redress arrangements has been somewhat glossed over here – firstly as LHB's have to have significant provision put aside for this, while local authorities have much less resource for this. Secondly as one can foresee that complainants may well want to purse a complaint against one partner rather than another as expecting a better (financial) outcome.

There may well be a case for separation of the complaints investigation process and the adjudication process that determines any redress to complainant.

TCBC: Agree with points above

What further issues would you want us to take into account in firming up this proposal?
This is an instance where good intentions may have unintended consequences, so there may well be a good case for a step by step approach. A first step would be to require different organisations to share details of complaints – who has complained, what complaint is, what action is being proposed – and crucially, whether the complaint involves other organisations. It that is done, then there can be agreement

as to who best investigates the complaint, and who responds (so preventing duplication of activity). A second step may be to use common documentation – again mirroring safeguarding – so it is evident within organisations and with citizens that there is a common process in place. A third step may be to develop cross organisation complaints investigation teams or jointly contract for independent investigators. Overall we would urge that there is early and close engagement with those most used to the current complaints process to look at what is practicable and achievable within set timeframes.

TCBC: Agree with above but would also add;

Would a new organisation made up of staff from Social Care and Health be worth looking at? Another option would be co-location to promote joint working and collaboration.

Definitely think there needs to be a one point entry system and assigned lead officer to coordinate the response, thus avoiding the "round the houses" scenario.
The lead officer (from Social Care or Health) would then gather the necessary information from all relevant organisations rather than having separate investigations working independently.

Representing the Citizen in Health and Social Care

Do you support this proposal?

We have some reservations here as what is proposed is only in outline. There seems to be a move away from regional bodies to a national one. Firstly we would fully agree that health and social care organisations should be working with the public to co-design and co-create services, but would highlight caveats noted previously – public expectations are not always possible to be met as resources available – whether staff or finances – are not there. It is never possible to please all of the people, all of the time. The proposals around duty of candour mean that organisations should be open and honest, and this should include the 'limits of possibility' with resources available. The approach has to be more about 'how can this service be developed/improved with the resources that we have' and 'if we had more resources how would we make a service better than it is now'.

In reality it can be very hard to get a cross section of citizens involved in co-design/co-creation of services, so there has to be some realism here. It would seem sensible to draw on the experience and the processes already put in place for citizen engagement under Social Services and Wellbeing Act and Wellbeing of Future Generations Act as well as better targeted engagement with those that use and need specific services. There are examples across Wales where this is being done, and so this experience does need to be drawn on.

In terms of the specific proposals as to abolition of CHC's then it is not clear what added value may come from this from having a new national citizen voice body – would this have a set number or representatives from each health board area in Wales? Would it be wholly national recruitment or take regional nominations? How would this relate to regional citizen panels required under the Social Services and Wellbeing Act? How would this approach fit with the independent scrutiny and

investigation role exercised by the Older Persons Commissioner/ Children's Commissioner/Future Generations Commissioner roles set up in Wales?

It may well be that having a 'Care Commissioner' type role, visiting and linking with groups across Wales (50+ forums, mental health groups, youth forms, regional citizen panels, stroke survivor groups, etc, etc) may be an alternative approach – so that there is focused scrutiny on particular areas of care – potentially informed by complaints information – and able to undertake public engagement both through specific events and through linking with what already exists.

Having taken a focus on regional working arrangements for health and social care in previous legislation, it seems sensible to retain a regional level focus on engagement and scrutiny – bringing together existing resources across health and social care (so rather than Community Health Councils there might be Regional Public Care Groups). For national overview and co-ordination these regional groups could come together a couple of times a year as a Wales Public Care and Health Assembly or similar – and could work with a national 'Office of Care Commissioner' to support a programme of information gathering and monitoring visits.

TCBC: Agree with all the points made above. Share the reservations as a lot of good work comes from the CHC's. If we lose the local link we may lose the power to act and get resolution at a local level.

Can you see any practical difficulties with these suggestions?
At present there is insufficient information to highlight all possible issues, but there does need to be some realism here. Those who have worked directly with public engagement know how hard it can be, and adding a fresh national citizen voice body is most likely to draw on the same cadre of people who already engage and are involved in local and regional groups. We would suggest that same visits are made by those developing policy to existing citizen groups on the ground to test ideas further.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
The broad principles are appreciated, but an important principle that needs to be considered is proportionality – what is seen as 'substantial change' by one may not be seen as such by another, so ceasing a local clinic on wound dressings would be seen as substantial change by those who use it regularly, but would not be seen as such by a Service Director.

So, we feel the parameters for what constitutes substantial change need to be set out clearly – and then yes, these do need to be reported for a level of scrutiny drawing on clinical evidence and the evidence of public engagement.

Community Health Councils will have had valuable experience in being a conduit for such scrutiny at regional level and it will be useful to draw upon this – perhaps through bring that expertise into the support office for a 'Care commissioner' type role (as outlined in previous section)

Again, we would make the point, that having looked to establish citizen engagement processes at a local and regional level, these should be drawn upon alongside any independent clinical evaluation.

TCBC: Agree with points above.

We would question the need for substantial change. Torfaen currently actively seeks the views of its citizens either independently or through various citizen panels. These views are crucial to the formation and evaluation of our corporate plans.

What further issues would you want us to take into account in firming up this proposal?
Many of the points made under the previous question pertain here as well – it is hard to so far see how suggested change, on top of mechanisms put in place for regional working under the Social Services and Wellbeing act (which are still bedding in), will add value.

TCBC: Agree

We would advocate for expansion of the current statutory advocacy provisions to provide advice and assistance to vulnerable citizens.

Inspection and Regulation and single body
What do you think of this proposal?
Broadly yes, there should be full and close co-operation on inspection where care spans several settings – which in real terms will be the majority of instances.

Are there any specific issues you would want us to take into account in developing these proposals further?
We would note at this point the value of taking an iterative approach rather than a 'big bang' type change.

TCBC: We would like to see the introduction of an agreed set of high level standards to be inspected by a new independent body.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
We have noted possible consideration of a care commissioner role – independent of Welsh Government and able to call for evidence, visit local and regional groups.

TCBC: Agree that there needs to be clearer framework for the role undertaken by HIW. We would like to see a new body with increased inspection duties and greater accountability.

Would you support such an idea?
In principle – but we would want to see greater level of detail before making full commitment.

What issues should we take into account if this idea were to be developed further? Take full account of points noted previously in the consultation response.

WGWPMB158: Social Care Wales
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes, we support these proposals.

What further issues would you want us to take into account in firming up these proposals?
We would support the view of the need for consistency and that this is likely to mean that some key skill areas are required on all boards. While any Board should continually monitor the skills they need and have ways of responding to such needs we would also agree that there may be occasions where time limited appointments will be necessary and these may need to be specified externally

Board Secretary
Do you agree with these proposals?
Yes, we believe this is a sensible approach, that would ensure any challenges were raised and responded to in a public board meeting, to safeguard the Board Secretary and enable public scrutiny, unless it was in the public interest not to do so.

What further issues would you want us to take into account in firming up these proposals?
Social Care Wales as a body which undertakes both a regulatory and improvement role has addressed a similar issue in the appointment of a Registrar with responsibilities for certain regulatory decisions which may not be undertaken by the Chief Executive of Social Care Wales. Although in its early stages of implementation we believe that this could offer a model for the Board Secretary role. Similarly, as a WGSB, the CEO is Accountable Officer to the Director General and can challenge the Chair or Board if there are risks to propriety and regularity of their intended actions.

We are also aware that some organisations may already have adopted variations to the Board Secretary model by making certain roles accountable to the Board Chair rather than Chief Executive. It would be interesting to see how such models are currently operating and whether they offer the safeguards that are sought in these proposals

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?

Critical to greater collaboration between health and particularly social care but also wider local authority functions is shared approaches to population needs assessment and shared approaches to the planning of responses to those needs. We would also agree that such a duty needs to operate at the local, regional and national levels and it is likely that both health boards and local authorities will need support and guidance on how to undertake such collaborative arrangements, which acknowledge the sovereignty of the individual organisations and ensures robust governance arrangements are in place.

Duty of Candour

Do you support this proposal?

Yes.

What further issues would you want us to take into account in firming up this proposal?

One of the existing duties of candour referred to is Social Care Wales' Professional Duty of Candour. It will be important to ensure alignment between professional and organisational duties of candour but where this is achieved there should be greater level of openness. Social Care Wales is currently consulting on a Code of Practise for Employers of Social Care Professionals which mirrors the individual duty of candour with employer support for openness. This code for employers is to be included in statutory guidance for employers in regulated care service and compliance with the code will be inspected by the Care and Social Services Inspectorate for Wales. It may be helpful for the NHS to adopt similar practice.

Setting and Meeting Common Standards

Do you support this proposal?

Yes, although health care and social care address different but complimentary needs, which would need to be factored into any standards.

What further issues would you want us to take into account in firming up this proposal?

We fully support the establishment of such a set of standards but careful consideration will need to be given to the achievement of a set of standards which are applicable across health and care and still have meaning to the experiences of those receiving care. We do believe however that it will be possible to develop of standards which are defined in terms of the direct experience of care recipients, particularly issues relating to dignity and respect.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Yes

What further issues would you want us to take into account in firming up this proposal?

It is vitally important that investigations undertaken by service regulators share information with professional regulators. As the professional regulator for social care

workers we have developed a good relationship for sharing intelligence with the Care and Social Services Inspectorate for Wales. This relationship should be maintained and enhanced under any new arrangements and lessons from Health Inspectorate Wales also shared with social care regulators. This becomes increasingly important as teams are more closely aligned and the traditional service barriers are broken down.

Social Care Wales regulates the managers of regulated care services and a proportion of these are nurses who will also be registered as nurses with the Nursing and Midwifery Council. We have developed a collaborative arrangement to investigations where there is agreement on whether the nursing or social care regulator should take the lead dependent on the nature of the allegations. This needs to be developed further possibly to the point of joint investigations under circumstances where both regulators have a significant interest.

In a context of greater collaboration and multidisciplinary working the move to joint investigation of complaints is essential and such a process needs to reduce the time taken in investigating complaints but must also offer an opportunity for learning for health and social care. There may also be benefits in health and social care organisations sharing the learning from near misses and critical incidents, so that good practice can be developed at pace.

Representing the Citizen in Health and Social Care
Do you support this proposal?
Broadly yes

Can you see any practical difficulties with these suggestions?
There is potential for confusion with the newly established citizen panels supporting Regional Partnership Boards under the SSWB Act. An independent voice of the citizen, as embodied by the CHCs, must be maintained, even if the organisation changes.

While there are clear advantages to the citizen perspective coming alongside the inspection bodies the structure and governance arrangements for such a body will need careful consideration to ensure that the functions and effectiveness of the separate parties are not undermined by being brought together within one overarching body.

It is also important to ensure that connections are made to local people across Wales to gather wider views – this could potentially be the regional citizen panels??

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
To a degree

What further issues would you want us to take into account in firming up this proposal?

We would agree that developing public understanding of why changes to policy or practice is supported by quality evidence is essential if major change, particularly in the health care sector is to be achieved. We are not wholly clear how the citizen voice body will act to influence change at the local or regional level. There is a danger that the national body would be seen as remote from experience at the local or regional levels. While we agree with the aim, the means by which local ownership and confidence in such a body can be achieved will need very careful consideration. There is some merit in considering how the voice of citizens, through their locally elected members, can also be harnessed. The role of public service boards may also bring additional lay perspectives to proposed service changes.

Inspection and Regulation and single body

What do you think of this proposal?

We agree

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?

Yes, in principle.

What issues should we take into account if this idea were to be developed further?

There are some advantages in bringing the inspection of health and social care more closely together, if this demonstrates efficiency and shared learning. However, many parts of healthcare delivery, especially acute and tertiary care, are not easily aligned with social care delivery. Integration at the primary care and community level may benefit from an integrated inspection approach. A WGS body could provide more independence to the Inspection approach aligned to the national citizen voice body.

However, there is a risk that the process of establishing such a body could cause a great deal of disruption at a time when there is already a great deal of change in health and social care. One also needs to consider the financial cost of setting up a new institution outside of government, unless efficiencies can be delivered by re-aligning the current inspection and CHC bodies.

It will also be important to acknowledge that the secondary care health agenda could overwhelm the social care and community health agenda, as this is often where media attention is focussed. This would be unfortunate at a time when public policy favours delivering more health and social care in communities as near to people's homes as possible.

It would be a priority for Social Care Wales to have a good relationship with a new joint inspection body. As the professional regulator for the social care workforce, our work relies on a good relationship with the service regulator to support regulation for improvement

WGWPMB159: Hywel Dda University Health Board
Location: Carmarthen

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
What further issues would you want us to take into account in firming up these proposals?
The Board agrees that there should be shared key principles for Health Boards and Trusts, as outlined in the White Paper. This would provide greater coherence between NHS bodies in the pursuit of improving health and health services across Wales. It would also provide consistency across Health Boards and support the principles of across Wales working between Board members with professional responsibility.
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. The Boards' view is that 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, including reviewing the roles of Associate Member roles, would provide a more streamlined focus in order that the Board could adapt to more strategic decision making.

There is an important shift in thinking required in the overall governance of the Board, moving away from the concept of representativeness of membership. A smaller Board cannot represent all relevant constituencies or stakeholders nor should they attempt to do so; rather a smaller Board should demonstrate the knowledge, understanding and awareness of issues to properly take into account all relevant interests, such as those of different groups of health professionals whilst not necessarily attempting to represent them.

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 an 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 determine the executive structure that is required rather than this being prescribed by regulations. 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 as this facilitates All-Wales working through All-Wales groups, there is room for some discretion to give Boards greater flexibility.
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 Board is of the view that it should be given more freedom to

appoint Independent Members with the skills the Board feels it needs rather than the current model requiring specific areas of expertise.

Giving Boards discretion over a certain number of Executive and Independent Members with no specified background provides 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. However, if such an arrangement was put in place for Health Boards, there is a risk that one Health Board could end up with a completely different structure than a 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.
The principle of having a greater number of Independent Members (IMs) compared to Executives should be maintained, as the challenge and holding to account that IMs bring are cornerstones of good Board governance. Ways of increasing diversity amongst Board members would be welcomed; however, this needs to be progressed in a manner which ensures openness and transparency at the outset as to the actual time commitment required of IMs. Posts are currently advertised indicating a commitment of 4 days per month, whilst in reality, to discharge the role effectively, requires at least twice this time commitment.

If any changes are implemented, there is a need to ensure that the outcome results in greater integration between health and social care and those professions are appropriately and consistently represented at Board level.

The proposal to allow some flexibility for Welsh Ministers to make time-limited particular appointments is supported assuming that this would apply to both Independent Members and Executive Directors. However, in order to understand the rationale and the potential impact, the Board would require further information in relation to the proposal that the Cabinet Secretary for Health, Well-being and Sport should have the authority to appoint additional Board members under the circumstances described. The Health Board suggests this flexibility is afforded not only for situations cited in the consultation (i.e. special measures) and should include opportunities for additional Board appointments during times of new ventures/significant change programmes.
Detailed consideration would need to be given as to whether such appointments, if made, should be full or associate Board members, how this affects the balance of the Board, the purpose of the role, the appointment process and ensuring the appropriate composition of the Board is maintained. Whether or not such appointments would need to be given Board membership, even on a time limited basis, would need individual consideration so as not to undermine the effective working of the substantive Board.

Board Secretary
Do you agree with these proposals?
What further issues would you want us to take into account in firming up these proposals?

There is support for greater clarity for the role of Board Secretary. There is increasing recognition that robust and effective Corporate Governance is integral to high-performing organisations. Since the inception of Health Boards in 2009, the role of the Board Secretary as Corporate Governance Adviser has evolved and matured. 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.

The strengthening of this role provides an opportunity to correct longstanding misperceptions regarding the seniority and status of Board Secretaries. The role however should retain its unique position of trust as an independent adviser.
While the role of Board Secretary is stipulated in Standing Orders, and a model job description has been produced by Welsh Government, the Board 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.
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 within the organisations. However, at this stage, this is not always the case and the role is not well understood in some organisations. Therefore, the profile and re-emphasis that a clear designation of the role would bring would be welcomed as would be consistency in the remuneration of the post across Wales as currently there remains variation from the equivalent of an 8D level to Very Senior Managers‟ Pay.

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, makes the role a statutory requirement for all Local Authorities and gives them a legal duty to report on legal issues and mal-administration, manage the Code of Conduct and complaints associated with conduct of Principal officers and elected members, manage the standing orders, 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.

As detailed within the model standing orders the Board Secretary role would be directly accountable for the conduct of their role to the Chair (and Chief Executive), and report on a day to day basis to the Chief Executive.

Duty of Quality for the Population of Wales
Do you agree with these proposals?

What further issues would you want us to take into account in firming up these proposals?

The Board does 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 repeals recent legislation, therefore more needs to be done to streamline rather than „add to".

There is a risk that the introduction of further legislation may only serve to make the position more complicated and complex although the White Paper could provide 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 White Paper should not be developed in isolation and will need to be drawn up to complement and be consistent with the emerging legal frameworks.

The Board recognises the significance of, and welcomes, the recently introduced legislation, including 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 legislation introduced 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, all of which are welcomed. The Health Board recommends that the Social Services and Well-Being (Wales) Act 2014 and the Well-Being of Future Generations (Wales) Act 2015 are 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.

Integration of services is important for patients and service users, however again these arrangements have brought challenges of their own regarding governance, accountability, financing and staffing. If the White Paper can again look at this to clarify these arrangements, especially community based accountabilities, we believe it could be powerful, especially if this is focused on clear alignment with the new Social Services and Well-Being (Wales) Act 2014 and also the Well-Being of Future Generations (Wales) Act 2015.

As health, local government and other public service partners increasingly work together to define and deliver against agreed aims and objectives through Public Services 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 White Paper. 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 Services Boards.

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 meet the populations health needs and improve population outcomes.
The Health Board is supportive of the emerging ways of working between NHS bodies as part of Regional Planning Committees. However, particular consideration needs to be given to the work undertaken by the Mid Wales Health Collaborative and the Joint Planning Committee with ABMU, and how the benefits of these wider partnerships can be retained whilst at the same time developing mechanisms that are more streamlined and focused on improving NHS delivery.

Quality
The Health Board believes in continuing to build on the existing systems and apply the tools which already exist which evidence quality and safety of care.

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 only 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.

Current legislation and specifically the NHS planning framework make 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 upon 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 out 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.

As a Health Board, Hywel Dda UHB requires an integrated impact assessment, including quality to be undertaken when considering service changes and this principle could be more generally introduced. The Health Board believes that ensuring quality will rely on the organisational structures, their accountabilities and the performance regime, and not legislation alone. If these are clarified through this

White Paper and expectations are clear, organisational and individual behaviours and cultures will be framed in different ways. There is a 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, clear lines of professional accountability through Professional Codes already exist. This could be strengthened further by aligning standards used across health and social care to support integration and co-operation.

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 simply 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 health care support workers.

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 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, providing time limited intelligence on performance.

Duty of Candour

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

This is supported in principle as it correlates with the NMC Professional Standards of Practice for Nurses and Midwives as laid out in the Code. In firming up this proposal, consideration of regulatory body standards should be taken into account.

The Health Board believes specific clarity is required on what „duty of candour" means and how this will fit with existing policies that empower staff to speak out and protect patients, or raise other issues concerning the organisation they work for, without fear of victimisation (e.g. whistleblowing). This must include the acknowledgement that candour is a two-way process as it also requires that any patient who is arguably disadvantaged or, worse, harmed, by the provision of less than safe or high quality care, is informed of the fact and is offered appropriate remedy, regardless of whether they have made a complaint or questioned their care; only in that way will we start to see the seismic shift that we need towards truly patient-centred care.

As detailed above, professional groups already hold a duty of candour and it would be powerful if this is extended across the NHS. The NHS in Wales needs to be clear about its 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 about as part of redress or part of investigations. If these principles are applied in the 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.

We also need to be clear that it is not enough to simply give staff the ability to respond to systemic problems or instances of poor care through a formal mechanism; they also need an independent authority to turn to if they feel their concerns are not being listened to or acted upon. In England there is a National Guardian and a network of local Freedom to Speak Up Guardians across all NHS Foundation Trusts and NHS Trusts. We need to know how this would work in Wales if we are considering a similar model, particularly in terms of our integration agenda and partnership working – there needs to be clear lines of sight for staff working in services to know where to go to when their efforts to raise issues have not been effectively managed via the usual chain of command.

There is, of course, an additional safeguarding element to consider here too, particularly in terms of the speed at which problems could or should be addressed or mitigated, possibly some kind of prioritisation system might be needed in order to ensure that action plans can be delivered at the pace required.

It will also not be enough to make „duty of candour" a statutory function and expect this to underpin a move to a more open, transparent and honest culture. In the same way that we expect staff to embody the values of an employer, we need these proposals not only to focus on a mandatory system of reporting or escalation to a national mechanism, instead there needs to be an additional expectation on staff to consider the moral implications of their own behaviour – for example, the imperative to not only set an example for colleagues by questioning behaviours and practices they believe may not be right, appropriate or lawful, but also to apply the same reasoning and integrity to their own practices and behaviour.

Setting and Meeting Common Standards

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

The Health Board supports the concept of having in place consistent standards, which should be integrated with social care, the third sector and the independent sector. This common set of requirements should not only set out a clear description of safe and acceptable quality but should also be used as the framework for continuous improvement in order that a measureable rise in achievement can be tracked. Associated monitoring arrangements would need to be similarly joined up. The Health Board believes that a review of the Putting Things Right regulations would be timely and helpful, particularly in light of the suggestion to introduce a duty of candour.

A common set of standards across the NHS and independent sectors may improve patient outcomes and experience, would provide certainty and clarity for patients and service users and would have implications for the function and role of the regulators which need to be considered.

Standards already apply to the NHS and it would be helpful to have an integrated set of standards across health and social care, together with joined up regulatory and monitoring arrangements. This is particularly important given the changes in legislation, such as the Social Services and Well-Being (Wales) Act 2014.

Furthermore, the Health and Care Standards have recently 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 framework 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.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

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 redress 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 redress that this also includes primary and social care. It is also important to consider whether the NHS redress 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 could 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 as recently highlighted within the Silk II Commission report. 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.

Representing the Citizen in Health and Social Care

Do you support this proposal?

Can you see any practical difficulties with these suggestions?

The CHC‟s function in providing a service for patients across the area served by Hywel Dda UHB, its input into shaping and improving services and its constructive challenge is valued in terms of representing the population served by the Health Board. The CHC as an entity is a recognised brand in the public domain, with the public having a general understanding of their role and remit. The positive relationship with the CHC has provided a source of advice, guidance and constructive challenge for the Health Board. The CHC has also provided important insights into the views of patients, their families and carers about the Health Board's services and the quality of health care received. The Health Board has invested significant time in the engagement and joint arrangements with the CHC, and this does add value to the ways in which local health services are planned and delivered.

The proposal to abolish CHCs is therefore seen as a radical option and that in making this proposal, the Welsh Government is not aware of the close and established links the CHC has with the Health Board. If the inference of the White Paper is that the patient's voice is currently not being heard adequately, then this is not the case locally. We also have concerns that the proposed changes to the inspection process would focus on the clinical perspective and detract from the patient voice. The proposal to replace the current system with that based in some respects on the Scottish Health Council is not seen as feasible as that organisation has a different role and remit in comparison to Wales. The Scottish model does not provide advocacy services, inspections or speak for the citizens and therefore is not reflecting the citizen voice. This role is delegated to the thirty integrated partnerships which are integral to the Scottish model.

The Health Board believes there is potential for the current model to evolve, especially by re-examining the membership and recruitment processes in order to reflect the wider community representation and indeed for the new body to

incorporate the views and advocacy services for children as well as adults. There is a need to build upon the strengths of the current system in order to maintain a strong independent voice and further developing the independent clinical scrutiny role as part of national level arrangements working closely with inspectorates. Lessons should be learnt from elsewhere in the UK to ensure that any new mechanism best meets the requirement to represent patients and the public, with a clear route for challenge and an appropriate balance between clinical and non-clinical matters. If it is determined that the current statutory CHCs are replaced then particular attention should be given to ensuring alternative arrangements are put in place to provide a service similar to their role in supporting and advocating for patients who have raised concerns. Should it be that a new body is established it is essential that it would have the expertise in engagement, consultation and co-production particularly in relation to major service change and have the skills and ability comment on proposals from a patient's perspective.

With the introduction of the Social Services and Well-Being (Wales) Act 2014 and given what the Parliamentary review is suggesting in its interim report, health and social care services are working in a more integrated way and need to develop this even further. It is important that there is one organisation representing the citizen's voice in both health and social care. Currently the way the seven CHCs are configured enables them to represent the public's interest in the health service, something which is not reflective of an increasingly integrated approach to service delivery, because as it stands, there is no specific statutory body for citizen engagement within social care. Local authorities are under a duty to promote user-led services and to involve people in the design and provision of services but there are no specific statutory bodies for citizen engagement within social care as there are in health with CHCs.

In addition to the integrated agenda, Health Boards are working in a more integrated way across organisational boundaries and services are being provided regionally, especially for specialist health services. This therefore has the potential to cause issues when there are health service changes across organisational boundaries, and is an area that could be reviewed further as we move more and more towards regional planning.

Further clarification in relation to service redesign decisions and referring decisions to the Cabinet Secretary when the local CHC, after significant consultation with local Health Board, reject the service redesign proposals put forward, needs to be undertaken. At present, CHCs have the power to refer a decision to the Cabinet Secretary when they do not agree with a decision that the Health Board makes. The CHCs are not under a duty to provide alternative recommendations which causes challenges, especially when regional redesign is discussed, and the CHCs membership is not clinically qualified to do this and this aspect could be further reviewed.

CHCs should be able to listen to the public and consider whether the Health Board has followed the correct processes and whether their engagement process was robust. It has been unfair to ask CHCs, made up of lay members, to comment on proposals themselves, however 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?

The Board supports that the CHC (or new body) will work alongside Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales. There have been some instances in the past where some of the CHCs‟ activities, such as inspections, duplicate the work of other bodies. The Health Board agrees that positioning the new arrangement alongside the Inspectorates, will increase profile and visibility, remove a number of duplicative activities and functions currently invested in CHCs, for example inspection of premises, and embed the patient voice more systematically within the work of the Inspectorates. 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 it. It is key that the three organisations in the future work in a more integrated way and their functions are not duplicated, while also ensuring that they are independent of each other. In doing so, attention needs to be given to potential financial costs, governance issues and ensuring current legislation is used rather than the creation of new legislation.

The Health Board has developed mechanisms for robust and systematic engagement and has begun involving local people in co-designing and co-creating services in order that the care is more patient centred. Efforts to achieve effective and meaningful patient and public involvement in healthcare have therefore been evolving and maturing over the past few years. The Health Board believes that rather than building new networks, it is essential we build on and work through existing structures and networks. HDdUHB has a long established membership scheme, Siarad Iechyd (Talking Health) with 1500 members where interested and motivated patients and public self nominate to participate in focus groups and be a part of any service changes. This together with another 3000 stakeholders, forms a strong basis to continually engage with and any new body would need to ensure this was not duplicated and cut across. The membership model is stronger than a patient panel as this is formed from people with a lived experience.

The Health Board together with colleagues in BCUHB and the Consultation Institute are developing and testing a tool which will enable the Health Board to build and track progress in how it is building public confidence through continuous engagement.
As a Health Board we believe that we do not want to lose this local critical friend role undertaken by the CHC which has been invaluable. It is necessary to have a body that stimulates better local dialogue, improved co-production and local support to make changes. However it is recognised some form of national overview will still be required.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
What further issues would you want us to take into account in firming up this proposal?

The proposal to introduce an independent mechanism to provide clinical advice on substantial service change decisions is not supported. The establishment of such a process 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 that a permanent panel would not have the local knowledge and accountability required. 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 it would 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.

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 Cabinet Secretary should appoint such a panel when required rather than having a permanent panel. It is felt that a process of referral to the Cabinet Secretary should remain in place, since this ensures that referrals are not made lightly and that referrals to the Cabinet Secretary are made in exceptional circumstances only.
The Health Board does 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 a further strengthening of engagement. The effectiveness of the existing arrangement within 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.

Citizen's voice
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.

The Health Board 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.
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 in order 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.

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 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.

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 constrain the NHS in the use of innovative engagement methods.

Inspection and Regulation and single body

What do you think of this proposal?

Are there any specific issues you would want us to take into account in developing these proposals further?

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 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 Welsh Government. Furthermore, as highlighted, once a 10 year vision for the NHS has been agreed then we need to consider the regulatory framework and regulator that 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 the HIW does in order that their reports become valued by citizens. The standard of the investigating officers and investigations also needs to be reviewed.

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.

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. There is also an argument for closer cross-referencing with CHCs as their work provides very rich and insightful information about the quality and safety of services and importantly patient experience.

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 upon 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 healthcare provision. Such a move must be properly resourced and introduced in a careful, incremental fashion.

The role of the Auditor General as part of the inspectorate discussion, especially in light of the tripartite escalation discussions, needs to be explored as part of these arrangements.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Would you support such an idea?
What issues should we take into account if this idea were to be developed further?
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. The Health Board agrees that there should be underpinning legislation for integrated inspection and regulation, leading to the development of a single regulator for health and social care, which should be independent of Welsh Government. Regulators need to be robust and have appropriate resourcing in order that they can maintain their independence and have clear boundaries in order that the public can have confidence in the Regulator.

WGWPMB160: Centre for Public Scrutiny
Location: London

Response to Specific Questions

Board Membership and Composition

Do you agree with these proposals?

We welcome the principles that underpin these proposals. Governance of health boards and NHS boards should keep the health needs of local populations and the quality of services provided for local people at the centre. Flexibility in structures and processes is important to reflect local circumstances, but should be guided by an overarching governance framework to ensure consistent standards and outcomes are maintained across Wales. The governance framework should be supported by effective board performance evaluation which keeps service improvement and better outcomes for people at the centre, not just in terms of the services that are provided but also actions to reduce inequalities that restrict life chances and risk poor health.

We welcome the proposal that boards should have a vice-chair to support skilled leadership. All boards should have a robust board development programme and performance evaluation for their members so that boards perform to the highest standards and that every board member is able to add value to the work of the board.

We welcome the proposals for time limited Ministerial appointments to boards where other improvement and recovery mechanisms have failed to improve board and organisational performance. Boards should have a clear and realistic approach to 'risk and resilience' to mitigate against poor performance. Boards should not focus only on the financial cost of services, but also on the outcomes achieved for the value of the 'health pound' in Wales.

We welcome the proposals for boards to include some key positions that are consistent across Wales, but the principle should be 'parity of esteem' across all board members whether they are executive, clinical or public members.

What further issues would you want us to take into account in firming up these proposals?

The challenges of planning and delivering health and care services in 21st century Wales require comprehensive strategies that recognise the impact of the wider determinants of health to support a strong economy, tackle inequalities, improve life chances and provide equitable access and outcomes from the highest quality services. Such strategies should be underpinned by a comprehensive outcomes framework for public health, healthcare and social care, recognising that the NHS and local government need to work effectively together to improve the whole of the health economy in Wales.

Boards should be able to demonstrate how insight and information from communities, patients and staff influence board priorities and how boards provide feedback to stakeholders about the key measures of performance and outcomes.

The proposals to development board effectiveness need to be supported with a comprehensive package of implementation support.

Board Secretary

Do you agree with these proposals?

We welcome the proposal to introduce a statutory role for Board Secretaries with protection for them to challenge Chief Executives and Boards and to report on any challenges made. Similar arrangements already operate in other parts of the public sector across the UK.

We welcome the proposal for an independent process to be involved in decisions to dismiss board secretaries. We think that the role of board secretaries could be strengthened further through a requirement to report on a few key measures that indicate the effectiveness of boards.

What further issues would you want us to take into account in firming up these proposals?

Proposals to strengthen the role of board secretaries should be underpinned with a package of implementation support that sits alongside support for implementing proposals to improve the effectiveness of boards more generally.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

We welcome the proposals to extend and enhance the duty of quality, to support collaboration and co-operation beyond traditional organisational boundaries. The proposals should be underpinned by a comprehensive framework that sets ambitions for improving quality, including tackling inequality, together with a range of support to assist implementation.

What further issues would you want us to take into account in firming up these proposals?

Performance against the duty to improve quality should be a key element of scrutiny of the effectiveness of NHS boards and local government leadership. Effective scrutiny, especially of the role of Public Service Boards in securing collaboration and co-operation between partners, should be underpinned by a comprehensive package of implementation support.

Duty of Candour

Do you support this proposal?

We welcome the proposals to introduce a statutory duty of candour across health and social care services. The duty should cover all health and social care providers in community, primary care and acute care settings as well as covering services aimed at both physical health and mental health. The duty of candour should extend beyond the traditional health and social care complaints mechanisms.

What further issues would you want us to take into account in firming up this proposal?

Providing health and social care services is not ‘risk free’ and the duty of candour should not always be associated with failure. It is important that the duty sits within a comprehensive strategy for patient safety and safeguarding, together with a comprehensive approach to sharing learning from incidents and implementing solutions across the system. Lessons can be learnt from other ‘safety central’ industries such as aviation and construction.

Setting and Meeting Common Standards

Do you support this proposal?

We welcome the proposal to establish a common set of high level standards applied to health and social care, regardless of location of care. We welcome the proposal that the standards should be ‘rights based’ and should be developed in partnership with people with lived experience and/or people who speak on their behalf. The standards should cover leadership and value measures, not just service performance measures.

What further issues would you want us to take into account in firming up this proposal?

We think that all providers of health and social care should report on their outcomes against the standards, not just at the time of a formal inspection. One way to do this could be through extending the powers of local authority overview and scrutiny to cover commissioning and providing of healthcare services. We think that extending local council scrutiny powers could complement proposals for a ‘people’s voice’ body.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

We welcome this proposal to integrate the investigation of complaints that involve healthcare and social care.

What further issues would you want us to take into account in firming up this proposal?

The emphasis of an integrated healthcare and social care complaints process should not only be on the ‘mechanics’ of the process, but also on the ‘dynamics’ of the process – the extent to which learning from complaints is shared and changes to systems and services are implemented quickly. A refreshed approach to complaints should sit alongside the proposed duty of candour to support patient safety and safeguarding.

Representing the Citizen in Health and Social Care

Do you support this proposal?

We welcome the proposal to establish a strong, independent body that can gather and present the views of citizens and people who use healthcare services. Linking the work of the public voice body to the functions of the healthcare and social care inspectorates should increase visibility and influence. The inspectorates should have a duty to take account of the views of the public voice body and make a public response to those views.

We think there should be clarity around ‘right of entry to services’ and ‘inspection of premises’. The ‘right of entry to services’ for the public voice body should relate only to the function of hearing and gathering people’s views about their care in settings where that care is being delivered. The right to speak to people in their care settings is very powerful and valuable.

‘Inspection of premises’ sits better with regulators as part of their regulatory function – but regulators should include individuals from the people’s voice body on their inspection teams. The people’s voice body should have a role in assuring involvement in people’s own care and well as involvement in decisions about improvements/changes to services.

We think that clarity around ‘accountability’ is important. Local council scrutiny committees could be recognised as one of the scrutiny bodies to which the people’s voice body can make recommendations and expect a response.
The role of council scrutiny committees regarding health and care services should be strengthened to enhance democratic oversight of health and care planning and delivery.

We do not think that judicial review is the most accessible or effective way to challenge decisions of commissioners or providers. There should be a local mechanism to trigger referrals to Ministers rather than rely on judicial review – this mechanism should include provisions for local resolution before referrals are made. Consideration should be given to establishing a body comprising people with a range of insight (e.g. managers, clinicians and lay people) to advise Ministers on contested proposal for changes to services.

Can you see any practical difficulties with these suggestions?
We think that clarity about implementation support is important. We think there should be a comprehensive, accessible package of implementation guidance and support that is planned ahead of any changes in order to build knowledge and skills of commissioners, providers, regulators, scrutiny bodies (including council scrutiny), the people’s voice body and volunteers.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
We welcome the proposal to establish an independent clinical advice mechanism on substantial service change decisions but we are less clear about the extent to which this should represent a ‘more directive and guiding role on the part of Welsh Government’.

We think that there should be a presumption that standards of engagement and consultation will apply equally to all decisions about people’s individual care/treatment and decisions about improvements/changes to services. However, it should be recognised that there are circumstances where some decisions will have particular effects on individuals and groups and should therefore be regarded as ‘substantial’.

We do not think that decisions about what constitutes a ‘substantial variation of services’ or that decisions to make referrals to Ministers can be left only to commissioner or provider boards - there should be a local route to challenge decisions other than through judicial review, either through the people’s voice body or strengthened council scrutiny mechanisms. Such challenges should include a mechanism for local resolution prior to referral.

What further issues would you want us to take into account in firming up this proposal?
We are mindful of the different arrangements that exist to support public voice and tackle proposals for substantial service changes that exist in different parts of the UK. We have significant experience of working with the arrangements in England that involve Healthwatch England and the local healthwatch network, council scrutiny of health and care and the Independent Reconfiguration Panel that advises the Secretary of State for Health.

Inspection and Regulation and single body
What do you think of this proposal?
We welcome the proposal to at least closer align the ways in which the healthcare and social care inspectorates carry out their work in Wales to better reflect the way people experience services and the collaborative and co-operative framework within which services are planned and delivered.

Are there any specific issues you would want us to take into account in developing these proposals further?
We think that the way in which inspectorates approach their work should be rooted in the standards set for the planning and delivery of services and the outcomes framework for public health, healthcare services and social care services.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
We would welcome proposals to establish arrangements for more independent regulation, inspection and citizen voice.

What issues should we take into account if this idea were to be developed further?
We are aware of the different arrangements for healthcare and social care inspection and public voice that exist in different parts of the UK. We have significant experience of working with the arrangements in England that include the Care Quality Commission, Healthwatch England and the local Healthwatch network.

WGWPMB161: Betsi Cadwaladr University Health Board
Location: Bangor

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
What further issues would you want us to take into account in firming up these proposals?
The Board agrees that there should be shared key principles for Health Boards and Trusts, as outlined in the White Paper. This would provide greater coherence between NHS bodies in the pursuit of improving health and health services across Wales.

The Board supports the formal appointment of Vice-Chairs to Trusts. This model has underpinned good governance arrangements in Local Health Boards to date.

The Board supports the proposal that the Cabinet Secretary for Health, Well-being and Sport should have the authority to appoint additional Board members under the circumstances described. The Board must have the means and skills to lead the organisation so that decision making is effective and the right outcomes are delivered for patients. Building upon the positive impact made by specialist advisers appointed by Welsh Government when the Health Board was placed in special measures, additional skills and capacity focussed on key areas is seen as a positive intervention.

In respect of the composition of boards, BCUHB believes that generally, there should be consistency in some key positions for Executive Officers but also allowing some local flexibility to appoint based on local priorities. Regulations should permit the Board to determine the final Executive structure that best meets its own requirements. The principle of having a greater number of Independent Members (IMs) compared to Executives should be maintained, as the challenge and holding to account role of Independent Members is a cornerstone of good governance. Boards should have greater flexibility than currently prescribed to determine the best fit / skills sets when appointing IMs. In respect of succession planning and board stability, IM appointments should be staggered to avoid significant numbers of tenures ending at once.

The Health Board believes that it is important to preserve the staff voice at Board level as a non-officer member with the same legal duties and responsibilities as other board members. Having the employee voice within the formal governance structure brings a different perspective and information set that is shown to improve the quality of Board decisions.

Board Secretary

Do you agree with these proposals?

What further issues would you want us to take into account in firming up these proposals?

There is increasing recognition that robust and effective Corporate Governance is integral to high-performing organisations. Since the inception of Health Boards in 2009, the role of the Board Secretary as Corporate Governance Adviser has evolved and matured.

The proposal to provide greater profile and clarity is welcomed, to assist in ensuring the role is perceived at an appropriately senior level and be seen as a trusted position providing independent advice to the Chair, Chief Executive and Board. This will also enable the role to be in a position to effectively challenge and advise Boards (Executive and Independent), 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.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

What further issues would you want us to take into account in firming up these proposals?

If we are to ensure that we put the needs of people at the centre of our plans and services, then a duty of quality is fundamental and integral to the ways in which we work with organisations delivering health and care services. However, BCUHB does not believe that there is a need for further legislation as regards a duty of quality for the integrated system, because it is considered that this is already dealt with adequately by the requirements for closer collaborative working between health and other public services set out in the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015. Additional legal duties could create unintended governance challenges to system wide working, inhibiting partnerships from working effectively at scale and pace.

The Health Board is supportive of the emerging ways of working between NHS bodies as part of Regional Planning Boards. However, particular consideration needs to be given to the work undertaken by the Mid Wales Health Collaborative. We recognise the benefits of this wider partnership but seek to develop mechanisms that are more streamlined and focused on improving NHS delivery.

Duty of Candour

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

BCUHB is committed to ensuring that honesty and transparency are the norm. We support the introduction of a statutory duty of candour to strengthen the expectation for openness that currently exists. The principles of openness and candour must extend beyond the current requirements set out in Putting Things Right regulations, to include the design of care plans as well as the delivery of health care, building upon the duty of candour already held by registered health professions. Introducing a legal requirement would enable inspection to take place and this commitment to be tested. However, this would be reliant upon clarification as to what would count as evidence of being open and transparent. Any such duty introduced within Wales will need to be aligned to the regulations introduced within NHS England in 2014, in regard to the thresholds in place to measure the consistency of standards. This will be important to ensure there is a common basis for proportionate regulatory action if required.

Setting and Meeting Common Standards

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

BCUHB supports the concept of having in place consistent standards, which should be integrated with social care, the third sector and the independent sector. This common set of requirements should not only set out a clear description of safe and acceptable quality but should also be used as the framework for continuous improvement so that a measureable rise in achievement can be tracked. Associated monitoring arrangements would need to be similarly joined up.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

The Health Board believes that the complaints process should be integrated. Statutory guidance should set out a transparent joint complaints process for service users who wish to complain about health and social care, where their package of care includes both. Cross border cases would also benefit from better transparency and communication systems. All opportunities to support and encourage organisations to learn lessons to improve their services would be embraced.

Representing the Citizen in Health and Social Care

Do you support this proposal?

Efforts to achieve effective and meaningful patient and public involvement in healthcare care have been evolving and maturing. Locally, the Health Board has developed mechanisms for robust and systematic engagement and has begun, involving local people in co-designing and co-creating services so that the care is more patient centred.

Scrutiny of these arrangements is already in place via a number of existing mechanisms including Local Authorities, Voluntary Groups and Welsh Government as well as the CHC. The CHC's function in providing an advocacy service for patients across North Wales, its input into shaping and improving services and its constructive challenge has been very effective in representing the population served by the Health Board. The Health Board will of course support any arrangement that can be more effective than our current arrangements in representing the patient's voice.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

What further issues would you want us to take into account in firming up this proposal?

BCUHB is supportive of the proposals to make it possible for health boards to make more decisions locally with access to and support from, "an independent mechanism" providing clinical advice on substantial service change decisions.

Inspection and Regulation and single body

What do you think of this proposal?

Are there specific issues you would want us to take into account in developing these proposals further?

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?

What issues should we take into account if this idea were to be developed further?

The Health Board agrees that there should be underpinning legislation for integrated inspection and regulation, leading to the development of a single regulator for health and social care, which should be independent of Welsh Government. Regulators need to be robust and have appropriate resourcing so that they can maintain their independence and have clear boundaries so that the public can have confidence in the Regulator. However, caution may need to be exercised with regard to connecting within a single organisation those responsible for regulation with those responsible for citizen engagement and thereby elements of co-production. This could potentially create conflict in situations where regulators were commenting on a process that its own organisation had already had a part in.

WGWPMB162: Kevin Brennan MP
Location: Cardiff

General Comments

I submit this letter as a response to the above named consultation.

I understand the case for reform. We need Community Health Councils (CHCs) to be brought up to date, and to refresh their place in the landscape of the Welsh NHS.

However, I hope that any reforms will retain a series of essential characteristics of the long history of CHCs. I list these here:

- We need to retain a means by which the collective voice of patients can be heard in the Welsh NHS.
- The very well regarded advocacy service provided by CHCs should continue into the future
- A sufficiently local structure should be retained to allow for the direct involvement of people and patients in the day to day operation of CHCs or their successors

I hope that the consultation exercise will result in reforms that maintain these very important roles currently provided by Community Health Councils.

WGWPMB163: Cardiff and Vale University Health Board
Location: Cardiff

Response to Specific Questions

Board Membership and Composition

- The current Health Boards have been in place since 2009 and require review. There is an opinion that the current size and configuration of Health Boards ' Membership is too large and diverse. The current size of the Board (20 Members plus 3 Associate Members as a minimum) as set out in the Standing Orders should be reviewed.
- We support the proposal for a formal Vice Chair to Trusts. This has worked well in Health Boards and underpins good governance arrangements.
- We support the proposal for the Cabinet Secretary for Health, Well Being and Sport to have the authority to appoint additional Board Members. This should include both Executive and Independent Members.
- The current Associate Directors are not "citizen representatives" and Health Boards should have more discretion on who to appoint.
- We welcome the opportunity to review the role, purpose and terms of reference of the Health Professionals' Forum, Local Partnership Forum and Stakeholder Reference Group. Each of these has a critical role to play in delivering the Board Strategy but require review.
- Do we need to be prescriptive about the role of Independent Members in relation to specific expertise they will bring? In their recruitment we should be able to look at opportunities to take the right members who have the correct expertise and experience required by the Board. General skills are the priority along with the flexibility to respond to need.
- Health Boards should have more discretion on the designated roles required for the Executive Directors as full Board Members. The Health Board believes that all Health Boards need to have the same core composition of Executive Directors.
- For the Board to make the change needed to make the transformation required in health care, clinical leadership of all the professions will be needed. The changes made in 2008 strengthened the Executive clinical leadership and moved away from "traditional" structures, recognising that healthcare had shifted to become multidisciplinary. It is therefore recommended that the model of Executive Directors for Clinical Services be maintained, whilst the Board is able to also have flexibility regarding the other Executive roles.
- The change of title of an Independent Member to "Public Member" is not supported as this could be misleading and not well understood.
- The Board supports the importance of the staff representative at Board level.
- Independent Members provide support well in excess of 4 days per month and this should be increased to 6 days per month.

Board Secretary

- This is a very important role and appropriate qualification and experience is required. The post needs a level of independence and statutory change could be considered.
- The proposal to give greater clarity to the role is welcomed, ensuring the role is perceived at an appropriately senior level to effectively challenge and advise Board Members.
- Some NHS organisations still used the title Board Secretary when other use the more appropriate title of Director of Corporate Governance.
- The role should directly be accountable to the Chair and report to the Chief Executive.

Duty of Quality for the Population of Wales

- It is agreed that working across boundaries and budgets to meet the population needs will encourage innovation and partnership working to fully understand and address the population needs. To be transparent in the service design to meet the population needs in a quality driven manner that makes the most prudent use of the available resources.
- We do not support any further change to law to strengthen local collaboration in planning and meeting people's health and wellbeing needs close to home.
- The new legislation recently introduced - Social Services and Well Being Wales Act 2014 and Well Being of Future Generations (Wales) Act 2015 is sufficient to ensure closer collaborative working between Health and other public services.
- More time should be given to develop the recently introduced Regional Planning Forums to improve regional planning of service.

Duty of Candour

- The Board fully supports the introduction of a statutory duty of candour to strengthen the expectation for openness that currently exists.
- The Putting Things Right Regulations have embedded at their core a duty of candour. There would need to be joint investigation agreements across health and social care that would require legislative changes and review of reasonable timeframes. This would be a far more effective and equitable process for people who often have issues across multiple organisations. The Welsh proposal does not seem to include independent health providers as the Scottish model does. These should definitely be included.
- The principles of openness and candour could extend beyond the current requirements set out in Putting Things Right regulations while professional groups already have a duty of candour for patients and their families, this would be a strong message to extend this across NHS Wales.
- Introducing a legal requirement would enable inspection to take place and this commitment to be tested.

Setting and Meeting Common Standards

- The Health Board supports the concept of having in place consistent standards, which should be integrated with social care, the third sector and the independent sector.
- This common set of requirements should also be used as the framework for continuous improvement.
- Associated monitoring arrangements would need to be similarly joined up.
- Standards would need to be developed and defined in terms of providing person centred outcomes.

Joint Investigation of Health and Social Care Complaints

- Statutory guidance should set out a joint complaints process for service users who wish to complain about health and social care, where their package of care includes both. This would provide better transparency and communication systems.
- All opportunities to support and encourage organisations to learn lessons to improve their services would be embraced.
- The Health Board believes that a review of the Putting Things Right regulations would be timely and helpful, particularly in light of the suggestion to introduce a duty of candour.

Representing the Citizen in Health and Social Care

- We have a very constructive and positive working relationship with our Community Health Council. We have also developed mechanisms for robust and systematic engagement which involves patients and carers in helping to co-design and co-create services to ensure they are more patient focused.
- The CHC function in providing an advocacy service for our patients is very much welcomed and valued. However, the Health Board believes it is timely for this approach to be reviewed and evolved. This could build upon the strength of the current system to maintain an independent voice for the patients whilst considering further developing an independent clinical scrutiny role as part of the national level arrangements in place.
- The independent inspection of the Health Board's service and premises has had its value but a new mechanism/approach which best meets the needs and requirements to represent patients and the public should be considered.

Co-producing Plans and Services with Citizens

- The proposal to introduce an independent mechanism to provide clinical advice on substantial service change is not supported. This would create additional stages in the planning process and could undermine the current engagement and consultation requirements.
- The Health Board does not support the proposal for more legislation to ensure Health Boards co-planning take place.
- Introducing this proposal would undermine the very constructive partnership working we already have with our Stakeholder Reference Group.

Inspection and Regulation and single body

- The Health Board supports the proposal to have underpinning legislation for integrated inspection and integration.
- It was agreed that that there should be one inspectorate body but the view was that the role of the Ombudsman with their new powers also needed to be considered. The role and remit of the inspectorate body should be transparent with a proportionate approach to investigations. This should include independent providers, and consideration of how we provide the same standard for patients whose care is commissioned outside Wales, either by private providers or NHS Trusts.
- We would specifically like to see children and young people represented more robustly. We would welcome true participation by capturing and listening to the citizen's voice and using the many varied methods of doing this through technology and personal contact to have a truly representative view.

WGWPMB174: Llyr Gruffydd AC
Location: Rhuthun

Sylwadau cyffredinol

Diolch am y cyfle i ymateb i Bapur Gwyn Llywodraeth Cymru, Gwasanaethau Sy'n Addas I'r Dyfodol.

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Ni all sefydliadau barhau i weithio ar wahân, a rhaid iddynt edrych y tu hwnt i'w ffiniau eu hunain wrth wneud penderfyniadau am ba wasanaethau a chamau fydd yn arwain at y canlyniadau gorau i ddinasyddion.
Rhaid i bobl gael llais gwirioneddol ac ystyrlon yn yr hyn sy'n digwydd iddynt yn unigol ac, yn ehangach, yn y penderfyniadau am wasanaethau.

Pwy all anghytuno gyda'r gosodiadau ac amcanion uchelgeisiol yma?
Mae hefyd yn dda gweld fod yr ymatebion a gafwyd i'r Papur Gwyrdd yn dangos awydd i weld fwy o gydweithio rhwng Byrddau Iechyd, a mwy o ymwneud a'r cyhoedd a llais y dinesydd.
Ymhellach i hyn, wrth gyflwyno'r rhesymeg y tu ôl i'r Papur Gwyn, dywed y pwynt cyntaf un,
mai ein prif nod yw galluogi a grymuso sefydliadau a dinasyddion i gydweithio (t. 9)
Mae hyn yn sicr yn amcan clodwiw.
Mai pwynt 14 yn ymhelaethu ar Gynghorau Iechyd Cymunedol Cymru, gan ganolbwyntio yn llwyr ar yr hyn sy'n cael ei weld fel gwendidau'r Cynghorau Iechyd. Yn wir mae'n cael ei ystyried mor bwysig fel ei fod yn ymddangos ar y rhestr Galluogwr, ar ddiwedd yr adran,
Trefniant newydd ar gyfer defnyddio model llais y dinesydd yn hytrach na model presennol y Cyngor Iechyd Cymuned i ganolbwyntio ar y ffordd y caiff sefydliadau eu dwyn i gyfrif am eu dulliau o ymgysylltu â'r cyhoedd. (t. 11)
Dyma'r tro cyntaf y down ar draws yr awgrym i ddiddymu'r Cynghorau Iechyd Cymunedol.
Mae'r ddogfen drwyddi draw yn cyfeirio at yr angen i'r Gwasanaethau Iechyd a'r cyrff sydd ynghlwm a'r Gwasanaethau Iechyd fod yn dryloyw ac yn agored. Mae hyn, unwaith yn rhagor, yn ganmoladwy.
Ond rhaid datgan fy angrhedinedd fod y Papur Gwyn yma yn disgwyl i gyrff eraill i fod yn dryloyw, tra fod y Llywodraeth, wrth gyflwyno'r Papur Gwyn heb fod yn hollol dryloyw ei hun.
Nid oedd yna son yn y Papur Gwyrdd am ddiddymu'r Cynghorau Iechyd. Ond eto dyma'r Papur Gwyn yma yn gwneud hynny, a hynny heb drefniadau digonol i gynnal digwyddiadau ymgynghori digonol a chynhwysfawr ar draws y cymunedau fydd yn cael eu heffeithio ar hyd a lled Cymru.
Byddwch yn ymwybodol fod y '*Consultation Institute'* wedi tynnu sylw at wendidau yn y broses ymgynghori, ac y bu'n rhaid trefnu cyfres o ddigwyddiadau ar fyr rybudd.

Nid yw trefniadau brysiog o'r fath yn dderbyniol ac meant yn tanseilio hyder y cyhoedd yn y broses ymgynghori ac mewn unrhyw benderfyniad terfynnol a wneir yn ei sgil.
Byddwn I hyd yn oed yn mynd mor bell a chwestiynnu dilysrwydd yr ymgynghoriad hwn oherwydd y blerwch efo sicrhau cyfleoedd digonol i glywed llais y cyhoedd yn y broses ymgynghorol yma. Gan nad oedd cam mor radical a diddymu'r Cynghorau Iechyd Cymuned yn y Papur Gwyrdd blaenorol ni ellir dibynnu ar yr ymgynghori a wnaed ar hwnnw fel rhai perthnasol l'w hystyried wrth edrych ar gynigion y Papur Gwyn hwn.
Yn ogystal â hyn rhyddhawyd y Papur Gwyn dros gyfnod yr Haf, o bosib y cyfnod anoddaf posib i sicrhau ymwybyddiaeth eang ac i gael pobl i gymryd rhan yn y broses. Mae hyn ymhell o fod yn dderbyniol, yn enwedig gan fod y Papur yn cyflwyno cynnigion pell gyrhaeddol.
Mae'r helyw o'r Papur yn dweud pethau cynnes am, er enghraifft, 'Iechyd a Gofal sy'n Canolbwyntio ar yr Unigolyn'. Ni does gen i gwyn am hyn.
Gorwedd fy nghwyn a phryder pennaf felly gyda chynnwys Pennod 4, 'Llais Effeithiol Dinasyddion, Cydgynhyrchu ac Arolygu Clir'. Cofiwch fod y Papur Gwyn yn credu fod hwn yn bwynt mor bwysig fel ei fod wedi cael ei nodi yn y pargraff cyntaf, a ddyfynwyd uchod.
Mae'r bennod yn gorffen gyda phwynt 89 yn datgan,
Byddai angen deddfwriaeth sylfaenol er mwyn diddymu'r Cynghorau Iechyd Cymuned ar eu ffurf bresennol a sefydlu corff newydd â chyfrifoldeb am gynrychioli buddiannau'r cyhoedd ar draws y maes iechyd a gofal cymdeithasol.
Ond nid yw'r pwyntiau blaenorol yn gosod unrhyw ddadl rhesymegol na synhwyrol er mwyn cyrraedd at y casgliad yma.
Er enghraifft, ym mhwyntiau 80 ac 82 dywedir,
Nid oes unrhyw gyrff statudol penodol yn bodoli ar gyfer ymgysylltu â dinasyddion ym maes gofal cymdeithasol, fel ym maes iechyd gyda Chynghorau Iechyd Cymuned.
…
Mae'r ffordd y mae Cynghorau Iechyd Cymuned yn cael eu trefnu ar hyn o bryd yn eu galluogi i gynrychioli budd y cyhoedd yn y gwasanaeth iechyd, rhywbeth nad yw'n adlewyrchu dull o ddarparu gwasanaethau sy'n gynyddol integredig.

Mae'r pwyntiau yma yn dangos gwendid y drefn, ond nid ydynt yn rheswm i gael gwared ar y Cynghorau Iechyd Cymunedol. Yn wir, i'r gwrthwyneb, maent yn ddadleuon i'w grymuso ymhellach.
Teimlaf fod cyfle fan hyn i adeiladu ar lawer o gryfderau'r strwythur bresenol trwy ychwanegu cyfrifoldeb am ofal cymdeithasol i gyfundrefn ddiwygiedig o Gynghorai Iechyd Cymuned yng Nghymru.
Ymhellach i hyn, mae pwynt 81 yn ceisio cyfiawnhau'r cynnig trwy ddyfynu sylwadau sydd wedi eu gwneud, yn ôl awdur y Papur Gwyn, sy'n dangos ffaeleddau y Cynghorau Iechyd Cymunedol. Mae'n cyfeirio at adroddiad a wnaed gan Marcus Longley yn 2012, '*Moving towards world class? A review of Community Health Councils in Wales'.*
Pwrpas papur Marcus Longley oedd i gryfhau y Cynghorau Iechyd Cymunedol, nid eu diddymu. Un o'r prif argymhellion oedd i'r CIC fod yn fwy cynhwysol, gyda mwy o amrywiaeth o bobl er mwyn adlewyrchu poblogaeth Cymru yn well. Yn wir, dyma a ddywedodd y Gweinidog Iechyd ar y pryd, Lesley Griffiths AC,

They (CIC) play a leading role in ensuring the National Health Service delivers for the people of Wales and, therefore, must have the structures and arrangements in place to enable them to perform well.
Yn yr un modd cyfeirir at adroddiad Ann Lloyd CBE. Ond unwaith yn rhagor mae eu beirniadaeth hithau yn cyfeirio at adroddiad Marcus Longley, ac yn atgyfnerthu'r pryder nad yw'r Cynghorau Iechyd gyda digon o amrywiaeth. Mae'n son am yr angen i weddnewid y CIC o ganlyniad, ond nid yw mewn unrhyw ffordd yn son am ganoli'r Cynghorau Iechyd i un bwrdd cenedlaethol, nac ychwaith yn son am grebachu ar eu gallu.
Yn olaf, mae Pwynt 14 yn cyfeirio at farn yr OECD o'r CIC. Mae'n gywir fod yr OECD wedi cwestiynu elfennau o ddyletswyddau'r CIC yn eu cyhoeddiad, 'OECD Reviews of Health Care Quality'.

Ond er bod yna amheuaeth ynghylch peth o rôl y CIC yn cael ei fynegi, mae'r OECD yn gwneud yn glir fod yna werth penodol i'r CIC:
Community Health Councils (CHCs) are a key feature in the architecture of Wales, with a clear role to engage with and ensure that the patient voice is heard. Community Health Councils, which are made up of members of the public and have a role representing patients and collecting patient's views, and scrutinising NHS services. … The Welsh Government have recently made changes to the Regulations which govern Community Health Councils in Wales, principally to strengthen the leadership role of the CHC Board to allow them to set standards for the way in which CHCs carry out their functions. This includes how they interact with other bodies such as Healthcare Inspectorate Wales and the provision of an effective and responsive advocacy service…
With comprehensive representation and advocacy of patient views, for which the CHCs have an important role to play, public scrutiny of NHS Wales can still be appropriately maintained

Felly o roi'r cyd-destun cywir i adroddiad yr OECD, yn hytrach na chael ei ddefnyddio fel sylw negyddol mae'n dangos yn glir fod yna bwrpas i'r CIC.
Yn wir, fuaswn i'n mynd ymhellach a dweud os oes yna wendidau yn bodoli yna gwendid ar ran y Llywodraeth ydyw am fethu a gosod trefn gywir wrth ail strwythuro yn y gorffennol. Mae'r OECD yn gweld gwerth i'r CIC o gael y drefn cywir mewn lle. Mae'n resyn felly fod y Papur Gwyn wedi cyfeirio at y pethau hyn fel rheswm i ddiddymu'r CIC, pan nad dyna oedd bwriad yr awduron.
Wrth drafod eu hargymhellion felly mae'r Papur Gwyn yn cynnig canoli gwaith y CIC (pwynt 84) a chreu corff newydd yn ymdebygu i'r un sy'n bodoli yn yr Alban (pwynt 85).
Rhaid nodi yma fod Cyngor Iechyd yr Alban yn cael ei weld fel model methedig. Nid yn unig ei fod wedi cael ei gyfeirio ato fel "Bochdew di-ddanedd" gan gydlynydd Pwyllgor Iechyd a Chwaraeon Senedd yr Alban, Neil Findlay ASA, ond hefyd yr wythnos hon cyhoeddwyd y caiff ymchwiliad ei gynnal i ddyfodol Cyngor Iechyd yr Alban yn dilyn adolygiad a gafwyd ym Mis Ebrill eleni. Y pryder ydyw nad yw'r corff canolog yma yn ymgysylltu yn ddigonol â'r cyhoedd. Dyma ganlyniad canoli gwasanaeth fel y CIC, a lleihau'r ddealltwriaeth a chyswllt lleol.
Os yw'r corf cenedlaethol newydd wedi ei leoli yn un rhan o'r wlad yna mae peryg gwironeddol y bydd yn gweithredu ymhellach I ffwrdd o'n cymunedau ac y bydd yn cael ei weld fel corf mwy "remote" gan gleifion a darparwyr gwasanaethau. Mi fydd hynny'n colli un o gryfderau di-amheuol rol bresenol y Cynghorau Iechyd Cymuned.

Nid ydwyf wedi cael unrhyw sicrwydd y bydd y corff newydd yn annibynnol; yn cynrychioli llais ein dinasyddion; a chyda'r gallu i dreiddio i mewn i'n cymunedau er mwyn sicrhau fod eu llais yn cael ei glywed.
Rwy'n edrych ymlaen at weld ymhellach y cynlluniau ar sut y mae disgwyl i'r gwahanol gyrff iechyd gydweithio - mae hyn yn holl bwysig.
Edrychaf ymlaen hefyd i weld defnyddwyr ein gwasanaethau cymdeithasol yn cael eu cynrychioli gan gorff annibynnol (credaf y dylai fod yn rhan o rôl y CIC).
Ond nid ydwyf yn cefnogi'r cynnig i ddiddymu'r CIC presennol, a chreu corff newydd fydd wedi ei ganoli, nac a fydd yn annibynnol, ac na fydd yn medru herio a sgriwtineiddio'r Byrddau Iechyd mor effeithiol.

WGWPMB175: Pro-Mo Cymru
Location: Cardiff

Response to Specific Questions

Joint Investigation of Health and Social Care Complaints
Do you support this proposal? What further issues would you want us to take into account in firming up this proposal?
Whilst we agree that different organisations should be working together, we think it is more important that citizens should be able to express any concerns and dissatisfaction before reaching the point of complaint – in line with Part 10 of Social Services Well-being Act ie: spectrum of advocacy, including independent professional advocacy (IPA). Early notification and resolution of issues will ultimately ensure cost and time savings for services and prompt and improved provision/support/help for individuals. A complaint should be the final part of an issue resolution process and not the beginning.

Representing the Citizen in Health and Social Care
Do you support this proposal? Can you see any practical difficulties with these suggestions?
We can see potential conflicts inherent in expectations of functions to deliver independent meaningful citizen engagement and voice, working alongside HIW and CSSIW, and holding LHBs to account.

The public sector should look to harness the expertise and experience of specific third sector values-based co-production organisations such as ProMo-Cymru, who are better placed to engage with a wide audience.

WGWPMB176: Monmouthshire County Council
Location: Monmouthshire

General Comments

This response has been developed by Monmouthshire County Council following engagement with Members of the Adult and Children's Select Committees. We would like to thank colleagues from Welsh Government who engaged with the Council in a joint Select Committee session to outline the thinking and principles that underpin the White Paper proposals and take questions. This has enabled us to make a fully informed response. The rest of this paper responds specifically to each part of the White Paper.

Introduction
The introduction talks about 'working together' to 'prevent ill health and provide the care people need, when they need it.' It states (health and social care) 'cannot continue to work in isolation and we must now look beyond the boundaries when making decisions about what services and actions will deliver the best outcomes'. These statements do not recognise that in some parts of Wales integrated working between health and social care is very well established and has been delivering improved health and wellbeing for people on a local and regional basis over a number of years. There are really good examples at a local level with Monmouthshire integrated services, delivered fully integrated community services in community hubs in Chepstow, Monmouth and Abergavenny. On a Gwent wide basis, there are many examples of integrated health and social care services working across local authority boundaries such as Gwent Frailty, Integrated Equipment Services and Share Lives. It is also important to note that integrated working to support improved health and well-being needs to include partners beyond health and social care: education, housing and third sector organisations are all critical and really good working arrangements with other partners can be as (or more) important to people's well-being as health and social care working well together.
The consultation references 'mature partnership working' needed at every level. This is facilitated in legislative terms through both the Social Services and Wellbeing Act (Wales) Act and the Wellbeing of Future Generations Act implemented within the last 15 months. Mature relationships take time to develop and deliver sustainable change We question whether an additional legislative layer is really needed in additional to the really progressive legislation we have which has not had time to sufficiently embed and transform practice. The timing of the White Paper is interesting in that it is issued in advance of the recommendations to be made by the Parliamentary Review into Health and Social Care in Wales. Proposals in the resulting Green Paper will need to consider further and align with further proposals to come from the Parliamentary Review and as such may require further consultation.

Co-production is at the heart of these proposals; people making joint decision about their own care. The paper states systems across health and social care now need to make a real shift towards this way of working and as a result standards and quality will be driven up. The paper does not reflect that co-production is common practice in social services across Wales, now reflected legislatively in the Social Services and Wellbeing (Wales) Act. The change to culture and practice in social services has been a journey over the last 10 years – whilst there is always more to do, by

describing ‘health and social care’ as one the paper does not recognise what is already in place in key parts of the system. The benefits of co-production are that we do what matters to the person, align services and approaches to the outcomes they identify with us, in a way that is cost effective and ultimately more sustainable. The emphasis on quality and standards mean these benefits are not appear reflected strongly, and it is not clear if they are understood, in the consultation proposals.

The paper references a subsequent Green Paper which will seek views on how to improve the quality of services provided by the NHS in Wales as well as the governance and accountability of the organisation and the people who manage the NHS. There is no mention of engaging with people with care and support needs who have contact with social services. In summary, there is a sense within the consultation that the proposals have really been developed to support change and improve standards in the NHS and that the need for change within social services is not driving the proposals in any meaningful way.

Chapter 1: Effective Governance
The role and composition of Health Boards need to reflect principles of good governance. There is clearly a balance to be struck between the numbers of people on a Board to ensure a wide range of skills and expertise, and the need for a cohesive structure. It is important that there continues to be a Director of Social Services Associate Member and a Local Authority Independent Member given the critical importance of expertise in partnership working, well-being and integration as part of a range of skills on the Board.

We are also supportive of the proposals around the independence role of Board Secretary which reflects the role of Local Authority Monitoring Officer. The impartiality of this role, set out in statute will really support effective governance of Heath Boards.

Chapter 2: Duties to Promote Cultural Change
We note the intention to update and enhance the duty of quality to better reflect the integrated system and the need to work collaboratively across boundaries. As a boarder county, we would welcome further consideration to be given to working with counties on the English side of the boarder. Working with all neighbouring counties should include planning and delivering significant services in a way which is far beyond the administrative arrangements currently in place. A current example of the need to do this effectively is the consultation into the future of community hospitals in the Forest of Dean. This will impact on Welsh health services yet there is no requirement in the green paper which will mean that English or Welsh health organisations need to plan together when they develop proposals which impact each other.

Improving standards in the quality of care is fully supported. The practical mechanisms on how this achieved require more thought. Traditional quality standards do not necessarily reflect what is important to people and a really open debate with citizens at an individual and population letter around what matters to them is necessary so standards are truly person centred. There is strong evidence that target driven approaches do not support quality systems that are meaningful to

the people who experience them. Measuring what matters requires a far more thoughtful approach and in the spirit of the White Paper, should be genuinely co-produced. Evaluative methods such as understanding the 'most significant change' should be actively supported through a renewed approach to doing things better and understanding the impact of what health and social care services do.

Our overarching observation is that the duties set out in this chapter would bring NHS standards closer to those which are already in place in social care or in English health service, e.g. the duty of candour. Learning from good practice across sectors and boarders is essential if our public services in Wales are to be the best they can be.
We would welcome explicit confirmation that the proposed changes would not impose a health model on social care systems. Many of the proposals are largely in place in social care services, for example, in the area of person centred care. It is really important that any new standards are outcome focussed and reflect what is in the Social Services National Outcomes Framework.

It is also critically important, given the fragility of the social care provider market, that the cost implications of any new standards are fully understood. The evidence base between should be clear, therefore, how any standards will actually improve quality of outcome and experience.

Joint Investigations of Health and Social Care Complaints
It is already good practice for the NHS and social services to work together if a complaint cuts across the duties of both organisations. Embedding this in statute may provide the opportunity to develop a joint health and social care complaints team across organisational boundaries and is supported.

Chapter 4: Effective Citizen Voice, co-production and clear inspection
We are concerned about the proposals to abolish Community Health Councils (CHCs) and replace them with a national body which may not have really effective local connections. We recognise that, as with all public bodies, the current model of CHCs in Wales can be significantly improved. In considering those improvements, there are some really important principles that need to be reflected:
1. Ensuring a strong local voice in the work of the organisation that ensures the patient voice is heard. The role of the CHC in supporting complainants and inspecting local health services is as important as the critical role they play in consultation and engagement in service change. Local perspectives are also absolutely critical in engagement prior to consultation on service changes, and during the consultation processes. A national body may struggle to meaningfully understand the impact of changes to primary care, for example, on small rural communities. Whilst the proposal is for the national body to advise whether adequate involvement of the public has been achieved in drawing up the proposals, adequate involvement of hard to reach groups such as people with disabilities, mental ill health, frailty, dementia and carers may be really difficult to determine if the national body is not integrally connected to understanding local populations and the particular needs of communities.

2. A truly independent voice for patients is vital – positioning the new body with HIW and CSSIW may mean it will not be able to take an independent view on the

effectiveness of regulation and inspection of health and social care services are in driving up standards of care. The 'commissioner' model would give an opportunity for a far more obviously independent and strongly heard voice speaking for citizens in the quality and transformation of care and support services. Legislating for real powers for the champion for the patient voice would seem to provide some balance of power to the understandable importance given to clinical leaders and Royal Colleges in determining the future of health services.

3. Openness and transparency – as with all public bodies, it will be important that the organisation representing the patient voice is fully accountable for the views it puts forward and the positions it takes on behalf of citzens. The role of locally democratically elected politicians in scrutinising health services, alongside social care services should be considered carefully in the design of the legislation.

We understand that the Board of CHCs have submitted progressive proposals for reform which include engaging directly with individuals and local communities to ensure the citizen voice is understood. They also propose representing the interests of people by scrutinising health and care services on a local, region and national basis. We would support the very thorough consideration of these proposals in designing the way forward.

Inspection and Regulation
We do not have any particular comments about the underpinning legislative framework for Health Inspectorate Wales. Independence of the regulatory and inspection function is important to its effectiveness and public confidence in it. The governance structures should ensure this independence is unquestionable.

Conclusions
The opportunity to comment on this important consultation is very welcome. The aspirations to improve standards and governance in health and social care are understood and supported. The detail of how to do this in a way which ensures the voice of citizens, and specifically vulnerable groups, are heard requires further consideration. We would welcome the opportunity to be part of any further engagement in this area.

WGWPMB177: Citizens Advice Cymru
Location: Cardiff

General Comments

Citizens Advice Cymru welcomes the White Paper Consultation 'Services fit for the future; Quality and Governance in health and care in Wales'.
Over the past 12 months Citizens Advice Cymru have supported 114,000 people with 436,254 problems, 49% of those had a disability or long-term health condition. This insight from working with those with an existing condition can inform sector-understanding of need, as well as assist health and social care providers to understand and improve health care design and outcomes.

Health and social care touches the lives of all citizens in Wales and the White Paper is timely in helping improve the standards of health and care in Wales. We support the general principles outlined in the White Paper of improving governance to strengthen the voice of the citizen and build more accountability, including board membership and composition, the role of the board secretary, promoting cultural change and person-centred health and care.

We make the following specific recommendations;
1 . Joint investigation of health and social care complaints
Making a complaint about health and care services should be seamless. If problems arise it should be easy for people to complain and to be able to make one complaint rather than multiple complaints to different agencies, following different processes. We believe that any proposals to strengthen the voice of people in Wales must be built around the need of the person and not the services they are using. Having clearly defined complaints procedures that are easy to access is essential for improving services and ensuring problems are not repeated. The powers for managing joint complaints must be clearly established in advance to avoid confusion and possible
lack of redress for complainants. The outcomes of complaints should be published, this would enable people to see how complaints are managed and any resulting improvements.

We know that for every person that makes a complaint, there are many more that do not. We are also aware of problems faced by people needing to make a complaint but feeling unable to do so because they are still receiving health and care services and are worried about how their complaint might impact on their service or treatment. Having the option to raise a concern without making a formal complaint is therefore very important. Citizens Advice Cymru recognise that many people will not feel comfortable or, in some cases, able to make a complaint and should be made aware of and have access to advocacy services. We also believe that consideration should be given to how the evidence that organisations like Citizens Advice can provide (from supporting people to resolve their problems, but where a citizens choses not to make a formal complaint) can inform service improvement and prevent others from facing similar problems in future.

2. Representing the Citizen in Health and Social Care

We strongly support strengthening the voice of people in the way health and social care is planned and delivered. The third sector has vast experience of supporting and representing people through advice and advocacy arrangements, referrals and signposting. With this experience we believe it is important that any arrangements for representing citizens and engaging with patients and the wider public is established with;

- a clear vision
- leadership that ensures people and patients are treated as equals in health and social care
- is easy to access
- provides clear and timely feedback
- demonstrates the importance and value of representation and engagement
- draws on existing experience and knowledge both locally and nationally and includes the third sector
- excellent governance and clear accountability
- access to all relevant information and ability to draw on expertise as required
- considers outcomes not outputs
- ensures local services are meeting local needs
- equal status

Citizens Advice Cymru would welcome the opportunity to discuss ways in which we can support the development of a new national arrangement for the role of representing citizens in health and social care in Wales through our expertise in delivering a national service at a local level and the resulting impact on people's health and well-being.

WGWPMB178: The Board of Community Health Councils
Location: Wales

General Comments

EXECUTIVE SUMMARY
The CHC Board agrees with the Welsh Government's aspirations for a health and social care system that enshrines good governance, telling the truth, and delivering high quality services which are independently checked by an effective inspection and regulation regime. We agree with many of the proposals in the White Paper in this regard, recognising that in many instances legislation alone could not provide the catalyst to deliver real and long lasting cultural change.

Our response focuses on those aspects of the White Paper where the people we heard from expressed clear views. We welcome the Welsh Government's intention to create a stronger people's voice across health and social care. The White Paper provides a once in a generation opportunity to do this in a way that best serves the people of Wales in health and social care.

We believe therefore that people in Wales deserve an independent, strong and effective voice. One that is working hard locally, regionally and nationally to make sure peoples' views and experiences influence how their health and social care services are designed and delivered, encouraging and valuing the diverse range of voices across Wales. A voice that is capable of making sure service providers across health and social care are held to account for the services they provide to people and communities in Wales. To achieve this, a new body would need the necessary powers. Its functions should include:

To encourage and support the involvement of people of all ages as individuals and communities in the design and delivery of services by:
Engaging directly with individuals and communities on the things that matter most to them, including whilst they access services
Working with others to support engagement, co-production and co-design

To represent the interests of people in health and social care by:
Scrutinising health and social care policy, plans and performance locally, regionally and nationally. Challenging service providers and policy makers where improvement is needed
Scrutinising the work of health and social care inspectorates
Sharing ideas, information and concerns about health and social care to support service improvement
Involvement in the co-design and development of services (including service change proposals)
Providing independent advocacy support and assistance to people of all ages raising a concern about health and social care services

We believe our outline proposals for a new people's voice body provide a strong framework on which to base future arrangements in Wales. The success of any future model will depend on the detailed arrangements being co-produced with

partners and stakeholders. We ask that the Welsh Government looks to facilitate this approach over the 6-12 months following the consultation period.

The Board of Community Health Councils in Wales (the CHC Board) welcomes the opportunity to respond to the Welsh Government's White Paper: Services fit for the future. Our response has been produced in conjunction with the 7 Community Health Councils (CHCs) in Wales.

The Board of CHCs in Wales provides advice and support, sets standards, provides guidance and performance manages CHCs in Wales. CHCs are the independent watch-dog of NHS services within Wales and we seek to encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities. CHCs seek to work with the NHS and inspection and regulatory bodies to provide the crucial link between those who plan and deliver the National Health Service in Wales, those who inspect and regulate it, and those who use it.

CHCs maintain a continuous dialogue with the public through a wide range of community networks, direct contact with patients, families and carers through our enquiries service, complaints advocacy service, visiting activities and through public and Patient surveys. Each of the 7 CHCs in Wales represents the "Patient voice" within their respective geographical areas. Further information about CHCs is set out in the Annex.

Over the summer CHCs have asked people what is important to them about the proposals and looked at the different arrangements across the UK and beyond. We considered in detail what others have said about the strengths and weaknesses of related arrangements in other UK countries.

We collected over 1,400 responses from individual members of the public which have been forwarded separately to the Welsh Government.

OVERVIEW

The CHC Board agrees with the Welsh Government's aspirations for a health and social care system that enshrines good governance, telling the truth, and delivering high quality services which are independently checked by an effective inspection and regulation regime.

We particularly welcome the aspiration to strengthen the people's voice across health and social care, and embedding the key principles of co-design and co-production.

We recognise that primary legislation can play an important role in achieving these aspirations. However, there is little evidence to suggest that primary legislation alone would provide the catalyst to deliver real and long lasting change.

The Board of CHCs has concerns that in some areas the White Paper places an over reliance on legislation to deliver its policy aspirations rather than looking at other ways of doing so. There is a real risk in over using legislation in terms of the

ability and flexibility of health and social care services to deliver real cultural change and respond flexibly to future needs.

We set out below our detailed response to each of the proposals.

Response to Specific Questions

Board Membership and Composition
We agree that the boards of both health boards and NHS trusts should share some core key principles including delivering in partnership to deliver person centred care and a strong governance framework to enable boards to work effectively and meet their responsibilities. We also agree that all boards should have vice chairs, and that executive officer membership should include some key positions which are consistent across local health boards but also allow some flexibility in appointments.

However:

- the proposals in the white paper individually or collectively do not appear to address the issues about board culture identified in earlier governance reviews of NHS bodies.
- We do not agree with all the core key principles identified. Specifically, we cannot see that a re-titling of the role of 'independent' members would bring about a change in the perspective these members will bring – nor why such a change is needed. There is already a clear need for the whole board (and not just a re-titled public member) to understand and respond to the perspectives of the population in all board discussions and decisions.

We consider that a re-titling of the current 'independent members' to 'public members' may cause confusion and give an impression that their role is to represent the public. It is our view that the public currently recognise and accept the governance and leadership role of all voting NHS board members.

We agree that a representative voice should be heard at NHS board level. Associate membership of boards could contribute to achieving this. However, any such associate member would need a clear mandate from the wider population, eg., a representative from a new, stronger, people's voice body.

Board Secretary
We recognise the important role that Board Secretaries have within NHS organisations and welcome proposals to ensure this role is carried out consistently and not compromised through conflicting duties and responsibilities.

In order that board secretaries are able to carry out their role as principal advisors to their NHS boards on governance matters, and so that they can properly protect the organisation they serve it is important that the role has sufficient status and protection.

Duty of Quality for the Population of Wales

We consider that as the current duties and definitions of quality are set out differently in a variety of places, it is complex for both bodies and individuals to understand and measure.

We would want any new legislation to genuinely simplify and clarify what is expected of service providers and what quality means from a service users perspective.
We believe that the actions needed to deliver services that meet public expectations on quality must extend beyond introducing primary legislation. Legislation in itself will not bring about a shift in culture and behaviours.

Duty of Candour
In general terms, the public should and do expect that those responsible for providing their health and social care (both individuals and organisations) do so in a manner that is open, honest and frank.

We recognise that the current duty for NHS bodies to promote rather than require candour means that there is currently no sanction on bodies who fail to do so.
On this basis, we support in principle the introduction of a duty of candour for health and social care providers.

However, primary legislation in itself cannot bring about the cultural change necessary to embed this at every level in every organisation. We are concerned that the introduction of new legislation – if not done properly – could focus on the wrong things and distract from, rather than bring about the change needed.

To date, we are unaware of any significant evidence that the introduction of a duty of candour in England is benefitting patients by having a meaningful impact.

Setting and Meeting Common Standards
The public expects clear and meaningful standards that apply wherever and whoever provides their care. Any such standards should be informed by and reflect what is important to people.

We recognise that there may be a need to address the limitations within current regulations that specify what standards must be followed. In doing so, it is important that any new legislation is framed in a way that allows flexibility and adaptability to meet future expectations.

Joint Investigation of Health and Social Care Complaints
We consider that people who have concerns about their health and social care should only need to raise these concerns once in order for them to be investigated thoroughly and on a timely basis.

We agree that there should be a common complaints process across health and social care accessed through a single point.

The focus of any new arrangements must be to ensure:

- easy access for people to raise concerns
- objective, timely and co-ordinated investigation and response
- shared learning

Any new arrangements must recognise the need to ensure co-ordination within health and social care organisations/sectors and not just between them.

We consider that a single complaints advocacy service should form part of a new, independent people's voice body.

Representing the Citizen in Health and Social Care

We welcome the Welsh Government's intention to create a stronger people's voice across health and social care. The White Paper provides a once in a generation opportunity to do this in a way that best serves the people of Wales in health and social care.

We are not convinced however that the proposals as outlined will achieve this and are concerned they will dilute rather than strengthen this voice in the NHS. Further, we are concerned that the evidence presented in support of the proposals is flawed in some key aspects.

Over the summer CHCs asked people and bodies who represent them what is important to them and looked at the different arrangements across the UK and beyond. We considered in detail what others have said about the strengths and weaknesses of the different models. We have reflected on what works well in our current arrangements.

Given that the Welsh Government's proposals are drawn, in large part, from the arrangements in place in Scotland, we paid particular attention to the role and remit of the Scottish Health Council. We visited the Scottish Health Council to hear from them directly about the current arrangements; the recent review which identified a clear case for change in their role and remit; and the on-going consultation about their future direction. We are concerned that the White Paper proposals for a stronger citizens' voice body in Wales are predicated on a model that is not, and does not currently describe or consider itself to be a citizen's voice body.

We are grateful to all the UK bodies who took the time to share with us their experiences and learning.

From this we have developed our own ideas on how best to fulfil the Welsh Government's stated aspirations – outlining what we consider should be the key functions and principles underpinning the detailed design of a new people's voice body for health and social care in Wales.

We recognise that legislation can provide for the introduction of a new people's voice body with a range of functions and responsibilities. A change in structure and remit itself however, cannot address all the challenges identified. Evidence suggests that some of these challenges, for example, the level of public awareness and perceived independence of bodies set up to represent the interests of people in health and social care are common across the UK.

1 The Right Time, the Right Place (2014) https://www.health-ni.gov.uk/topics/health-policy/donaldson-report

Kings Fund, Local Healthwatch: progress and promise (2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417395/KF_Healthwatch_with_cover.pdf

Pam Whittle CBE: a review of the Scottish Health Council (2017) http://www.scottishhealthcouncil.org/about_us/consultation.aspx#.Wb072P6GOUk

We believe a new, strong and meaningful peoples' voice body should be designed and developed with others in Wales, for Wales. We should learn from others' approaches and experiences and build on what is valued within our own current arrangements.
We should grasp the opportunity to co-create a new and exciting people's voice body with the capacity and capability to work with others to drive flexible and innovative ways of engaging and involving people of all ages - on the things that matter most to them and using their preferred ways of communicating.

Why do we need a people's voice body at all?
We agree with the aspiration set out in the White Paper that health and social care bodies should get things right for themselves by continuously engaging with their communities. We also know that these bodies do not yet get this right every time – and we do not believe that new legislation alone will make this happen.

In Wales, by and large we don't have a market driven health and social care system. It's therefore important that our services are created with and for the people that use them. Not only do services need to engage on the matters they are thinking about, but people must have the opportunity to have a collective voice on the things that matter most to them.

Health and social care organisations have the responsibility to respond appropriately when concerns are raised with them. However, those people in the most vulnerable situations may not be in a position to raise their concerns without independent support. We believe therefore that people in Wales deserve an independent, effective voice.

One that is working hard every day to make sure peoples' views and experiences influence how their health and social care services are designed and delivered, encouraging and valuing the diverse range of voices across Wales. A voice that is capable of making sure service providers across health and social care are held to account for the services they provide to people and communities in Wales.

We consider the purpose of a new people's voice body in Wales should be to: "reflect the views and represent the interests of people in their health and social care services".

What should a people's voice body do?

We believe a new people's voice body in Wales should have the following functions:
To encourage and support the involvement of people of all ages as individuals and communities in the design and delivery of services by:
Engaging directly with individuals and communities on the things that matter most to them about their health and social care services. Including engaging directly with people whilst accessing services.

Supporting, encouraging and facilitating engagement and involvement through a formal alliance with others to promote co-production and co-design (building on the Scottish Health Council's model Our Voice).
http://www.scottishhealthcouncil.org/patient__public_participation/our_voice/our_voice.aspx#.Wb0-jf6GOUk

Working collaboratively and across-boundaries to develop a creative, bilingual and accessible platform for individuals, communities, regions and the wider population to share their views and experiences and influence health and social care design and delivery on a local, regional and national level.

Informing the development of national standards and guidance for engagement and consultation. Advising and supporting providers on involving people, including on engagement and consultation activity.

Monitoring and evaluating the effectiveness of involvement, engagement and consultation. Checking that people have had the opportunity to be heard and that their views are properly considered and responded to.

Whilst we do not consider a new people's voice body should be checking compliance against standards (this sits better with others) it could and should refer concerns to responsible bodies if it appears standards for engagement and consultation have been breached.

To represent the interests of people in health and social care by:
Scrutinising health and social care policy, plans and performance locally, regionally and nationally. Challenging service providers and policy makers where improvement is needed
Scrutinising the work of health and social care inspectorates
Sharing ideas, information and concerns about health and social care to support service improvement
Involvement in the co-design and development of services (including service change proposals)
Providing independent advocacy support and assistance to individuals raising a concern about health and social care services

It should have the following rights:
Right to visit unannounced wherever health and social care is delivered in health and social care settings

Right to co-operation from care providers in contacting people on their behalf for the purpose of collecting independent feedback about health and social care services

Right to be heard in health and social care (including on service change) by:
- Policy makers
- Service providers
- Scrutiny bodies
- Inspectorates

Right to a full, public and timely response from the above on concerns raised.

We do not consider a new people's voice body should take on the following existing CHC functions, duties or powers:

- Provide advice and information on health and social care services

We believe the responsibility for this should be with health and social care bodies. The new people's voice body must have the right to challenge services where the advice and information is not sufficient, clear, accessible or accurate.

- Inspect premises

We believe this responsibility should sit with relevant inspectorates/regulators

- Responsibility to develop alternative models to service change proposals where agreement cannot be reached

We believe any lay organisation would not be equipped to meet this responsibility.

- Right of referral to Ministers on service change proposals

We believe a new people's voice body should not be the decision making body for a proposed service change. All service change proposals should be open to public scrutiny.

Where decisions are not considered to be in the public interest, the appropriate challenge is through judicial review.

What should a new people's voice body look like?
So that a new people's voice body is, and is seen to be, independent, it should be established as a single legal entity on a stand-alone basis.

So that it is accessible and can respond quickly to what matters most to people and communities about their local services it should have a strong local presence and focus. The organisational design of a new people's voice body must:

- enshrine the principle of decisions being taken as close as possible to the people impacted
- provide for local determination of priorities according to evidence of local needs
- provide for the agility to take decisions that impact locally, regionally and nationally
- provide for clear lines of accountability within a strong standards & governance framework

Volunteers should be representative of the communities they serve and:

- be the lifeblood of a new people's voice body
- have the opportunity to contribute in different ways according to their skills and interests underpinned by a strong framework of modular and competency based learning and development.

A new people's voice body must be free to determine how it recruits its volunteers. In summary, we believe our outline proposals for a new people's voice body provides a strong framework on which to base future arrangements in Wales. However, the success of any future model will depend on the detailed arrangements being co-produced with partners and stakeholders. We ask that the Welsh Government looks to facilitate this approach over the 6-12 months following the consultation period.

Co-producing Plans and Services with Citizens

We consider that there should be a single approach across health and social care to handle service change proposals and are concerned that the detail in the white paper proposals around a new service change process does not provide for this.

Integrated service developments should be driven by communities whose contribution must be valued and utilised by decision makers in both health and social care. It makes no sense to develop a detailed service change process centred on health board decision making alone.

We also have concerns that the detailed process described in the proposals are based upon current practice in the NHS in Scotland which has been subject to a recent review that recommends a move away from this approach in light of experience. Specifically, the review recommends a shift from defining service change as significant or otherwise. The review states "decisions as to whether something should be seen as 'major' or 'minor'……. have become divisive, confrontational and detrimental to public confidence in the NHS".

Our experience is that where service change has been successful the level and nature of involvement, engagement and consultation was proportionate and responsive to the needs of those affected.

We consider that all service change should be open to public scrutiny.

We agree with the proposals to revise existing guidance. We believe that the guidance needs to illustrate what effective engagement based on co-production principles looks like in health and social care. In revising and extending this guidance to social care, the Welsh Government should work with NHS bodies, social care providers, the people's voice body and others with a role in helping communities to be heard.

The revised guidance should explicitly recognise that decisions taken nationally and regionally have a direct impact on how health and social care services are designed and delivered locally and should provide greater clarity as to how co-production principles will be used to ensure people are engaged at all levels.

Inspection and Regulation and single body

We are not clear how the proposals to overhaul HIWs underpinning legislation would inevitably lead to more integration and common methodologies between the two existing inspectorates (CSSIW and HIW).

We recognise that removing the existing inspectorates from within Welsh Government and housing them within a Welsh Government Sponsored Body would bring more independence from government.

However, it is difficult to see how the governance and accountability arrangements would work in a model that seeks to preserve the independence of three separate bodies within one Welsh Government Sponsored Body. The experience in Scotland with its Healthcare Improvement Scotland model (which houses within it a range of distinctive groupings, including its inspectorate and the Scottish Health Council) illustrates the challenges of maintaining an individual and independent identity for each.

WGWPMB181: Abertawe Bro Morgannwg Community Health Council
Location: Neath

General Comments

BACKGROUND
Abertawe Bro Morgannwg Community Health Council (ABMCHC) welcomes the opportunity to respond to the Welsh Government‟s White Paper: Services fit for the future.

ABMCHC is the independent watch-dog of NHS services within Bridgend, Neath Port Talbot and Swansea. We seek to encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities.

We seek to work with the NHS and inspection and regulatory bodies to provide the crucial link between those who plan and deliver the National Health Service accessed by people in our area, those who inspect and regulate it, and those who use it.

We maintain a continuous dialogue with the public through a wide range of community networks, direct contact with patients, families and carers through our enquiries service, complaints advocacy service, visiting activities and through public and Patient surveys. You can see more about our activities during 2016/2017 in our Annual Report included in the annex.

We are one of 7 CHCs in Wales representing the “Patient voice” within their respective geographical areas.

Over the summer CHCs have asked people what is important to them about the proposals and looked at the different arrangements across the UK and beyond. We considered in detail what others have said about the strengths and weaknesses of related arrangements in other UK countries.

We collected over 600 responses from individual members of the public in our area; these have been forwarded separately to the Welsh Government.

Overview
Overall, ABM CHC agrees with the Welsh Government‟s aspirations for a health and social care system that enshrines good governance, telling the truth, delivering high quality services which are independently checked by an effective inspection and regulation regime.

We particularly welcome the aspiration to strengthen the people‟s voice across health and social care, and embedding the key principles of co-design and co-production.

We recognise that primary legislation can play an important role in achieving these aspirations. However, there is little evidence to suggest that primary legislation alone would provide the catalyst to deliver real and long lasting change.

We share the concerns outlined by the Board of CHCs that in some areas the White Paper places an over reliance on legislation to deliver its policy aspirations rather than looking at other ways of doing so. We believe that there is a real risk in over using legislation in terms of the ability and flexibility of health and care services to deliver real cultural change and respond flexibly to future needs.

We set out below our detailed response to each of the proposals.

Response to Specific Questions

Board Membership and Composition
Overall, we agree that the boards of both health boards and NHS trusts should share some core key principles including delivering in partnership to deliver person centred care and a strong governance framework to enable boards to work effectively and meet their responsibilities. We also agree that all boards should have vice chairs, and that executive officer membership should include some key positions which are consistent across local health boards but also allow some flexibility in appointments.

However:

- the proposals in the white paper individually or collectively do not appear to address the issues about board culture identified in earlier governance reviews, including the recent independent review in to the Financial Governance at ABMU. This review highlighted the importance of establishing a finance committee to ensure proper oversight and scrutiny on financial issues. This may be something which should be mandatory for all Boards and Trusts.
- We do not agree with all the core key principles identified. Specifically, we cannot see that a re-titling of the role of „independent" members would bring about a change in the perspective these members will bring – nor why such a change is needed. There is already a clear need for the whole board (and not just a re-titled public member) to understand and respond to the perspectives of the population in all board discussions and decisions.
- We consider that a re-titling of the current „independent members" to „public members" may cause confusion and give an impression that their role is to represent the public. It is our view that the public currently recognise and accept the governance and leadership role of all voting NHS board members. Any confusion could detract from the recommendations made by the independent review of ABMU"s financial governance which sought to reinforce the collective responsibility of the whole board in scrutinising plans and taking decisions.
- Currently ABM CHC has a seat at the table during Abertawe Bro Morgannwg University Health Board (ABMU HB) Public Board meetings, this enables us to publically challenge the board on behalf of patient"s and the public or to feed in their views and experiences to inform the decision making process. Our national standards require us to contribute in way that gives a balanced

reflection of the range of views and experiences of local people, drawn from our other activities.

It is unclear from the White Paper how the proposed Associate membership would be decided. Care would be needed to ensure that any Associate member charged with bringing a representative voice was able to draw on the wider views and experiences of the public and had a clear mandate to reflect their collective interests. Individual members or those with a narrow interest or mandate could serve to skew board decisions. A representative from the new people‟s voice body might be best placed to provide a representative voice assuming that the new body was established in such a way to ensure its independence and duty to hear from and represent the interests of its communities.

Board Secretary

We recognise the important role that Board Secretaries have within NHS organisations and welcome proposals to ensure this role is carried out consistently and not compromised through conflicting duties and responsibilities.
In order that board secretaries are able to carry out their role as principal advisors to their NHS boards on governance matters, and so that they can properly protect the organisation they serve it is important that the role has sufficient status and protection.

Duty of Quality for the Population of Wales

We consider that as the current duties and definitions of quality are set out differently in a variety of places, it is complex for both bodies and individuals to understand and measure.

We would want any new legislation to genuinely simplify and clarify what is expected of service providers and what quality means from a service users perspective.

We believe that the actions needed to deliver services that meet public expectations on quality must extend beyond introducing primary legislation. Legislation in itself will not bring about a shift in culture and behaviours.

Duty of Candour

In general terms, the public should and do expect that those responsible for providing their health and social care (both individuals and organisations) do so in a manner that is open, honest and frank.

We recognise that the current duty for NHS bodies to promote rather than require candour means that there is currently no sanction on bodies who fail to do so.
On this basis, we support in principle the introduction of a duty of candour for health and social care providers.

However, primary legislation in itself cannot bring about the cultural change necessary to embed this at every level in every organisation. We are concerned that

the introduction of new legislation – if not done properly – could focus on the wrong things and distract from, rather than bring about the change needed.

To date, we are unaware of any real evidence that the introduction of a duty of candour in England is benefitting patients by having a meaningful impact on organisational behaviour.

Setting and Meeting Common Standards

The public expects clear and meaningful standards that apply wherever and whoever provides their care. Any such standards should be informed by and reflect what is important to people.

We recognise that there may be a need to address the limitations within current regulations that specify what standards must be followed. In doing so, it is important that any new legislation is framed in a way that allows flexibility and adaptability to meet future expectations.

Joint Investigation of Health and Social Care Complaints

We consider that people who have concerns about their health and social care should only need to raise these concerns once in order for them to be investigated thoroughly and on a timely basis.

We agree that there should be a common complaints process across health and social care accessed through a single point.

The focus of any new arrangements must be to ensure:

- easy access for people to raise concerns
- timely and co-ordinated investigation and response
- shared learning

Any new arrangements must recognise the need to ensure co-ordination within health and care organisations/sectors and not just between them.

We consider that a single complaints advocacy service should form part of a new people‟s voice body.

Representing the Citizen in Health and Social Care

We welcome the Welsh Government‟s intention to create a stronger people‟s voice across health and social care. The White Paper provides a once in a generation opportunity to do this in a way that best serves the people of Wales in health and social care.

We are not convinced however that the proposals as outlined will achieve this and are concerned they will dilute rather than strengthen this voice in the NHS. Further, we are concerned that the evidence presented in support of the proposals is flawed in some key aspects.

Over the summer we asked local people and partners what is important to them and worked with other CHCs and the Board to consider the different arrangements across the UK and beyond. We considered what others have said about the

strengths and weaknesses of the different models and reflected on what works well in our current arrangements.

We contributed along with the other CHCs to the development of our own ideas on how best to fulfil the Welsh Government‟s stated aspirations – outlining collectively what we consider should be the key functions and principles underpinning the detailed design of a new people‟s voice body for health and social care in Wales.

We recognise that legislation alone will not provide the answer to all the challenges faced by CHCs. We note that public awareness for example remains a challenge for similar bodies across the UK regardless of the model adopted. We are concerned based on our own experience that the White Paper proposals risk delivering a new body that would face even greater challenges in terms of public awareness and even more so in demonstrating value to people and communities.

In recent times, ABM CHC have taken considerable steps to build our profile and add value for our local communities. We have rebalanced our activities across our functions with a far greater focus on reaching out to more people and on planning our activities to focus on the things that matter most to them. We believe this is evidenced by the number of people who share with us their views and experiences to inform service developments and by the number of people in our area who have responded to this consultation.

We are not yet where we need to be, however our experience is that public awareness is improved by direct contact on the issues that matter most to them and that public confidence is improved where people can see the impact of their contribution.

Over the last 18 months we have heard from people about many aspects of their care in and out of hospital, about the difficulties they experience in accessing services and about problems that sometimes occur in the handover between different services or different providers. We published our findings and used them to inform our scrutiny of health board plans and our contributions at health board committees:
ABM CHC, Stroke Services http://www.wales.nhs.uk/sitesplus/902/opendoc/306286
ABM CHC, Urgent Care and http://www.wales.nhs.uk/sitesplus/902/opendoc/299709
ABM CHC GP Telephone Triage
http://www.wales.nhs.uk/sitesplus/902/opendoc/303211
ABM CHC Cancer Services http://www.wales.nhs.uk/sitesplus/902/opendoc/304944
ABM CHC Food and Drink http://www.wales.nhs.uk/sitesplus/902/opendoc/304944

This work did not duplicate the work of others, was not inspection, did not require clinical expertise and did not seek to provide assurance. It did however drive improvements in some key areas and could and should have delivered greater impact if there was a requirement on providers to fully consider and respond publically to the issues raised.

We are concerned that White Paper proposals do not set out how or if the new body would hear directly from people (including whilst people are receiving care). We are concerned that the functions as outlined would provide little opportunity for local

people to set the engagement agenda or share their experience of care or care pathways and therefore to influence service development on the issues that they identify as important. We are concerned too, that the proposals do not set out if or how the new body could hold decision makers to account for taking action in response to the views and experiences that people have shared.

Whilst we recognise that current arrangements in Wales have given rise to questions of governance and independence, we note that issues around the perception of independence have also been raised in Scotland and Northern Ireland where arrangements co-locate the Scottish Health Council and Patient and Client Council with their respective regulators.

The Right Time, the Right Place (2014) https://www.health-ni.gov.uk/topics/health-policy/donaldson-report

Kings Fund, Local Healthwatch: progress and promise (2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417395/KF_Healthwatch_with_cover.pdf

Pam Whittle CBE: a review of the Scottish Health Council (2017) http://www.scottishhealthcouncil.org/about_us/consultation.aspx#.Wb072P6GOUk

We believe that a new, strong and meaningful peoples‟ voice body is required in Wales but we also believe that any new body should be designed and developed in Wales, for Wales. We must learn from what has worked well in others‟ approaches and from what is valued within our own current arrangements. We must learn too from the things that have not worked as well and be prepared to try new ideas where previous ones have not delivered what was intended or in response to the changing landscape.

We should grasp the opportunity to co-create a new and exciting people‟s voice body with the capacity and capability to work with others to drive flexible and innovative ways of engaging and involving people of all ages - on the things that matter most to them and using their preferred ways of communicating.

Why do we need a people's voice body at all?
We agree with the aspiration set out in the White Paper that health and social care bodies should get things right for themselves by continuously engaging with their communities. We also know that these bodies do not yet get this right every time – and we do not believe that new legislation alone will make this happen.

In Wales, by and large we don‟t have a market driven health and care system. It‟s therefore important that our services are created with and for the people that use them. Not only do services need to engage on the matters they are thinking about, but people must have the opportunity to have a collective voice on the things that matter most to them.

Health and care organisations have the responsibility to respond appropriately when concerns are raised with them. However, those people in the most vulnerable

situations may not be in a position to raise their concerns without independent support.

We believe therefore that people in Wales deserve an independent, effective voice. One that works hard every day to make sure peoples‟ views and experiences influence how their health and care services are designed and delivered. A voice that is capable of making sure service providers across health and social care are held to account for the services they provide to people and communities across Wales.

We consider the purpose of a new people‟s voice body in Wales should be to: “reflect the views and represent the interests of people in their health and social care services”.

To represent the interests of people in health and social care by:
Scrutinising health and care policy, plans and performance locally, regionally and nationally. Challenging service providers and policy makers where improvement is needed

Scrutinising the work of health and care inspectorates

Sharing ideas, information and concerns about health and social care to support service improvement

Involvement in the co-design and development of services (including service change proposals)

Providing independent advocacy support and assistance to individuals raising a concern about health and care services

It should have the following rights:
Right to visit unannounced wherever health and social care is delivered
Right to co-operation from care providers in contacting people on their behalf for the purpose of collecting independent feedback about care services
Right to be heard in health and social care (including on service change) by:
- Policy makers
- Service providers
- Scrutiny bodies
- Inspectorates

Right to a full, public and timely response from the above on concerns raised.
We do not consider a new people‟s voice body should take on the following existing CHC functions, duties or powers:

- Provide advice and information on health and social care services

We believe the responsibility for this should be with health and social care bodies. The new people‟s voice body must have the right to challenge services where the advice and information is not sufficient, clear, accessible or accurate.

- Inspect premises

We believe this responsibility should sit with relevant regulators/inspectorates

- Responsibility to develop alternative models to service change proposals where agreement cannot be reached

We believe any lay organisation would not be equipped to meet this responsibility.

- Right of referral to Ministers on service change proposals

We believe a new people's voice body should not be the decision making body for a proposed service change. All service change proposals should be subject to public scrutiny.

Where decisions are not considered to be in the public interest, the appropriate challenge is through judicial review.

What should a new people's voice body look like?
So that a new people‟s voice body is, and is seen to be, independent, it should be established as a single legal entity on a stand-alone basis.
So that it is accessible and can respond quickly to what matters most to people and communities about their local services it should have a strong local presence and focus. The organisational design of a new people‟s voice body must:

- enshrine the principle of decisions being taken as close as possible to the people impacted
- provide for local determination of priorities according to evidence of local needs
- provide for the agility to take decisions that impact locally, regionally and nationally
- provide for clear lines of accountability within a strong standards & governance framework
- Volunteers should be representative of the communities they serve and:
- be the lifeblood of a new people‟s voice body
- have the opportunity to contribute in different ways according to their skills and interests underpinned by a strong framework of modular and competency based learning and development.

A new people's voice body must be free to determine how it recruits its volunteers.

Co-producing Plans and Services with Citizens

We consider that there should be a single approach across health and social care to handle service change proposals and are concerned that the detail in the white paper proposals around a new service change process does not provide for this.

Integrated service developments should be driven by communities whose contribution must be valued and utilised by decision makers in both health and social care. It makes no sense to develop a detailed service change process centred on NHS decision making alone.

We also have concerns that the detailed process described in the proposals are based upon current practice in the NHS in Scotland which has been subject to a recent review that recommends a move away from this approach in light of experience. Specifically, the review recommends a shift from defining service change as significant or otherwise. The review states "decisions as to whether

something should be seen as “major‟ or “minor‟……. have become divisive, confrontational and detrimental to public confidence in the NHS”.

Our experience is that where service change has been successful the level and nature of involvement, engagement and consultation was proportionate and responsive to the needs of those affected.

We consider that all service change should be open to public scrutiny.

We agree with the proposals to revise existing guidance. We believe that the guidance needs to illustrate what effective engagement based on co-production principles looks like in health and social care. In revising and extending this guidance to social care, the Welsh Government should work with NHS bodies, social care providers, the people‟s voice body and others with a role in helping communities to be heard.

The revised guidance should explicitly recognise that decisions taken nationally and regionally have a direct impact on how health and social care services are designed and delivered locally and should provide greater clarity as to how co-production principles will be used to ensure people are engaged at all levels.

Inspection and Regulation and single body

We are not clear how the proposals to overhaul HIWs underpinning legislation would inevitably lead to more integration and common methodologies between the two existing inspectorates (CSSIW and HIW).

We recognise that removing the existing inspectorates from within Welsh Government and housing them within a Welsh Government Sponsored Body would bring more independence from government.

However, it is difficult to see how the governance and accountability arrangements would work in a model that seeks to preserve the independence of three separate bodies within one Welsh Government Sponsored Body. The experience in Scotland with its Healthcare Improvement Scotland model (which houses within it a range of distinctive groupings, including its inspectorate and the Scottish Health Council) illustrates the challenges of maintaining an individual and independent identity for each.

WGWPMB182: NHS Board Secretaries Group
Location: Wales

Response to Specific Questions

Board Membership and Composition
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 in the NHS was not fully understood. Since that time the role, including its responsibilities, has varied to a greater or lesser extent across NHS Wales organisations. The proposal to provide greater clarity and awareness of the role is welcomed. It is anticipated that this will assist in ensuring that the role is better understood, especially the seniority of the role and its key position of providing independent advice to the Chair, Chief Executive and Board. It is important that the role is positioned effectively to challenge and advise Boards (Executive and Independent Members), 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, it is suggested that there is no significant deviation from the model to ensure the protection of the independence of the Board Secretary role and eliminate opportunity for operational conflicts of interest. It is essential that operational management is not allowed to encroach on the stipulated accountabilities of the Board Secretary. It is suggested that no additional responsibilities should be added which could compromise the independence of the role.

The understanding and status of the role may be strengthened if it were renamed (e.g. Director of Corporate Governance) and professional lead arrangements within Welsh Government are clarified, as is the case with other Board level roles in NHS Wales.

The ways in which the role is understood across NHS organisations and is also utilised does vary across NHS Wales. Therefore, the profile and re-emphasis that clear national recognition and designation of the role would bring, is welcomed. However, it is still not clear whether statutory protection is required to enable a Board Secretary to fulfil their role. The key will be the knowledge, skills, behaviour and aptitude of the individual and not only the requirements designed into the role and the protection afforded to it. A good Board Secretary in line with all good NHS employees and public servants should act with integrity and impunity in the interests of the people served by their organisation and on behalf of the organisation.

If statutory protection is to be applied, similar roles exist in other public bodies upon which it could be modelled. However, it wil be important that the role in the NHS is modelled to be the requirements of HNS bodies and therefore it not proposed that models from other public services are just transferred to NHS Wales 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 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 orders etc. The Local Government (Wales) Measure also provided a statutory resource to support the Monitoring Officer in undertaking his/her duties in order to fulfil the corporate requirements of the role. The only caveat here would be that in an NHS environment it is suggested that the role might not necessarily need to have a legal qualification, but would require clear qualifications and experience of NHS and public sector governance. Therefore, clarity would be required in the role specification what the level of qualification and experience should be for a Board Secretary role.

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. It is suggested that the role should be directly accountable to the Chair of the Board and report to the Chief Executive on a day to day basis. It will also be important that in order to undertake the role appropriately that Board Secretaries should be given adequate resources and staff to be enable them to execute the requirements of the office and run the governance and assurance arrangements of the organisation.

Therefore, it is suggested that the proposals will be important to assist with the profile of the role, recognition of the role and its importance for organisational governance and assurance arrangements within NHS Wales.

WGWPMB183: Hywel Dda Community Health Council
Location: Carmarthen

General Comments

BACKGROUND
Hywel Dda Community Health Council (CHC) welcomes the opportunity to respond to the Welsh Government's White Paper: Services fit for the future.

Hywel Dda CHC is the independent watch-dog of NHS services within Carmarthenshire, Ceredigion and Pembrokeshire. We seek to encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities.

We seek to work with the NHS and inspection and regulatory bodies to provide the crucial link between those who plan and deliver the National Health Service accessed by people in our area, those who inspect and regulate it, and those who use it.

We maintain a continuous dialogue with the public through a wide range of community networks, direct contact with patients, families and carers through our enquiries service, complaints advocacy service, visiting activities and through public and Patient surveys. We are one of 7 CHCs in Wales representing the "Patient voice" within their respective geographical areas.

Over the summer CHCs have asked people what is important to them about the proposals and looked at the different arrangements in place across the UK and beyond. We considered in detail what others have said about the strengths and weaknesses of related arrangements in other UK countries.

We reflected on the developments within the CHC movement in Wales since the introduction of new regulations in 2015 and the agreement of National Standards for Community Health Councils in Wales.

We worked collaboratively with CHCs to inform the response from the Board of Community Health Councils in Wales (the CHC Board) – and Hywel Dda CHCs views are consistent with those set out in the CHC Board's response.

OVERVIEW
Overall, Hywel Dda CHC agrees with the Welsh Government's aspirations for a health and social care system that enshrines good governance, telling the truth, and delivering high quality services which are independently checked by an effective inspection and regulation regime.

We particularly welcome the aspiration to embed the key principles of co-design and co-production, and to strengthen the people's voice across health and social care. Our members consistently raise issues from their communities about social care services which highlight the links and impact of social care developments and services on the NHS. Members of the public don't, nor should they, identify a

distinction between the two services – they simply want services to meet their needs whoever provides them. This often leaves our members frustrated that they have a clear voice and right to be heard in the NHS but not in related social care services.

We recognise that primary legislation can play an important role in achieving these aspirations. However, there is little evidence to suggest that primary legislation alone would provide the catalyst to deliver real and long lasting change.

We share the concerns outlined by the Board of CHCs that in some areas the White Paper places an over reliance on legislation to deliver its policy aspirations rather than looking at other ways of doing so. We believe that there is a real risk in over using legislation in terms of the ability and flexibility of health and social care services to deliver real cultural change and respond flexibly to future needs.
We set out below our detailed response to each of the proposals.

Response to Specific Questions

Board Membership and Composition
Overall, we agree that the boards of both health boards and NHS trusts should share some core key principles including working in partnership to deliver person centred care and a strong governance framework to enable boards to work effectively and meet their responsibilities. We also agree that all boards should have vice chairs, and that executive officer membership should include some key positions which are consistent across local health boards but also allow some flexibility in appointments. However:

- Because the proposals in the white paper individually and collectively concentrate on legislative/structural changes they do not directly address the aspects of board leadership and culture which are key to effective co-design and co-production of integrated health and social care services. The significant governance failures in the NHS within and outside Wales all point to failures in leadership and culture.
- Our own experience in Hywel Dda demonstrates the positive difference that more open and inclusive leadership can bring without legislative change. The relationship between the CHC and the Health Board has developed well over the past three years. We work effectively together, yet can and do disagree (passionately and constructively) on occasions without it damaging our relationship overall.
- This has required a strong investment in the relationship from the Health Board and the CHC, based on a common goal of improving services to individuals and our communities.
- We do not agree with all the core key principles identified. Specifically, we cannot see that a re-titling of the role of ‘independent’ members would bring about a change in the perspective these members will bring – nor why such a change is needed. There is already a clear need for the whole board (and not just a re-titled public member) to understand and respond to the perspectives of the population in all board discussions and decisions.
- We consider that a re-titling of the current ‘independent members’ to ‘public members’ may cause confusion and give an impression that their role is to

represent the public. It is our view that the public currently recognise and accept the governance and leadership role of all voting NHS board members.

Currently Hywel Dda CHC has a seat at the table during Hywel Dda University Health Board (HDUHB) Public Board meetings as well as the range of scrutiny committees that support the board's decision making. This enables us to publically scrutinise and challenge the Health Board on behalf of patients' and the public and to feed in their views and experiences to inform decision making. Our national standards require us to contribute in these meetings in a balanced way reflecting the range of views and experiences of local people drawn from our other activities.

It is unclear from the White Paper how the proposed associate membership on the board would be decided. Care would be needed to ensure that any associate member charged with bringing a representative voice was able to draw on the wider views and experiences of the public and had a clear mandate to reflect their collective interests. Individual members or those with a narrow interest or mandate could serve to skew board decisions.

We think a representative from the new people's voice body would be best placed to provide such a representative voice provided that the new body was established in such a way to ensure its independence and duty to hear from and represent the interests of its communities.

Board Secretary

We recognise the important role that Board Secretaries have within NHS organisations and welcome proposals to ensure this role is carried out consistently and not compromised through conflicting duties and responsibilities.

In order that Board Secretaries are able to carry out their role as principal advisors to their NHS boards on governance matters, and so that they can properly protect the organisation they serve it is important that the role has sufficient status and protection.

Duty of Quality for the Population of Wales

We consider that as the current duties and definitions of quality are set out differently in a variety of places, it is complex for people and bodies to understand and measure.

We would want any new legislation to genuinely simplify and clarify what is expected of service providers and what quality means from a service users perspective.

We believe that the actions needed to deliver services that meet public expectations on quality must extend beyond introducing primary legislation. Legislation in itself will not bring about a shift in culture and behaviours.

Duty of Candour

In general terms, the public should and do expect that those responsible for providing their health and social care (both individuals and organisations) do so in a manner that is open, honest and frank.

We recognise that the current duty for NHS bodies to promote rather than require candour means that there is currently no sanction on bodies who fail to do so. We think it is important that people know that they can expect their health and social care services to let them know if they have made mistakes in their care and treatment – whether or not they are themselves aware of any problems.

On this basis, we support in principle the introduction of a duty of candour for health and social care providers.

However, primary legislation in itself cannot bring about the cultural change necessary to embed this at every level in every organisation. We are concerned that the introduction of new legislation – if not done properly – could focus on the wrong things and distract from, rather than bring about the change needed.

To date, we are unaware of any significant evidence that the introduction of a duty of candour in England is benefitting patients by having a meaningful impact on organisational behaviour.

Setting and Meeting Common Standards

The public expects clear and meaningful standards that apply wherever and whoever provides their care. Any such standards should be informed by and reflect what is important to people.

We recognise that there may be a need to address the limitations within current regulations that specify what standards must be followed. In doing so, it is important that any new legislation is framed in a way that allows flexibility and adaptability to meet future expectations.

Joint Investigation of Health and Social Care Complaints

We consider that people who have concerns about their health and social care should only need to raise these concerns once in order for them to be investigated thoroughly and on a timely basis.

We agree that there should be a common complaints process across health and social care accessed through a single point.

The focus of any new arrangements must be to ensure:

- easy access for people to raise concerns
- timely and co-ordinated investigation and response
- shared learning

Any new arrangements must recognise the need to ensure co-ordination within health and care organisations/sectors and not just between them.
We consider that a single complaints advocacy service should form part of a new people's voice body.

Representing the Citizen in Health and Social Care
We welcome the Welsh Government's intention to create a stronger people's voice across health and social care. The White Paper provides a once in a generation opportunity to do this in a way that best serves the people of Wales in health and social care.

We are not convinced however that the proposals as outlined will achieve this and are concerned they will dilute rather than strengthen this voice in the NHS. Further, we are concerned that the evidence presented in support of the proposals is flawed in some key aspects.

Over the summer we asked local people and partners what is important to them and worked with other CHCs and the Board to consider the different arrangements across the UK and beyond. We considered what others have said about the strengths and weaknesses of the different models and reflected on what works well in our current arrangements.

We contributed along with the other CHCs to the development of our own ideas on how best to fulfil the Welsh Government's stated aspirations – outlining collectively what we consider should be the key functions and principles underpinning the detailed design of a new people's voice body for health and social care in Wales. We recognise that legislation alone will not provide the answer to all the challenges faced by CHCs. We note that public awareness for example remains a challenge for similar bodies across the UK regardless of the model adopted. We are concerned, taking into account the experience in Scotland and reflecting on our own experience that the White Paper proposals risk delivering a new body that would face even greater challenges in terms of public awareness and even more so in demonstrating value to people and communities.

In recent times, Hywel Dda CHC has taken considerable steps to build our profile and presence within local communities. We have rebalanced our activities across our functions with a greater focus on reaching out and engaging directly with more people and on planning our activities with our communities to focus on the things that matter most to them. We are also building a positive social media presence that is helping us to reach out to a wider audience.

We are not yet where we need to be, and there remains considerable potential to work more closely with other community and representative groups. Our experience is that public awareness is improved by contact on the issues that matter most to them and that public confidence is improved where people can see the impact of their contribution.

Over the last 18 months we have heard from people about many aspects of their NHS care, about what is working well and the difficulties they experience in accessing services locally and across longer distances and about problems that sometimes occur in the handover between different services or different providers. We have worked hard to encourage and support people to share their views and experiences of the NHS. We have used this information to inform the design and development of NHS plans and the scrutiny of NHS performance. We have done this

through our contributions at health board and trust board and committee meetings and their attendance at ours.

Our activities complement rather than duplicate the work of others, is not inspection, does not require clinical expertise and does not seek to provide assurance. It does help to make sure the needs and interests of people and communities are at the forefront of NHS thinking and decision making. Our annual report for 2016/2017 illustrates the kind of activities we carry out, and is included as an appendix to this response.

We are concerned that the White Paper proposals do not set out how or if the new people's voice body would hear directly from people (including whilst people are receiving care). We are concerned that the functions as outlined would provide little opportunity for local people to set the engagement agenda to influence service development on the issues that they identify as important. We are concerned too, that the proposals do not set out if or how the new body could hold decision makers to account for the action they take in response to the views and experiences that people have shared.

Whilst we recognise that current arrangements in Wales have given rise to questions of governance and independence, we note that issues around the perception of independence have also been raised in Scotland and Northern Ireland where arrangements co-locate the Scottish Health Council and Patient and Client Council with their respective regulators.

The Right Time, the Right Place (2014) https://www.health-ni.gov.uk/topics/health-policy/donaldson-report
Kings Fund, Local Healthwatch: progress and promise (2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417395/KF_Healthwatch_with_cover.pdf
Pam Whittle CBE: a review of the Scottish Health Council (2017) http://www.scottishhealthcouncil.org/about_us/consultation.aspx#.Wb072P6GOUk

We believe that a new, strong and meaningful people's voice body is required in Wales but we also believe that any new body should be designed and developed in Wales, for Wales. We must learn from what has worked well in others' approaches and from what is valued within our own current arrangements. We must learn too from the things that have not worked as well and be prepared to try new ideas, where previous ones have not delivered what was intended or in response to the changing landscape.

We should grasp the opportunity to co-create a new and exciting people's voice body with the capacity and capability to work with others to drive flexible and innovative ways of engaging and involving people of all ages - on the things that matter most to them. Such a body needs to be reflective of the communities it serves in the way in which it engages and communicates with people – in their language of choice and using their preferred engagement and communication methods. In the areas served by Hywel Dda CHC, enabling people to live their lives through the medium of welsh if they wish will be key for any new body.

Why do we need a people's voice body at all?
We agree with the aspiration set out in the White Paper that health and social care bodies should get things right for themselves by continuously engaging with their communities. We also know that these bodies do not yet get this right every time – and we do not believe that new legislation alone will make this happen.
In Wales, by and large we don't have a market driven health and care system. It's therefore important that our services are created with and for the people that use them. Not only do services need to engage on the matters they are thinking about, but people must have the opportunity to have a collective voice on the things that matter most to them.

Health and care organisations have the responsibility to respond appropriately when concerns are raised with them. However, those people in the most vulnerable situations may not be in a position to raise their concerns without independent support.

We believe therefore that people in Wales deserve an independent, effective voice. One that works hard every day to make sure peoples' views and experiences influence how their health and care services are designed and delivered. A voice that is capable of making sure service providers across health and social care are held to account for the services they provide to people and communities across Wales.
We consider the purpose of a new people's voice body in Wales should be to: "reflect the views and represent the interests of people in their health and social care services".

What should a people's voice body do?
We believe a new people's voice body in Wales should have the following functions:
To encourage and support the involvement of people of all ages as individuals and communities in the design and delivery of services by:

Engaging directly with individuals and communities on the things that matter most to them about their health and care services. Including engaging directly with people whilst accessing services. Supporting, encouraging and facilitating engagement and involvement through a formal alliance with others to promote co-production and co-design (building on the Scottish Health Council's model Our Voice) http://www.scottishhealthcouncil.org/patient__public_participation/our_voice/our_voice.aspx#.Wb0-jf6GOUk. Working collaboratively and across-boundaries to develop a creative, bilingual and accessible platform for individuals, communities, regions and the wider population to share their views and experiences and influence health and social care design and delivery on a local, regional and national level.

Informing the development of national standards and guidance for engagement and consultation.

Advising and supporting providers on involving people, including on engagement and consultation activity.

Monitoring and evaluating the effectiveness of involvement, engagement and consultation. Checking that people have had the opportunity to be heard and that their views are properly considered and responded to.

Whilst we do not consider a new people's voice body should be checking compliance against standards (this sits better with others) it could and should refer concerns to responsible bodies if it appears standards for engagement and consultation have been breached.

To represent the interests of people in health and social care by:
Scrutinising health and care policy, plans and performance locally, regionally and nationally. Challenging service providers and policy makers where improvement is needed

Scrutinising the work of health and care inspectorates

Sharing ideas, information and concerns about health and social care to support service improvement

Involvement in the co-design and development of services (including service change proposals)

Providing independent advocacy support and assistance to individuals raising a concern about health and care services

It should have the following rights:
Right to visit unannounced wherever health and social care is delivered outside of people's homes
Right to co-operation from care providers in contacting people on their behalf for the purpose of collecting independent feedback about care services
Right to be heard in health and social care (including on service change) by:
- Policy makers
- Service providers
- Scrutiny bodies
- Inspectorates

Right to a full, public and timely response from the above on concerns raised.
We do not consider a new people's voice body should take on the following existing CHC functions, duties or powers:

- Provide advice and information on health and social care services

We believe the responsibility for this should be with health and social care bodies. The new people's voice body must have the right to challenge services where the advice and information is not sufficient, clear, accessible or accurate.

- Inspect premises

We believe this responsibility should sit with relevant regulators/inspectorates

- Responsibility to develop alternative models to service change proposals where agreement cannot be reached

We believe any lay organisation would not be equipped to meet this responsibility.

- Right of referral to Ministers on service change proposals

We believe a new people's voice body should not be the decision making body for a proposed service change. All service change proposals should be subject to public scrutiny. Where decisions are not considered to be in the public interest, the appropriate challenge is through judicial review.

What should a new people's voice body look like?
So that a new people's voice body is, and is seen to be, independent, it should be established as a single legal entity on a stand-alone basis.

So that it is accessible and can respond quickly to what matters most to people and communities about their local services it should have a strong local presence and focus. The organisational design of a new people's voice body must:

- enshrine the principle of decisions being taken as close as possible to the people impacted
- provide for local determination of priorities according to evidence of local needs
- provide for the agility to take decisions that impact locally, regionally and nationally
- provide for clear lines of accountability within a strong standards & governance framework

Volunteers should be representative of the communities they serve and:

- be the lifeblood of a new people's voice body
- have the opportunity to contribute in different ways according to their skills and interests underpinned by a strong framework of modular and competency based learning and development.

A new people's voice body must be free to determine how it recruits its volunteers.

Co-producing Plans and Services with Citizens
We consider that there should be a single approach across health and social care to handle service change proposals. We are concerned that the detail in the white paper proposals around a new service change process does not provide for this by focusing primarily on health boards.

Integrated service developments should be driven by communities whose contribution must be valued and utilised by decision makers in both health and social care. It makes no sense to develop a detailed service change process centred on decision making by health boards alone.

We also have concerns that the detailed process described in the proposals are based upon current practice in the NHS in Scotland which has been subject to a recent review recommending a move away from this approach in light of experience. Specifically, the review recommends a shift from defining service change as significant or otherwise. The review states "decisions as to whether something should be seen as 'major' or 'minor'……. have become divisive, confrontational and detrimental to public confidence in the NHS".

Our experience is that where service change has been successful the level and nature of involvement, engagement and consultation was proportionate and

responsive to the needs of those affected. Our experience in Hywel Dda over the past few years illustrates that moving from a process driven approach to one that looks to develop better services through co-design and co-production requires an organisation wide commitment and investment from the start and throughout the development. This investment may not lead to quicker service change but will certainly lead to better service change - a failure to invest in this way risks significantly more in terms of public faith and confidence.

We consider that all service change should be open to public scrutiny.

We agree with the proposals to revise existing guidance. We believe that the guidance needs to illustrate what effective engagement based on co-production principles looks like in health and social care. In revising and extending this guidance to social care, the Welsh Government should work with NHS bodies, social care providers, the people's voice body and others with a role in helping communities to be heard.

The revised guidance should explicitly recognise that decisions taken nationally and regionally have a direct impact on how health and social care services are designed and delivered locally. It should also provide greater clarity as to how co-production principles will be used to ensure people are engaged at all levels.

Inspection and Regulation and single body

The relationship between Hywel Dda CHC and the 'relationship manager' within Healthcare Inspectorate Wales (HIW) is a positive one. Our regular discussions and information sharing reflects the complementary yet distinctive nature of our activities. Locally, we share our plans so that our visiting activities are co-ordinated with HIWs inspections. The different roles we currently play means that our shared interest lies largely in current service delivery. This represents only a proportion of Hywel Dda CHCs activities locally.

We are not clear how the proposals to overhaul HIWs underpinning legislation would inevitably lead to more integration and common methodologies between the two existing inspectorates (CSSIW and HIW).

We recognise that removing the existing inspectorates from within Welsh Government and housing them within a Welsh Government Sponsored Body would bring more independence from government.

However, it is difficult to see how the governance and accountability arrangements would work in a model that seeks to preserve the independence of three separate bodies within one Welsh Government Sponsored Body. The experience in Scotland with its Healthcare Improvement Scotland model (which houses within it a range of distinctive groupings, including its inspectorate and the Scottish Health Council) illustrates the challenges of maintaining an individual and independent identity for each.

WGWPMB184: Older People's Commissioner
Location: Cardiff

General Comments

Older people are the largest users of health and social care services across Wales. The growth in the number of people living with dementia and the increase in the number of people living longer means that older people using health services have increasingly high levels of acuity and complex health needs. As their needs very often span a number of sectors, particularly health, social care and housing, older people need different organisations to work together, be focused on common outcomes and at all times ensure that their rights and needs are at the heart of organisational priorities.

2. Many older people using these services face significant barriers to articulating their concerns, needs and wishes. Many will need time to consider their options and be provided with assistance to make decisions that they are comfortable with. When there are service failures, older people need to feel that their concerns are validated, taken seriously and responded to effectively. For older people, how care is provided is as important as what care is provided.

3. Older people need and expect healthcare providers to have a consistent and clear definition of quality that underpins service delivery, regardless of location. They want, and have a right to, full and effective involvement in decisions that will affect them. Boards must have an accurate grasp of the quality of care being provided, both directly and through commissioning and contacting arrangements, and have in place timely and effective mechanisms to identify poor care and manage risk, and rectify things when they go wrong.

4. Older people expect healthcare professionals to be open, honest and accountable for the quality of care provided and the action taken when care falls below an acceptable level. Health and social care providers must operate within a culture of ongoing improvement, where they continually learn from both good practice and service failures.

5. I recognise that the current health and social care system is going through a period of significant change in response to local challenges and recent legislation. However, it is clear from my own work that there are still huge variations in service delivery and that our best practice is not standard practice. I have seen this through my own regular visits to services and it is also raised by the Parliamentary Review's interim report.
Parliamentary Review of Health and Social Care in Wales (2017) Interim Report, https://beta.gov.wales/sites/default/files/publications/2017-07/170714-review-interim-report-en.pdf

6. Furthermore, it is clear from my work that despite a welcome recent focus on outcomes, public bodies are still struggling to align these outcomes to individuals, as well as to their own systems for reporting.

7. It is clear that there has been a significant policy shift towards multi-agency partnership working at a regional level, which the White Paper recognises and focuses on. Whilst this is important, older people would expect any White Paper concerned with 'quality' and 'governance' to also focus on the overall experience of using health and social care services. This includes information and access to services; the patient journey; interaction between organisations; and the quality of day-to-day care provided. This would also include the extent to which service users are empowered and active participants, and have their rights promoted and made real, throughout the health and social care experience.

8. The White Paper's focus is primarily at a strategic level, which is important. However, it misses an opportunity to also operationalise quality in a way that is meaningful and measurable across all elements of service delivery, which weakens its ability to achieve its overall intent.

9. It is clear that the White Paper is looking to align approaches across health and social care and this is welcomed. However, it is too selective and limited in this approach, leading to missed opportunities to draw across learning from the considerable change that has occurred in social care.

10. On a more general note, I have concerns that many aspects of the proposals within the White Paper are lacking in detail and there is a risk that many of the proposals will be left to secondary legislation and Codes of Practice, which will not receive sufficient scrutiny.

11. Whilst I welcome many of the proposals within the White Paper, I do not believe that they are sufficient to fully address the issues that matter most to older people within the health and social care system and so I outline, in addition to responding to specific questions, further action I believe should be included in future legislation or taken through a non-legislative route.

Chapter 1: Effective Governance

12. I have spoken many times about the concerns I have in relation to health board governance, including writing to the National Assembly for Wales's Public Accounts Committee following the publication of Trusted to Care. Whilst I agree with the broad sentiment laid out in this Chapter, I do not believe the proposals are sufficient to ensure that health board governance is as effective as is required given its importance to individuals' wellbeing and the scale of public money invested in healthcare.

Older People's Commissioner for Wales (2015) Quality & safety of health care services: reporting and scrutiny, http://www.olderpeoplewales.com/Libraries/Publications_E/Letter_to_PAC_March_15_Eng.sflb.ashx

Andrews, J. & Butler, M. (2014) Trusted to Care: An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board, http://gov.wales/docs/dhss/publications/140512trustedtocareen.pdf

13. The White Paper's proposals on governance are limited only to Board composition and the role of the Board Secretary. Whilst these are important, they are not the only elements of an effective governance framework. The sheer complexity of governance and the vast number of related procedures and mechanisms in a large health body requires a strong, integrated and comprehensive governance model wrapped around its operation. A strong and comprehensive governance model will assist the Board and management in fulfilling their duties and ensuring they do so in a way that is consistent with core public sector values, in particular the Nolan Principles and FREDA Principals.
Curtice, M. J. & Exworthy, T. (2010) FREDA: a human rights-based approach to healthcare, The Psychiatrist, 34 (4), pp. 150-156,
http://pb.rcpsych.org/content/pbrcpsych/34/4/150.full.pdf

14. I am disappointed that there is no mention within the White Paper of the following:

- The role of the Board; its key functions and duties; and oversight of the discharge of these
- Approach to, and reporting of, risk management
- External scrutiny of the organisation, including performance of the Board
- Key performance indicators drawn from a consistent definition of quality across the NHS in Wales that is relevant to current policy and people's experiences

15. Whilst some elements of these may already be contained within other documents and guidance, the governance framework should be set out comprehensively in one place to ensure both an integrated and consistent approach is taken by all NHS bodies.

Board Membership and Composition
16. Ensuring Board members have the appropriate skills, knowledge and competencies are crucial to successful representation and scrutiny, which are an essential part of effective governance. I agree with the proposal that core membership of Boards should be prescribed, including both executive and non-executive roles and that job descriptions should have a core degree of standardisation. However, this should not prevent Boards from being able to co-opt members according to local circumstances. It is also important that any proposed core membership does not reinforce a narrow medical model of healthcare but reflects the key role of non-medical and nursing professionals. I also believe that representatives of the new citizen voice body should also be core members of NHS bodies' Boards (see Chapter 3).

17. I am of the opinion that Chairs of NHS bodies should be appointed on a cross-party basis, and that Vice Chairs should continue to be appointed by the Chair, following a public appointments process. I agree with the White Paper's proposal for all NHS bodies to have Vice Chairs.

18. I hold the view that every executive Board member should become a Responsible Individual for specific aspects of care, mirroring the duty placed on independent social care providers and local authorities in the Regulation and

Inspection of Social Care (Wales) Act 2016 (Regulation and Inspection of Social Care (Wales) Act 2016, s21). This would address an important concern raised by older people that no one seems to be accountable when things go badly wrong. It would also strengthen the chain of accountability from the Board to the front line of service delivery. Each Responsible Individual should present an annual report to the Board on the safety and quality of services within their remit, again mirroring the approach taken in social care.

19. Given the crucial importance of those sitting around the Board table having the right knowledge, skills and competencies to discharge their roles, responsibilities and duties, it is my view that a consistent core skills, competencies and knowledge matrix must be used to underpin the recruitment and performance evaluation of both executive and non-executive Board members.

20. At present, non-executive Board members are appointed for approximately one day per week. I do not see this as sufficient given the scale, breadth and complexity of the provision of healthcare and believe these should be two days per week posts. I believe this would make them more attractive to a broader demographic and is an important way to further “professionalise” these important positions. This would also ensure each non-executive has capacity to focus on both general issues and increase their knowledge around specific areas.

21. As I suggest should be the case for Responsible Individuals, the annual governance statement of the Board should also make clear reference to the overall performance of the Board, against the agreed skills, competencies and knowledge matrix.

22. The White Paper mentions nothing about the roles of the Chair and Chief Executive. It is my view that overall accountability for ensuring high quality services and for failures in care sits with the Chief Executive and that this cannot be delegated. This should be reflected in duties prescribed in law, to include an annual report to HIW and the Chief Executive of the NHS in Wales, within a prescribed format, on the safety and quality of care provided, mirroring the approach taken in social care. This should include the overall effectiveness of public engagement and consultation and the extent to which the NHS body has a culture of continuous improvement and is learning from failures in care.

23. I believe the Chair should be a Responsible Individual for the quality of governance of the Board and should be required, given the scale of public money and the relationship between overall governance and the safety and quality of services, to produce an annual statement in relation to the overall governance and effectiveness of the Board’s discharging of its statutory duties. This should be subject to external review and verification. This could include the extent to which the core key principles for NHS bodies (p.13) have been complied with; however, I note that the majority of these are structural, rather than value-based. These would need further development to include value-based principles, such as co-production and the Nolan principles.

24. In addition, the White Paper makes little mention of sub-Board structures, yet this is important to ensure that the Board has robust data to inform its decision-making

processes. Given the consistency in core function of Health Boards, I hold the view that this should have a core standardisation, linking directly into the Registered Individual & assurance role of executive Board members. It is crucial that these sub-Board structures are resourced appropriately.

25. I agree with the proposal in the White Paper for Welsh Ministers to appoint additional Board members during times of poor performance and escalation, this should include the appointment of additional patient representation to give service users the strongest possible strategic voice. However, this should not negate the overall role that the Welsh Government may have to suspend the Board and put NHS bodies into special measures when necessary. The criteria and procedures for doing this should be clear and continue to be published in the public domain, as should updates on progress towards improvement.

26. The White Paper mentions nothing specifically about the Welsh Government's oversight of Health Boards' performance. I hold the view that the Chief Executive of the NHS in Wales should include specific reference to the safety and quality of healthcare services in their annual report, based on the annual reports that I propose Chief Executives of NHS bodies should submit. This should be submitted to the relevant Welsh Government Minister. Furthermore, it is my view that the Welsh Government should annually publish the performance criteria and quality targets that it has set NHS bodies and place regular performance updates in the public domain.

Board Secretary

27. The role of Board Secretary is an important one and I support the proposal in the White Paper to place it on a statutory footing. Their primary function should be to advise the Chair and wider Board on the efficient administration of the organisation, particularly in regard to ensuring compliance with statutory and regulatory requirements and ensuring decisions of the Board are implemented. I hold the view that the Board Secretary should report directly to the Chair of the Board.

28. The White Paper recognises this and also that the Board Secretary may become aware of issues or practices, which are so significantly outside of good governance or the Board's key duties and responsibilities, that they may need to be raised formally. I welcome the degree of protection suggested to be given to the Board Secretary to do this.

29. Despite this, I have concerns that the Board Secretary would, in reality, be unable to effectively independently challenge the decisions of the Chief Executive and the Board. The White Paper appears to make the Board Secretary role the ultimate 'watchdog'. Furthermore, this dilutes the responsibility placed on all Board members to raise issues of concern that they might have, either directly with the Chief Executive or the Chair.

30. The Board Secretary cannot be the ultimate assurance for everything. Their role is limited to governance and they cannot have oversight of issues such as the quality of care, patient safety, risk management or the strength of management controls. The ultimate assurance for full compliance across the breadth of governance, probity and quality of care must sit with the Chair and Chief Executive. I have put forward proposals to create Responsible Individuals as outlined in the previous section.

Chapter 2: Duties to Promote Cultural Change

31. I welcome the proposal to enhance the duty of quality and to explore options to further strengthen openness, transparency and candour but I do not believe they go far enough. The White Paper does not provide a definition of what “quality” is. I hold the view that there should be an agreed and consistent definition of “quality”, which is used by and applied to all NHS bodies in the assessment and delivery of care and support; the commissioning and contracting of services; and in the assessment of their performance.

32. In addition, the White Paper makes little reference to accountability, which must sit alongside transparency and candour. In particular, this opportunity should be used to strengthen the accountability of those in positions of authority, in particular executive Board members.

Duty of Quality for the Population of Wales

33. Recent legislation has been moving public services towards a more integrated model of strategic planning, prioritisation and, to a lesser extent, delivery, through both formal and informal action. This includes the creation of the Regional Partnership Boards and a range of requirements under the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015. The Social Services and Well-being (Wales) Act 2014 placed a range of duties upon local authorities that it seems sensible to mirror within healthcare in order to both promote and drive wellbeing outcomes for older people and develop a consistency across sectors, which appears to be one of the intentions of the White Paper. This includes the reciprocal duty to work in partnership and the strengthening of the existing planning duty referred to in the White Paper.

34. However, the proposals in the White Paper are limited in scope and there are other areas that I believe should be included to ensure consistency in approach. These include:

- Establishing equivalent Registered Individual roles within NHS bodies, as is now proposed for social care providers; I have expanded upon this in my response to Chapter 1
- Requiring NHS bodies and the regulator and inspectorates of health and nursing care to pay due regard to the United Nations Principles for Older Persons as social services departments are now required to do under the Social Services and Well-being (Wales) Act 2014. (Social Services and Well-being (Wales) Act 2014, s7.)
- Making explicit that Health Boards have a clear accountability for the quality of services commissioned from nursing homes and in the equitable delivery of preventative, enabling and primary care to people living in care homes

35. Whilst I support the alignment of duties across health and social care, these are not the only sectors that have a direct influence upon the quality of care provided. Housing, for example, also has a crucial role to play and future consideration should be given to aligning duties beyond just health and social care.

36. Whilst being able to access services is a vital aspect of their overall quality and is inherently linked to the integration of services, most people would understand quality to be far wider than just the strengthening of joint-working at a strategic level. There is nothing in the White Paper that directly addresses the other aspects of quality, for example, safety, effectiveness and the extent to which people are treated with dignity and respect.

37. The opportunity should not be missed to develop a standardised definition of operational quality that NHS bodies have a duty to deliver against. This would be a significant step forward in developing a consistent approach across Wales and should form the basis of both high-level reporting and information placed in the public domain, through annual statements and the annual report of the Chief Executive of the NHS in Wales. It must be clearly articulated both through the direct delivery of services and contacting and commissioning mechanisms.

Duty of Candour

38. I welcome the proposal in the White Paper to introduce a duty of candour across all health and social care bodies. This is a strengthening of the current general focus in respect to promoting openness in the management of complaints and when harm has been caused, both of which are inevitably after the event has occurred and too late to prevent poor care and its consequences. This builds on the approach taken within the Regulation and Inspection of Social Care (Wales) Act 2016 in respect of social care, which is currently being consulted upon.(Draft Regulated Services (Service Providers and Responsible Individuals) Regulations 2017, s12. http://bit.ly/2j9OGUS). This should be both proactive and reactive in nature.

39. Whilst this duty of candour is welcome, it is not sufficient in isolation. It is important that all staff providing health and social care services have the confidence, organisational support and ability to report their concerns when they identify issues that impact on the provision of care, particularly when they are under a legal duty of candour. This may require current whistle-blowing guidance to be updated.

40. Furthermore, to promote a preventative, rather than a reactive approach, I hold the view that all NHS staff in a managerial role should be under a code of practice. This would remove the disparity that currently exists between the accountability of clinical and non-clinical staff. This mirrors the approach adopted in relation to the social care sector.

41. Where there are significant breaches of the duties of candour, to act or comply with core principles, there must be effective sanctions, yet the White Paper makes no reference to this.

Chapter 3: Person-centred Health and Care

Setting and Meeting Common Standards

42. I strongly welcome the recognition in this chapter that people have the right to receive high quality care and support regardless of where they live. The disparity in care depending on where a person lives was a key issue I raised in my Care Home Review. Standards of care and support should not differ across healthcare sectors or

between healthcare providers. It should be equal and consistent wherever an individual resides. This applies not only to clinical care but also more general standards and knowledge that older people expect all healthcare providers to have. This should include core knowledge and skills to care for people living with dementia, an understanding of the needs of an older person receiving care and respecting their dignity and human rights. In effect, the healthcare standards for Wales must be applied across all aspects of the NHS, commissioned nursing care home placements, CHC care in the community and contracted services.
Older People's Commissioner for Wales (2014) A Place to Call Home? A Review into the Quality of Life and Care of Older People living in Care Homes in Wales, http://bit.ly/2w5dIcI

43. There is potential to look at specific aspects of the draft regulations under Section 27 of the Regulation and Inspection of Social Care (Wales) Act 2016 in respect of their applicability to the delivery of healthcare. There is also potential to apply to healthcare services the approach taken by the National Outcomes Framework for People who need Care and Support and Carers who Need Support. This would provide a very clear set of person-centred and individualised outcomes that could be used to make explicit what users of healthcare services can expect to receive and uphold their rights to participate and for their views to be heard and actively considered in all decision-making.
Draft Regulated Services (Service Providers and Responsible Individuals) Regulations 2017, Part 7, http://bit.ly/2j9OGUS
Welsh Government (2016) National outcomes framework for people who need care and support and carers who need support, http://gov.wales/docs/dhss/publications/160610frameworken.pdf

44. Care must be taken to prevent these 'high-level' standards from becoming beyond measurement and therefore scrutiny. The White Paper does not cover how these common principles would be made a reality for people receiving services.

45. Whilst independent advocacy is referenced, the White Paper makes no further proposals on how this could be delivered, despite this being detailed in relation to a range of circumstances in the Social Services and Well-being (Wales) Act 2014 (Social Services and Well-being (Wales) Act 2014, s181-183). It is my view that duties should be placed upon healthcare providers similar to those under the Social Services and Well-being (Wales) Act 2014 to promote independent advocacy and further promote consistency of approach across sectors.

Joint Inspection of Health and Social Care Complaints
46. I support the White Paper's proposal to require organisations to work together to investigate and resolve complaints which cover both health and social care.

47. When older people and their families contact my casework team, they describe the challenges they face in resolving issues and making complaints about both health and social care services. Frequently, issues arise when transitioning between services, such as when being discharged from hospital. When things do go wrong, there is often insufficient clarity around who is responsible and who older people should complain to, especially for self-funders in care homes.

48. The White Paper needs to address the lack of clarity that exists about how safeguarding processes and complaints interact and how to ensure people (including family members) have the knowledge and support necessary to understand the role of respective organisations and navigate their way through the systems that are in place.

49. Older people must be supported and provided with information that both explains complaints procedures and provides regular updates and assurances that their concerns are being dealt with effectively and with sensitivity. This should include an active offer of independent advocacy support to assist the individual in raising their concerns and ensuring these are appropriately responded to.

50. Evidence suggests that public bodies in Wales are not good enough at learning from their mistakes and there is no structured approach within Wales to share learning and avoid these mistakes being made again in the future. This applies to both common issues that can arise on a regular basis and more serious issues, such as those from Adult Practice Reviews. The sharing of this learning across sectors should be made a duty in legislation to make clear its vital importance.
Public Services Ombudsman for Wales (2017) Ending Groundhog Day: Lessons from Poor Complaint Handling, http://bit.ly/2nUY4dx

51. I am aware of work underway to amend the Social Services Complaints Procedure (Wales) Regulations 2014 and associated Code of Practice. This must be taken into account if health and social care organisations, as well as independent providers of health and social care, are to be brought together under a joint complaints process.

Chapter 4: Effective Citizen Voice, Co-production and Clear Inspection
52. I welcome the intent of the White Paper to strengthen the voice of individuals through the proposed creation of a citizen voice body. Service users have valuable personal experience and are often highly knowledgeable about the current quality of care and what needs to change, both locally and strategically, across health and social care. I have consistently been clear that the more public services listen to older people, the more effective they will be at both delivering a high quality service and delivering the outcomes that they aspire to and older people expect. I recognise that this principle has been woven through many of the changes taking place in social care and I welcome it as a principle to be extended into healthcare.

53. However, this section of the White Paper appears to misunderstand the nature of co-production and the difference between co-production and participation. Co-production goes far beyond the “continuous involvement and engagement with the public on how decisions are reached” (p.27). True co-production would see citizens and professionals sharing power to plan and deliver service changes together, recognising that both have vital contributions to make. This must be embraced if services are to be co-produced as is intended.

54. Furthermore, I hold the view that NHS bodies should be under a duty to pay due regard to what they hear and provide a clear explanation when they do not agree with the views of the public.

55. This must be an inclusive process that takes account of people at most risk of marginalisation, such as people living with dementia, carers and people with learning disabilities. Effective equality impact assessments should identify those groups that Health Boards need to engage and consult with. The opportunity should be taken to further strengthen the approach to impact assessment within Wales, through regulations and codes of practice. My Guidance to Local Authorities on Equality and Human Rights Impact Assessments highlights the need to take a rights-based approach to assessments, to ensure that older people are not disproportionately affected by any changes to service provision, and to consider the needs and circumstances of older people as early as possible. This approach should be adopted by all those responsible for delivering services for older people across Wales.
(Older People's Commissioner for Wales (2016) Equality & Human Rights Impact Assessments: Guidance for Local Authorities, http://www.olderpeoplewales.com/Libraries/Uploads/EHRIA_Guidance_-_Web2.sflb.ashx

Representing the Citizen in Health and Social Care
56. I welcome the intent of the White Paper to further strengthen the voice of citizens in how health and social care is planned and delivered. It is right that there should be a statutory body for citizen engagement in social care, as exists in healthcare.

57. I support the White Paper's proposal to create a new national citizen voice body that would represent the interests of the public across health and social care. This must be an independent body and I hold the view that this should be a national body that is able to operate, where necessary on an integrated basis, at both a strategic and local level. The Chair of the body should be appointed on a cross-party basis. The body must be sufficiently resourced in order to ensure that its vital duties are carried out effectively.

58. The White Paper proposes that this new body focuses on the provision of a complaints advocacy service, as undertaken by the current Community Health Councils. I welcome that the new body would continue to host the NHS Complaints Advocacy Service and hold the view that this should be extended to also cover complaints about social care services. Further work will be required to ensure that the Complaints Advocacy Service is fully promoted and linked with other services such as Information, Advice and Assistance Services required under the Social Services and Well-being (Wales) Act 2014 (Social Services and Well-being (Wales) Act 2014, s17.) to ensure that the public are made aware of the service.

59. The new citizen voice body must have a strong and effective network across Wales, through which it can source intelligence about people's day-to-day experiences and access local people's views about local and strategic changes being proposed.

60. Local views and complaints are a rich source of information, about both good and poor care. The new citizen voice body should have a role to periodically advise NHS bodies on important issues being raised and when these are in relation to poor

care, the body must be under a duty to formally respond, with a copy of all responses submitted to HIW and placed in the public domain.

61. This should continue to include visits to services to hear from service users about their experiences of non-clinical care. I do not support the view that such an approach is a duplication of the work of regulators and inspectors as their focus will be different from that of these statutory bodies and can be much more responsive and flexible to local issues and concerns, enabling them to act as an 'early warning system' to Health Boards, inspectorates and the Welsh Government. Clear memorandums of understanding should be in place between these organisations and care must be taken to ensure an appropriate balance between the independence of the citizen voice body and the benefit to regulators and inspectors.

62. This would still enable the citizen voice body to support health and social care organisations in improving the way they engage individually and jointly with their communities on health and social care service matters, and have an important role in monitoring and evaluating the way in which health and social care organisations involve local people. However, if their role was limited only to this, it would be insufficient; independent assessment of service provision must remain part of its remit.

63. My Care Home Review clearly highlighted the benefits of using lay inspections, which far outweigh the cost of poor care to the individual and the system. I called for lay assessors to be used on as a formal and significant part of the inspection process to help ensure that opportunities to make small changes that can make a significant difference to individuals' quality of life and care are not missed and to help ensure that safeguarding issues are identified at an early stage.
Older People's Commissioner for Wales (2014) A Place to Call Home? A Review into the Quality of Life and Care of Older People living in Care Homes in Wales, p.96 & p. 119, http://bit.ly/2w5dIcI

64. I would suggest that the Welsh Government considers the progress and insights gained by the Scottish Care Inspection and Improvement Agency in their use of volunteer assessors. Evidence demonstrates that their input has helped the inspectorate to better understand the concerns of service users and provide useful intelligence that has been able to drive further improvements in care homes for older people. A recent pilot carried out with people living with dementia has been particularly enlightening for both the inspectorate and care home providers, identifying small changes, which have had a significant impact on residents' lives.
Care Inspectorate (2016) Themes emerging from the Dementia Inspection Focus Areas, http://bit.ly/2wnUD3E

65. Lay assessors will often be better placed to build trust with residents and listen to their concerns and could be useful to amplify the voices of older people. It is vital that we do not miss this opportunity to openly reflect on the added value of lay assessors particularly in their ability to relate, understand and listen to the experiences of people receiving care and support.

Co-producing Plans and Services with Citizens

66. Over the past decade, there have been many substantive changes to how health and social care are provided across Wales. It is clear that service changes are often poorly communicated and older people are often engaged with ineffectively, leading to a position where the rationale for service changes are not always understood by service users and as a result, health and social care services may find themselves making decisions that do not have the support of their local population. Therefore, more effective mechanisms to engage and consult with older people must be developed to ensure that they are both consulted about service changes and able to access the new services that are provided.

67. I welcome the proposal in the White Paper for the citizen voice body to have a greater role in advising health and social care services on how to effectively engage and consult. This should reduce the variation in practice across Wales and ensure that best practice becomes standard practice.

68. However, genuine co-production is much more than just engagement and consultation. It is about sharing power when it comes to decision-making and enabling people to influence the decisions made.

69. Whilst it is right that the White Paper focuses on regional and strategic working, this must not lead to the exclusion of local service issues. With a growing understanding of the importance of 'place' within people's overall health and wellbeing, ensuring a local voice for local issues is equally important.

70. The White Paper makes reference to the importance of using digital methods of engagement, such as social media, to improve its effectiveness and ensuring it becomes more inclusive and representative. However, this also brings risks of excluding those that are not able to engage digitally and exacerbating inequality between groups that runs contrary to the Equality Act 2010 and the ethos that sits behind the public sector equality duty in Wales.

71. It is my view that the new citizen voice body must continue to have a role in scrutinising proposals for change and where necessary, challenging these. It appears that this function would cease under the White Paper's proposals. This should not include the continuation of the current requirement placed upon Community Health Councils to produce alternative plans, which is a disproportionate requirement.

72. It is my view that the independent clinical panel, that forms part of the proposed service change decision matrix (p. 34) should include lay members as is already the case with bodies such as the General Medical Council and Nursing and Midwifery Council.

73. The revised decision matrix does not make it clear what is meant by 'substantial'. What may seem like a small issue can have huge consequences for individuals. It also feels as though the main decision-making criteria sit with professionals. This is not to take away from their important role but this does not feel like a co-produced relationship of equals.

74. Whilst accepting that the strongest possible focus should be on local resolution, the Welsh Government must retain a role in respect of dispute resolution and assurance in respect of overall Board governance and quality.

Inspection and Regulation

75. It is my view that the merger of CSSIW and HIW is not right at this time given the significant changes currently underway, both through the requirements placed on CSSIW under the Regulation and Inspection of Social Care (Wales) Act 2016 and more generally the challenges to the sector as a whole. However, whilst a merger at this point would distract from delivery, I do welcome the White Paper's proposal to strengthen joint working of the inspectorates.

76. I support the proposal to overhaul HIW's underpinning legislation to ensure it has a clear, single, legislative framework to work to, as CSSIW now does following the Regulation and Inspection of Social Care (Wales) Act 2016. This must focus on outcomes for citizens and enable the inspectorate to hold public service providers, both directly commissioned and contracted, to account. This should include a requirement of what must be placed in the public domain as part of the wider promotion of openness, transparency and public assurance. An alignment of healthcare and social care standards would further support this.

77. I do not support the proposal to create a new Welsh Government Sponsored Body to encompass both inspectorates, as well as the national citizen's voice body. This would disrupt their current operational work, as well as seriously compromise the independence of the proposed new body for citizen engagement, undermining the public's confidence of the body's scrutiny of the inspectorates.

78. However, in the longer term, I would advocate for an integrated inspectorate for health and social care, and a degree of standardisation would be a precursor to this. I hold the view that this should be a fully independent body, with its Chair appointed on a cross-party basis. This would provide an opportunity to look at the integration of the citizen voice body.

79. In the interim, as I outlined in my Care Home Review, I hold the view that annual integrated reports should be published between inspectorates that provide an opinion on the quality of life and care of older people in care homes and an annual report on the quality of clinical care of older people living in care homes should be published in line with fundamentals of care. The move towards common standards provides the foundation for this to take place.
Older People's Commissioner for Wales (2014) A Place to Call Home? A Review into the Quality of Life and Care of Older People living in Care Homes in Wales, p.120, http://bit.ly/2w5dIcI

WGWPMB185: Chief Pharmacists Wales
Location: Llanelli

Response to Specific Questions

Board Membership and Composition
The Chief Pharmacists of Wales would like to draw attention to Recommendation R3 of the WAO Report Managing Medicines in primary and secondary care (December 2016) in view of the significant resource implications of medicines and the opportunities presented by the expanding role of pharmacy teams embedded within multi-disciplinary healthcare teams to deliver services to the people of Wales.

Reference
https://www.wao.gov.uk/system/files/publications/Medicines-management-2016-english.pdf

R3 Prescribing and medicines management need a higher profile within health bodies. The Trusted to Care report has raised the profile of certain issues but there is a risk that this focus will not be sustained. Pharmacy is not well represented at Board committees and not all Chief Pharmacists report directly and regularly to an executive director.

a. Health bodies should ensure their Chief Pharmacist is, or reports directly to, an executive director.

b. Health bodies should have an annual agenda item at the Board to discuss an annual report covering pharmacy services, medicines management, primary care prescribing, homecare medicines services and progress in addressing the issues identified in Trusted to Care.

WGWPMB186: Health and Safety Executive
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
What further issues would you want us to take into account in firming up these proposals?
How will employee voice be represented on these Boards?
Strong leadership in the form of a Board member with specific responsibility for health and safety can be effective in improving performance in a key business risk area. Although you would also need to consider how to ensure their competence and what skills/experience would they need to fulfil this role.

Board Secretary
Do you agree with these proposals?
Yes.

What further issues would you want us to take into account in firming up these proposals?
Whether or not the Board Secretary could have accountability for health and safety.

Duty of Candour
Do you support this proposal?
Yes – this duty already exists in the NHS in Scotland and England and it is sensible to ensure parity with other parts of the UK.

What further issues would you want us to take into account in firming up this proposal?
There should be consistency between the proposals for health care and the requirements for social care staff already laid out in the Regulation and Inspection of Social Care Act (RISCA) 2016.

In order to complement the Duty of Candour, you should also consider a whistle-blowing policy to encourage staff to actively speak out without fear of reprisal in order to highlight poor practices and improve standards. This would need to be supported with appropriate policies/procedures to ensure that the staff member raising concerns is protected.

Setting and Meeting Common Standards
Do you support this proposal?
Yes – this is an area highlighted by HSE in our response to the Green Paper. Namely that there is inconsistency currently between standards which are mandatory for independent healthcare providers but not for NHS providers. The standards should be the same for both to ensure equivalent standards for service users and improve clarity for providers.

What further issues would you want us to take into account in firming up this proposal?
Develop a common set of standards and ensure they are applied equally to both health and social care providers, whether private or publicly owned.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?

Yes - Individual organisations with overlapping responsibilities working together to resolve issues can only be a good thing. Although there must be clear demarcation between them and they must have aligned procedures to work together effectively.

What further issues would you want us to take into account in firming up this proposal?
The White Paper refers to CSSIW having an overview of complaints, but cannot investigate them. Although the policy rationale is not explained. If CSSIW were able to investigate complaints it would provide an independent follow up of service users' concerns if they are unhappy with the action taken by the provider. If the volume is too high, perhaps a triage process could be applied so that only the most serious concerns are followed up. HSE follows up complaints in this way and we also deal with concerns about patient and employee safety in health and social care. Complaints are often useful intelligence for how well an employer is managing health and safety and may lead to enforcement if serious breaches are identified. Poor management of one area may indicate failings in another.

Alternatively, a separate body could be created to investigate complaints and/or incidents, (or the remit given to the proposed new citizen voice body) with information relating to the most serious being passed to HIW or CSSIW where remedial action may be needed or where there are wider learnings. This body would need to have adequate powers to be able to investigate and require improvements to be made.

This section of the paper also makes no mention of HIW's role in following up complaints in healthcare. We understand they too have a policy of not investigating complaints. Because CSSIW and HIW do not follow up complaints, service users often contact HSE as the regulator of last resort, even when the issues fall outside of our policy - for example, matters relating to the quality of care or because they do not meet our criteria for investigation. This can be frustrating and time-consuming for the complainant. This means there is a gap in the systems to ensure complaints are effectively handled.

Referring complainants to the Public Services Ombudsman if they are not happy with the provider's internal investigation is not ideal as the Ombudsman does not investigate all complaints received, taking on only the most serious. This means that service users may not have an effective avenue for resolving their complaints.

Representing the Citizen in Health and Social Care

Can you see any practical difficulties with these suggestions?
It is not clear what the powers and responsibilities of the new national citizen voice will be and how it will 'sit alongside' HIW and CSSIW.

Inspection and Regulation and single body

What do you think of this proposal?
We agree that a clearer underpinning legislative framework for HIW will assist: it will provide greater clarity on what HIW can and cannot do and provide them with greater powers to take action swiftly where failings are identified. Secondly it should facilitate better working with CSSIW as it will help identify who is responsible for what and which organisation can take action most effectively.

As we have previously identified there is a regulatory gap in respect of certain public safety matters that HSE will not investigate and where HIW and CSSIW have no powers to investigate or take action. This can mean that health and social care providers may escape being held to account even where they have deliberately flouted regulatory requirements or care standards with possibly serious consequences for the patient/service user.

This would also help to align the powers of CSSIW and HIW so that equivalent regulatory action is taken across health and social care to ensure a consistent approach.

Are there any specific issues you would want us to take into account in developing these proposals further?
One way of achieving a consistent approach in the regulation of both health and social care would be having a single regulatory body which would make all of the above more straightforward and provide a 'one stop shop' for the public.

WGWPMB187: Action against Medical Accidents (AvMA)
Location: Croydon

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes, it is important that the size and structure of Boards ensure they achieve the stated aims of being "dynamic" and "agile".

Independent/public members need to have the power and resources to be effective and where necessary to be able to challenge executive members. Training and support needs to be provided. The Boards may need to change how they work to ensure effective participation of public members.

Boards should have clearly defined structures and processes for addressing patient safety and improvement in respect of all the services it provides, including primary health care and care for people with a mental illness. A named member of the Board should have specific responsibility for patient safety and learning with a brief that requires that person to make sure the Board considers the substance of complaints and claims made against Board organisations not just headline figures such as turnaround time for complaints or the overall value of claims made.

Board Secretary
What further issues would you want us to take into account in firming up these proposals?
It is important that Board Secretary has statutory protection to ensure independence.

More generally the Welsh Government should ensure there are sufficient measures in place to protect staff who have brought concerns to the attention of the Board or Board organisations.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
The duty of quality needs to be defined so that it is clear there is an overriding principle of safe care.

What further issues would you want us to take into account in firming up these proposals?
The distribution of the population in West and North Wales and in rural areas, means that the Welsh Government faces difficult problems delivering high quality care across Wales geographically as well structurally. To meet these challenges consideration should be given to accessing care across the border in England if necessary.

Duty of Candour

Do you support this proposal?
Yes

AvMA has argued that a statutory Duty of Candour is needed in Wales as much as other parts of the UK. Despite the fact that in 2011 there was a step forward in promoting openness with patients when things go wrong with the introduction of the "Putting Things Right" regulations, we have argued this is far from sufficient as they

do not require a member of staff to make a notification as the regulations deal with concerns and complaints if made

do not require responsible bodies to promote openness

do not give a sufficiently high profile to being open

The Duty of Candour needs to:

be high profile and have the status of other essential healthcare standards

be clearly recognisable as a Duty of Candour

apply to all NHS providers (including GPs and dentists for example) and the private sector

provide the regulator/s, currently HIW and CSSIW, with the statutory power, backed by sanctions, to hold organisations to account if they do not comply. The regulator/s must ensure that the Duty of Candour is given the standing that is required and that effective action is being taken to ensure the Duty of Candour is working in practise.

require the notification to a patient or next of kin of any incident which causes, or may have caused, significant harm (in England significant harm triggering the duty of candour is equivalent to 'moderate harm' or worse in NHS definitions). To make the duty effective it is essential that the duty covers the situation where injury may have been caused as well as incidents where it is clear injury has been caused.

be accompanied by guidance which makes it clear that to comply with the duty the organisation needs to be able to demonstrate that it makes its staff aware of the duty, provides training and support in complying with the duty, and deals with breaches of the duty by individual staff members by taking disciplinary action and/or referring to professional regulators where appropriate

be backed up with a programme of awareness raising and training and that this programme should be put in place ahead of the duty being implemented.

It would seem to us that inclusion of a Duty of Candour might most appropriately be incorporated in the Healthcare Standards for Wales.

Whilst on the whole the introduction of the Duty of Candour has been a success and a major step forward, we are keen that the Welsh Duty of Candour avoids some of the mistakes which we believe have been made in England which include:-

The confusion created by defining the duty differently for secondary care as opposed to primary and private care. (Further consultation has been promised to create a single standard duty across all providers in England.)

It should not be overly bureaucratic or seek to mandate “apologies” (the English regulations require the provider to issue a letter including an ‘apology’ and this letter of apology must be sent at a very early stage which in practise often means the provider has not had the opportunity to investigate properly. We do not think that genuine apologies can be mandated – they need to be sincere and informed.)

What further issues would you want us to take into account in firming up this proposal?

AvMA remains committed to supporting the development of a statutory Duty of Candour in Wales in any way we can.

Consideration should be given as to whether the duty should be framed in such a way that a patient can enforce the duty directly if there is a breach.

Setting and Meeting Common Standards

Do you support this proposal?

Health care standards should apply equally across the public and independent sectors – of particular concern are home-based and nursing home care, also mental health primary care. Standards should be revolve around outcomes, and refer to processes, outputs and governance only where needed.

Obviously quality in practice not only requires the right legal framework but also requires embedding cultural change at a grassroots level and leadership.

The standards need to be accompanied by a strong system of monitoring and inspection.

What further issues would you want us to take into account in firming up this proposal?

We would repeat the point that it is essential to ensure that ways are found to ensure standards are maintained across the service geographically as well across different organisations and providers.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Yes, unequivocally. Our experience of joint investigations in England is, however, that health and social care organisations do not always operate the provision completely or with confidence – or sometimes at all. Introducing these arrangements must be accompanied by a vigorous development programme and feedback from people with cause to complain, and their advocates.

CHCs would provide an important source of support to patients and service users in using a joint process, helping resolve any difficulties and providing feedback as to how it is working.

Learning and improvement should, of course, be core to how the complaints process works in practise.

Representing the Citizen in Health and Social Care

Do you support this proposal?

No, not as set out in the consultation. AvMA accepts that changes need to be introduced to ensure CHC members better represent their local communities. We accept that some CHCs, not all, need to do more to make themselves known and available to local people. However, we believe that de-coupling CHCs' advocacy and complaints work from the wider representation and visiting work would be a serious mistake. It would repeat the serial errors of the NHS in England, where the value of combining information about services from different community based sources was badly underestimated. When it dispersed CHC work, this powerful tool was lost forever.

Can you see any practical difficulties with these suggestions?

AvMA believes that advice and advocacy through CHCs is extremely important. It is essential that patients and their families have skilled support when they need to make a complaint or raise a concern.

Equally important is that this is linked to policy work initiated and undertaken at a local level. We believe that the proposals set out in the White paper will splinter the policy work from local concerns and knowledge and will make the citizens voice less, not more, effective.

Concerns raised by the public either directly and through the CHCs are an early warning system when things are going wrong. It is essential that CHCs not only deal with individual concerns but link this with policy work so that broader issues are identified and addressed.

If patients are to be properly supported and if the redress scheme in Wales is to fulfil its considerable potential, CHC advocacy services must be given greater profile.

We do not believe that other CHC functions should be curtailed in the ways suggested. The CHC visiting programme has increased in value with recent work to establish a standards-based approach to visits. It does not replicate HIW visits. CHC visits mean that well-trained and equipped members, with sound local knowledge

- visit services frequently and regularly
- look at a service in depth or examine an issue (eg Bugwatch, EDwatch)
- speak to staff, patients and relatives on site
- feedback information to senior managers immediately if needed and very soon after the visit as a matter of routine
- collate and examine information about services across an organisation, together with information from other sources eg membership of quality and

audit committees, meetings with members of the public, the complaints and advocacy service; and discuss the outcome with NHS managers.

Staff will often raise concerns with CHC members when they might be less willing to do that with their own managers or HIW inspectors.

Taken all together, the visiting programme means that CHCs should be the eyes and ears of HIW between its infrequent visits.

NHS organisations should be required to respond in full, and quickly, to CHC inspection reports.

CHCs are already finding ways to review social care services and to follow the connection between them for patients, their carers and families. This is managed by consent. It should be added to CHCs' statutory responsibilities to mirror the other changes in the White paper.

AvMA does not think that a body based on the Scottish Health Council that subsumes some or all of the current CHC responsibilities is an effective way to ensure the citizen's voice is heard.

Inspection and Regulation and single body

What do you think of this proposal?

The two inspectorates should merge

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. What issues should we take into account if this idea were to be developed further?

AvMA does not think that a body based on the Scottish Health Council is an effective way to ensure the citizen's voice is heard. See 4.1 above.

WGWPMB188: Healthcare Inspectorate Wales
Location: Merthyr Tydfil

General Comments

HIW welcomes the proposals set out in the White Paper. They begin to address issues that are important to underpinning safe and effective services for patients and are fundamental to enabling health services to operate in a joined-up way with other public services.

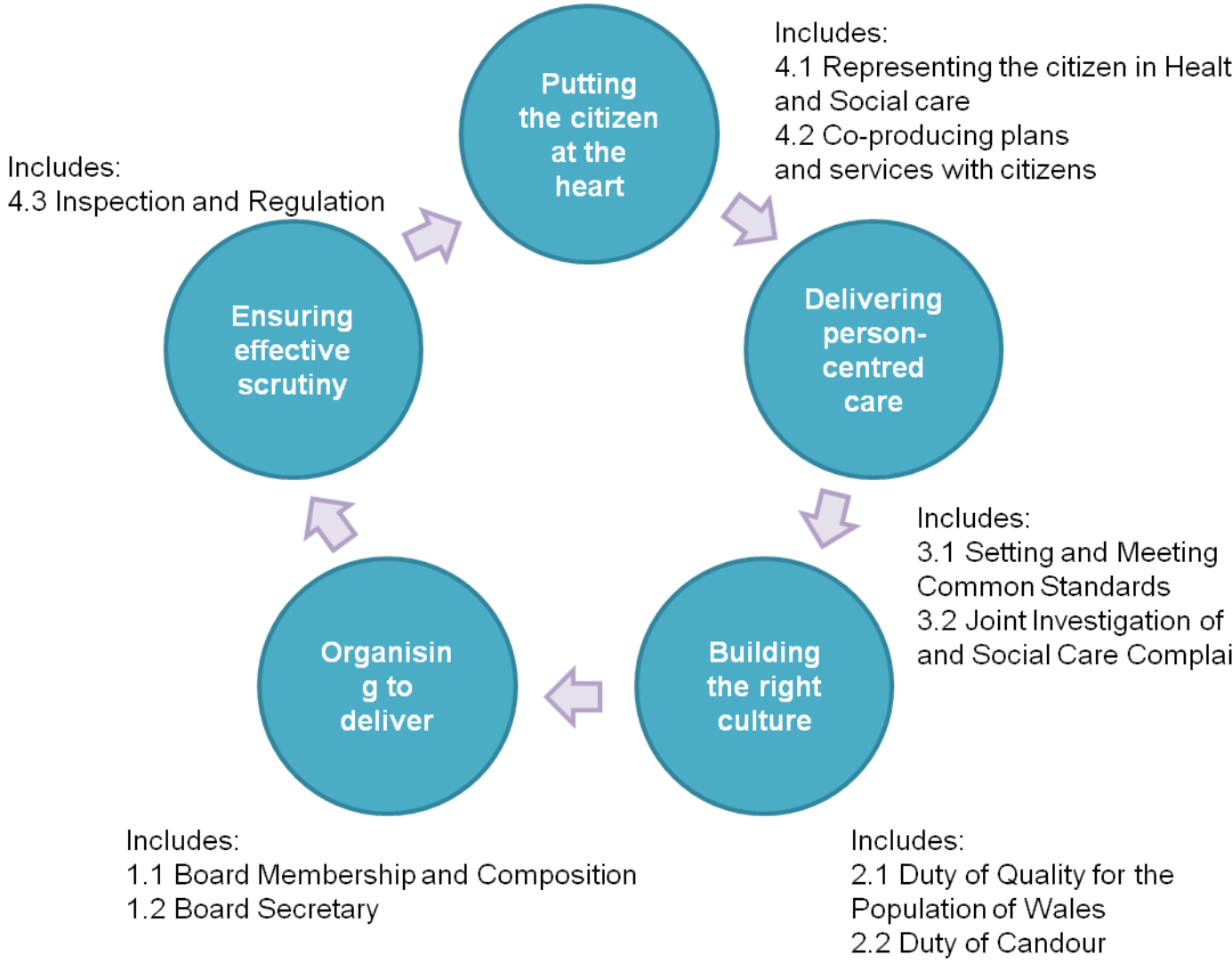
In broad terms we welcome the focus on the need to ensure alignment between sectors. This includes alignment between the independent health sector and the NHS, and also alignment between standards and expectations in health and social care. However, it is important to recognise that services will frequently highlight that financial rules can be a key barrier to the delivery of more effective and joined-up services and we note that financial issues are not addressed in this consultation.

It will be important to be able to articulate how any subsequent legislation will operate alongside and align with other strategies and legislation to ensure that public services in Wales are able to seamlessly support the needs of the people of Wales in a person-centred way.

Consideration needs to be given in particular to:

- Wellbeing of Future Generations (Wales) Act 2015
- Social Services and Wellbeing (Wales) Act 2014
- Public Health (Wales) Act 2017
- Regulation and Inspection of Social Care (Wales) Act 2016
- Local Government Reform (Reforming Local Government: Resilient and Renewed - White Paper)
- Taking Wales Forward 2016-2021 (Welsh Government's four cross cutting strategies)

At one level it could appear that the consultation simply addresses a number of building blocks for high quality care. However, it is clear that taken together the proposals in the White Paper present a coherent narrative for how parts of the system need to change in order to achieve the goal of sustainable person-centred care, supporting the principles of Prudent Healthcare. Specifically:



This narrative is consistent with the Welsh NHS principles. This makes it clear that the proposals in the White paper are part of an interdependent package of measures and we have therefore responded to the proposals on that basis.

Response to Specific Questions

Representing the Citizen in Health and Social Care
HIW supports this proposal.

New national body
HIW welcomes the proposal for a national dedicated citizen voice body. We welcome the opportunity to engage and work alongside an organisation that can work with us, and we can see great benefit in aligning our operations to bring inspection and citizen voice closer together. We discuss this further towards the end of our response.

We consider it is essential that the new body is governed as a national organisation so that it can consider the regional and national needs of the people of Wales and is able to support the proposals under the 'Duty of Quality', which require Health

Boards to work in the best interests of the population of Wales across organisational boundaries. We would observe that the CHC model can present challenges to this way of working due to their primarily local focus. It is our experience that the CHC approach of local autonomy, co-ordinated centrally, has failed to deliver the consistent good practice and effective delivery that were envisaged when the CHC regulations were recently reviewed. In practice we find that the CHCs remain 7 distinct local organisations, of variable effectiveness, with limited national perspective and presence. In our experience, this means that whilst there may be agility to respond to local issues, this is less evident on a national or regional level. However, it is important that in moving to a new body we do not lose the advantages of the local presence offered by CHCs. In those areas where CHCs are working well we have found it extremely useful to receive their local intelligence to inform our planning. We note the White Paper refers to the national body having "autonomy to decide how it will operate at a local level". It is essential this autonomy is characterised as local presence within a national model, with clear lines of accountability and a strong governance framework.

There are examples of bodies operating in other industries which successfully marry a national organisation with regional and local presence. One such example is the Consumer Council for Water, whose role is to provide advice and information; take up complaints; and carry out research on a wide range of water issues relevant to consumers and publish their findings. There would be value of looking outside of the health sector to consider good practice from other public facing industries when considering the functions of the new body.

The views presented by the new citizen voice body should be truly representative of the citizens of Wales. We welcome the fact that the new national body would be expected to work closely with local community organisations, user groups and others to promote the co-design and co-creation of services. This will ensure there is engagement with the wider Welsh public, including harder to reach groups, children and young people We can also see how this will work alongside the duty for local authorities to promote the availability of social enterprises, cooperatives, user-led services and the third sector under the Social Services and Wellbeing (Wales) Act 2014. In addition to the requirement to engage closely with local community organisations, there will need to be careful consideration given to the membership of the new organisation, with a concerted effort to ensure it attracts as diverse a membership as possible.

<u>Removal of duplicatory functions</u>
We wholeheartedly support the removal of duplicative activities from the functions of the new citizen voice body. This will aid clarity of purpose, and will enable the citizen voice body to focus on its primary task of ensuring that people have a voice in their care at an individual, community and national level. The current practice of some CHCs undertaking many hundreds of local visits can risk providing false assurance on the quality and safety of services, given that CHCs are only equipped to look at the dimension of patient experience. More worryingly there have been occasions on which CHC visits have strayed in to clinical issues which are outside their competence.

Extension of citizen voice body to social care

We support the proposal to extend the role of the new citizen voice body to cover both health and social care. This is consistent with the direction of travel towards integrated services and would simplify the landscape for the citizen. It is not clear how this would sit with regard to the lack of prescription around citizen engagement in relation to implementation of the Social Services and Well-being (Wales) Act 2014 and associated regulations.

We further support the proposal that the current independent advocacy service provided by CHCs should be extended to cover social care. Such a move would enable the citizen to be supported with taking forward concerns about all aspects of their care, and reinforces the message that care should be person-centred and seamless with no arbitrary sectoral boundaries. As noted in the consultation it also supports the proposal for joint investigation of complaints.

Consideration needs to be given to the advocacy and support provision for children who receive health and social care. At present, under the Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010, CHCs are only obliged to provide independent complaints advocacy for persons aged 18 years of age and older.

Joint working with Inspectorates

A core value for HIW is to place patients at the heart of what we do. HIW has therefore sought to work as closely as we can with the CHCs. We have an operating protocol with the current Board of CHCs, which sets out the basis on which we work together. At times, this has worked well. For example, HIW identified issues on an inspection in Cardiff & Vale UHB which related to patient experience which were followed up by CHCs. The relationships between individual HIW Relationship Managers and local CHC Chief Officers in sharing intelligence has also generally been constructive. In addition, we invite a representative from the CHCs to sit on our various Stakeholder Reference Groups, for example relating to our work in primary care. This invitation has, on occasion, been accepted and has worked well. We have, however, experienced difficulties in trying to engage with the CHCs across Wales on a consistent basis, for example in respect of undertaking our GP inspections alongside members of the local CHC.

As noted above, we welcome the proposal that the new citizen voice body should work with local community organisations. There are exciting opportunities for such work to feed into and enhance HIW's activity. The White Paper talks about embedding patient voice "more systematically within the work of the inspectorates". HIW is currently considering how best to include patient voices and participation in our work as part of our new three year strategy. There could be a very useful role for the new citizen voice body in gathering patient views to feed into our risk based inspections and in to our thematic work.

Under paragraph 86, one of the proposed functions of the new citizen voice body is to "monitor and evaluate the way in which health and social care organisations involve local people, probably in accordance with agreed standards". Further detail will be required about these "agreed standards" such as who develops the standards, how monitoring will take place, and what would be the status of such

standards (and the consequence of not meeting them). It will be important that citizens themselves are able to play a part in developing these standards.

Public engagement
Establishment of a strong national identity for the new body would be valuable as we could raise awareness of our complementary roles to aid public understanding of the system as a whole, and how we can support them. It is disappointing that we have been unable to achieve this with the existing CHCs and is clearly not in the best interests of patients given the CHC's limited visibility to the public.

A closer relationship between HIW and the new citizen voice body would also make things easier when a member of the public wants to tell us that something has gone wrong in the care they receive. Currently when a member of the public contacts HIW's concerns team with a personal complaint our team will advise that complaints should first be directed to the Health Board and send contact details of the local CHC, suggesting the individual should contact the CHC if they require support. If the national citizen voice organisation were more closely aligned with HIW, perhaps with a single point of access, it would simplify matters for the public and aid them in receiving assistance. This could be particularly useful for children and young people (and their families) and those with additional needs.

Co-producing Plans and Services with Citizens
The Welsh Government is proposing to introduce an independent mechanism to provide clinical advice on substantial service change decisions, with advice from the proposed new citizen voice body. It suggests that this will encourage continuous engagement and increase the pace of strategic change through enabling a more evidence-based transparent process and a more directive and guiding role on the part of the Welsh Government.

HIW supports this proposal, although it will be important to define when a change would be deemed as "substantial".

We note that proposals for service change "must be based on strong clinical evidence", and that if health boards cannot reach a decision they may refer the matter to an independent clinical panel. HIW can see the benefit in such a group being established as this would aid the public in understanding the system as a whole. It would also help the public to understand the rationale for why certain decisions are taken.

However, some important questions remain: as there is no one recognised group which provides the definitive clinical evidence in Wales, Who appoints to the panel? How does the panel relate to other advisory mechanisms around NHS Wales? There are already a large number of organisations, panels and committees engaged in providing advice, assurance, and supporting improvement relating to NHS Wales. What if the advice of the proposed independent panel differs from other published advice? It would be helpful to have some clarity over the landscape and where this new advisory panel would sit in relation.

The proposal for the national citizen voice body to provide advice on the level of engagement relating to service change is supported. A single national voice will ensure local, regional and national needs are taken into account, in the best interests of the people of Wales.

Setting and Meeting Common Standards
HIW supports this proposal.
There should be no arbitrary sectoral boundaries as to the level or standard of care a citizen should expect to receive. Although health was not covered in depth in what became the Social Services and Well-being (Wales) Act and the subsequent Regulation and Inspection of Social Care Act, social care is moving on at pace with standards and regulations in this area. Regulation for health services now needs to be aligned.

The challenge of the current system of different standards for different settings was evident in our inspections of NHS residential settings for people with a learning disability in 2016. Some health boards provide NHS residential accommodation for people with learning disabilities. These settings are, for all intents and purposes, people's homes. However, as these are NHS settings, staffed by NHS staff, they are subject to the Health and Care Standards, which are the same standards expected of hospitals. Very similar settings are regulated and inspected by CSSIW using a framework and standards which assess the settings as people's homes. Why should individuals living in NHS residential settings expect a different standard to individuals living in a setting commissioned or operated by a local authority?

It is essential that any new standards join up throughout the system with consistent wording to ensure the intention of the standard reaches the care actually being provided to the individual. This could mean that the need to join up standards could apply in a wider realm than health and social care, and could extend, for example to housing and other public services.

Consistent wording will not only be clearer for those delivering the care, but it will also help the public know what standard of care they can expect to receive. Prudent healthcare assumes that patients will be able to be partners in their own care and clarity on standards and expectations will help with this. For example, the same guidance to professionals on reducing the likelihood of falls should apply with the same standards to all relevant settings regardless of sector. Likewise, an individual should expect the same standard of nutrition and hydration whether they are in hospital, in a care home or receiving care in their own home, and whether that care is provided by the NHS, social care or an independent provider.

Joint Investigation of Health and Social Care Complaints
HIW supports this proposal.

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. There will need to be effective communication with the public so that they can be clear what to expect when they complain and how to do so.

Whilst we support the proposal, there is further detail required as to the mechanisms for health, social care and independent providers of health and social care to come together to agree to follow a joint complaints process. Who will devise the complaints process? Who will check that it is sufficient and being adhered to? We have some concerns that the implementation of this could result in complex attempts to 'glue together' non-aligned separate complaints systems. Further thought is required on how this would work in practice (and seamlessly through the eyes of the citizen). There may be value in considering introducing a single, consistent approach to complaints across all Welsh public services. Further consideration should perhaps be given to the proposals in the draft Public Ombudsman Bill proposed by the Finance Committee of the previous Assembly such as the establishment of a Complaints Standards Authority to verse greater consistency across public service complaints handling.

The Ombudsman investigates individual complaints. HIW and CSSIW are able to consider how the system treats individuals, and how organisational complaints systems operate. The WAO also has a role in considering how efficiently and effectively the system is operating. We believe that there may also be a role for the new patient voice organisation at all these levels to represent patient views as to how the complaints system is working and impacting on individuals, if its role and advocacy service is extended across health and social care. However, it is important that these organisations all work together to avoid duplication and provide consistent messages in order to support improvement.

Duty of Quality for the Population of Wales

HIW supports the principle of a duty of quality, but we would question what barriers a statutory duty of quality overcomes. Given that there is already a duty of quality in the Health and Social Care (Community Health and Standards) Act 2003, how can additional advantage be secured by a new statutory duty of quality?

It would appear that there are a number of further questions to be answered in this section of the White Paper:

- NHS bodies are already under a duty of quality which is set out in legislation. When and how has the current duty been enforced? What stops this happening at the moment?
- We note that "Welsh Government believes that strengthening the existing planning duty will make sure health boards work together on the needs of the population of Wales in the planning and delivery of quality healthcare services." HIW's experience suggests that health boards can sometimes struggle to plan and deliver services within their own footprint where significant local resistance can arise: managing these local dynamics across organisational boundaries will be even more challenging. The White Paper has not described in what way a statutory duty of quality can support improved collaborative, regional and all-Wales working.
- The White Paper also does not describe the role of Welsh Government/NHS Wales in relation to the duty of quality. There is no information about what happens when health boards disagree with one another about a solution, or what should happen when the All-Wales or cross regional solution conflicts

with local population need as assessed by the Regional Partnership Board. Is there a role for NHS Wales in these circumstances?

- There is an absence of an All-Wales planning mechanism in the system at present. It is difficult to identify from the White Paper where and how all-Wales planning should take place.
- The White Paper does not deal with the question of long term planning. The introduction of Integrated Medium Term Plans (IMTPs) in 2014 signalled a move away from a focus on annual plans, towards a more medium-term approach. However, significant service or structural change would require thinking and planning much further ahead into the future. Whilst the NHS Wales Planning Framework 2017-20 sets out an expectation that every NHS organisation will have a board-approved long-term strategy, this needs to be aligned to the long term vision for the shape of health and care services in Wales, and this has not yet been defined. It is unclear what responsibilities individual organisations would have under the proposed statutory duty of quality to align with this vision?
- There is no information in the White Paper about who should monitor the effectiveness of service planning. Evidence from our review of BCUHB suggests that even with a strong commitment to the principle of joint planning, it can sometimes fail in the face of competing priorities.

We support the idea that a health board's planning duties should be aligned with the duties placed on local authorities through the Social Services and Well-being (Wales) Act. We agree it should reflect the integrated system, but we wonder if the duty should be extended further towards other bodies, for example housing services, the police and the third sector. Any duty to create new plans will of course need to be aligned with Local Wellbeing Plans and Area Plans which the health boards should already contribute to. Further, alignment should be considered in respect of the overarching duties expressed in section 7 of the Social Services and Well-being (Wales) Act.

Duty of Candour

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.

To be meaningful and effective this duty should apply equally across health, social care and perhaps other public services too. There should not be sectoral distinctions and citizens should expect the same level of openness and honesty whichever public body provides their care. Any statutory duty of candour for bodies in Wales should also be aligned with the professional duty of candour expected by UK professional regulators such as the Nursing and Midwifery Council and the General Medical Council.

The White Paper does not address the issue of who monitors and enforces any statutory duty of candour. What if the duty is not complied with?

The White Paper mentions the duty of candour already in place in England and Scotland. In England the threshold for the duty of candour was taken from the Dalton

Williams review and includes death, severe and moderate harm (collectively referred to as 'significant harm'). In Scotland, the duty is triggered when one of the outcomes listed in section 21 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 occurs. The Regulations consulted upon for social care providers in Wales did not propose a threshold for candour:
"The service provider must act in an open and transparent way with—
(a) individuals who are receiving care and support,
(b) any representatives of those individuals, and
(c) in the case of a child who is provided with accommodation, the placing authority."

These proposals would indicate that in Wales a proactive, continuous duty of candour is proposed rather than one which is triggered by an event. This would seem consistent with the principles of co-production and the involvement of patients as equal partners in their own care. It would be helpful if this was explicit so that organisations and the public expectations can be clear.

The proposed duty of candour for social care in Wales is included in Regulations under the Regulation and Inspection of Social Care Act. The White Paper has not addressed the question of why a statutory duty of candour is required in primary legislation for health services, when it was not included in primary legislation for social care. There are practical considerations with this; for example, in the case that any amendments to legislation are required.

Board Membership and Composition
HIW supports the idea that there should be flexibility for Boards to consider and reflect their remit and priorities in the appointments they make. Whilst flexibility might sacrifice consistency of structure across Boards and trusts in Wales, it should not compromise consistency of outcomes. It will, of course, always be important for the public and others to know who has responsibility for delivering the service, and who is in charge.

It is also essential that there is clarity of role and remit of each Board Member. To facilitate proper scrutiny by the Board, members must be properly informed and equipped, both individually and collectively to play their full part in board business. The evidence from our joint review of governance in Betsi Cadwaladr UHB with the WAO was that the relationship between Executive and Independent Board members could be improved by developing a common understanding of the respective roles. Our governance work in Betsi Cadwaladr also highlighted issues with the capacity of Independent Board Members to thoroughly assimilate the information they need to inform their decision making and scrutiny role. The Board felt that more independent members would increase their effectiveness.

A further point for consideration should be the terms of individual Board members. When a cohort of Board members is recruited at the same time, with the same term, the result is that there is a potentially significant loss of experience and knowledge at the time the term ends. It would perhaps be better if the start dates and/or terms of Board members were staggered, to avoid a situation whereby many Board members need to be replaced at the same time.

It may be of benefit to consider whether particular committees should be specified, so that it is clear where responsibility lies for particular functions. For example, should a Quality and Safety Committee be mandated to ensure the Board gives sufficient attention to these matters?

The specific question of an associated member for citizen participation is perhaps not clear. The White Paper states at paragraph 22 that the current Regulations specify that there are three associate members, with the ability, subject to Ministerial approval, to appoint a fourth. Three of the positions are specified in the current Regulations. Paragraph 26 of the White Paper (Core Key Principles for all NHS organisations) states that: "associate membership of Boards should address citizen representation". Is the intention therefore that the current Regulations will be amended, so that an additional member for citizen representation is allowed on top of the current 3(or 4) or is the proposal that a fourth associate member will be appointed for citizen representation? How is it proposed that associate membership addresses citizen representation?

Board Secretary

We support the proposals for the role of Board Secretary to be placed on a statutory basis. We particularly support the principles of statutory protection to allow the role to be independent and able to challenge, and that an independent process is put in place to dismiss a Board Secretary. In our governance review of Betsi Cadwaladr UHB, we highlighted that:

"The role of the Board Secretary in supporting the Chair and Chief Executive…is critical in ensuring that the Board is properly equipped to fulfil its responsibilities. The relationship between the Chair and the Board Secretary is a fundamental one…The relationship should be protected by a clear and direct line of accountability from the Board Secretary to the Chair."

It is critical to the successful running of the Board that the Board Secretary is able to report if there is a key issue of concern to either the Chair or Chief Executive depending on where the concern lies.

Inspection and Regulation and single body

We support the proposal to align and future-proof the system of regulation and inspection of health and social care.

<u>Joint working between HIW and CSSIW</u>

There is currently no organisational barrier to HIW and CSSIW working together where this is appropriate. 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. Recent examples of joint work include a review of community learning disability services, and forthcoming reviews of community mental health teams and of healthcare provision in care homes. HIW and CSSIW are also both members of Inspection Wales, where interfaces with other bodies such as Estyn and the WAO are explored and exploited.

However, as well as similarities there are important differences between CSSIW and HIW, such as:

- CSSIW undertakes a high volume of similar inspections in the independent sector, with a low volume of inspections in the public sector. HIW undertakes a high proportion of its work in the NHS and a smaller volume of work in a small, diverse, independent healthcare sector.
- HIW undertakes its inspections using teams of people led by an inspection manager. Those teams include peer reviewers (who are experts currently working or recently retired from working in the area being inspected) and lay reviewers whose role is to look at the service from the patient perspective.
- HIW and CSSIW operate under different legislative frameworks. Following the Regulation and Inspection of Social Care (Wales) Act, CSSIW will register services, rather than individual settings. HIW registers independent healthcare under the Care Standards Act 2000 and the Independent Healthcare (Wales) Regulations 2011, which dictate that registration is on an establishment or agency basis. In practice this means that where there are issues with the corporate owner of a number of services, HIW would need to take enforcement action in relation to each individual setting, whereas CSSIW would need to take action once against the service provider in relation to the service as a whole. This can cause confusion amongst providers who need to register with both HIW and CSSIW if, for example, they provide care homes and independent hospitals. New legislation bringing HIW's legislative framework into alignment with CSSIW will assist with this. This points to the need to update HIW's legislative framework.

<u>HIW's legislative framework</u>

As the independent healthcare market has evolved, HIW has identified increasing gaps and incoherency in its legislative framework (See Annex A for details).
For example, HIW currently has responsibility for registering and inspecting class 3B and 4 lasers. These lasers can be used for surgical purposes (such as laser eye surgery), and more commonly for non surgical purposes such as for tattoo removal. In its report following consideration of the Public Health (Wales) Bill, the Health, Social Care and Sport Committee of the National Assembly for Wales recommended that lasers used for non-surgical purposes be added to the list of 'Special Procedures' under that new legislation. This would mean that responsibility for the registration (and inspection) of non surgical lasers would pass to local authorities. HIW welcomes this proposal.

As noted above, CSSIW now registers services rather than individual establishments or agencies. HIW considers it essential that its legislative framework in respect of independent healthcare is aligned with the provisions in the Regulation and Inspection of Social Care (Wales) Act 2016, with a move towards service based regulation in healthcare. In reviewing HIW's legislative framework, particularly in respect of independent healthcare, we would emphasise the need to look to the future. The Care Standards Act 2000 specifies particular types of establishment or listed services which are required to register. In England, the Health and Social Care Act 2008 introduced 'regulated activities'. If a service carries on any regulated activities they must register with the Care Quality Commission, unless they are

specifically excluded. This, we would suggest, is a more future proofed approach which is more appropriate for an evolving private healthcare market.

It is important to note at this stage that whilst the White Paper suggests CSSIW now has a clear, single, legislative framework to work to, the Regulation and Inspection of Social Care (Wales) Act is predominantly adult focussed and does not address the legislation concerned with child care.

In considering the overall legislative framework, further consideration will need to be given to whether HIW has the right powers and responsibilities in relation to the NHS in Wales. For example, in Scotland, Healthcare Improvement Scotland has the power to give directions to Health Boards to close hospital wards to new admissions where the Inspectorate believes that, in the absence of such a direction, there is a serious risk to the life, health or wellbeing of persons.

Welsh Government Sponsored Public Body

The Welsh Government also believes there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

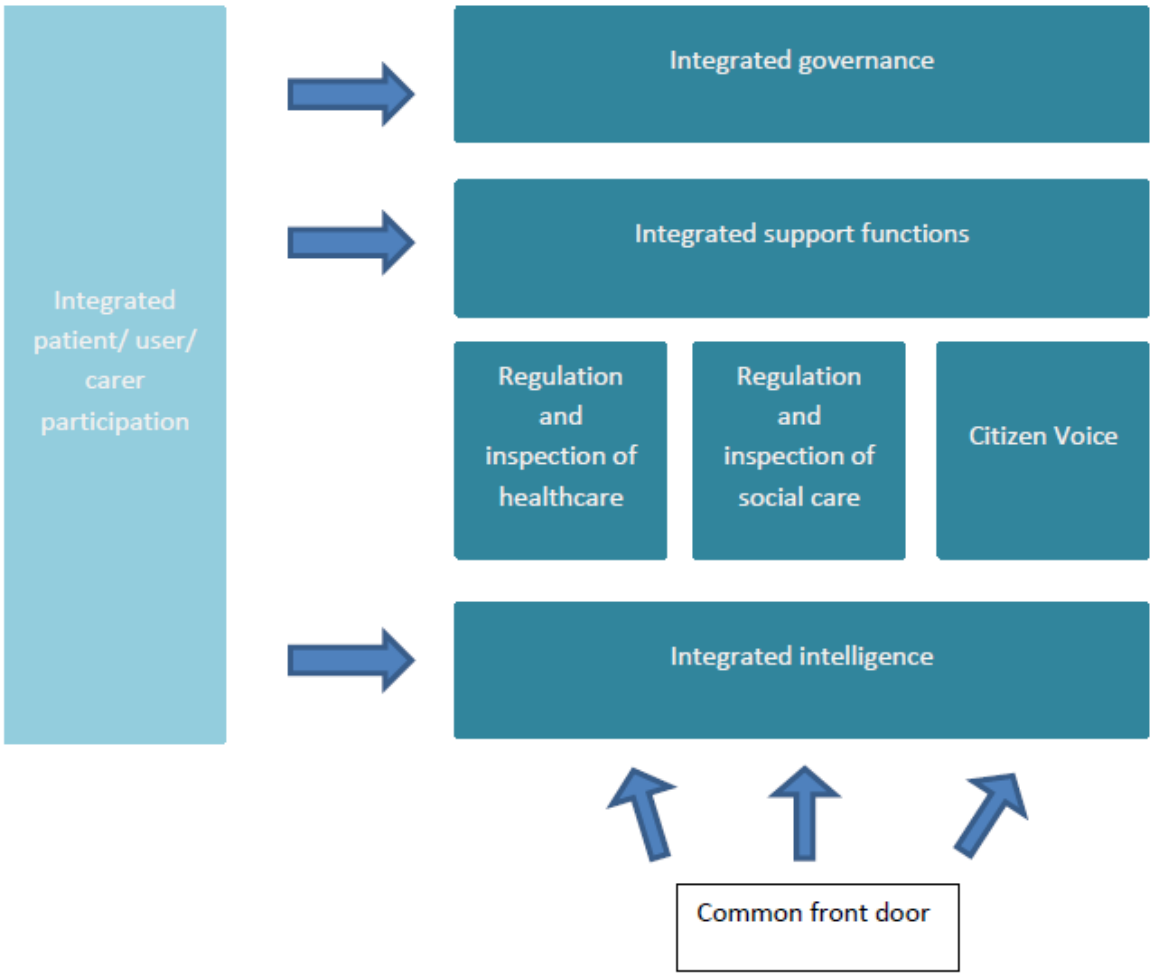
HIW (and CSSIW) are already operationally independent and mechanisms are in place within Welsh Government to ensure that HIW and CSSIW do not report to the Cabinet Secretary for Health, Wellbeing and Sport or the Minister for Social Services and Public Health. Organisational arrangements within Government ensure that there is a separation between funding decisions, performance management of Chief Executive of HIW and Chief Inspector of CSSIW, and operational decision-making regarding the work of the inspectorates. This is formalised in a Memorandum of Understanding between HIW, CSSIW and Welsh Ministers.

However, clearly the location of both HIW and CSSIW within Government contributes to a perception of a lack of independence. This is further compounded by a lack of overt scrutiny of our work. If we were to stay within Government there would be merit in considering introducing a remit letter in which the Welsh Government sets out it expectations of the organisations. These are routinely used for other arms-length bodies and would ensure a degree of transparency underpinning the allocation of funds and what those funds are expected to be used for. There would also be merit in ensuring routine public scrutiny of inspectorate plans and/or Annual Reports. Such scrutiny could take place in a National Assembly for Wales Committee or debate in Plenary.

If there were a view that the inspectorates should be moved outside of Government, it would make sense to combine the inspectorates into one single body, to preserve the benefits we currently enjoy of being part of the same wider organisation. However, there are considerations about what type of body is created. A non-ministerial public body along the lines of Estyn would also be a possible option.
If a new body is to be established outside Government, then serious consideration should be given to HIW, CSSIW and the national citizen voice organisation being hosted together under one umbrella, potentially with distinct branding. There could be organisational benefits from such a model in terms of the ability to combine

governance, support functions and intelligence handling across the different component parts (see figure 1).

More importantly, there could be benefits to the public in simplifying a rather crowded organisational landscape, making it easier for individuals to access the support they need and ensuring that the role of patients, users and carers is fully recognised across all aspects of the body's work.



WGWPMB189: Public Health Wales
Location: Cardiff

General Comments

1.1.1 Public Health Wales is the national public health agency in Wales and exists to protect and improve health and well-being and reduce health inequalities for people in Wales. Our vision is for a healthier, happier and fairer Wales.

1.1.2 Public Health Wales welcomes the opportunity to respond to this consultation. Our response has been structured under the four chapters listed within the consultation document.

1.1.3 One overall comment is that the document refers predominately to Health Boards. We suggest that the document should be equally applicable to NHS Trusts in Wales. Two of the NHS Trusts provide services across the whole of Wales. This needs to be taken into account when considering demands placed upon Board members and the complexity of service user/ stakeholder engagement.

Chapter 1: Effective Governance

1.1.4 Whilst the introduction to the White Paper (paragraph 2) references the Well-being of Future Generations (Wales) Act 2015 and the need for health and social care to work together with staff, partners and the public to further their aims this does not manifest itself in proposals within the document. The strategic intent and direction which the Act provides, requires organisations to work differently and much more effectively as an integrated Public Service system. This will require new and different collaborative governance arrangements; whilst Public Health Wales is not a statutory partner within the Public Service Board structure it is well placed to secure such arrangements for programmes of work which aim to impact on improving population health outcomes. It is currently strengthening its collaborative governance arrangements and is well placed to provide support and advice to other public bodies and third sector organisations who need to work much collaboratively in order to realise the aspiration of 'Prosperity for All'. The organisation is of the view that there should be a greater emphasis on collaborative governance within the document and reference to the Well-being of Future Generations (Wales) Act.

1.1.5 We recognise that Health Boards and Trusts have different statutory establishment orders and that Trusts do not have an externally appointed Vice-Chair. However, in Public Health Wales we have internally appointed a Vice Chair as we recognise the importance and value of this role in supporting the Chair. As the role is appointed from within the existing Non-executive Director cohort there is currently no allowance for the additional time commitment this role entails. There is also no ability to remunerate accordingly. The organisation is of the view that this role should be placed on a more formal footing and reflected within the Membership and Procedure Regulations as a designated role. The additional responsibilities would not require the same time commitment as a Vice-Chair of a Local Health Board (13 days per month) as the portfolio would differ; the suggested time commitment is 8 days per month.

1.1.6 The Core Key Principles set out within the document reference person centred care, however within the context of public health the use of the word 'care' is generally not recognised as appropriate and we would prefer if the reference in this context, was to person centred and population focused (where appropriate) provision/ delivery of services and functions. Please also see the reference above to the need to strengthen reference to the requirements of the Well-being of Future Generations (Wales) Act 2015.

1.1.7 Public Health Wales agrees that there should be a majority of independent members (Non-Executive Directors) over executive officers in order to provide external scrutiny and support transparency. Within the current compliment of Non-Executive Directors there are sometimes difficulties in achieving the full range of duties during the current time commitment (4 days per month). This could potentially be alleviated if a Vice-Chair were appointed with additional time commitment (see paragraph 1.1.4).

1.1.8 While we recognise the drive behind the proposal to change the name of independent members to that of public members, these individuals would not represent the public. We strongly support the use of consistent terminology across NHS Wales and the use of the terms 'Non- Officer Member' or 'Non- Executive Director' is recognised across the public and third sector.

1.1.9 We agree that the Board should be supported by a strong governance framework and have a well-functioning and supporting committee structure which is informed by stakeholders, professionals and users of services in the broadest sense of the word services (we would therefore request that a reference to service users is used in addition to patients).

1.1.10 Public Health Wales agrees that there should be provision to appoint time limited Associate Board Members. However, we do not think that this should be limited to times of poor performance or escalation. We are of the view that this should provide the opportunity to bring additional skills to the Board where, for example there may be a specific demand for bringing specialist or additional knowledge and expertise to the Board. These individuals should be independent from the organisation.

1.1.11 We support the idea that some Associate Board Member positions should address citizen representation but seek clarity on how this would be achieved and via what process so that there would be consistency across Wales. NHS Trusts do not have the same requirements as Health Boards in relation to having specific fora or groups whose Chairs are Associate Board Members.

1.1.12 Whilst not mentioned within the White Paper we recognise the importance of encouraging diversity amongst Non-executive Directors whilst ensuring that they have the appropriate leadership skills and knowledge to allow them to function as Board members in highly complex operating environments. The NHS should seek to establish a "development pipeline" (perhaps similar to that of the All Aboard pilot). Associate Board Member roles could also be utilised to help address this need and give such individuals some legitimacy within the Board environment. Even without such a system Public Health Wales is looking to work with the Public Appointments

Unit as requested by the Cabinet Secretary for Communities and Children in his letter of 4 July 2017.

1.1.13 Whilst Public Health Wales is not a Health Board we recognise some of the issues identified in relation to the inflexibility of the current structures of Boards. In relation to the proposal to stipulate a number of core roles, there is concern about how these roles would be determined and that any change should be undertaken with safety, quality and achieving strategic outcomes as priorities. There is a potential that certain groups could be marginalised and seen as not important. The other proposal to be altogether less prescriptive could lead to a lack of consistency across Wales resulting in less potential leverage to address pan Wales issues via peer group basis.

1.1.14 In relation to NHS Trust Boards we agree that there should be flexibility to appoint up to three additional executive officers which maintains the current status quo within Public Health Wales. If at any point there was a decision to increase the number of Non-Executive Directors it may be necessary to review this to ensure the balance is maintained.

1.1.15 Public Health Wales recognises the important role that the 'Board Secretary' plays in relation to maintaining a strong governance framework within an NHS organisation. We would support the proposal for the role to be strengthened, given a greater profile and clarity. This should be achieved by ensuring it is placed on a statutory basis within the respective membership and procedure regulations.

1.1.16 The model role profile specified within the 2009 Model Standing Orders requires updating to reflect the evolution of governance arrangements in the intervening years. Strengthening the role profile will help to clarify the status of the position, which should be seen as equal to that of a Board member.

1.1.17 Whilst it is recognised that there may not currently be a single suitable qualification for a "Board Secretary" operating in the NHS in Wales it is important to ensure the professional standing and knowledge of post-holders. Consideration should be given to identifying recognised qualifications and skills for Board Secretaries across NHS Wales.

1.1.18 As previously indicated it is important to recognise the seniority of the Board Secretary role. It is a unique role providing independent advice to the Chair, Chief Executive and the Board. As is the case within Public Health Wales the post holder should report directly to the Chair with an indirect report to the Chief Executive, whilst retaining the unique position of trust as an independent advisor to the Board and its members. There is a risk that the "Board Secretary" title in isolation of the term Head or Director of Corporate Governance is often confused with that of the 'committee secretary' or 'minute taker'. It is important to maintain this distinction and consideration should be given to how this can be improved.

1.1.19 Whilst there could be benefit in providing statutory protection it could be construed that this is already in existence within the Public Interest Disclosure Act 1998. What may be more important is to clarify the expectations and actions which the Board Secretary should take if they were of the view that they need to take such

action. This is required as protection under the Public Interest Disclosure Act only comes into play when other appropriate avenues have been exhausted.

1.1.20 Recognition of the need to ensure 'an appropriate level of resource to support Board Secretaries' is welcomed but is also open to interpretation. Each organisation will need to consider what this should consist of having considered the resources required to maintain and run the governance and assurance arrangements for the organisation.

Chapter 2: Duties to Promote Cultural Change

1.1.21 Public Health Wales supports the need for NHS organisations to work with partners to co-create/design programmes and services. Due to the nature of our work we currently have arrangements in place where services/programmes are jointly planned with partners, however we recognise the need to do more and to be able to demonstrate this robustly.

1.1.22 We also fully support the Triple Aim Model, Prudent Healthcare and the Wellbeing of Future Generations (Wales) Act 2015. However, we also acknowledge that a duty of quality spanning organisations would enhance and support existing legislation and provide a greater focus on quality.

1.1.23 Public Health Wales supports the proposal to strengthen the existing planning duty to consider the needs of the population of Wales in the planning and delivery of quality healthcare services. The use of the term 'health services' as opposed to 'healthcare services' may be more appropriate use of terminology.

1.1.24 When considering the needs of the population and planning services it is essential to ensure there is sufficient focus on knowledge exchange and evidence. The importance of the NHS in Wales working much more closely with academic institutions should be strengthened to ensure the research agenda and the sharing of knowledge supports Prudent Principles. This will help to create and utilise the best available evidence to drive improvements that benefit individuals, communities and wider population health.

1.1.25 Public Health Wales welcomes and supports the move to place a statutory duty on all health and social care bodies to be open and transparent, building on the existing 'Putting things Right' legislation. We support the proposal that candour should be encouraged at all levels and not rely on a concern being notified.

Chapter 3: Person-Centred Health and Care

1.1.26 We agree that individuals and populations receiving services/functions/programmes and care should feel confident that the standard will remain the same regardless of where they are receiving these and overall we support developing common principles. However, it should be noted that there are significant differences between in-hospital care, community care, care at home and promoting population health and well being. Any principles developed would need to be broad enough, and encompass promoting wellbeing and health as opposed to merely addressing ill health. The terminology used in the report should reflect the breadth of services provided by NHS organisations.

1.1.27 We agree that the current process for individuals to make a complaint against health and social care can involve submitting a number of complaints and that they should be able to raise their concern at any point in the system without being burdened by a response from multiple touch points of the health and social care system. The 'System' needs to be experienced as if it were operating as one joined up system. Whilst we strongly agree in principle to making the process easier and working together with partners in social care to investigate complaints and learn lessons, there are issues such as the confidentiality of clinical information which will need to be worked through. As Public Health Wales frequently works with our NHS partners to investigate complaints, the time line of responding to complainants will also need to be considered as this can increase significantly where there is the need to compile information across more than one organisation.

Chapter 4: Effective Citizen Voice, Co-Production and Clear Inspection

1.1.28 Public Health Wales fully supports the strengthening of the public's voice in health and social care and agrees that they should be involved in co-creating services.

1.1.29 We fully support the proposal to engage and involve the public more in service planning, delivery and change. The mentioned guidance to illustrate what effective engagement based on co-production principles looks like, is welcomed.

1.1.30 The proposal to establish an independent mechanism to provide advice and assurance on a substantial change proposal is supported as Public Health Wales recognises the need to gain an independent view on proposals. The document appears to currently only refer to Health Boards, as opposed to NHS Trusts. The diagram on page 34 is helpful to understand the proposed process, although Step 5 references feedback from the independent clinical panel and citizen voice panel which Step 2 states is not applicable if the change is not described as substantial. We would suggest that the diagram is amended to clarify the process if the change is not described as substantial. Guidance on what would be classed as 'substantial change' would be welcomed.

1.1.31 Public Health Wales would support the proposal to amend Healthcare Inspectorate Wales (HIW) underpinning legislation to help foster closer integration and joint working if a new body were not formed. It is anticipated that by avoiding duplication, more focus can be given to identifying areas of concern.

1.1.32 In relation to the wider proposal to create a new independent body encompassing both inspectorates, consideration would need to be given to ensuring the specialised elements of each inspectorate, requiring specialised knowledge, would be maintained so that this is not diluted in any new organisation, albeit that there would be a more integrated focus on quality and safety. Maintaining independence from relevant public bodies will assist with credibility and public reporting.

Conclusion

1.1.33 Public Health Wales welcomes this consultation on quality and governance in health and social care and supports and acknowledges the importance of empowering organisations, staff and citizens.

1.1.34 We are committed to continuously improving our organisation and its culture and this can only be achieved by listening to, and learning from, the public and people who use our services, functions and programmes. We acknowledge that we still have more to do in this arena.

1.1.35 We believe that Public Health Wales should be transparent and work with in a strong and enabling governance framework which facilitates strategic decision making and effective provision of services, functions and programmes via strong leadership.
Where the organisation has demonstrated its support of recommendations within the White Paper it will seek to take forward those which are within its remit regardless of the outcome of the consultation exercise.

WGWPMB190: Abertawe Bro Morgannwg University Health Board
Location: Port Talbot

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
The Board agrees that the core key principles for all NHS organisations outlined in the White Paper should be adopted across NHS Wales.

What further issues would you want us to take into account in firming up these proposals?
The Board believes that there should be consideration over whether the size of the Board is too big. More flexibility over the Executive members' roles on Health Boards should be introduced to allow for variation to meet different challenges in different organisations.

The Board agrees that is logical to introduce authority for Ministers to appoint additional Board members on time limited appointments under escalation procedures if a Health Board is under performing.

Board Secretary
Do you agree with these proposals?
The Board agreed that standardisation of the role and job description of Board Secretary posts across Health Boards in NHS Wales should be supported.

What further issues would you want us to take into account in firming up these proposals?
The Board agreed that the proposal to introduce statutory protection to allow the Board Secretary to be independent with safeguards in place to challenge the Chief Executive of an NHS organisation or the Board more widely is logical but the practicalities of how this would be achieved needs further definition. There was also concern that this role should not include operational responsibilities as this detracts from the individual's ability to perform the described role fully.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
The Board agrees that the proposal to place a new enhanced duty of quality on NHS bodies to enable and require them to demonstrate that where needed they collaborate on planning and agreeing regional or all Wales solutions to secure quality services for the population of Wales makes sense. This will be particularly helpful in relation to the three regional planning arrangements between Health Boards which is being introduced. However the inclusion of the "where needed" statement could give rise to differing views across different Health Boards about when this duty

should apply. Furthermore it is unclear how an individual Health Board would necessarily have the knowledge and understanding of the impacts on quality across the whole of Wales as all our planning systems currently concentrate on our own population, not across the three planning regions or at an all Wales level necessarily. How such information would be provided, and developed in such a way that all Health Boards across Wales could accept this as the basis for their decisions needs further consideration.

What further issues would you want us to take into account in firming up these proposals?
Bearing in mind the increasing amount of cooperation and partnership working between Health Boards, Local Authorities and the third sector, extending the powers of Health Boards to cooperate and work in partnership with these bodies would be helpful. However as this would align Health Boards with the duty already placed on Local Authorities, the extent to which this requirement is acted upon would seem to vary significantly between different ones, which is unhelpful. Therefore it would also be opportune for the issue of how this duty could be discharged by all the organisations involved, consistently across Wales, could be given further consideration by Welsh Government.

Duty of Candour
Do you support this proposal?
The Board is committed to openness in all that it does and so supports the proposal that all health and social care organisations and providers should be under similar duties to be open and transparent. It is important that this duty applies across all aspects of Health Board's responsibilities and not just to "Putting Things Right"

What further issues would you want us to take into account in firming up this proposal?
Whilst the Board supports the aim that all health and social care bodies are under a statutory duty to be open and transparent, in all dealings with individuals as well as at a population level, it feels it would be helpful if it was made clear as part of this that this applies to primary care (via their contracts perhaps) and other providers of services such as independent and private providers as well as the third sector.

Setting and Meeting Common Standards
Do you support this proposal?
The Board supports the proposal that common standards underpinning care should have common principles regardless of where people receive their care. These should apply across health, social care, the third sector and the independent sector.

What further issues would you want us to take into account in firming up this proposal?
In order to ensure that services commissioned and provided are both safe and of an acceptable quality not only will common standards be in place but also integrated ways of monitoring improvement against these.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

The Board supports the proposal that organisations should be required to work together to investigate and resolve complaints which cover both health and social care. These arrangements will need to standardise the process across primary and secondary health care as well as with social services. The implementation of this will be complicated as the processes followed vary in process terms and approach, particularly if as outlined in the White Paper, this should also be a standardised process followed by independent providers of health and social care services.

What further issues would you want us to take into account in firming up this proposal?

The Board believes that because of the risk to destabilising or adding additional layers to current processes the timescales for this change and the need to radically review these processes will be important. Also the issue of different health care organisations being required to work together to investigate and resolve complaints is not mentioned, but this is an area where arrangements do not always work well and could be improved if the duty extended to this as well.

Representing the Citizen in Health and Social Care

Do you support this proposal?

The Board supports the principle of further strengthening the voice of people in the way health and social care is planned. However it is not convinced that the proposed way forward will achieve this. The Health Board, jointly with the Community Health Council, and working with the Regional Partnership Board and the three Public Service Boards in the area, have been working to ensure that ongoing effective and meaningful patient and public involvement in planning are in place and evolving.

The CHC's input into shaping and improving services and its constructive challenge to the Health Board in terms of representing our population is valued, although the Board recognises that working across different Health Board's to take service change forward has been complicated and needs to evolve into a more effective way of making such wider regional or national decisions more straightforward. However the Board is not convinced that replacing the statutory, independent CHCs with a national Citizen's Voice will actually strengthen individual and community engagement and believes that further work needs to be done to carefully consider the best way forward for this, building on existing best practice within Wales which has been recognised by expert bodies such as the Consultation Institute.

One way of achieving the objectives set out in this White Paper would be to develop strengthened citizen voice arrangements, building on the CHC's work, on a regional basis, as if services are increasingly going to be planned and delivered on a 3 region basis across Wales, having these revised citizen voice arrangements, aligned to each region, would make more sense and support this new arrangement more appropriately. This would also make the linking of established mechanisms such as the Regional Partnership Board's Citizen's Panels, the Health Boards' Stakeholder

Reference Groups, and the Regional Third Sector Networks etc. more manageable and ensure a focus on the best outcomes for the region, not just for each small area within it. Effectively establishing and managing citizen engagement which is linked to local communities is a challenge at Health Board population level, expanding this to regional level could be realistic, but having this organised and delivered through a national organisation would be logistically difficult and would likely lead to a Cardiff centric bias as seen in other all Wales bodies. As a result the populations of South and West Wales could well lose out in such an arrangement because their voice would be drowned out by the much larger population in South East Wales.

Can you see any practical difficulties with these suggestions?
The Board is concerned that moving to a completely different system of citizen engagement will be disruptive, lose the independence and constructive challenge which comes from the Community Health Council, and result in a significant reduction in meaningful, ongoing public engagement which has taken years to establish within Health Boards, and which is still evolving. There is a significant risk that such a complete change would actually slow up progress with implementing service changes and make the likelihood of Judicial Review more likely during the transition, while building on and evolving the current model would reduce this risk. Whichever way forward is considered there needs to be considerable more detailed work carried out to ensure that any changes proposed are practical, will fit with other policy directions (e.g. SS&WBA and WBFGA) and not be to the detriment of the patients / citizens we serve and their ability to tell us their views on issues and service changes in an effective manner.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
The Board supports the requirement for all Health Boards in Wales to identify all change proposals meeting the criteria for substantial change and reconfiguration. This will need agreement of the criteria to be used to judge this but would lead to standardization across different Health Boards of when engagement is required, whereas currently this can vary.

What further issues would you want us to take into account in firming up this proposal?
The use of expert panels, including citizens, to consider service change issues which have impact across more than one of the three planning regions, could be used as a way of achieving independent clinical advice and assurance on substantial change proposals, as happened in relation to work on the South Wales Programme and the work of the NHS Collaborative.

This could then be used as part of the evidence for the engagement with the public / stakeholders about the service change, whether or not this is via a new arrangement as proposed or an amended version of the existing arrangements. The changes proposed earlier in the White Paper should address the governance issues across Health Boards which made the agreement of the outcome of public engagement and consultation so difficult.

Inspection and Regulation and single body

What do you think of this proposal?

The Board supports the proposal to overhaul HIW's underpinning legislation to ensure it has a single clear framework to work to, in line with CSSIW.

Are there any specific issues you would want us to take into account in developing these proposals further?

The Board believes there is a need to consider further the implications of the longer term proposal of creating a new independent body to encompass both CSSIW and HIW so that common approaches to inspection and regulation apply across health and social care.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?

The Board would support considering a new body to incorporate CSSIW and HIW, but would question whether whatever the new "citizen voice" body or bodies are should be part of this. The independence of this citizen voice is seen as critical to its effectiveness and making it part of a body with inspection agencies is not seen as being in line with this.

What issues should we take into account if this idea were to be developed further?

The independence of the Citizens Voice arrangements is critical to its effectiveness and needs to be preserved at all costs. In particular the CHCs ability to choose areas to focus on and health services to visit based on the concerns and expressed priorities of the public is a critical role which should not be lost in any change proposed. If this is to be regionally based a more effective arrangement might be to link this to existing organisations such as Councils of Voluntary Services, who have facilitators already in place with expertise in community and citizen engagement who support the Citizen's Panels and Stakeholder Reference Group. The concern with managing the inspection and citizens voice arrangements under the same organisation would be the likely focus on inspection and regulation within the citizen's voice role rather than the wider engagement work.

WGWPMB191: Parkinson's UK
Location: Pontypridd

Response to Specific Questions

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Parkinson's UK supports the proposals to enhance the duty of quality to stipulate collaboration beyond health board boundaries for planning and securing solutions to delivering services for Wales at a regional/ all Wales level.

Further we welcome the extension of that duty and the broadening of power in local health boards and trusts to cooperate and work in partnership with local authorities and other bodies including the third sector when planning services.

These would seem like appropriately logical actions towards ensuring the needs of the population of Wales are planned for effectively, regardless of where someone lives.

Parkinson's UK is acutely aware that many people affected by Parkinson's may live in one locality and receive a variety of services from primary care in one are, secondary care in another area (including cross border with England – something else that needs to be considered as a part of enhancing the duty of quality) as well as local authority and third sector services/ support from other places.

With the Social Services and Well-being (Wales) Act 2016 realistically still in the early days of full implementation, it is essential that effectively enhancing arrangements and strengthening the existing planning duty through legislation is key to the successful integration of health and social care services, including those provided by the third sector.

What further issues would you want us to take into account in firming up these proposals?
Whilst welcoming the sentiment around this proposal we are cautious as to how it can be effectively implemented through future legislation.

Planning and securing service provision on a more flexible basis, responsive to need regardless of health board boundaries must not mean that areas are left void of specific services, rather that sensible ways of improving access are sought to meet the needs of citizens everywhere.

We would like to better understand how different agencies will be required to work together at a regional and pan-Wales level to make things happen.

For example, will this relate to specific policy areas? Or will it be at the discretion of those agencies involved as to what they collaborate on and, if so, how can meaningful engagement of all stakeholders be ensured from the outset of any planning?

We would like to better understand how the third sector will be proactively involved in these enhanced arrangements in the future.

We would like to better understand how citizens can also be proactively involved in these enhanced arrangements in the future.

We would like to better understand how the realities of financial planning across boundaries and organisations will be legislated for to ensure that collaborative planning is also underpinned by clear means of financial planning without which collaborative service provision cannot become a reality.

Duty of Candour

Do you support this proposal?

Yes, we support the duty of candour to consolidate existing duties as it is essential that openness and transparency become a normalised way of doing business across the health and social care sectors at all levels and that the duty is similar across different bodies for consistency.

What further issues would you want us to take into account in firming up this proposal?

We would like to understand how any new duty of candour will be promoted to citizens as well as third sector organisations and other agencies working with health and social care bodies so that people are clear on what this means/ what the expectations on health and social care organisations and providers are in order that people can be knowledgeable about how they can challenge things when they do not believe a duty of candour is being adhered to.

There is still a way to go to ensure openness and transparency in the way health and social care services operate when concerns are raised, let alone in all of their dealings with people.

We would therefore be keen to see what practical measures, along with the duty, are put in place to strengthen the culture of openness in a meaningful way that a duty alone will not achieve on paper.

Setting and Meeting Common Standards

Do you support this proposal?

We support the notion that every person in Wales who uses health and social care services or who supports others to do so has the right to receive excellent care as well as advice to maintain their health and well-being and that care should be person centred and individualised.

We also acknowledge that differing standards across the sector can be confusing for both service users and providers.

We would therefore support a set of common standards in principle as a step towards further integrating health and social care.

What further issues would you want us to take into account in firming up this proposal?
We would wish to highlight that any common standards should be co-produced with service users and representatives of the third sector as well as those working in health and social care statutory bodies to ensure they are relevant and fit for purpose.

We would caution that any 'high level standards' developed should not be of too high a level so as to become unrealistic, unmeaningful or impossible for an individual service user to comprehend what expectations they should realistically have of a service – co-producing the standards should help alleviate this.

"Person centred care" is a frequently used term, referenced in many Welsh Government policies and strategies. Whilst common standards are welcomed, we would like to see a real step change in realising person centred care across the health and social care sector, something that new standards alone will not achieve without supporting cultural change.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
We support the proposal to have a joint process for managing complaints that span health and social care to ensure that a person's issue can be dealt with in the most effective joined up way.

However, our members have experience of the complexities of navigating one complaint system. Someone with Parkinson's may receive their care from a neurologist or care of the elderly specialist, a GP, an occupational therapist, a speech and language therapist and a physio, all with differing individuals potentially involved in a complaint investigation.

We would there be concerned as to whether the suggestion that 'health and social care will need to come together to agree to follow a joint complaints process for these types of complaint.' (page 26, paragraph 74) could actually make the process more complicated and prolonged for complainants.

What further issues would you want us to take into account in firming up this proposal?
We would want to see clear guidance from Welsh Government on what issues of complaint health and social care should jointly investigate and also guidance on how this process should be conducted. It is not sufficient to leave 7 health boards to determine this with 22 local authorities – health boards could otherwise potentially have slightly different joint complaint policies for each of the local authorities they work with.

We would want to see consistency of approach and quality standards for dealing with joint complaints (in line with comments on 3.1), rooted in Welsh Government guidance.

We would want to see, in striving for transparency, quality and consistency of approach and services fit for the future, accessible information for the public on how joint complaint processes will work so that it is easy for people to understand how to make a complaint and how it will be handled where it straddles both health and social care.

Representing the Citizen in Health and Social Care

Do you support this proposal?

We do not support the proposal to replace current statutory CHCs with a new national arrangement.

Can you see any practical difficulties with these suggestions?

We accept the need to reform a body that may need improvements but it is another thing to remove that body altogether. The role of CHCs should evolve to encompass a social care remit alongside their health remit, underpinned by additional resources to make this happen and grow their effectiveness.

We feel this is the further erosion of legitimate channels for patients' and service users' concerns and voices to be effectively heard. It appears to go against Welsh Government's own philosophy of co-production and empowerment and strikes us as weakening local accountability and influence.

We are very concerned that the proposal in the White Papers makes reference to replacing CHCs with the creation of a new arrangement based, in some respects on the Scottish Health Council model at the very time when the SCH is subject to an internal review due to the fact that although the SHC has a role in facilitating patient / community involvement on matters of service change by NHS Boards, it is actually a part of the NHS in Scotland and therefore cannot be viewed as being sufficiently independent. We would not wish for such a situation to prevail in Wales.

In light of the criticism of the Scottish model and also the less than successful models tried and tested in England since the abolition of CHCs there, we would prefer to see CHCs in Wales strengthened with greater power and responsibility at the local level. With reform they have the potential to be a solid asset to the way in which we ensure health and social care services in Wales are scrutinised and challenged.

We would also like to see CHCs being more visible to the public so that there is greater understanding of their role and the advocacy support they can provide. Again, this would need to be underpinned by sufficient resources.

There is insufficient detail as to how the proposed Wales wide body would work at a local level and we believe, instead, that CHCs should be invited to discuss a constructive fit for purpose way forward with Welsh Government before their abolition is sought to be replaced by aspects of a model that is already under heavy scrutiny in Scotland.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

We wholeheartedly agree with the ethos of co-producing plans and services with citizens. At Parkinson's UK, everything we do is in conjunction with people affected by Parkinson's so we are accustomed to continuous engagement and working in an evidence based way. We firmly believe that sound clinical advice on substantive service changes should also be handled in a consistent way across Wales.

However, as outlined in response to 4.1, above, we do not support the abolition of CHCs or the adoption of a model of a single, countrywide citizen engagement body like the Scottish model. Therefore, we cannot support the detail of this proposal as it is described because it builds on the detail of 4.1 and the establishment of a single Wales wide citizen voice body to the detriment of CHCs.

What further issues would you want us to take into account in firming up this proposal?

There is scope for Welsh Government to develop ways of better co-producing plans and services through reform of CHCs and through other mechanisms set out in this White Paper where citizens are involved from the outset.

The reform of CHCs to incorporate greater responsibility and accountability to local people, including a remit for social care, would be one way of improving the independent scrutiny of health and social care services at a local level while continuing to give people a voice about the services that affect them.

Inspection and Regulation and single body

What do you think of this proposal?

We would support better joined up working of HIW and CSSIW.

Are there any specific issues you would want us to take into account in developing these proposals further?

We would like a clearer understanding of how this will work in practice and how any new ways of working will link with the proposals for managing joint health and social care complaints.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Would you support such an idea?

Again, we would prefer to see the reform of CHCs than a new national citizens' voice body.

What issues should we take into account if this idea were to be developed further?

With particular reference to the establishment of a Welsh Government sponsored body to incorporate both inspectorates and the newly established citizens' voice, we would be concerned, as with the Scottish model, that by incorporating the citizens' voice body, it would not be possible for such a body to be sufficiently independent in representing the public's view.

WGWPMB192: MacMillan Cancer Support
Location: Bridgend

Response to Specific Questions

Duty of Quality for the Population of Wales

Do you agree with these proposals?

Macmillan supports this approach in principle. Improved partnership working that enables partnership working across all levels of health and social care is critical to delivering a seamless and consistent experience for people living with cancer.

What further issues would you want us to take into account in firming up these proposals?

An overarching all Wales process and supporting structure for planning, accountability and performance, reducing the variation that exists between organisations and hospital sites; decreasing the inequalities in the experience of patients with various tumour types and learning from patients' experience of care are crucial steps towards delivering the highest standard of care for everyone affected by cancer in Wales.

Through the course of their cancer journey, people living with cancer must cross multiple clinical pathways, into and out of primary, secondary, social and community care, spanning multiple organisations. That needs to be as seamless and consistent as possible.

Clear strategic partnership-wide leadership which operates in an open and transparent way, setting priorities, ensuring accountability and managing performance should help reduce inequalities in treatment and care whilst enabling public commitments are delivered consistently for anyone across Wales needing care.

Duty of Candour

Do you support this proposal?

Macmillan Cancer Support welcomes the duty in principle.

What further issues would you want us to take into account in firming up this proposal?

Going forward, further exploration is required to better understand and communicate its merits and other implications. In practice – when it comes to the implementation of the duty, the needs of people affected must be factored into and inform the processes and decisions taken concerning candour.

We believe that this will be in the best interests of a person-centred system. The development of process-driven responses should not unintentionally contribute to or further exacerbate distress and need to achieve the aim in a sensitive and appropriate way.

Setting and Meeting Common Standards

Do you support this proposal?

Macmillan Cancer Support welcomes the proposal which we hope would embed person-centred care at the centre of an integrated health and social care service. Doing so would reflect our calls for person-centred care and greater consistency of care for people with cancer, regardless of location.

There are however several points we wish make to in order to ensure that person-centred care is defined in a way that makes it meaningful to the person needing care and the professionals providing care; and ensures it is delivered consistently and seamlessly across Wales.

What further issues would you want us to take into account in firming up this proposal?

There is no single definition of person-centred care, though attempts have been made to understand the components of the approach. In Wales steps have been taken to articulate the concept – for instance, within the 2012 Cancer Delivery Plan . While it applies in the CDP to cancer, the overarching approach – meeting people's needs,

"People are placed at the heart of cancer care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of cancer."

can be applied across conditions. The Person Centred approach carried on over into the 2016 Cancer Delivery Plan following its refresh. From the introduction to the plan;

"We must see the patient as an equal in their care plan, working in true partnership to help them recognise and achieve their goals and supporting them during and beyond treatment. Services must ensure people affected by cancer are at the heart of service design. Particular attention should be given to the points where a patient's care transfers to another organisation or service and consistent application of supporting interventions such as the allocation of a key worker. Increasingly digital technology will support patients and enable them to play a part in their own care; providing access to their own health records, care plans and needs assessments, as well as enabling them to be shared throughout the healthcare system."

Person Centred Care is also broadly understood and accepted as an approach that:

"is holistic, meets the person's needs or priorities before the system or its professionals, engages people in their care as fully as possible and attempts to support people to take decisions and to be in as much control as possible" (National Voices, 2017).

In its current form, the approach to person-centred care set out in paragraph 66 of the white paper does not reflect the approach as generally understood, it is also repetitive, and feels imposed from above, rather than co-produced with stakeholders.

Attention to human rights and rights concerning the Welsh Language are duties on public bodies required by law. Remedies are available to citizens to seek recourse separately. We would not want to see these conflated with a person-centred care approach and would prefer seeing these sit alongside and complement person-centred care. Not doing so risks complicating the approach, especially one that is based on a set of common standards and Welsh Government guidance.

There's little sense of structure, or order, to the approach in its current form. In its recent report "Person-centred care in 2017" National Voices focused on a short range of recognisable features of person-centred care and develops a narrative that can be easily understood by the cared for person and professionals:

"Information is the foundation for people to be engaged in their health, care and support. Tailored information — that makes it useful for the individual — is the first step to 'personalisation'.
Information may come in many forms, but in care contexts…

Communication between people and staff is the principal way in which information is conveyed, discussed and tailored. More than that, it is the opportunity for the person to surface their own expertise, feelings, values and preferences. Communication should be two-way and as equal as
possible. This in turn makes possible…

Participation in decisions as a marker for care that is enabling and empowering, and where people's own values and preferences can be brought to bear. An advanced form of decision making is…

Care planning so that people can consider the future course of their care, treatment and support, and direct it as much as possible. Personalised care and support planning can enable people to identify their goals (for their lives, not just their treatment) and develop a sense of control. People's ability to achieve progress towards these goals is then helped by…

Care coordination so that care and support are built around the individual and their carer(s), with services working together for the outcomes important to the person." (National Voices, 2017)

This approach is also articulated in slightly more condition specific terms within the Cancer Delivery Plan 2012, pages 8 – 10.

We support the stress placed on the importance of information for patients, which we support. Paragraph 66 fails to refer to information at all, which is disappointing. Macmillan has a long-term call for a national, strategic NHS Wales Information for Patients strategy that draws together the fragmented information for patient policies found in multiple plans and strategies. The strategy we call for would align information for patients across multiple media, such as digital, print and face to face communication.

Macmillan has also developed tools – for instance, the holistic needs assessment and electronic holistic needs assessment (eHNA) that helps both cared-for person

and professional to co-produce and plan for care and gather information on a population cohort basis of needs.

The National Voices Report also refers to support and education for the self-management of longer term conditions, which is also something we would supporting seeing referred to within the approach here in Wales, especially with regards to cancer.

Engaging with cared for people and acting on their experience is a feature of person-centred care that's also missing from the approach set out within paragraph 66. The 2016 Cancer Delivery Plan notes the importance of the first Wales Cancer Patient Experience Survey in identifying pockets of poor experience and lack of consistency occurs and the challenges that brings to the goal of co-production. We recommend Welsh Government reflects on that learning during the development of this set of principles (page 13).

Macmillan has worked in partnership with the Welsh Government to measure and act on the findings of the Wales Cancer Patient Experience Survey – the most recent was published in July this year. The survey results provide a robust and comprehensive analysis of people's experiences of cancer care in Wales, capturing the views of 6,714 patients, a response rate of 65%. The learning is rich and improvement can be targeted as data is disaggregated to LHB level. Patient experience is a key feature of cancer care, and evidence suggests that experience of good integration of care is the most important driver of overall satisfaction with cancer care (Gomez-Cano et al, 2017). High quality patient experience, measures over time can be used to drive improvement to services and outcomes. Going forward, we would expect the high-level standards concerning person-centred care to address the role of patient experience.

Finally, we believe that the common principles underpinning person-centred care will require the development of a set of indicators to measure performance and ensure compliance is consistent across Wales. The National Voices report found that person-centred care is inadequately measured, co-ordination of care is not measured and data concerning people's experiences is patchy. Commencing development of a suite of person-centred care indicators now, alongside the development of person-centred common standards, will go toward addressing these known weaknesses.

Macmillan is able to work in partnership offering support and sharing learning with the Welsh Government around the development of these principles, if that is believed to be helpful.

Representing the Citizen in Health and Social Care

Do you support this proposal?

No comment on the current detail of the proposal, but we wish to make the following comments to be taken into account moving forward.

Can you see any practical difficulties with these suggestions?

Statutory organisations are not the only way through which the patient voice is represented. We wish to highlight that other organisations many in the third sector, including Macmillan Cancer Support actively engages with people affected by cancer and have an important role to play highlighting and bringing their views to the NHS and its partners at a strategic level (as well as at a more local level) in order to shape and improve services.

The Wales Cancer Patient Experience Survey is a rich source of information and we encourage its use by other organisations, including LHBs/CHCs etc to focus practice in areas that have been identified as needing further attention to improve experience and outcomes.

WGWPMB193: Hafal
Location: Swansea

General Comments

Hafal welcomes the opportunity to respond to the Welsh Government's consultation. We are Wales' leading charity for people with serious mental illness and their carers. Covering all areas of Wales, Hafal is an organisation managed by the people we support: individuals whose lives have been affected by serious mental illness.

Much of our response mirrors the written evidence we submitted to the Parliamentary Review into the Future of Health and Social Care in Wales, and we will focus on what we think are the two key issues relevant to quality and governance in health and care in Wales;
The need to ensure that people who use or who will use health and social care services drive how those services are planned, designed, delivered and evaluated, and that the voice of citizens is significantly strengthened
The need for fully integrated services - including regulatory and inspection services

Duties for health and social care which promote cultural change

A 'Wide Duty of Quality' is proposed 'to encompass the population needs of Wales', and to promote collaboration across Health Boards, social care and other organisations. Hafal fully supports the principles of co-production, prudent health care and the need for health and social care services to be person centred and person driven.

The starting place for planning and delivering high quality services in Wales is understanding both what the size and the nature of demand is - and is likely to be in the future - for services. Having a clear understanding of the nature of demand and what it is should in turn help to reduce waste in the system. It should help ensure people receive the most effective and most appropriate service first time. Having the right service at the right time in the right place and delivered by the right people.

Across Wales there is limited information and knowledge about what people with mental health problems/mental illness (and other illnesses and conditions) require to help alleviate those problems, both in terms of reducing symptoms and minimising the adverse consequences experienced as a result of living with their condition.

Information and data about needs and demands for services should be collated and held centrally to establish a picture across Wales, to identify where there may be particular hot spots, and to establish where and what further information and data is required. This should significantly inform the planning and resourcing of services on an all Wales basis.

Service models
The nature of the demand and the number of people who need a particular service should drive how services are designed, planned and delivered. In determining this it is crucial to ensure that there are effective systems and processes in place to

meaningfully and genuinely engage and involve a wide and diverse range of service users and carers.

An effective and democratic model for engaging with and involving mental health service users and carers has been developed in BCUHB through a service called 'Caniad'. We believe this model works well in involving and engaging a wide and diverse range of people with mental health problems as well as people with alcohol and substance addictions.
http://caniad.org.uk/

We think that services must be planned and delivered on the basis of people achieving outcomes that they value and that make a difference to their lives. Services that are flexible, adaptable and person centred rather than designed with a narrow focus and delivered within over bureaucratic structures.

Integration of health and social care services

We hear from many people who use health and social care services about how they feel let down because of weaknesses in delivering fully integrated services across health and social care agencies. Health boards and local authorities have varying interpretations and are at different stages of developing fully integrated services.

We want to see:
A single integrated performance framework across health and social care
A single outcomes framework across health and social care
A single regulatory and inspection body for health and social care services in Wales

Strengthening Citizen Voice

We agree with the view of Co-ops and Mutual Wales in what it says about effective citizen voice, co-production and clear inspection. We echo their concern that Citizen Voice is not described in any detail in the consultation document. We also agree that the proposal for the CHC/Citizen Voice to cover health and social care is sensible. The current system of CHCs holding Health Boards to account has been effective, and a wealth of expertise and knowledge has been built up about the health service and about patients' and service users' experiences. We think it is essential to build on these strengths to engage with patients/service users in both health and social care settings. As Co-ops and Mutual Wales say, one of the CHC strengths is that claimed benefits for changes can be checked by the CHC once the changes have been introduced.

We want to see a much strengthened Citizen Voice that has increased power and influence, has the ability to independently challenge Health Boards when appropriate, and has greater 'clout'.

WGWPMB194: Dr. E. Williams & Mr. M. Thornton
Location: Anglesey

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Broadly, yes, we agree with the proposals but see comments below.

What further issues would you want us to take into account in firming up these proposals?
This, in itself, will not make a great difference as many, if not most, health boards already have Vice Chairs.

Health boards which are underperforming or in escalation measures should receive assistance which may include appointing additional board members with appropriate skills to mitigate the problems identified.

Current guidance from Welsh Government Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009) has limited Independent Member (IM) appointments to a narrow range of sectors rather than choosing people for their skills and wider experience. This guidance should be revised to allow IM appointments which have a broader range of experience whilst retaining the necessary skill mix to make Health Boards effective. Boards should have appointed members who have a proven record of supporting and delivering culture change in large organisations.

Renaming “Independent Members” to “Public Members” of Health Boards is likely to have little practical benefit and may indeed cause confusion in the eyes of the public. The public will not understand why “Public Members” do not always appear to support the local public views regarding health services provision, with the potential consequence of further adversely affecting the reputation of Health Boards and their members.

Board Secretary
Do you agree with these proposals?
Broadly, yes we agree but see comments below.

What further issues would you want us to take into account in firming up these proposals?
Again, this proposal is unlikely to confer a great benefit in isolation. Currently, the Public Interest Disclosure Act provides statutory protection for “whistle blowers” who raise serious concerns, provided they meet the criteria laid down in the legislation. This has proved largely ineffective in protecting individuals from adverse consequences as a result of raising major concerns. Board Secretaries would always be wary of “biting the hand that feeds them”.

The only way to ensure that Health Board Chief Executives and Board Members

are properly challenged and held to public account is to have a strong and effective “patients’ voice” organisation representing the views and best interests of the communities they serve, and has formal, statutory, rights of engagement with Health Board Executives and Members. This removes any conflict of interest that Board Secretaries may suffer, perceived or otherwise.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

No, or at least not yet.

This aspect has already been largely covered by recent legislation - The Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015.

What further issues would you want us to take into account in firming up these proposals?

Health Boards and Local Authorities are already busy finding ways to implement “The Social Services and Well-being (Wales) Act 2014” and “The Well-being of Future Generations (Wales) Act 2015”. Further change at this time would be a distraction from the task at hand. Public Services Boards and the, so called “Part Nine Boards” are busy preparing their plans and assessments. To change direction now would seem a waste of committed effort and resource.

Once the above legislation has been fully embedded within the NHS and Local Authorities the effectiveness can be properly assessed. We would envisage this taking a further two years, at the end of which informed amendments to the legislation could be considered.

Duty of Candour

Do you support this proposal?

Yes, we support this proposal, but see comments below.

What further issues would you want us to take into account in firming up this proposal?

Most professional bodies within the NHS already have a duty of candour within their codes of conduct. Equally BCUHB has a “Being Open” policy which, if followed, ensures a duty of candour to patients and we would expect other health boards in Wales to have similar policies. Bringing a duty of candour to social care providers would be a positive step.

Fundamentally, statute and policy are not what ensures a “duty of candour” but it is the culture embedded within an organisation. So while bringing in a statutory duty may succeed in aligning regulation to intent, it will not fully ensure delivery. Regulation alone will not deliver a change in NHS culture in Wales.

Setting and Meeting Common Standards

Do you support this proposal?

Broadly agree, but there must be adequate flexibility within the standards to accommodate local differences in geography, demography and social factors, as

well as variations in the type of care provided.

What further issues would you want us to take into account in firming up this proposal?
Because of the great differences in the types of care listed in the paper, which are supplied by a wide range of organisations, it is only going to be possible to produce a set of common standards at the very highest level. These are likely to be more aspirational than operational.

Operational standards which detail what each type of care looks like and what is actually expected to be delivered will still be necessary. Without detailed operational standards the high level common standards will have little influence or context in the day to day delivery of healthcare.

Further, any set of standards will be rendered meaningless in practice without an effective system of accountability and sanction for failure to meet those standards.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Yes, we support this proposal, but see reservations stated below.

What further issues would you want us to take into account in firming up this proposal?
The public and patients in Wales do not routinely differentiate between health or social care services be they provided by the NHS, GPs (through the GMS contract), Local Authorities, Social Service provision contractors or Welsh Ambulance Service Trust so it does make sense to require service providers to cooperate to investigate when things go wrong.

However, how would these requirements be enforced?

Complaints within the NHS are currently regulated by “The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011”. Few, if any health boards in Wales meet the requirements of the regulations in terms of complaint handling performance.

To take one example, there is a requirement within the regulations that “A responsible body must take all reasonable steps to send a response to the person who notified the concern within thirty working days beginning on the day upon which it received notification of the concern.” Currently, for BCUHB, 30% of complaints are handled in compliance with this regulation. With some slight variation from month to month, this has been the case for a number of years and appears to draw little or no consequence.

Welsh Risk Pool reports and the Keith Evans report “Using the Gift of Complaints” highlight the failure of the NHS in Wales to learn from mistakes. It’s hard to see how new legislation, on its own, will change the culture of health care providers to benefit from organisational experience.

In conclusion, without a system of accountability, enforcement and sanction any new regulations are likely to be as ineffective in meeting the reasonable expectations of the public and patients in Wales as the ones that are currently in force.

Representing the Citizen in Health and Social Care

Do you support this proposal?

No, we emphatically oppose this proposal.

"Those who do not learn from history are condemned to repeat it"

Can you see any practical difficulties with these suggestions?

In 2003 CHCs were abolished in England as part of the "NHS Plan 2000". There was little preceding discussion before this action was taken. We are now seeing a similar situation occurring here in Wales.

In 2007 evidence was emerging that there was something very wrong with the standards of healthcare being provided at the Mid. Staffordshire Hospital run by the Mid Staffordshire NHS Foundation Trust. Subsequent inquiries confirmed that between 2005 and 2008 there had indeed been serious failings with a large number of mostly elderly and vulnerable patients suffering terrible neglect in many cases resulting in avoidable death. Estimates of the number of avoidable deaths range between 400 and 1200.

In 2010 Robert Francis QC was commissioned to carry out a public enquiry into the events at Mid. Staffordshire Hospital. The report was published in Feb. 2013 which included many harrowing accounts of the neglect that family members had suffered at the hospital. The highly critical report also made 290 recommendations.

On p46, s1.19 of the Francis report executive summary, under the heading of "The Voice of the Local Community" Francis states:-

"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."

It is clear from the Francis report that the abolition of the CHCs in England was seen as one of the key factors that created the environment that allowed the disaster at the Mid. Staffordshire Hospital to occur.

It is probably also worth remembering that CHCs were established in England and Wales in 1974 as a response to a number of health care scandals which included

the mistreatment of mentally ill patients in Ely Hospital in Cardiff during the mid-1960s.

The White Paper states that “We would therefore propose the creation of a new, independent, arrangement to replace CHCs, based in some respects on the Scottish Health Council and working across health and social care.”
The Scottish Health Council (SHC) was established in 2005 in order to “…promote Patient Focus and Public Involvement in the NHS in Scotland. By ensuring that NHS Boards listen and take account of people's views.” In practice the SHC role is limited to ensuring that Scottish Health Boards carry out service change consultations in accordance with the Gunning Principles, no more and no less. The SHC takes no consideration as to whether the service changes proposed by health boards are in the best interests of the local population. Within this narrow remit they carry out their duties diligently, but they do not, and would not, claim to be the “patients’ voice”. They have no statutory powers to visit healthcare establishments to assess the patient experience nor do they supply advocacy services to patients and carers who have been let down by Health Boards.

It is this narrow focus that lead, in January 2017, to The Convener of the Health and Sport Committee of the Scottish Parliament describing the SHC in the following terms: “you are a toothless hamster. I do not see where you add value. A major overhaul of some kind is needed if we are to have transparency and processes in which patients and the public genuinely engage.”

It is strange then that the White Paper is proposing a model which has so recently been discredited by a Scottish Parliament committee. It is also somewhat ironic that the Scottish Parliament is currently undertaking a consultation in Scotland which is to consider strengthening the SHC by adopting practices from organisations like the CHCs in Wales.

CHCs in Wales currently provides a highly integrated service to local communities carrying out the following functions:

- Scrutiny of the operation of the health service, including the entry and inspection of premises;
- Engagement with the public on issues;
- Referral by individual CHCs of matters to Welsh Ministers in connection with service changes;
- Independent complaints advocacy services (a function of Welsh Ministers which has been conferred on CHCs through regulations).

Each element provides information and intelligence to determine how well the health boards are providing for the health care needs of local people. Statutory powers exist to have formal meetings with health boards to feed back the findings, observations and public views on health care provision. Much of this will be lost if the proposals are carried forward as written. There is a consistent theme throughout the White Paper to centralise, dilute and disperse the CHC functions reducing the influence that local people can have over local health care services. As such, it makes the stated aim within the White Paper “for further strengthening the voice of citizens in health and social care” appear disingenuous.

Much of the criticism of CHCs in the White Paper appears to originate from a lack of understanding of the role that CHCs currently carry out, as well as a misrepresentation of the content and context of the OECD report and Marcus Longley Review. The White Paper is also selective in its choice of other references carefully avoiding those which show how the public and patients support the work that CHCs currently do on their behalf.

One such misunderstanding is that the CHCs visiting and monitoring activities and HIW inspection activities are in some way a duplication of effort when, in fact, they are very different but complimentary activities. HIW carry out very formal and largely technical inspections of health care premises which is a very important activity beyond the capability of CHCs volunteer lay membership. These inspections are very detailed but are carried out relatively infrequently. CHC visits, on the other hand, are carried out more frequently and purely address the patients' experience based on what volunteer members see and hear from the lay perspective. Both activities are required if robust scrutiny and accountability of health care provision is to be maintained.

The BCUHB is on public record supporting the visiting and monitoring work that the North Wales CHC do in providing another independent source of information to support its improvement programme on its journey out of Special Measures. It particularly appreciates that it is the view derived from observations made by ordinary people from within the community that the Health Board serves.
If the Welsh Government genuinely wishes to strengthen the voice of patients and citizens, building on the strengths that the CHCs in Wales currently have, it should consider the following:-

- Retain all the current statutory powers that CHCs currently hold.
- Extend those powers to cover establishments where social care and commissioned nursing care is provided in Wales.
- Broaden the referral arrangements to include formal referral of matters of concern to health and social care regulators.
- With appropriate guidance, allow CHCs to directly recruit membership which would allow better representation of local communities and allows people to contribute in different ways.

In conclusion, Welsh Government should seek to build on the strengths that CHCs in Wales currently have by extending their activities to better protect and represent people who are in social care as well as those who receive NHS care.
There is no impediment for CHCs to take a role in co-creating local services at the moment, and many CHCs do work constructively with Health Boards in this area. The proposals, as they stand now within the White Paper, are very likely to create the perfect environment for repeating the terrible mistakes of the past.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

No we do not agree with the proposals as stated in the White Paper.

What further issues would you want us to take into account in firming up this proposal?

The problem is overstated in the White Paper and usually arises because Health Boards fail to consult and engage their local and wider populations effectively. They fail to adequately articulate the benefits of proposed service changes and don't present a compelling case that there is an appropriate balance to be made between local, regional and national services.

The proposals appear aimed at weakening the citizens' voice in order to be able to more easily implement unpopular service changes with little public resistance. We recognise that there is an appropriate balance to be struck for local, regional and national service provision. The solution is for Welsh Government to direct Health Boards to ensure that public consultation and engagement are a core part of their service to the people of Wales. CHCs (or a genuinely strengthened successor body, rather than the one being proposed) alongside other bodies representing the public and citizens interests should be part of the continuous engagement arrangements, helping co-design and co-produce health and social care services locally, regionally and nationally.

The proposals to set up an independent panel to review major service change has some merit as well as that formalising the process for scrutinising major service changes. This would provide some welcome consistency across all Health Boards.

We note that the Welsh Government only want Ministers to become involved as a last resort. However, Welsh Government Ministers are always ultimately responsible for the provision of health and social care to the people of Wales whatever administrative arrangements are in place.

Inspection and Regulation and single body

What do you think of this proposal?

Broadly supported in principle.

However, there is insufficient detail in the White Paper to indicate how this would work in practice.

Are there any specific issues you would want us to take into account in developing these proposals further?

Without further detail it is difficult to comment.

Clearly, organisations with different cultures and different ways working may find closer integration and joint working challenging. As an analogy, Natural Resources Wales took over the work of Countryside Council for Wales, Environment Agency Wales and Forestry Commission Wales and that particular transition was not without its difficulties.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?

No, we would not support such an idea without further detail regarding how the arrangements would work in practice.

What issues should we take into account if this idea were to be developed further?
In our view, the general thrust of the White Paper has been to weaken the citizens' voice by centralisation and reducing the statutory powers currently held by CHCs in Wales.

There is a real risk in the proposal that the citizen's voice body could become the poor relation, subservient to the regulators if it was placed within the same organisation.

CHCs already work closely with HIW, less so with CSSIW due to restriction that Welsh Government place on CHCs barring visiting establishments that provide social care or commissioned health care. Moving under the "same roof" does not seem to provide any obvious benefit but does present significant risk to the independence of any patients' or citizens' voice organisation.

WGWPMB195: Children's Commissioner for Wales
Location: Swansea

General Comments

I welcome the development of this White Paper as an opportunity to align duties between health and social care. However, whilst I understand that the White Paper sets out its aim to work as an "enabler for change" (2017:8), I must question the timing of proposals, given that we have not yet received the final conclusions of this high-level and wide-ranging report for Wales.

I admire and agree with the overall aim to build a culture of quality improvement within the NHS in Wales and I recognise that the Organisation for Economic Co-operation and Development (OECD) stated that the building blocks have largely been established here in Wales, I am disappointed that there is no specific mention of children and young people throughout both the review or the White Paper. There is consequently no recent review of how the healthcare system in Wales is or indeed, is not, meeting their particular needs.
http://www.oecd.org/health/health-systems/oecd-reviews-of-health-care-quality-united-kingdom-2016-9789264239487-en.htm

However, the OECD Review did highlight that a truly systematic approach to working in partnership, citizen voice, quality improvement was lacking. All of which reflects what I am now highlighting for adoption by all public services - a Children's Rights Approach. I have recently published "The Right Way" which is a principled and practical framework for working with children and young people, grounded in the United Nations Convention on the Rights of the Child (UNCRC). It's about placing the UNCRC at the core of planning and service delivery and integrating children's rights into every aspect of decisionmaking, policy and practice. Given that many proposals outlined within the White Paper can be said to reflect the five principles of a Children's Rights Approach, this is a unique opportunity to secure its adoption within the NHS in the long term and I urge the Welsh Government to strongly consider this.
https://www.childcomwales.org.uk/wp-content/uploads/2017/04/The-Right-Way.pdf

Whilst I agree with much of the content of the proposals, I do believe that its structure could be improved. Citizens' voice and their rights should be at the centre and run throughout the proposals. What they should expect from health and social care services via a person-centred approach and no matter where they are received or by whom should then follow. This would reflect duties of quality and candour placed on such services which are well understood, with an alignment of standards and complaints procedures. The appropriate governance structure should then allow for this to be achieved locally and ensure appropriate accountability is in place.

Response to Specific Questions

Effective Governance:
In principle, I agree with the proposals set out within the White Paper under this section. However, I must highlight the fact that I have only responded below to areas that reflect my remit and where I feel best placed to respond, according to the rights of children and young people.

Board Membership and Composition
When considering governance issues, my view is that engaging young people in national governance is critical and the proposals here allow the Welsh Government and NHS Wales to take up the opportunity to ensure that children and young people do not to feel excluded from decision-making and governance processes within health in Wales. Given that over 20% of the population is aged between 0 and 17 years old3, the sustainability of any developments here should, in my view, require their ownership, involvement and participation. There is a requirement to fulfil children and young people's right under the United Nations Convention on the Rights of Child to be involved in decisions that affect them. If I may take this opportunity to offer my own experience of this, their contribution brings added value to my organisation, through providing unique insights and an alternative source of scrutiny and feedback. I have now established both a Young Persons Advisory Panel made up of children and young people between the ages of 11 to 18, and a Commissioner's Advisory Panel, which includes both the chair and vice-chair of my Young Persons' Advisory Panel. Both of these panels work to hold me to account on the delivery of my three year and annual work plans and provide strategic support and challenge. This is in addition to structured opportunities for large numbers of children and young people to feed their views and experiences into my work programme each year. I would expect all LHBs and Trusts to develop structured opportunities for children and young people in their local population to give feedback on services, be involved in service development, and to provide strategic support and challenge.

http://www2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/3653c00e7bb6259d80256f27004900db/fc57159cf0046a8a80257c28004aa6ea/$FILE/Children%20and%20YP%20Profile%20Wales%20report%20-%20low%20res%20(Eng).pdf

Consideration of the composition of LHBs/Trusts provides an opportunity to establish a distinct role to represent the views/champion the cause of children and young people and to consider the value of their direct involvement too. In response to the Welsh Government's Green Paper 'Our Health, Our Health Service' in 2015, I described my experience of children's champions and how the role of these independent members is one to be welcomed, but that there continues to be limitations in how effectively they can provide challenge to and scrutiny of local health boards in their services for children
and young people. Given the fact that I had made reference to my concern that Board Champions do not currently have the time or resources to properly reflect and influence the development of services for which they are responsible, I am disappointed not to see further development on this within the White Paper proposals. Local Health Boards and NHS Trusts remain duty bound by the Children Act 2004 (http://www.legislation.gov.uk/ukpga/2004/31/section/27) to appoint a lead

member and a lead non-member to represent the interests of children and young people, particularly for the purposes of achieving the wellbeing goals as defined within the Social
Services and Wellbeing (Wales) Act 2014. I am unaware of any recent review of this role, however, my concerns above remain as my experience to date and the opportunities presented by the White Paper could allow for the cementing of this core role to represent children and young people on each Board. I would be happy to engage in further dialogue on this with Welsh Government to ensure that any proposed development in relation to effective governance has children and young people's views and interests at its heart.

I am currently engaged with each NHS organisation in Wales through the Designated Liaison Officer role established as a result of Lord Carlile's Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales: "Too Serious a Thing" in 2002 (http://www.wales.nhs.uk/publications/English_text.pdf). I have recently written to each Board/Trust to acknowledge the value I place on this and to highlight my expectations to strengthen my links with the NHS Wales Safeguarding Network, hosted by Public Health Wales. I have recently utilised my engagement here as an opportunity to host an Annual Child Health Seminar to encourage developments within child health and a children's rights-based approach. I would therefore be keen to strengthen my relationship with local leads on children and young people's health and ensure that I reflect developments with the proposals here within any of my engagement work.

With this in mind, whilst flexibility would potentially allow NHS organisations to better meet the particular needs of their population, a more prescriptive model could help navigation of the system and accountability to children, young people and their families. However, consistency in outcomes should clearly be the ultimate aim here.

I have recently published 'The Right Way' (https://www.childcomwales.org.uk/wp-content/uploads/2017/04/The-Right-Way.pdf), a principled and practical framework for adopting a children's rights approach in Wales, grounded in the UNCRC. The model set out in my guide has been developed with public authorities in Wales in mind and takes account of themes consistently highlighted as integral to a Children's Rights Approach rooted in the UNCRC. Many parts of NHS Wales will already have ways of working which are consistent with a Children's Rights Approach but adopting the principles, language and practices described will complement or improve what is already working. This approach is about placing the UNCRC at the core of planning and service delivery and integrating children's rights into every aspect of decision-making, policy and practice. Adopting this approach could mean that children are provided with meaningful opportunities to influence decisions about their lives and it could help provide the consistency mentioned above, as well as a common set of shared values and language. In applying this approach to governance, the NHS in Wales should help build the capacity of young people to engage with this and to also consider building the capacity of decision-makers to engage with and respond to their needs. Consideration of how we fulfil these requirements should be part of any further developments here.

Whilst I agree with the introduction of core key principles to enable a level of consistency across Wales, I am keen for their value and applicability to better reflect the needs of children and young people. The core principles proposed could, in my view, be improved to ensure the inclusion of children and young people as citizens and an integral part of the populations of which LHBs/Trusts will need to provide for.

Board Secretary
I agree that providing statutory protection for this role should be considered. Its independence should be prioritised but consistency in adopting key principles should be adopted consistently across all LHBs and Trusts. This allows for consistency, clarity, accountability, monitoring and reporting. This role should be protected and supported to raise concerns and challenge independently the decisions of the CE and the Board more widely.

Duty of Quality for the Population of Wales
In principle I agree with the proposals outlined to enhance the current duty of quality upon NHS bodies so that more collaborative planning and delivery of healthcare services can be ensured. I believe that this extension should allow for the establishment of services on a regional or national basis, aligned with recent legislative developments within social care and future generations. Further development here should reflect the need for a duty of quality to ensure that the rights and needs of the population, including children and young people are prioritised. They should also ensure that mechanisms are in place to oversee such a duty, with clear procedures in place to ensure any disagreement in practice can be resolved quickly. The Population Needs Assessments established as a result of the Social Services Act, should be jointly undertaken by LHBs and Local Authorities. Therefore, work in partnership to identify needs and develop a plan to ensure that those needs are being met in each local authority area should already be in place. Crucially, children are a specific area of priority focus within those assessments so LHBs should be working with their respective local authorities in order to prioritise their needs.

Given that these proposals are seeking to align the statutory duties placed on local authorities and/or other public bodies, I must take this opportunity to advocate that this is done in a consistent manner. Included within these developments should be the requirement for NHS bodies to have due regard to Part 1 of the United Nations Convention on the Rights of the Child (UNCRC) (http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx). This would allow for complete alignment with Section 7 of the Social Services and Wellbeing (Wales) Act 2014 (the Social Services Act) (http://www.legislation.gov.uk/anaw/2014/4/contents/enacted), guarantee further collaborative and integrated working and ensure that their rights are secured.

As a result of Section 7, those exercising functions under the Act must consider the rights of children and young people in Wales, as laid out within the UNCRC. This was a significant milestone in the history of children's rights in Wales and I would urge the Welsh Government to consider the need to align developments with the White Paper proposals with those that have already been put in place for social

service colleagues. Currently local authorities must demonstrate compliance with the overarching duties
in a meaningful way and I understand that Welsh Government are currently drafting proposals to evaluate the impact of the Act. This should demonstrate the feedback I have received from those implementing it that this duty has had a positive impact on their ability to consider the wider needs of children and young people within both decision-making processes and service delivery. I consider this to be a unique opportunity to ensure that the consideration of children and young people's rights does
not only apply should they be accessing one type of service within Wales and not across the board. In fact, given the legal obligations set out within the Social Services Act, it would be incongruous if a situation is allowed to develop whereby looked after children, young carers, and children with care and support needs as recognised under the Social Services Act, would have numerous professionals directly supporting them from social services who are obliged to pay due regard to the UNCRC, yet would not have the same level of provision from professionals surrounding them in their healthcare needs.

I am convinced that a legal duty will consistently promote and underpin the cultural change and innovative practice that is required to secure improved outcomes for children, explicitly setting the proposals within a coherent, politically neutral and internationally agreed set of values.

Issues raised by children, young people and the adults who care for them, too often reflect the lack of integration between health and social care services. By fulfilling entitlements to the rights under the UNCRC, as mentioned above, I remain convinced that we can live in a country where children and young people can achieve their full potential.

I have made the same recommendation to the Parliamentary Review Team and urged them to carefully consider how far their findings and recommendations to Welsh Government could help facilitate the placement of explicit duties of due regard to the UNCRC for those delivering public services in Wales and help reflect the coherent, politically neutral and internationally agreed set of values it would uphold. It would also have the potential to place children's rights as a guiding principle for health and social care service developments and make overt the role of local authorities, health boards, community health councils, health professionals and relevant others as duty bearers of the convention.

Duty of Candour

I agree with the proposal for a duty of candour to be applied for the health service, and in particular the need to ensure this culture of openness and transparency occurs intrinsically and not only when a concern has been raised or an incident occurs. Such an approach will contribute positively to the wider context of ensuring patients, including children and young people are fully involved in the decisionmaking process for their care. This could reflect a rights-based approach and help ensure the information that children and young people have a right to receive is considered as part of this duty. In

his 2014 review of 'Putting Things Right': the way NHS Wales handles concerns and complaints,
http://www.wales.nhs.uk/sites3/Documents/932/MB%20MD%202702%2014%20-%20Report%20-%20A%20review%20of%20concerns%20%28complaints%29%20handling%20in%20NHS%20Wales%20-%20Using%20the%20gift%20of%20complaints%20by%20Keith%20Evans%20-%2020140611%20Doc%201.pdf

Mr Keith Evans reflected that "…the general public would appreciate honesty and candour in their dealings with the NHS. This should be a basic patient right not something that is decided by the NHS and informed to users on a need to know basis" (2014:96). A view I wholeheartedly concur with and the reason behind agreeing with the proposal for its positive implications for children and young people, as members of society. This duty of candour, in its widest form, should be explicitly defined to ensure that health bodies and professionals tasked with applying it are fully aware of its intentions and that the wider public, including children and young people, are fully aware of what they can expect of it. With this particular point in mind, I urge Welsh Government to reflect Keith Evans' recommendation that any legal duty of candour should "not rest only on the shoulders of individual employees, but should be reflected on the employing organisation as a clear corporate responsibility and tone for the organisation." (2014:70).

In relation to this proposal, I have currently been trying to clarify the arrangements for the provision of health-related advocacy for children and young people (i.e. Under 18s). Whilst the recently reviewed and updated patient information leaflet on the Putting Things Right (PTR) arrangements included a childfriendly version, I have raised my concerns with the accuracy of its content. It is currently unclear as to how consistently Local Health Boards and NHS Trusts are approaching their provision for under 18s who
wish to make a complaint about care and treatment provided to them as part of the health service in Wales. Given the national approach for statutory advocacy for children now in place and the availability of such is improving for children and young people receiving care and support under the Social Services Act, I strongly believe that these proposals provide us with the opportunity to align the statutory requirement to provide such services and ensure that children and young people have access to the same level of provision, no matter which service they are receiving care and support from.

Despite my general approval of this proposal, I do believe that further consideration should be made as to the mechanisms to monitor and review this duty. There needs to be further detail on who would oversee its implementation. Children and young people themselves could play a part in holding Health and Social Care bodies to account on this duty and I would encourage Welsh Government to include them in any further developments.

Person-Centred Health and Care:

I wholeheartedly agree with a person-centred approach which again, could help uphold the rights of children and young people to be fully involved in decisions which directly, or indirectly affect them.

Setting and Meeting Common Standards

Children, young people and the adults who care for them have often raised with me issues regarding the lack of integration between health, education and social services available to them. This is particularly pertinent for those with mental or physical health needs and disabled children. Whilst I believe this to reflect a need for integrated care for children and young people across geographical boundaries such as Local Authority and Local Health Board footprints, common standards could potentially go some way to address this as a first step.

However, I am keen to see a stronger push towards integrated services to meet the ongoing healthcare needs of children, young people and their families. As part of our investigations and advice casework, my office often deals with difficulties in service provision and planning for disabled children and young people, including around health and social care needs related to their education and transport to access services. This is particularly an issue upon transition between children and adult services. These
difficulties, in my view, arise at least in part, from a lack of pooled budgets and integrated working, as families often find themselves caught between different teams, even within the same local authority or health board area. I am therefore keen to see improved impetus and movement around integrated care reflected in the design and delivery of services for children and young people and as such, I would, again,
urge the Welsh Government to consider the opportunity to apply a children's rights-based approach within developments here.

Welsh Government's current Health and Care Standards, established in 2015, includes a standard relating to People's Rights (Standard 6.2) and makes the following reference that "The health service will need to consider the following criteria for meeting the standard: …The rights of children are recognised in accordance with the United Nations Convention on the Rights of the Child (UNCRC)." (2015:31). The inclusion of this is hugely valuable and I seek assurances from Welsh Government that this will not be lost in any proposed new set of standards. In fact, the current White Paper could help strengthen and build upon its application through the adoption of a rights-based approach more systematically here.

We are aware, through our engagement with Healthcare Inspectorate Wales (HIW), that there are only a limited number of reviews of late, where their inspection against this standard has helped inform its conclusion and recommendations. As part of a very recent unannounced inspection of a health setting, recommendations were made to the LHB in question under this Standard (http://hiw.org.uk/docs/hiw/inspectionreports/170914noahsarken.pdf) although we now have the opportunity to further distinguish how far healthcare services are upholding the rights of children and young people across Wales. I believe that the Welsh Government, by continuing to reference the UN Convention within any new set of common standards, and by formally adopting my recent guidance 'The Right

Way', could support health and social care settings to embed this approach within practice and enhance the basis by which the Inspectorates scrutinise progress.

Within healthcare settings, the National Centre for Equality and Human Rights, already established within the NHS in Wales and currently part of Public Health Wales could help support this agenda by strengthening its role and purpose to include a focus on children and young people. My office has recently met with colleagues at the Centre in the hope that I too can support this development. This work could also help achieve Lord Carlile's first recommendation within his Review of Safeguards for Children and Young People Treated and Cared for by the NHS in Wales (2002): "Too Serious a Thing" (http://www.wales.nhs.uk/publications/English_text.pdf) states that:

…all staff having access to children should be trained to a full understanding of children's rights and an appropriate level of awareness of the needs of children, and that they should be required by their employers, as a matter of specific contractual obligation to respect and apply those rights rigorously. (Paras 1.13, 1.14, 1.15, and 1.20).

This recommendation was accepted in principle by the Welsh Government and work to achieve it was to be "discussed with partners" (Welsh Health Circular (2002) 84) (2002:6). I understand that work will have taken place since this time to address these recommendations, however, it seems sensible to utilise the opportunity afforded to us via the White Paper to strengthen this further. Therefore by continuing with the need for a rights-based standard and the formal adoption of my recent guidance, the Welsh Government could help ensure that the expectation on services across both health and social care in paying particular attention to basic human rights are clear and that these standards are understood and equally applied throughout service provision. I would be happy to help support developments here and offer advice on how health bodies across Wales could embed a children's rights-based approach within their organisations.

Joint Investigation of Health and Social Care Complaints

In addition to the points I make above relating to the lack of integration between health, social care and education services, I believe a joint process of investigation may be a helpful development. However, further detail is needed before I can provide a clear view on this. What does concern me slightly is that the proposed joint complaints process between health, social care and independent providers will operate in addition to their individual processes currently in place. Whilst I acknowledge the intent in proposing this, on a practical level, this may prove to be confusing for children, young people and their families trying to navigate this route and potentially at a distressing time. What may be more beneficial is one defined approach to handling complaints, across all public services. However, communicating this clearly, succinctly and proactively to children, young people and their families must be acknowledged and addressed within any proposals.

Representing the Citizen in Health and Social Care

I agree with the proposals set out here to strengthen the voice of the citizen in the way health and social care is planned and delivered. Developments in this regard must include methods to engage children and young people and uphold their right to do just this. Again, the UNCRC includes articles on participation which are based on the idea of the child or young person as someone who actively contributes to society as a citizen in the here and now and not just someone who is passively on the receiving end of good or bad treatment from others. All children should be supported to freely express their opinion on the health services they receive and should be both heard and listened to.

Participation should not be understood as an end in itself, but as a process, which is safe, enabling and inclusive, and which supports dialogue between children and professionals. Any new arrangement developed as a result of these proposals should ensure that this principle is reflected and the rights of children and young people to be involved in the decision-making process is upheld.

Given that the new citizen voice body will be expected to work across health and social care, I would agree that it would make sense for them to sit alongside HIW and the Care and Social Services Inspectorate Wales (CSSIW). I also agree that the body should operate with a sufficient degree of autonomy so that issues identified by the public, including children and young people, can help inform the direction of its work programme.

I agree overall with the proposed new set of functions considered for application by the new citizen voice body. However, as I have mentioned, we must be clear that this should include the voices of children and young people and this agenda must not lose sight of their contribution here. Any involvement of children and young people here should reflect the application of the National Participation Standards for Children and Young People in Wales. This body, in its autonomy, should not only measure the level of engagement undertaken by LHBs/Trusts on substantial changes, but also distinguish and represent the views of the public on areas outside of this agenda (i.e. the public, through this body, should be encouraged and supported to set the agenda items for consideration by Boards/Trusts, in addition to engaging on agenda items (i.e. service changes) already set).

Whilst I am aware that the proposals will help ensure the promotion of co-production; supporting local networks; improve and monitor level of engagement and inform Welsh Minister of this; all of which must include children and young people's contribution; I would welcome further clarity on the role of the new body in terms of embedding patient voice within the work of the Inspectorates. I understand that HIW currently utilise a pool of Lay Reviewers to gain the perspective of the patient and identify their feedback on the services they are receiving/have received. How will this continue under these new proposals?

There is a distinct difference between identify patients' feedback on services and how far they feel they have been involved in co-design/co-creation of services. Will the role of the lay reviewer continue under these arrangements? How far can these proposals develop this role to ensure that the voices of children and young people are strengthened in inspection work? I would welcome further clarity here.

In relation to health-related advocacy for children and young people, it is my view that proposals here could potentially address an issue that I have recently highlighted relating to the availability of independent advocacy arrangements for children and young people across NHS Wales. There has been substantial progress on statutory advocacy for children and young people under the Social Services Act and I welcome the fact that all of the regions are moving towards full implementation of the National Approach. However, within health settings, the picture is unfortunately different. It is my understanding that a previous Health Minister had issued guidance on this issue to Local Health Boards in 2011 http://gov.wales/topics/health/publications/health/letters/2011/directions/?lang=en, however, its implementation is currently unclear. I have raised this issue with both the Cabinet Secretary for Communities and Children, and the Cabinet Secretary for Health, Well-being and Sport and whilst I have had a productive response, I do believe these proposals could help address this issue further, for children and young people accessing healthcare and in need of independent advocacy.

As a minimum, the proposals should point out that the definitions of 'people' and 'the public' would include and promote the particular attention required in addressing the needs of children and young people, who, as re-iterated within the Evans Review of Concerns (Complaints) Handling in NHS Wales (http://gov.wales/docs/dhss/publications/140702complaintsen.pdf) (2014:247):

…need special attention through the complaints process. Children do not tend to complain in the traditional manner of adults using any formal processes that are put into place or by utilising materials that most adults would search out to use as the tools of complaint. It is important to understand the work done in this area to be able to provide the correct and different environment to help children and younger people make their views known.

We are currently aware that whilst not under any statutory obligation to do so, some Community Health Councils (CHCs) are providing under 18s with access to advocacy across Wales. However, this provision is patchy and in need of addressing. The current Putting Things Right publication for children and young people recommends contacting the Meic service. (http://www.wales.nhs.uk/sites3/Documents/932/Healthcare%20Quality%20-%20Children%27s%20-%2030679_English_WEB%20-%20FINAL%20-2017%2003%2002.pdf)

This is a valuable telephone and on-line service for children, but it is not commissioned to facilitate face-to-face advocacy support. Children and young people are therefore being left without a suitable alternative in many areas across Wales.

Inspection and Regulation and single body

As I have mentioned previously, as part of our investigations and advice casework, my office often deals with difficulties in service provision and planning for children and young people whose needs reflect both health and social care. Again, I would be keen to explore the benefits of an improved impetus and movement towards integrated care reflected in the design and delivery of services for children and

young people and as such, I would agree that the consideration of a joint inspectorate to address such
issues could help develop services working in partnership on the ground and therefore a potentially better level of service for children and young people.

At the very least, I would agree that the current duplication between CHCs and HIW in relation to local ‘inspections’ should be addressed. Similarly, I would agree that HIW’s legislative basis should also ensure that their power to regulate and review are fit-for-purpose. Most importantly for me is the opportunity we have through the current proposals to embed a rights-based approach to the health service in Wales. I would agree that we need to align the legislative framework in which HIW work to the framework developed as part of the Social Services Act, particularly in relation to placing a duty of due regard on the face of any forthcoming primary legislation.

WGWPMB196: Anonymous
Location: Anonymous

Response to Specific Questions

Representing the Citizen in Health and Social Care

Do you support this proposal?

The [redacted] believes that it is impossible to support a proposal as vague and unspecific as this. Insofar as it proposes to abolish a well-established mechanism with statutory powers and administrative checks-and-balances with a wholly unspecified alternative, we can only invite the Welsh Government to do more work on its plans and come back to the Welsh public to seek its views on a better formulated proposal.

Can you see any practical difficulties with these suggestions?

With goodwill and proper resourcing there are no insurmountable problems. The Scottish model has worked well in many aspects but there are challenges with ensuring that local communities feel properly represented and that their rights to be consulted are not diminished.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

As with other questions in this consultation, this is a statement of intended outcomes as seen by the Government. Consultees are, in effect invited to agree with the Government's opinion that its plans will encourage continuous engagement and increase the pace of change. Our response is that it will achieve these goals only by convincing local communities that its proposals for service change are well thought-through and deliver the services that people need. This will certainly not be accomplished if the Government is perceived to be withdrawing the CHC's right to refer contentious proposals to the Cabinet Secretary or reducing its commitment to full public consultation.

Given that the proposal as currently worded is ambiguous, we cannot support it.

What further issues would you want us to take into account in firming up this proposal?

The Government must clarify its intentions. Does it or does it not intend to amend the S.183 provision in the 2006 Act? It also needs to re-affirm its commitment to full public consultation where proposals are controversial.

WGWPMB197: Welsh Independent Healthcare Association
Location: London

Response to Specific Questions

Duty of Candour
Do you support this proposal?
WIHA supports this proposal.

There is currently a legal duty of candour that is applicable to the health service bodies in England. Similarly, in Scotland, a duty of candour procedure is set out in Part 2 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016. This duty applies across all health and social care services, including independent health care, GPs, dentists and pharmacists.

The development of a statutory duty of candour across health and social services in Wales would promote 'joined up working' across health and social care and align Wales with its UK counterparts.

The principle of a 'duty of candour' is supported by the independent healthcare sector. Doctors have an ethical duty to tell patients when things have gone wrong, apologise and try to put things right. The GMC's 'Good medical practice' (2013) says that doctors 'must be open and honest with patients if things go wrong'. Therefore, we feel that a statutory 'Duty of Candour' in Wales would only formalise what is essentially good practice and is ultimately 'the right thing to do'.

What further issues would you want us to take into account in firming up this proposal?
WIHA would ask for clear guidance on the thresholds for notification. WIHA would also suggest that the Welsh government note the example in Scotland where the person assessing the degree of harm would not have been involved in the original incident.
It is crucial that Duty of Candour requirements are applied and regulated consistently in the NHS and independent sectors.

Setting and Meeting Common Standards
Do you support this proposal?
WIHA agrees that individuals receiving care can be left perplexed as to why different standards operate in different settings when they feel they have the right to the same standard of care regardless of where they receive it.

The National Minimum Standards for Independent Healthcare are a useful benchmark for independent hospitals to work from and providers aspire to provide healthcare to excellent standards.

In terms of applying the same standards across health and social care, while supportive in principle, WIHA considers this might present a significant practical challenge for social care providers given how different services are delivered.

What further issues would you want us to take into account in firming up this proposal?

The independent sector would be keen to ensure that consistent standards are applied across healthcare settings. The Care Quality Commission has taken this approach in England in recent years with a standardised set of five key questions and underpinning Key Lines of Inquiry for NHS and independent providers. This has been well received, but has not been without its challenges in how the framework has been applied. For example, independent hospitals do not generally provide the range of services that a typical NHS Trust does and there is a marked size differential between NHS and independent hospitals.

It is still the case the independent sector provides some services that the NHS does not and these services would need to have their own bespoke set of standards, e.g. cosmetic surgery, long-term conditions etc.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

WIHA support this proposal of a joint complaints process. A patient centred approach is appreciated by the individual and their family. Issues relating to patient confidentiality would need to be carefully navigated, as permission to disclose information to other agencies would need to be sought from the patient prior to any joint working. This process is likely to impact the NHS health and social care organisations to a higher degree as these sectors frequently provide concurrent care to an individual.

Instances where a patient complains about NHS-funded care in an independent sector setting are already handled through a joint process and these patients have access to the Public Services Ombudsman for Wales.

What further issues would you want us to take into account in firming up this proposal?

There is an organisation called the Independent Sector Complaints Adjudication Service (ISCAS) that provides an independent review of privately-funded patient complaints in WIHA member hospitals and they would be a good organisation to consult with as proposals are developed.

Inspection and Regulation and single body

What do you think of this proposal?

WIHA believes HIW to be an effective regulator and would want to be assured that closer integration and joint working with CSSIW would enhance HIW's current operations.

WGWPMB198: NHS Listening and Learning from Feedback Group
Location: All-Wales

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
What further issues would you want us to take into account in firming up these proposals?
The consensus opinion was supportive of Welsh Government appointed Board members appointed on a fixed term as part of escalation procedures. It was emphasised that there was a need to ensure there was multi professional representation across all Welsh Health Boards and organisations.

It was agreed that all Health Boards should have Vice Chairs who have specific skills in leadership and supporting the organisation to progress.

All Boards should have an Executive Nurse and Medical Director to ensure that quality and safety and patient experience are a focus and have a voice on the Board

Alongside the Nurse and Medical Directors a Director of Therapies and Health science is equally important particularly with the increased focus on Rehabilitation community and social services.

Board Secretary
Do you agree with these proposals?
What further issues would you want us to take into account in firming up these proposals?
The profile of the Board Secretary need to be raised to include sharing widely the key roles and responsibilities. The Board secretary needs to be suitably qualified to ensure they have the skills and autonomy to appropriately challenge the Executive Board to ensure a rigorous, vigilant and effective approach to governance.

The role of the Board Secretary need not be fixed term but agree with the suggestion that the WG should have the right to remove them if issues of performance are encountered.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
What further issues would you want us to take into account in firming up these proposals?
It is agreed that working across boundaries and budgets to meet the population needs will encourage innovation and partnership working to fully understand and address the population needs. To be transparent in the service design to meet the

population needs in a quality driven manner that makes the most prudent use of the available resources.

Duty of Candour

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

The Putting Things Right Regulations have embedded at their core a duty of candour. There would need to be joint investigation agreements across health and social care this would require legislative changes and review of reasonable timeframes. This would however be a far more effective and equitable process for people who often have issues across multiple organisations. The Welsh proposal does not seem to include independent health providers as the Scottish model does. These should definitely be included.

Setting and Meeting Common Standards

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

The adoption of common standards/principles would be welcomed.

The introduction of core standards will be easier for the public to understand what they should expect from care providers. However the standards set need to be achievable and carefully consulted upon and involve the public and patients in the setting of those standards

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

There should be one investigation if that is the preference of the individual raising the concern that has clearly identified terms of reference and crosses organisational boundaries

There should be one joint investigation that is in accordance with regulations that will reflect the pathway of care irrespective of the boundaries and this will encourage the development of joint actions in response to identified issues.

Although in principle this would provide a common framework for inspection and have some economies of scale so is to be supported currently the statutory frameworks do not align and so to change this would take time and effort.

An alternative would be to set up a National body with HIW Cssiw and the citizen voice sitting under this leadership to align work programmes.

Representing the Citizen in Health and Social Care

Co-producing Plans and Services with Citizens
Inspection and Regulation and single body

It was agreed that that there should be one inspectorate body but the view was that the role of the Ombudsman with their new powers also needed to be considered. The role and remit of the inspectorate body should be transparent with a proportionate approach to investigations. This should include independent providers, and how do we provide the same standard for patients whose care is commissioned outside Wales, either by private providers or NHS Trusts.

We would specifically like to see children and young people represented more robustly. This representation needs to be extended to UHB Boards and there needs to be a specific Children's Champion. This needs to be statutory. We would welcome true participation of capturing and listening to the citizen's voice and using the many varied methods of doing this through technology and contact to have a truly representative view.

The single body should also have a supportive role towards HB providing local links similar to the PSOW improvement officers. This improves communication and understanding of the local issues faced working together to make improvements.

WGWPMB199: The General Pharmaceutical Council
Location: London

Response to Specific Questions

Duty of Candour
Do you support this proposal? What further issues would you want us to take into account in firming up this proposal?
We know that health professionals being open and honest when things go wrong is one of the best ways to protect patients. We believe a culture of openness across healthcare is critical to improving safety and ensuring a greater focus on transparency, speaking up and learning from mistakes.

Along with eight other regulators of healthcare professionals, we have signed a joint statement on openness and honesty - the professional duty of candour. This 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.

It reminds all healthcare professionals, including pharmacists and pharmacy technicians, that they must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress. It is also a reminder of a duty to be open and honest with colleagues, employers and any other relevant organisations, including us as the regulator, and to raise concerns as appropriate.

Although it may be expressed in different ways within our statutory guidance, this common professional duty clarifies what we require of all the professionals registered with the eight regulators, wherever they work across the public, private and voluntary sectors.

The GPhC would support work to strengthen and embed candour across all healthcare settings and staff, and would be keen to see any new duty work with existing professional standards and guidance.

Setting and Meeting Common Standards
Do you support this proposal? What further issues would you want us to take into account in firming up this proposal?
The GPhC sets standards for pharmacy professionals and registered pharmacies in Great Britain. These standards help to make sure people using pharmacy services receive safe and effective care. We set standards in five areas:
Standards for pharmacy professionals
Standards for registered pharmacies
Continuing professional development (CPD)
Standards for the initial education and training for pharmacists
Standards for the initial education and training for pharmacy technicians

The standards for pharmacy professionals have recently been revised. The nine standards describe how safe and effective care is delivered through person-centred professionalism. They emphasise: person-centred care; demonstrating leadership; and greater accountability on the part of pharmacy professionals. They apply to all pharmacy professionals regardless of setting or location of care.

The standards provide a framework to help registrants when making professional judgements. Pharmacy professionals must work in partnership with everyone involved, and make sure the person they are providing care to is their first priority. However, we know that there are times when pharmacy professionals are faced with conflicting legal and professional responsibilities. Or they may be faced with complex situations that mean they have to balance competing priorities. Therefore, we would welcome a common set of high level standards across health and social care, which worked in support of existing professional standards and ensured consistent outcomes for patients.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal? What further issues would you want us to take into account in firming up this proposal?

We are one part of a complex system for overseeing and improving the quality of pharmacy care and services. We work collaboratively with a wide range of professionals, regulatory and oversight bodies in Wales to ensure safe and effective provision of pharmacy services. We also work closely with the government. We have set up Memoranda of Understanding (MoUs) with a number of organisations in Great Britain including Healthcare Inspectorate Wales and NHS Counter Fraud Services Wales. The MoUs are formal arrangements that set out how we work together and they help us to share information and intelligence and to avoid duplicating work.

In all areas of our work we understand that effective joint working with partner organisations and other regulators is essential. The GPhC wishes to build and use intelligence networks and effective operational partnerships with other regulators throughout Great Britain to identify and tackle risk. We also want to use the data and information we capture from our inspections and other regulatory functions to help inform and drive continuous improvement at a national and local level. We would therefore welcome work to strengthen intelligence gathering and sharing mechanisms with other bodies and to develop closer working across other scrutiny agencies. We would wish to play our part in future arrangements of this nature and to further develop and formalise collaborative working arrangements with other organisations

WGWPMB200: Powys Association of Voluntary Organisations
Location: Powys

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
The views which PAVO has received are supportive of the proposed approach. In particular we feel steps which will serve to enhance governance and effectively support the delivery of person-centred care are to be welcomed.

What further issues would you want us to take into account in firming up these proposals?
PAVO believes that the continued existence of arrangements for one of the independent board members to be drawn from the Third Sector is essential. Not only to help bring the sector's perspective and information to bear in the operation of healthy boards but also, as has been PAVO's experience, to act as valuable link between the Health Board and the CVC, wider Third Sector and citizens.

Consequently, we feel it would be a very retrograde step if the suggested changes to allow appointments "based on remit and priorities" were to be used as justification to disturb this particular arrangement in any fashion and that it would be useful to have explicit reference to its retention within any revised arrangements prepared by Welsh Government.

PAVO also notes that the White paper appears based on the presumption that legislation alone will change Health Board cultures. We believe that legislation alone will not successfully drive change to Board's operations and governance cultures; we recommend that further consideration is given to the support needed by Boards (and also Board Members as individuals) and that proposals for this are developed by Welsh Government.

Finally, notes that the current public appointment process for independent members does not include a role for service users and stakeholders. This feels inconsistent with acknowledged best practice in other aspects of care and health services. We therefore recommend Welsh Government gives further consideration to revising the public appointment processes for Board Members accordingly.

Board Secretary
Do you agree with these proposals?
PAVO supports the proposal as a means to strengthen robust governance and the capability to provide necessary challenge within NHS organisations and Boards. We do however query whether (as an employee of the Health Board) the Board Secretary will always feel the full freedom to independently challenge the Board (i.e. their employer) effectively? We recommend Welsh Government gives further consideration to ensuring there is sufficient protection to ensure that Board Secretaries are not inhibited or otherwise influenced in respect of their power to challenge.

What further issues would you want us to take into account in firming up these proposals?
PAVO has no further points to make regarding this proposal.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
PAVO agrees with the principle of creating the 'proposed duty of quality', however this would be contingent upon a number of practical issues being addressed (see comments below).

What further issues would you want us to take into account in firming up these proposals?
To operate effectively the duty needs to incorporate the practical provisions that are necessary for it to be able to be discharged in respect of cross-border services. Within Powys (which lacks a District General Hospital) £150m of services are annually contracted with a multiplicity of Welsh and English NHS providers. PAVO feels strongly that the detail given in the paper regarding the duty of quality does not satisfactorily explain how such a duty could work in practice. In particular; how could the duty be applied to English providers of contracted services who are outside of the legislative jurisdiction of Welsh Government?

In addition PAVO believes the White Paper does not acknowledge the other more general complexities faced by Powys residents and communities and how these would be addressed under any new arrangement, in particular:

- the complexities of cross-border/ English services commissioned for Powys patients.
- the complexities of cross-border/ English service changes for Powys patients

We note that Wales' Community Health Councils currently retain the power to compel English health providers to respond to them, but we see nothing within the proposed future arrangements to continue such a power of scrutiny. For citizens in border areas the loss of such power would represent a serious diminution of their ability to challenge and scrutinize services and is something which PAVO would be strongly opposed to. We see the need to project this existing power as a powerful reason in favour of retention of the present CHC structures.

Duty of Candour
Do you support this proposal?
PAVO agrees with the principle of creating the 'proposed duty of candour' but believes more detail is required regarding its intended application (see comments below).

What further issues would you want us to take into account in firming up this proposal?
In order for this duty to be fulling meaningful to citizens PAVO believes the proposed duty needs to be extended to include GP services as well as Health Board services. Consideration also needs to be given to whether the duty would also apply to dentistry and pharmacy services as well.

It is unclear from the paper whether the duty is intended to extend (through provisions with public sector contracts and funding) to funded Private Sector and Third Sector services.

PAVO believes that it is essential that any expectations regarding this are made clear in any supporting guidance for the new arrangements as it will be of significant importance to such commissioned providers of services in the fields of social care and health.

The current proposals do not satisfactorily address the matter of how compliance with the duty will be monitored and by whom. Greater detail needs to be provided by Welsh Government regarding their expectation for this arrangement.

Setting and Meeting Common Standards

Do you support this proposal?

PAVO supports the principle of unifying standards across social care and health. We note that current standards exist from CCSIW, HIW, Estyn and others; and demonstrating compliance with these is a major area of activity for public sector bodies. Furthermore, the need to demonstrate such compliance is typically then cascaded down to contracted Third Sector services.

The present situation seems to be unnecessarily complex and often has overlapping compliance and reporting requirements. This must have significant cost implications for public sector providers and certainly creates an extra cost burden for commissioned Third Sector services. For these reasons alone simplification and standardisation would be in the benefit of service providers in all sectors.

What further issues would you want us to take into account in firming up this proposal?

PAVO feels that regard needs to be given to who would 'inspect the inspector' under any revised arrangement. Our presumption is that this responsibility would fall to the Wales Audit Office but we suggest that any revised proposal make clear where this responsibility would lie.

PAVO also recommends that in developing a single set of standards that discussion is undertaken not only with statutory bodies but also representatives of private sector and third sector commissioned services (in the case of the latter such dialogue should happen with Third Sector Support Wales.)

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

PAVO supports the principle of establishing a mechanism for joint investigation of health and social care complaints. We believe it would simplify and improve the experience for the citizen.

We are mindful that public service bodies are complex entities with many different services being provided by them. Consequently PAVO believes it is essential that any new arrangements also recognise the need to ensure co-ordination within health

and care organisations/sectors and not just focus solely upon coordination between organisations.

What further issues would you want us to take into account in firming up this proposal?
As with the proposed 'duty of candour' the current proposals do not make clear the extent to which it is envisaged that such joint investigation should extend to, and involve, contracted private and Third Sector services.

Any revised proposal needs to set out any intentions regarding this and, if relevant, the mechanisms through which this would happen. Given the growing strategic alignment between all sectors in providing care and health services this need further consideration to be given and further dialogue with key stakeholder bodies including Third Sector Support Wales.

In addition, PAVO believes that a single independent complaints advocacy service should be an integral part of the services of the proposed new citizen voice body. This would serve to strengthen the utility of the new body to the citizen, but also serve to remove current anomalies whereby some patient advocacy services are based within the health bodies providing the services that the advocacy functions seek to challenge.

Representing the Citizen in Health and Social Care
Do you support this proposal?
The views PAVO has gathered on this question are consistently wary of the proposal, not as regards its underlying intention or principles, but as regards its utility. There are strong concerns that in practice the arrangements would within the current context diminish the power of citizen voice and ability to scrutinze and challenge.

For this reason PAVO strongly believes that the priority should be to reinvigorate the present CHC arrangements rather than replace them at this point in time.

Can you see any practical difficulties with these suggestions?
PAVO is concerned that under this proposal, a mechanism with very distinct powers to hold Health Boards and others to account, would be replaced with one which lacks such 'teeth' and is potentially capable of being marginalised into being a purely consultative or reference body rather than one with genuine power to scrutinise and hold public services to account.

For the proposed new body to be able to work effectively there needs to be sufficient maturity amongst public sector bodies' behaviours regarding co-production (which is inherently based upon a need to relinquish/share power). Collective experiences within Powys to date show that, notwithstanding the rhetoric around coproduction and placing the citizen in the centre, such a culture change in actual behaviours and practices is still a long way from happening universally.

We therefore feel on balance that the proposed the creation of a new body is in itself unlikely to drive such culture changes; particularly as it would lack many of the key powers currently enjoyed by CHCs.

At the very least we believe a managed transition between current CHC structures and a new body is essential and that strengthening the current remit of CHC's to address social care as well as health would be a practical means of ensuring continuation of effective scrutiny and challenge during any transition period.
We are mindful that in England it took from 2003 to 2013 to change from CHCs to Health Watch, something that illustrates that such changes can be complex and slow and also the risks inherent in removing existing powers/structures before new arrangements and service cultures have evolved to support their replacement.

There are also a number of other issues of concern:
Independence: We feel aligning the new body closely with CCSIW and HIW would inherently risk the new body becoming 'part of the system' rather than one which is independent of it with all the freedom to challenge derived from such independence. Even if this were not to happen in practice it would risk generating public perception that it would; thereby diminishing confidence within it.

Scottish Model: The paper proposes, ''the creation of a new, independent arrangement to replace CHCs'', and cites the model currently operated in Scotland. However, we are mindful that there is a growing perception that it he Scottish model is not working well, and that government is looking to make changes to it. So basing proposals on what to some appears to be a failing model is perhaps questionable.
Proximity to, and ownership by, the citizen: We feel that the White Paper does not recognise the value that community based membership (and networks) provides on behalf of patients and service users; the real 'eyes and ears'. We feel that the ability of citizens to interact with a body that has local identity, profile and responsibility is fundamental to enthusing citizens to engage with scrutiny and coproduction processes.

The proposed creation of a new body of national scope (most likely with its base in Cardiff) introduces elements of remoteness and geographical focus that PAVO believes would lead citizens to feel it is not 'theirs' and would be lacking in understanding and focus upon their more local community issues.

Similarly, we suspect it could potentially offer a potentially lucrative service contract that would attract bids from UK (or indeed international) firms and service institutions and thereby result in Welsh monies being taken out of the national economy rather than deriving the benefits of their full spend within the Welsh economy.

Consequently, if the decision is taken to replace present CHC arrangements with a new citizen voice body (or function) then PAVO recommends it should be configured to capitalise upon existing services structures and responsibilities rather than spurring the creation of a new NGO.

We believe that the function could potentially sit well within Third Sector Support Wales and derive significant added value from TSSW's existing infrastructure, expertise, and local knowledge and connectivity. PAVO therefore recommends that

Welsh Government gives consideration to discussing this option further with Third Sector Support Wales.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

PAVO acknowledges the advantages inherent in "introducing an independent mechanism to provide clinical advice on substantial service change decisions", however positioning the citizens voice to act only in providing 'advice' on changes rather than it having express power to challenge engagement decisions appears flawed.

Clinical practitioners cannot always effectively determine whether impact upon citizens and communities is significant or not; and where these decisions are made the arrangements as currently proposed would appear to leave decision making power with the clinical bodies alone.

This suggests the proposed model is in practice purely a consultative one as regards the citizen and therefore does not embody the principle of the citizen having equal power and influence in shaping the final decision that is implicit in a proper co-productive approach to planning service change.

In PAVO's view a detailed service change process centred on NHS decision making alone will in practice undermine rather than strengthen delivery of an approach to service change that meets citizens' needs. Indeed we suspect the proposed model holds a real prospect of generating an increase in citizens resorting to approaches such as political lobbying and judicial review to challenge instances where clinical bodies have determined that a change is not 'significant' enough to merit full citizen engagement.

This is particularly the risk in respect of public services based in a specific area not giving sufficient regards to the impact of changes upon citizens from outside the area who need to access them.

What further issues would you want us to take into account in firming up this proposal?

PAVO considers that there should be a single approach across health and social care to handle service change proposals and we are concerned that the detail in the White Paper's proposals around a new service change process does not provide for this.

Inspection and Regulation and single body

What do you think of this proposal?

PAVO believes that the proposed action would be a step in the right direction however; we would query why the paper does not propose the merger of idea of HIW and CSSIW?

Given the strong policy agenda promoted by Welsh Government for better health and social care integration, such a merger seems an obvious step to consider and

we feel it would potentially be beneficial to give further consideration formal merger of all regulation and inspection bodies (including the potential role of Wales Audit Office regarding care and health matters).

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Would you support such an idea?
Whether such a body could be supported is naturally dependent upon the nature of the proposed arrangements.

What issues should we take into account if this idea were to be developed further?
PAVO feels that combining a citizen voice function with a regulatory function in that fashion would need careful structuring to ensure the independence of action for both functions. There would be the risk, through the combination of two very distinct roles within a single entity, of the two functions being at risk of compromise; particularly if the expectations raised by 'voice' were not matched by sufficient capability to regulate.

Linked to this, careful consideration also needs to be given to how such a combined body would be viewed by the citizen. There is always the risk that such a merger could lead to public wariness regarding the objectivity and independence of such a body if the messages gathered through the 'voice' function conflicted with core regulatory responsibilities or practicalities.

Other Comments in respect of the draft proposals
PAVO believes the paper does not address some wider organisational issues across health and care in Wales which would help support achievement of the underlying aims of the draft proposal. We have received feedback regarding mental health services in particular, suggesting that all models used within mental health services have a single line management structure, a single information system and a single performance management process in place across health and social care.

WGWPMB201: The Welsh NHS Confederation
Location: Cardiff

General Comments

The Welsh NHS Confederation, on behalf of our members, welcomes the opportunity to respond to "Services Fit for the Future, Quality and Governance in Health and Care in Wales" (the White Paper).

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.

Summary
The Welsh NHS Confederation believes that the White Paper has stimulated 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 to ensure its functions are fit for purpose. Members do not necessarily support the introduction of new legislation in a number of areas and recommend strengthening a number of systems and mechanisms currently in place rather than placing further statutory duties on organisations.

The following are the main issues raised by our members:

- It is important that any legislation being considered as a result of the White Paper will not be developed in isolation and will be drawn up to compliment and be consistent with other legal frameworks (for example the Social Services and Well-being (Wales) Act 2014 and 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. Health and social care services are increasingly working together with agreed joint aims and goals through Public Service Boards and the current governance and management models operated by the NHS and local government in Wales could be improved to better support this.
- How speedily changes proposed by the White Paper could be achieved and whether or not such changes need legislative support requires 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.
- Attention should be placed on developing the culture, values and behaviours that support integrated health and social care services. Evidence clearly indicates that it is culture that may have a more profound and positive impact on the way services are provided, rather than legislative change alone.
- The continuous engagement of patients and the wider public in the design, planning and provision of health care services is increasingly important. 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 legislative framework that is already in place.

- 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).
- The proposal around a duty of candour 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.
- Theres a general view that the current size and configuration of Board membership inhibits the quality and flexibility 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.
- The Welsh NHS Confederation, and our members, value the role of the citizens (the public and patients) voice and the contribution Community Health Councils (CHCs) have made to the improvement of services and therefore the advocacy role that they provide should remain. However, we do believe that the CHCs can be reformed and we welcome the removal of an inspection role of CHCs (or incumbent body) and strengthening the engagement and cooperative working arrangements that support citizen involvement in planning and service improvement.

Response to Specific Questions

Board Membership and Composition

Overall the Welsh NHS Confederation and our members support the proposals put forward within the White Paper. We agree that there should be shared key principles for Health Boards and Trusts in Wales, as outlined in the White Paper. This would provide greater coherence between NHS bodies in the pursuit of improving health and health services across Wales.

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 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 (PHW) 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 PHW 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. In respect of the composition of Boards there should be consistency in some key positions for Executive Officers but also allowing some local flexibility to appoint based on local priorities. Regulations should permit the Board to determine the final Executive structure that best meets its own requirements.

In relation to the size of the Board it is important to consider the overall governance of the Board, moving away from the concept of representativeness of membership. A smaller Board cannot represent all relevant constituencies or stakeholders nor should they attempt to do so; rather a smaller Board should demonstrate the knowledge, understanding and awareness of issues to properly consider all relevant interests, such as those of different groups of health professionals whilst not necessarily attempting to represent them. Various studies have been conducted in the past to explore the link between different Board attributes and Board performance and effectiveness. There are several variables including Board size which have an impact although the most important variable is whether the Board has the right mix of skills and experience. Evidence suggests that larger Boards are less effective than smaller ones because they suffer from problems with coordination, communication and motivation. This in turn, can hamper strategic decision making and scrutiny functions. Large Boards are seen to be less effective because the coordination and process problems they experience overwhelm the advantages gained from having more people to draw on. There is no single right answer but the evidence suggests Board membership of between 10-12 is most likely to be conducive to effectiveness.

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. 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.

There is support for changing the title 'Independent Member' to better convey openness and the link to the public. However, the title 'Public Member' is not wholly supported as it is likely to be misleading and not well understood. Health Board regulations currently describe the role as 'Non-Officer Member' and the equivalent role in Trust regulations is described as 'Non-Executive Member'. These terms are well recognised and widely understood across both the public and private sectors and may be more appropriate terms to use. It is vital to ensure that Boards have independence in their accountability and scrutiny, therefore we support retaining 'Independent' in the title of Non-Officer members, but note an option for renaming to 'Independent Public Member'.

Ways of increasing diversity amongst Board members would be welcomed, however, this needs to be progressed in a manner which ensures openness and transparency at the outset as to the actual time commitment required of Independent Members. Posts are currently advertised indicating a commitment of 4 days per month, whilst in reality, to discharge the role effectively, requires at least twice this time commitment. We would support an increase in the notional commitment expected from IMs in their role, from 4 to a minimum 6 days per month. In practice, this still may be far from reflecting the current commitment required from Trust IMs, who are expected to deliver the same breadth of involvement as the larger cohort of IMs in Health Boards.

Vice Chairs
We supports the formal appointment of Vice-Chairs to Trusts. This model has underpinned good governance arrangements in Health Boards to date. The ability to increase the number of Executive Directors and Independent Members would assist Trusts to increase the level of capacity and capability at officer/independent member level to deal with the broad agenda set out across health, well-being, health /public services in the future.

Ministers appointing additional Board members
Overall, we support the proposal that the Cabinet Secretary for Health, Well-being and Sport should have the authority to appoint additional Board members under the circumstances described. The Board must have the means and skills to lead the organisation so that decision making is effective and the right outcomes are delivered for patients.

Detailed consideration would need to be given as to whether such appointments, if made, should be full or associate Board members, how this affects the balance of the Board, the purpose of the role, the appointment process and ensuring the appropriate composition of the Board is maintained. Whether such appointments would need to be given Board membership, even on a time limited basis, would need individual consideration so as not to undermine the effective working of the substantive Board.

We suggest this flexibility is afforded not only for situations cited in the consultation (i.e. special measures), but to also include opportunities for additional Board appointments during times of new ventures/ significant service change programmes.

Board Secretary

There is support for greater clarity for the role of Board Secretary. There is increasing recognition that robust and effective Corporate Governance is integral to high-performing organisations. Since the inception of Health Boards in 2009, the role of the Board Secretary as Corporate Governance Adviser has evolved and matured.

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, to assist in ensuring the role is perceived at an appropriately senior level and be seen as a trusted position providing independent advice to the Chair, Chief Executive and Board. This will also enable the role to be in a position to effectively challenge and advise Boards (Executive and Independent), as necessary. The strengthening of this role provides an opportunity to correct longstanding misperceptions regarding the seniority and status of Board Secretaries. The role however should retain its unique position of trust as an independent adviser.

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.

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 within the organisations. However, at this stage, this is not always the case and the role is not well understood in some organisations. Therefore, the profile and re-emphasis that a clear designation of the role would bring would be welcomed as would be consistency in the remuneration of the post across Wales as currently there remains variation from the equivalent of an 8D level to Very Senior Managers" Pay.

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, makes the role a statutory requirement for all Local Authorities and gives them a legal duty to report on legal issues and mal-administration, manage the Code of Conduct and complaints associated with conduct of Principal officers and elected members, manage the standing orders, 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. 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.

The understanding, status, and importance of the role may be strengthened if it were renamed 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 a Director level in the organisations. However, at this stage this is not always the case and the role is not well understood in some organisations. Therefore, the profile and reemphasis that clear designation of the role would bring would be welcomed. However, it is still not clear whether statutory protection is required to enable a Board Secretary to fulfil their role. The key will be the knowledge, skills, behaviour and aptitude of the individual rather than the requirements designed into the role and the protection afforded to it. A good Board Secretary in line with all good NHS employees and public servants should act with integrity and impunity in the interests of the people served by their organisation.

The Board Secretary role would be directly accountable for the conduct of their role to the Chair and Chief Executive, and report on a day to day basis to the Chief Executive in order to retain its unique position as an independent advisor and mediator. It will also be important that in order to undertake the role appropriately that the post be given adequate resources and staff to be able to execute the requirements of the office and run the governance and assurance arrangements of the organisation. Therefore, it is suggested by some of our members that to assist with the profile of the role and recognition of the role and its importance, that resources should be protected to possibly develop an office of the Director of Corporate Governance/Board Secretary to support the fulfilment of the role. Each organisation will need to consider what this should consist of having considered the resources required to maintain and run the governance and assurance arrangements for the organisation.

The proposal to provide statutory protection for the role is still not clear. There is a risk that awarding such protection may result in the role being seen as Chief Whistleblower for the organisation, and may impact on effective working relationships, particularly with the Executives. We do recognise potential benefits of providing such protection, particularly in circumstances when relationships and/or culture do not reflect healthy challenge but a greater understanding of what legal duties would be placed upon the individual and what qualifications and experience would be essential to deliver these duties.

We support the principle of ensuring an independent process for dismissal of the post holder.

Consideration should be given to ensuring an independent aspect in the appointment process for the role, noting the post should remain accountable to the Chair and indirectly to the Chief Executive.

Duty of Quality for the Population of Wales

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.

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.

In considering service change there is currently no requirement to complete a quality integrated impact assessment, whereas there is for other areas, including quality to be undertaken when considering service changes and this principle could be more generally introduced. Ensuring quality will rely on the organisational structures, their accountabilities and the performance regime and not legislation alone. If these are clarified through this White 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.

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 simply 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 health care support workers.

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.

Duty of Candour

Our members are committed to ensuring that honesty and transparency are the norm even when this may be difficult. 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. In firming up this proposal, consideration of regulatory body standards should be considered.

The principles of openness and candour must extend beyond the current requirements set out in Putting Things Right regulations, to include the design of care plans as well as the delivery of health care, building upon the duty of candour already held by registered health professions. Introducing a legal requirement would enable inspection to take place and this commitment to be tested. However, this would be reliant upon clarification as to what would count as evidence of being open and transparent. Any such duty introduced within Wales will need to be aligned to

the regulations introduced within NHS England in 2014, in regard to the thresholds in place to measure the consistency of standards. This will be important to ensure there is a common basis for proportionate regulatory action if required.

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.” 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.

We believes specific clarity is required on what “duty of candour‟ means and how this will fit with existing policies that empower staff to speak out and protect patients, or raise other issues concerning the organisation they work for, without fear of victimisation (e.g. whistleblowing). This must include the acknowledgement that candour is a two-way process as it also requires that any patient who is arguably disadvantaged or, worse, harmed, by the provision of less than safe or high quality care, is informed of the fact and is offered appropriate remedy, regardless of whether they have made a complaint or questioned their care; only in that way will we start to see the seismic shift that we need towards truly patient-centred care.

We also need to be clear that it is not enough to simply give staff the ability to respond to systemic problems or instances of poor care through a formal mechanism; they also need an independent authority to turn to if they feel their concerns are not being listened to or acted upon. In England there is a National Guardian and a network of local Freedom to Speak Up Guardians across all NHS Foundation Trusts and NHS Trusts. We need to know how this would work in Wales if we are considering a similar model, particularly in terms of our integration agenda and partnership working – there needs to be clear lines of sight for staff working in

services to know where to go to when their efforts to raise issues have not been effectively managed via the usual chain of command.

There is, of course, an additional safeguarding element to consider here too, particularly in terms of the speed at which problems could or should be addressed or mitigated, possibly some kind of prioritisation system might be needed in order to ensure that action plans can be delivered at the pace required.

Setting and Meeting Common Standards

We support the concept of having consistent healthcare standards, which should be integrated with social care, the third sector and the independent sector. This is increasingly essential as new treatment methods, technologies and ways of working allow high quality, safe, care to be delivered in the location that best suits the patient.

This common set of requirements should not only set out a clear description of safe and acceptable quality but should also be used as the framework for continuous improvement in order that a measurable rise in achievement can be tracked. Associated monitoring arrangements would need to be similarly joined up.

A shared understanding is needed, therefore a definition in the White Paper would have been helpful. If a primary purpose of both health and social care is to prevent ill-health, then families and communities need to be captured in the definition. For best outcomes, work needs to be with context families/communities, as well as individuals. This does not come through in the White Paper. While we agree that individuals and populations receiving services, functions, programmes and care should feel confident that the standard will remain the same regardless of where they are receiving these and overall we support developing common principles. However, it should be noted that there are significant differences between in-hospital care, community care, care at home and promoting population health and well-being. Any principles developed would need to be broad enough, and encompass promoting well-being and health, as opposed to merely addressing ill health. The terminology used in the report should reflect the breadth of services provided by NHS organisations.

Joint Investigation of Health and Social Care Complaints

We support the proposal to work towards a complaints process that is integrated, to include secondary, primary and social care. This is increasingly essential as new treatment methods, technologies and ways of working allow high quality, safe, care to be delivered in the location that best suits the patient.

Statutory guidance should set out a transparent joint complaints process for service users who wish to complain about health and social care, where their package of care includes both. Cross border cases would also benefit from better transparency and communication systems. All opportunities to support and encourage organisations to learn lessons to improve their services would be embraced.

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.

Co-operation between health and social care formulating joint consideration of concerns, timescales for finalising responses will inevitably increase. 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 Local Authorities and Health Boards are open and transparent and publicly set out what the joint complaints process is. It will be vital to ensure the current high quality of health organisations responses to concerns are not diluted by the inclusion of social services issues and the time line of responding to complainants will also need to be considered as this can increase significantly where there is the need to compile information across more than one organisation.

We believe that a review of the Putting Things Right regulations would be timely and helpful, particularly in light of the suggestion to introduce a duty of candour so that the public can have access to a clear and easy complaints system in which all services and organisations work together to deal with the problems raised.

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 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.” 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) as a matter of course of any complaints or concerns. This is important to ensure that Health Boards are commissioning safe and quality assured services in England.

Representing the Citizen in Health and Social Care

We recognise and value the patient voice to support plan and deliver healthcare services. The Welsh NHS Confederation, and our members, value the contribution CHCs have made to the improvement of healthcare services. Our members have

very constructive and positive working relationships with their CHCs and CHCs play a key advocacy role, which must continue. However, we do believe that the citizen's voice can be strengthened and that it is now necessary for the model to evolve, either by reforming the current CHCs or introducing a new body, building upon the strengths of the current system, to maintain a strong independent citizen voice.

Health Boards across Wales have positive relationships with CHCs and CHCs have provided a constructive source of advice, guidance and constructive challenge for Health Boards. CHCs have provided important insights into the views of patients, their families and carers about Health Boards services and the quality of health care received. The CHC's function in providing an advocacy service for patients across Health Board areas, its input into shaping and improving services and its constructive challenge, is valued in terms of representing the population served by Health Board areas. Where these arrangements work well, and several Health Boards have experience of this, they can develop into a positive "critical friend" role which may be harder to achieve with a more dispersed citizen engagement, co-production model. Health Boards invest a lot of time in the engagement and joint arrangements between CHCs and the Health Boards, and this does add value to the ways in which local health services are planned and delivered. There has also been a development of knowledge and understanding of the planning and engagement process which will need to be replicated in any new organisational arrangement.

While Health Boards across Wales have constructive relationships with their CHCs we do believe that the citizen's voice can be improved. We believe it is now necessary for the model to evolve, building upon the strengths of the current system, in order to maintain a strong independent voice and further developing the independent clinical scrutiny role as part of national level arrangements working closely with inspectorates as proposed in the White Paper.

We agree that the proposal to introduce a new national arrangement that represents both health and social care, working alongside both the health and social care inspectorates (HIW and SSIW respectively), will strengthen the citizens voice. As highlighted in our response to the Green Paper, the current CHC model is not fit for purpose in a more integrated system and the proposals put forward in the White Paper will ensure that citizens accessing social care services will have more of a voice.

With the introduction of the Social Services and Well-being (Wales) Act 2014 and given what the Parliamentary review is suggesting in its interim report, health and social care services are working in a more integrated way and it is important that there is one organisation representing the citizen's voice in both health and social care. Currently the way the seven CHCs are configured enables them to represent the public's interest in the health service, something which is not reflective of an increasingly integrated approach to service delivery because as it stands there is no specific statutory body for citizen engagement in social care. Local authorities are under a duty to promote user-led services and to involve people in the design and provision of services but there are no specific statutory bodies for citizen engagement in social care, as in health with CHCs. Effective citizen engagement is an expectation within the Social Services and Well-being (Wales) Act 2014 and the

new proposed national arrangement will ensure this without duplication between health and social care issues.

We agree that this refreshed citizen voice arrangement will provide better assurance and the impetus for health and social care organisations to improve the way they engage with the public and work in partnership to gather views and involve citizens in planning and delivery of services. This will ensure that the patient voice is listened to and consulted upon, while also ensuring that decisions are made for the wider population and also that clinical decisions and outcomes are considered. The proposals strengthen the citizen's voice and is an appropriate balance between individual citizen's views and voices, and the most appropriate clinical outcome for citizens. Whatever the CHCs are replaced with it is important to have a citizen voice (public and patient) function.

In addition to the integrated agenda, Health Boards are working in a more integrated way across organisational boundaries and services are being provided regionally, especially for specialist health services. This therefore has the potential to cause issues when there are health service changes across organisational boundaries, and is an area that could be reviewed further as we move more and more towards regional planning. At present the CHCs attachment to a particular geographical area and population causes challenges when cross-boundary working or service change is proposed because when proposals are put forward around local service change the duty on local CHCs is to consider their local population and so if their local population are not happy with the proposals they can reject service redesign/ change without putting forward alternative proposals.

Further clarification in relation to service redesign decisions and referring decisions to the Cabinet Secretary when the local CHC, after significant consultation with local Health Board, reject the service redesign proposals put forward, needs to be undertaken. At present, CHCs have the power to refer a decision to the Cabinet Secretary when they do not agree with a decision that the Health Board makes. The CHCs are not under a duty to provide alternative recommendations which causes challenges, especially when regional redesign is discussed, and the CHCs membership is not clinically qualified to do this and this aspect could be further reviewed.

CHCs should be able to listen to the public and consider whether the Health Board has followed the correct processes and whether their engagement process was robust. It has been 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.

Through introducing a new national arrangement, we hope that the membership is diverse and represents all citizens. In terms of the membership of CHC there has been some comments in the past about the diversity of their membership and whether more should be done to better reflect the communities which are

represented, especially protected equality groups. Furthermore, 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 the membership profile of future CHC (or the new body) is more reflective of the communities that they represent, for example more young people are part of their membership and equality groups.

We support that the CHC (or new body) will work alongside Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales. There has been some instances in the past where some of the CHCs' activities, such as inspections, duplicate the work of other bodies and detract from the true representation of citizens' voices. We agree that positioning the new arrangement alongside the Inspectorates, will increase profile and visibility, remove several duplicative activities and functions currently invested in CHCs, for example inspection of premises, and embed the patient voice more systematically within the work of the Inspectorates. 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. It is key that the three organisations in the future work in a more integrated way and their functions are not duplicated, while also ensuring that they are independent of each other and have parity of esteem. In doing so, attention needs to be given to potential financial costs, governance issues and ensuring current legislation is used rather than the creation of new legislation.

The proposal to replace the current system with that based in some respects on the Scottish Health Council is not seen as feasible as that organisation has a different role and remit in comparison to Wales. The Scottish model does not provide advocacy services or speak for the citizens and therefore is not reflecting the citizen voice which is vital. This role is delegated to the thirty integrated partnerships which are integral to the Scottish model.

We do not want to lose this local critical friend role undertaken by the CHC which has been invaluable. It is necessary to have a body that stimulates better local dialogue, improved co-production and local support to make changes. However, it is recognised some form of national overview will still be required. Lessons should be learnt from other countries to ensure that any new mechanism best meets the requirement to represent patients and the public, with a clear route for challenge and an appropriate balance between clinical and non-clinical matters.

Co-producing Plans and Services with Citizens

The proposal to introduce an independent mechanism to provide clinical advice on substantial service change decisions is not supported by the majority of our members. The establishment of such a process would add an extra step in the process and referrals to the Cabinet Secretary 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 always supported the NHS with service change / reconfiguration.

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 standard model without taking account of other factors (e.g. rurality). It is felt a permanent panel would not have the local knowledge and accountability. The question would be whether Boards in NHS organisations would become redundant in terms of decision-making relating to service change.

Our preference would be for each service change under consideration to have a separate panel appointed. However, it is felt important that the Cabinet Secretary should appoint such a panel when required rather than having a permanent panel. It is felt that a process of referral to the Cabinet Secretary should remain in place, since this ensures that referrals are not made lightly and that referrals to the Cabinet Secretary are made in exceptional circumstances only.

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.

Citizen's voice
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 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 primary care 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.

Given the increasing maturity of local and national arrangements to work with people who use services and work in specific areas to add knowledge and understanding to the development of plans and decisions, the requirement for Stakeholder Reference Groups and Healthcare Professional Forums as advisory committees of Health Boards should be re-visited. It is of note that there are inconsistencies in the way these Groups have been established across Wales and the variances in the scope of their roles and the way in which they discharge their function.

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; and
- Continuous support from the Health Board/ Trust.

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.

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.

Inspection and Regulation and single body

We agree that there should be underpinning legislation for integrated inspection and regulation, leading to the development of a single regulator for health and social care, which should be independent of Welsh Government.

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. Regulators need to be robust and have appropriate resourcing so that they can maintain their independence and have clear boundaries so that the public can have confidence in the Regulator. However, caution may need to be exercised regarding connecting within a single organisation those responsible for regulation with those responsible for citizen engagement and thereby elements of

co-production. This could potentially create conflict in situations where regulators were commenting on a process that its own organisation had already had a part in.

The proposals around 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 is supported. This will 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 would better reflect the integration of services that is underway.

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.

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. There is also an argument for closer cross-referencing with CHCs as their work provides very rich and insightful information about the quality and safety of services and importantly patient experience.

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. Furthermore, consideration would need to be given to ensuring the specialised elements of each inspectorate, requiring specialised knowledge, would be maintained so that this was not diluted in any new organisation, albeit that there would be a more integrated focus on quality and safety. Maintaining independence from relevant public bodies will assist with credibility and public reporting.

d) Merit in considering a new body

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.

The role of the Auditor General as part of the inspectorate discussion, especially considering the tripartite escalation discussions, needs to be explored as part of these arrangements. However, we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

The key areas raised by Local Health Boards and Trusts

92. Even though they are not within the remit of this White Paper, the issues below are some of the areas that our members have highlighted. As referenced in our response to the Green Paper, we still have some concerns around the following areas:

The need for legislation

The White 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.

The White Paper is helpful in supporting the current integration agenda both within the NHS and with partner organisations, particularly with social care. The White Paper could 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 White 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 White Paper.

An underpinning issue which is not addressed in the White Paper is the type of culture, values and behaviours that we are looking to develop and encourage within health and social care across 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.

Governance and links with other legislation

As highlighted previously, in addition to considering whether legislation is required, it is important that this White 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, and future legislation, including the Additional Learning Needs and Education Tribunal (Wales) Bill which will introduce new complaints processes.

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 has transformed the way the health and social care system operates. The Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 are impacting on the way health and social care operates but the requirements could be better aligned to reduce bureaucracy and improve delivery.

The health and social care services increasingly work together to define and deliver against agreed aims and objectives through 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. If any legislation is drafted it should positively encourage the delivery of an integrated health and social care system across Wales.

One scenario could be that respective Public Service Boards 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.

A second issue relates to the clarity about the role of Welsh Government in leading the NHS in Wales e.g. in some cases the current system is prescriptive and allows little freedom for health bodies to flex arrangements locally. 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. We hope this issue is considered in the final Parliamentary Review report.

Improving the current arrangements nationally
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, would be welcomed.

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.

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.

Consideration should be given to 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.

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 and social care 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.

Conclusion

In conclusion, it is widely acknowledged that the governance of the NHS in Wales is complex and therefore any changes resulting from this consultation should seek to clarify and not further complicate the wider understanding of accountability, citizen engagement and quality.

WGWPMB202: Professional Standards Authority
Location: London

General Comments

We welcome the opportunity to respond to this consultation from the Welsh Government on their proposals for reforms to health and care services in Wales. As the organisation with the remit for overseeing the statutory health and care professional regulators and accrediting occupational registers in the UK, our primary concern is public protection and ensuring a strong independent voice for patients in the regulation of health professionals. We are supportive of meaningful patient involvement in healthcare to ensure a patient centred approach.

We recognise that in Wales, as across the UK, the health and care system is coming under increased pressure and that Governments are seeking to implement reforms to improve efficiency of services and diversify the health and care skills mix to meet the needs of the population.

With relevance to the wider debate around service provision, the Authority oversees the Accredited Registers programme for organisations which hold voluntary registers of practitioners who are not required by law (http://www.professionalstandards.org.uk/what-we-do/accredited-registers). Registers are assessed to ensure that they meet our standard. There are currently over 80,000 practitioners on Accredited Registers including counsellors, sports therapists, public health practitioners, complementary therapists and foot health practitioners amongst many others. The scheme offers assurance to the public as well as employers, commissioners or GPs who may wish to refer to patients on, about the practitioners on these registers. We believe that this is an underutilised workforce and we would be very happy to discuss with the Welsh Government how it might be possible to raise awareness of the scheme and how this group of practitioners might be able to contribute further to service provision in Wales.

With regard to the proposals in this consultation we have commented on those areas where we have experience or information which may be relevant to the Welsh Government in moving forward in areas outlined.

As part of our role we share good practise and knowledge and promote our ideas around the improvement of regulation. We have recently published our ideas on radical reform of the health and care professional regulatory system in the UK to create clarity for patients, and allow greater flexibility of approach for regulators, employers, policy makers and others in shaping workforce (http://www.professionalstandards.org.uk/publications/detail/regulation-rethought).

We also promote our concept of right-touch regulation (http://www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation). Building on the principles of good regulation, right-touch regulation means understanding the problem before jumping to the solution and making sure that the level of regulation is proportionate to the risk of harm to the public.

The eight elements at the heart of Right-touch regulation are:

- Identify the problem before the solution
- Quantify and qualify the risks
- Get as close to the problem as possible
- Focus on the outcome
- Use regulation only when necessary
- Keep it simple
- Check for unintended consequences
- Review and respond to change.

We recommend use of this approach when considering the response to any regulatory problems and these principles guide us in our own thinking on the most appropriate course of action.

We are supportive of the introduction of a statutory duty of candour for health and care in providers in Wales. Although the duty of candour is now established in England in law and in regulators' codes of conduct, we are not sure how consistently it is applied in practice. It will be important to consider how to embed this principle beyond legislation. With regard to the professional duty of candour for regulated professionals, we have recognised in professional regulatory proceedings (http://www.professionalstandards.org.uk/docs/default-source/publications/professional-standards-authority-review-of-professional-regulation-amp-registration(annual-report-amp-accounts-english)0bed19f761926971a151ff000072e7a6.pdf?sfvrsn=0)

To ensure that patients receive safe and quality care, it is important that all bodies within the health and care service have a shared understanding of what is required to achieve this. We are therefore supportive of the proposals for shared standards across health and care services.

In Regulation rethought (http://www.professionalstandards.org.uk/publications/detail/regulation-rethought) where we laid out our proposals for a transformation of the regulation of health and care professionals we called for a shared purpose for all regulators and also a single statement of professional practice for all health and care practitioners. The statement of professional practice would define the standards of conduct, behaviour and ethics required of everyone working in health and care, irrespective of their profession or occupation.

In relation to the proposals to replace Community Health Councils with a new patient organisation, we recognise the Welsh Government's intention to improve the involvement of patients in the delivery of health and care in Wales and to address some of the criticisms of the current system. However, we would suggest that in depth consultation with stakeholders on what a new model for patient involvement might look like will be important to ensure that strengths of the current system are retained and to develop a strong and independent patient voice in Wales.

We have commented in further detail on some of the specified consultation areas below.

Response to Specific Questions

Duty of Candour
As highlighted we are supportive of the proposals to introduce a statutory duty of candour for all health and social care providers but would highlight the importance of considering other ways to embed cultural change on this issue, alongside legislation.

The statutory duty of candour was introduced in England in 2014 through amendments to the Care Quality Commission's powers under the Health and Social Care Act 2008. However, there has been concern expressed that it is not becoming embedded within services and not leading to cultural change. The Public Administration Committee following a hearing on the duty of candour in 2015 concluded that: 'more work must be done to fully implement the statutory Duty of Candour' and 'urged the Department of Health to press ahead with training staff across all NHS organisations in applying this principle (https://publications.parliament.uk/pa/cm201617/cmslect/cmpubadm/94/9407.htm).

The Authority produced advice for the Department for Health on implementing the professional duty of candour in 2013 (http://www.professionalstandards.org.ul/docs/default-source/publications/advice-to-ministers/Encouraging-candour-2013.pdf?sfvrsn=12). This led to a joint statement from the professional regulators highlighting how they intended to incorporate this duty into their standards for registrants (http://www.gmc-uk.org/Joint_statement_on_the_professional_duty_of_candour_FINAL.pdf_58140142.pdf). However, we have recently highlighted our disappointment that we have not subsequently seen the duty reflected in the allegations drafted against the registrant or references to the duty of candour in panel determinations (http://professinalstandards.org.uk/docs/default-source/publications/professional-standards-authority-review-of-professional-regulation-amp-registration(annual-report-amp-accounts-english)0bed19f76192697a151ff000072e7a6.pdf?sfvrsn=0).

The Authority also carried out research in 2013 into candour, disclosure and openness, highlighting a number of barriers to health professionals doing the right thing (http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/candour-disclosure-and-openness-2013.pdf?sfvrsn=6). These barriers can apply to reporting even extremely harmful and criminal behaviour. The report into the abuse and neglect of patients by staff at the Winterbourne View care home in Gloucestershire in 2011 (http://www.gov.uk/government/uploads/system/uploads/attachment_data/file213215/final-report.pdf) shows that when people do speak up this has not always been acted upon by those with regulatory oversight and also demonstrates that those in positions of authority should not be able to claim ignorance as an excuse for failing to prevent abuse.

We would be very happy to contribute further information relating to our work on candour or provide any further input on how the Welsh Government can seek to embed the duty of candour in Wales.

Setting and Meeting Common Standards and Joint Investigation of Health and Social Care Complaints

As highlighted we are supportive of common standards across health and social care bodies and also a common or joint approach to investigating complaints across health and social care. It is becoming increasingly clear that a closer alignment between the health and social care sectors is necessary as care for individuals often spans both and also crosses organisation boundaries. To ensure safe and quality care for patients, it is important that all bodies within the health and care service have a shared understanding of what is required to achieve this.

In Regulation rethought where we laid out our proposals for a transformation of the regulation of health and care professionals we called for a shared purpose for all regulators and also a single statement of professional practice for all health and care practitioners. The statement of professional practice would define the standards of conduct, behaviour and ethics required of everyone working in health and care, irrespective of their profession or occupation (http://www.professionalstandards.org.uk/publications/detail/regulation-rethought).

Representing the Citizen in Health and Social Care

In relation to the proposals to replace Community Health Councils with a new patient organisation, we recognise the intention to address some of the criticisms of the current system and welcome the intention to create a stronger public and patient voice with a remit across health and care which meets the needs of a changing service.

To ensure that such a body meets these aims and provides a strong voice for the public in Wales, it will be important to consult widely and ensure that a new system learns from the best of what is already in place and achieves buy in from relevant stakeholders. We note the ideas put forward by the Board of Community Health Councils on what a new public body should look like, following consultation with members of the public. (http://www.wales.nhs.uk/siteplus/documents/899/Board%20of%20CHCs%20White%20Paper%20Response%20%28FINAL%29%282%29.pdf)

In its report on the health and care system in Wales, the OECD states that: 'CHCs are a key feature in the architecture of Wales, with a clear role to engage with and ensure that the patient voice is head,' whilst highlighting the lack of clarity around certain functions and suggesting changes to improve public scrutiny of the NHS in Wales (http://www.keepeek.com/Digital-Asset-Managment/oecd/social-issues-migration-health/oecd-reviews-of-health-care-quality-united-kingdom-2016_9789264239487-en#.WcuSMTVry2w#page227).

We believe that in consultation with stakeholders and the public it will be possible to develop a new system to represent the public voice in Wales which fits the current context and meets the challenges of the health and care service and learns from what has been effective in Wales and elsewhere. We would be very happy to be involved in any further discussions in this area and share experience from our role in representing the interests of the public in health and care professional regulation.

Inspection and Regulation and single body

We are supportive of proposals to align more closely the regulatory systems across health and social services where practical. As noted previously, care for individuals frequently crosses sector boundaries and it therefore makes sense to take a common approach to regulation also. However, it is important to note that inspection, regulation and quality improvement are different things. The role of regulation is primarily to control quality and ensure minimum standards rather than to improve quality.

We would highlight the need for closer alignment between system and professional regulation. In Regulation rethought we put forward proposals for shared objectives for system and professional regulators along with greater clarity of roles to ensure clarity of purpose and alignment of effort towards common goals. We would be very happy to discuss any of our proposals for reform in more detail on this area or more broadly.

WGWPMB203: Academy of Royal Medical Colleges Wales
Location: London

General Comments

It is timely to respond to the challenges set by the OECD in its recent review of healthcare services in Wales. The challenges are not unique to Wales but we have a good record of responsive services, committed practitioners and a recognition of the importance of public health issues. Wales is starting to be aware of and make use of assets not directly part of healthcare. We recognise the unsustainability of current structures and systems in relation to increasing demographic challenges of an older population with more multi morbidity and higher expectations of what healthcare can deliver. We do not believe that the opportunities provided by health boards responsible for primary and secondary care have been full realised or there to be sufficient enthusiasm for innovation. We favour generally a once for Wales approach when possible, to increase efficiency and reduce variation whilst recognising the importance of a system that can respond to and address local issues. Whilst strongly supportive of the concept of patient centred/ orientated care, the Academy also feels that a stronger culture of valuing and caring for health care staff is needed. Sustainability of the NHS is intertwined with sustainability of other public services, crucially social care. Demands on adult social care are projected to rise faster than demand for NHS care; an average of 4.1% a year through to 2030/31. With past trends indicating that social care funding is unlikely to rise at the same rate, there is a real risk that the level of unmet health and social care need in Wales could further increase.

Patients should have greater involvement in their own care. This requires access to evidence based understandable information to aid decision making. The Academy is a leading partner in Choosing Wisely Wales which encourages a shift in the power balance in clinical conversations between clinicians and patients with a wider adoption of shared decision making.

Care should be delivered as locally as is practical within financial and structural constraints but the Academy recognises that safe care for more complex, complicated or uncommon conditions may be better delivered in regional centres. We would like to see more planning at an All Wales level with greater collaboration between Health Boards (and local authorities). We would expect more comprehensive and whole system approaches to health care delivery across primary and secondary care and in time more collaboration with social care providers.

Response to Specific Questions

Board Membership and Composition

Do you agree with these proposals?

Yes. Clear governance is vital to ensure efficient and effective delivery of health care but it must be facilitative to new ideas and not too risk averse. Board members need to appreciate a whole system approach, the need to focus on outcomes as much as processes. We would also welcome more diversity but not at the expense of having

the right skill mix. There certainly needs to be a greater focus on leadership skills and improved access to leadership programmes and continuing coaching for all those in leadership positions at all levels.

What further issues would you want us to take into account in firming up these proposals?
It will be important to ensure clinical memberships on all Boards as we do not believe the provision for the involvement of senior management, below the level of Executive Director, will guarantee sufficient clinical representation.

We suggest that there should be strong Public Health advice for Boards and consideration that the local director of Public Health may be a more effective as a non Exec director rather than being part of management. An external position may encourage more open scrutiny and challenge of the level and appropriateness of response to population needs.

We support that the following Core Key Principle should be introduced: 'Each organisation will ensure that mechanisms for consultation with essential medical (and other healthcare) professionals will be in place, underpinned by written process and guidance'.

Board Secretary
Do you agree with these proposals?
Yes we support the proposal for the role of the Board Secretary to be placed on a statutory basis, with statutory protection to ensure the required independence of the role.

What further issues would you want us to take into account in firming up these proposals?
We suggest that this appointment should be made from outwith the organisation to enable greater independence.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes, we welcome a focus on promoting "wellness" and supporting individuals to take more control of their own health.

Collaboration is essential and organisations and policy makers (and the public) must recognise that health status is as much influenced by social and environmental factors (including access to work) as by the quality of health care services.

What further issues would you want us to take into account in firming up these proposals?
We support the principle that there should be no legislative or organisational barriers to regional or all-Wales solutions, which can deliver a greater benefit to more people. We suggest "Improving" should be an additional descriptor of a quality organisation in the list put forward by the Institute of Medicine.

Duty of Candour

Do you support this proposal?

Yes, the Academy has supported the concept of a statutory duty of candour for all health and social care providers. We believe such candour helps to promote Trust and will aid effective decision making and a learning culture.

What further issues would you want us to take into account in firming up this proposal?

It is important that the introduction of statutory powers does not undermine the development of a low-blame learning culture which prioritises the safety of patients and the training of staff. Staff should be supported both professionally and emotionally when errors or potential errors are suspected or identified. This will encourage greater openness and avoid unnecessary strain on staff leading to further adverse impact on patient care. However where discipline is needed it should be applied fairly and promptly.

Setting and Meeting Common Standards

Do you support this proposal?

Yes, Standards should take account of need for variability in some locations and situations without allowing such variability to be an excuse for lower standards. There is a distinction between the proposal for common standards to 'provide a framework for continuous improvement in the overall quality of care people receive' - which we fully support - and common standards to 'provide a common set of requirements' – which could (unintentionally) limit the ability to adapt to provide care which reflects acceptable variation.

What further issues would you want us to take into account in firming up this proposal?

Standards should be realistic/achievable and relevant for both consumers and providers. We would wish to see frontline providers and the public involved in co-producing these standards rather than just being consulted.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Yes. Any system for complaints needs to be as simple and accessible as possible and the process needs to be truly collaborative with shared processes to avoid bureaucratic delays. Both complainants and those being complained about should be kept fully informed regarding the progress of complaints.

What further issues would you want us to take into account in firming up this proposal?

In an environment where resources are sparse, care should be taken to ensure that this will not cost more and create an avoidable drain on health and social care services.

Complaints sometimes arise from unreasonable expectations from either provider or consumer. Both need to be aware of what service is reasonable and that often

offering or striving for perfection can be inefficient (in time, cost and expertise) or frustrating.

Representing the Citizen in Health and Social Care

Do you support this proposal?

The Academy fully supports the involvement of patients and the public in the co-creation, development and design of services. This requires all parties to have good information on needs, evidence of what works and available resources. As referred to above this requires openness on all sides. This is particularly important when considering how “close to home” services can be provided and the need of a critical mass of expertise for less common interventions. We need assurance that the new proposals will work more effectively than current processes and would welcome wider debate and planning
before legislative proposals are finalised. We believe any new body or groups should be statutorily involved in planning at early stages rather than just being consulted.

Can you see any practical difficulties with these suggestions ?

The positioning of the new body alongside Healthcare Inspectorate Wales (HIW) and the Care and Social Services Inspectorate for Wales (CSSIW), working dependently only when required, could be beneficial. Generally the body should be independent of HIW and CSSIW and be in a position to critically review their work.

There certainly needs to be more diversity of representation which reflects all areas and groups in the country is vital. We are unsure of the value of lay experts as it is important that the public voice represents as many people as possible. Knowledge or skill gaps can be filled by suitable training.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

We support co-production in planning and decision making to allow understanding between groups rather than separate consulting with different groups. However there is need for independent as well as internal advice and we believe the clinical voice to be critically important.

What further issues would you want us to take into account in firming up this proposal?

The Academy is very keen to be part of the clinical advice structure and is well placed to be so whilst keen to maintain our independence. There needs to be a clear understanding on what is evidence based (and the strength and reliability of that evidence), what is consensus and what is anecdote.

Welsh Government should provide strategy and state high level outcomes and support all Wales processes and decisions but should avoid micromanaging LHBs. It should have clear expectations and requirements on efficient use of public money and therefore ensure there isn’t inappropriate duplication of effort.

Although public / patient input on proposed changes is very important - as outlined above - bold decisions from elected politicians can be essential when informed by independent clinical advice which reflects the limited resources available. We support decisions informed by public / patient input and clinical expertise; not decisions driven purely by limited vociferous public opinion which could deter Ministers from making difficult but necessary decisions.

We note the HB can itself determine what is a "substantial" change. This suggests if a HB decides a change is not substantial but the public disagree the HB could choose to ignore public opinion. There needs to be a method for the new patient voice body to appeal initially to the HB chair and if not satisfied with the response to the Minister. We also feel that local clinicians (as a group, not as individuals) should have a similar right of appeal against HB decisions. Hopefully is there is true co-production this will rarely occur.

Inspection and Regulation and single body

What do you think of this proposal?

We would support a clearer legislative framework if it will improve joint working and integration of HIW and CSSIW as is indicated in the proposals.

Are there any specific issues you would want us to take into account in developing these proposals further?

We repeat that the Citizen Voice should be distinct from HIW and CSSIW whilst we support collaboration and HIW and CSSIW remain distinct from NHS Wales and Local authorities and arms length from government.

However we also believe there could be merit in considering a new body for example, a Welsh Government Sponsored Body to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?

See above. We would rather see a merger of HIW and CSSIW than a completely new body. Full operational independence is essential to have the confidence of all parties.

A clearer legislative framework to improve the integration of HIW and CSSIW would be preferable.

What issues should we take into account if this idea were to be developed further?

See above.

WGWPMB204: Cystic Fibrosis Trust
Location: London

General Comments

We are pleased to respond to this White Paper to support health and social care in Wales. Our response focuses on Chapter 3, “Person-Centred Health and Care” and Chapter 4, “Effective Citizen Voice, Co-production and Clear Inspection”. Ensuring that healthcare in Wales remains high-quality, person centred and a hub for innovative research is vital to our ambition to ensure that everyone living with cystic fibrosis can look forward to a life unlimited by the condition.

Response to Specific Questions

Representing the Citizen in Health and Social Care

Do you support this proposal?

We believe designing seamless services for everyone with cystic fibrosis demands the expertise of people with cystic fibrosis. We support the co-design and co-creation of services, pathways, and systems. However, to improve co-design, we need a simpler system.

Between Regional Partnership Boards (RPBs), Patient Participation Groups, Community Health Councils (CHCs), and the Independent Complaints Advocacy Service it can be confusing working out how you can best raise your voice. It’s hard to work out the role of each of these bodies without specialist knowledge.

The system for responding to complaints is clear and strong, but the opportunities for routine and proactive involvement could be clearer. More stakeholders and people could be involved and in different innovative ways. For example, we call for recognition of the role patient organisations can play as brokers between different systems, amplifying and strengthening peoples’ voices.

The creation of a new body could rejuvenate co-production and co-design across the health and social care system. However, it could dilute accountability and transparency, contributing to an ever more complex system. We call for the empowerment of patient and public involvement.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

What further issues would you want us to take into account in firming up this proposal?

We support the standardisation of service change across Wales in principle. People with cystic fibrosis have a lifelong and close relationship with the healthcare system from diagnosis (median age of diagnosis in 2016 was 2 months). Proposed service changes cause anxiety, stress, and concern. As highlighted above, people who use services as patients hold unique expertise that is vital to service redesign. However, we request further involvement in the development and details of this policy to

ensure the policy does not result in rigid and formulaic processes that hinder involvement and optimisation.

WGWPMB205: British Heart Foundation
Location: London

Response to Specific Questions

Duty of Quality for the Population of Wales
Do you agree with these proposals?
What further issues would you want us to take into account in firming up these proposals?

CVD patients should receive safe, effective, patient-centred, and equitable care. BHF has developed evidence-based models of care that improve clinical outcomes, meet patient's needs, tackle inequalities and make cost efficient use of NHS resource. These evidence-based studies showcase that integrated services can maximise resources and improve population health by implementing new ways of working, including:

- early supported discharge and active hospital in-reach,
- nurse-led open-access hospital and community clinics,
- specialist service home visits,
- patient-led focus groups, shared decision making and self-management tools.

BHF encourages the NHS to adopt evidence-based innovations and educates and empowers health professionals to lead and deliver system change that can provide higher quality, cost-effective management of cardiovascular disease at scale.

Setting and Meeting Common Standards
Do you support this proposal?
CVD is one of the major determinants of health inequalities causing premature mortality in the most deprived communities. In the most deprived areas of Wales, incidence of heart disease is much higher and lags behind rates in more affluent areas. For example, the premature death rate for Blaenau Gwent is nearly twice as high as for the Vale of Glamorgan . The BHF would support standards that would ensure all patients received high quality health and care regardless of locality.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
What further issues would you want us to take into account in firming up this proposal?
We would also recommend considering the role and contribution of the third sector in the proposal.

As a medical research charity, BHF fund research into heart and circulatory disease and ensure discoveries from the lab bench make a difference at the patient's bedside. Investing in translational research means that BHF is uniquely placed to work in collaboration with the NHS to support system transformation.

BHF-funded research was instrumental for the development of the Welsh Familial Hypercholesterolaemia(FH) cascade testing model. FH is an inherited condition that causes abnormally high levels of cholesterol in a person's blood. Having FH means

a patient has a greater risk of getting heart and circulatory disease at an early age if the condition is left untreated. Without treatment, people with FH can die prematurely. Around 1 in 250 of the UK population has the condition. Early statin treatment, lifestyle advice and careful monitoring for people with FH can bring someone's life expectancy back to that of someone without the condition.

In 2010, BHF invested £450,000 over a three year period in developing the Welsh FH cascade testing model. When cascade testing began in 2010, Wales had just 97 known FH patients. Since then, BHF-funded nurses have identified 1,183 people who may have FH. Of these, 492 have been diagnosed with a genetic test and given life-saving treatment. NICE has estimated that if 50% of the predicted relatives of people with FH were diagnosed and treated, the NHS could save £1.7million per year on healthcare for heart disease by preventing cardiovascular events.

WGWPMB206: The Bevan Commission
Location: Swansea

General Comments

1.1 The Bevan Commission welcomes the need for the White paper seeking to address the quality and governance of health and social care services. The Commission has also recognised the urgent need to ensure an effective system is put in place to improve the quality of care consistently across the healthcare system in Wales.
The Commission has been considering the issue of improving quality in the NHS in Wales for some time and sets out its thinking in its paper 'Achieving Profound and Sustainable Improvement in Quality in NHS Wales'. This argues that further, far reaching and more radical actions are required to achieve the full potential of the health care system if it is to meet the objectives of Prudent Health Care by improving the quality, consistency and delivery of healthcare across Wales. It proposes that this will only be achieved through the introduction of a service wide quality management system, such as the International Standards Organisation (ISO) and other similar systems used by large organisations almost universally outside of the health care sector.
Furthermore this paper proposes that such a quality management system is not optional but should be mandatory and underpinned by legislation. This would ensure that should reforms, management changes and reorganisations supervene (as inevitable they have in the past) the quality of care is not adversely affected. This system would replace, not add to existing systems across Wales, releasing important resources, allowing the redistribution of manpower currently employed outside the immediate healthcare environment closer to the patient service interface, strengthening continuous improvement within the NHS.

This document outlines a much more radical and system change and includes recommendations which are not all covered within the questions that you pose. We would therefore refer you to this document for our more detailed response to the case for improving healthcare quality across Wales.
http://www.bevancommission.org/getfile/documents/Publications/FINAL_AqualitysystemfortheNHS_July2017.pdf

1.2 We would also wish to refer you to another key document which the Bevan Commission produced last year; 'Redrawing the Relationship between the Citizen and the State' .This is also of considerable relevance to other matters raised within this paper, particularly to the voice, representation and engagement of the citizen in the NHS and wider public services. We believe that working more closely with the people of Wales to help redraw and rebalance the relationship with the state is key to the future of more successful health outcomes for people and to more sustainable health and social care services in Wales. This paper identifies some of the key factors involved in achieving this, utilising a prudent approach to health and engaging with people to develop more equitable health and wellbeing to which all in Wales are entitled.
The ways of working described in this paper are in sympathy with and enhance the approach described in the Beecham report (Welsh Assembly Government 2006) and

subsequent public service and legislative frameworks. These highlight a distinct citizen centred, social model approach to health in Wales which is linked to collective action and where the drivers for this are moral, rather than being driven merely by resource constraints.
http://www.bevancommission.org/getfile/documents/Redrawing-the-relationship-FINAL-March-2016.docx

More details of our other publications can be found on the Bevan Commission website link below
http://www.bevancommission.org/publications

1.3 The Bevan Commission has also recently launched the first of a new series of papers entitled Exploiting the Welsh Health Legacy Series. A New Way of thinking; the Need for a Prudent Model of Health and Care. This sets out the case for a more social model of care moving away from the more traditional, more medical centred model to a more prudent social model.
This will shortly be followed by the next in the series Exploiting the Welsh Health Legacy Series. A New Way of doing; a new model of health and care in Wales, which will set out a new proposed model and will include specific reference as to how this may be organised to ensure greater local ownership and engagement with the public.
This will launched in November and will also provide further and more detailed information in response to the questions you raise and many others that are directly linked.
http://www.bevancommission.org/getfile/documents/Innovation%20Showcase/BevanLegacyPaper1-2017.pdf

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?

- Strengthening leadership of Health Boards to promote stronger governance and leadership to ensure services are led, planned and developed in the way they need to be in the years to come
- This proposal addresses only addresses one aspect of improving and strengthening leadership and a change in culture across organisations.
- The Bevan Commission has endorsed the need to strengthen leadership at all levels across the NHS. The Commission has identified the need for collective and collaborative leaders across the system supported by leaders who are courageous and bold and who are prepared to take managed risks in transforming the necessary services and systems needed to sustain health and care in Wales.
- This will not need more of the same, but leaders who are able to work flexibly and responsively with others to find better solutions and ways of working. An

emphatic focus on healthcare innovation is a paramount requirement. Moreover, leaders who are able to effectively manage risk will be crucial in driving transformational change and getting the best from their staff and patients.
- Co opting new and different individuals with different perspectives could help this process.
- How will the Boards and the appointment of these new positions be held to account in strengthening leadership

Board Secretary

Do you agree with these proposals?

Yes

Duty of Quality for the Population of Wales

Do you agree with these proposals?

- We would strongly encourage and support Boards to work together and the greater and more effective integration and adoption of a more prudent approach across all public services. We see this as just one aspect of a much bigger and more complex issue that needs to be addressed.
- What is not clear is if this will ensure this and how the impact of this will be measured and monitored?
- the introduction a Duty of Quality for the Population of Wales which will focus on health boards working together to meet the needs of the population in the planning and delivery of quality healthcare services
- The Bevan Commission believes that solely a duty of quality is unlikely to be adequate to lever and sustain the level and consistency of quality improvements needed across health systems in Wales.
- The Bevan Commission proposes an externally and independently validated process along similar lines to the ISO or equivalent Quality Standard Schemes as a basis for further debate and discussion.
- Various attempts undertaken over the years have made relatively insignificant changes and therefore calls for a much more robust and radical way forward. If, following robust consideration, dialogue and discussion of the Commission's proposals, these are accepted in whole or even part, Wales would be the first system to embrace such an approach.

What further issues would you want us to take into account in firming up these proposals?

- The Bevan Commission welcomes the need for the White paper seeking to address the quality and governance of health and social care services. The Commission has also recognised the urgent need to ensure an effective system is put in place to improve the quality of care consistently across the healthcare system in Wales.
- The Commission has been considering the issue of improving quality in the NHS in Wales for some time and sets out its thinking in its paper 'Achieving Profound and Sustainable Improvement in Quality in NHS Wales'. This argues that further, far reaching and more radical actions are required to

achieve the full potential of the health care system if it is to meet the objectives of Prudent Health Care by improving the quality, consistency and delivery of healthcare across Wales. It proposes that this will only be achieved through the introduction of a service wide quality management system, such as the International Standards Organisation (ISO) and other similar systems used by large organisations almost universally outside of the health care sector.

- This paper proposes that such a quality management system is not optional but should be mandatory and underpinned by legislation. This would ensure that should reforms, management changes and reorganisations supervene (as inevitable they have in the past) the quality of care is not adversely affected.
- This system would replace, not add to existing systems across Wales, releasing important resources, allowing the redistribution of manpower currently employed outside the immediate healthcare environment closer to the patient service interface, strengthening continuous improvement within the NHS.
- This document outlines a much more radical and system change and includes recommendations which are not all covered within the questions that you pose. We would therefore refer you to this document for our more detailed response to the case for improving healthcare quality across Wales.

http://www.bevancommission.org/getfile/documents/Publications/FINAL_AqualitysystemfortheNHS_July2017.pdf

Duty of Candour

Do you support this proposal?

We would support the proposal to strengthen this

What further issues would you want us to take into account in firming up this proposal?

- There is an opportunity to use the Prudent healthcare agenda to help reinforce this in practice as the principles refer to transparency and cooperation
- How will this work in practice and how will it be made easy for individuals
- How will this ensure patient confidentiality

Setting and Meeting Common Standards

Do you support this proposal?

Yes

What further issues would you want us to take into account in firming up this proposal?

- We already have prudent principles being applied in health - can we build on these rather than have another set as this is about working co productively with people ? – (other public services are also exploring the potential for their adoption) – we could then set out the standards that support these principles
- How will this work in practice
- Will it add to existing bureaucracy and create further problems

- How will the standards be monitored and implemented in practice
- What additional training and skills developments will be needed

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Yes we would encourage proposals to make this process easier and more transparent

What further issues would you want us to take into account in firming up this proposal?

the joint investigations of complaints which span health and social care, irrespective of setting – this will involve requiring different organisations to work together to investigate complaints making it easier for people when their concern is about both health and social care services

- The Bevan Commission would endorse the need to develop better systems for investigating complaints across organisations.
- However it would strongly recommend a much more prudent approach where greater emphasis and incentives are placed upon organisations to improve the quality of care and prevent complaints arising in the first instance.
- There should be a process for early intervention into concerns before they arise as formal complaints and dealing with these in a caring and compassionate way
- How will you publish and compare the impact and effectiveness or otherwise of these across Wales consistent with openness and transparency?
- Whilst these may help the process, it believes that a more systematic emphasis on prudent healthcare and greater accountability working together with partners is needed to secure systematic improvements in reducing such complaints
- Joint responsibility will be the key in this – how do we ensure that this happens in practice and is objective?
- There is a need to have greater engagement of people in the whole process including investigations

Representing the Citizen in Health and Social Care

Do you support this proposal?

We support arrangements to revise and strengthen public engagement and representation and greater integration and collaborative working, including the CHC's. Other options should be considered fully alongside this before decisions are made

Can you see any practical difficulties with these suggestions?

strengthening of the voice of citizens – this includes proposals to replace the current model of Community Health Councils with a new independent arrangements which would represent the interests of citizens across health and social care

- The Bevan Commission believes that local engagement and accountability is crucial to effective health and care systems, consistent with prudent health and care.

- The Commission advocates the need for much stronger mechanisms to support both ownership and engagement at all levels, with both professionals and the public, in order to find better solutions to problems most effectively together.
- It also sees this as an important facet in rebalancing the responsibility of the citizen and the state.
- The Commission would therefore advocate a stronger and new framework for local ownership at a local level as well as at national levels, in which citizens are more actively engaged and involved promoting better and more prudent health and care and in owning and finding better solutions together.
- Further details of its thinking around this consistent with a new Model of Health and Care for the Future Generation can be found in its forthcoming publication' Exploiting the Welsh Health Legacy Series'. A New Way of doing; a new model of health and care in Wales (due to be published in November)
- In this we would wish to see greater involvement of people at a community level, within primary and community health / care services eg GP services, which would feed into cluster levels and then to regional/ national representation

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

yes

What further issues would you want us to take into account in firming up this proposal?

a clearer process for service change - introducing an independent mechanism to provide clinical advice on substantial service change decisions, with advice from the proposed new citizen voice body, which will encourage continuous engagement and increase the pace of strategic change

- ensuring the application of the prudent health principles in particular the co production of health and care with people and professionals is already out there and will help this
- how will we make sure that the proposed independent advice on clinical service change encourages continual engagement ? - clinical advice with advice from a citizen body would not necessarily lead to continuous engagement or strategic change and certainly not address local matters of concern effectively.
- We need to ensure that this builds from the bottom up empowering and valuing equally the public voice and embedding engagement as a requirement and shared responsibility, not a top down solution

Inspection and Regulation and single body

What do you think of this proposal?

- A stronger and independent externally validated quality system would help ensure that high quality services are consistently applied across Wales and externally validated.

- This proposal will need to take full account of the Bevan Commissions 'Achieving Profound and Sustainable Improvement in Quality in NHS Wales' paper, understanding the wider impact and the ramifications for organisations such as HIW within this
- The paper proposes that such a quality management system is not optional but should be mandatory and underpinned by legislation. This would ensure that should reforms, management changes and reorganisations supervene (as inevitable they have in the past) the quality of care is not adversely affected.
- This system would replace, not add to existing systems across Wales, releasing important resources, allowing the redistribution of manpower currently employed outside the immediate healthcare environment closer to the patient service interface, strengthening continuous improvement within the NHS.

Are there any specific issues you would want us to take into account in developing these proposals further?

Full consideration of the proposals set out in 'Achieving Profound and Sustainable Improvement in Quality in NHS Wales, as they are of direct relevance to this

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

See proposals within the 'Achieving Profound and Sustainable Improvement in Quality in NHS Wales, paper which sets out the case for a new quality system which would address many of the underlying points raised

Would you support such an idea?
See proposals within the 'Achieving Profound and Sustainable Improvement in Quality in NHS Wales, paper

- The Bevan Commissions paper recognises that further far-reaching actions are required to achieve the full potential of health and care services in Wales to gain the objectives of Prudent Health Care and sets out the case for the introduction of an independent quality system for Wales.
- It proposes that this will only be achieved through the introduction of a mandatory service wide quality management system, such as that of the International Standards Organisation (ISO) and other similar systems used by large organisations almost universally outside of the health care sector.
- This system would replace, not add to existing systems across Wales, releasing important resources, allowing the redistribution of manpower currently employed outside the immediate healthcare environment, closer to the patient service interface, and strengthening continuous improvement within the NHS.
- The Commission recognises that the provision of quality care is reliant upon other services and organisations outside the NHS. Adherence to quality processes and management systems based around the needs of patients will also have to be reflected in other organisations, which are prepared to work

toward the common goal of a more prudent approach to care. Wales should lead the way to achieve sustained, high quality prudent health care by adopting an open and consistent Quality Management System.

WGWPMB207: Welsh Ambulance Services NHS Trust
Location: All Wales

General Comments

The Welsh Ambulance Services NHS Trust welcomes the opportunity to respond to the
Welsh Government's White Paper, Services Fit for the Future: Quality and Governance in Health and Care in Wales.

In reviewing the proposals contained within the White Paper, the Trust finds itself in broad agreement with the general principles laid out in the document and welcomes a number of areas where views expressed in response to the predecessor Green Paper have clearly been reflected in the White Paper.

Detailed below are the views of the Welsh Ambulance Service on those areas where Welsh Government has sought specific feedback on the proposals outlined in the White Paper

Response to Specific Questions

Board Membership and Composition
The Welsh Ambulance Service supports the proposal that the Boards of all NHS organisations should have a Vice-Chair. This is a particularly welcome reflection of the Trust's response to the Green Paper and brings Trusts in line with their Health Board partners.

The proposal that Welsh Government should have authority to appoint additional Board members on time-limited appointments at times of under-performance or in escalation is accepted.

In considering the role of public members, Welsh Government will wish to consider the approach to, and nature of, recruitment to such roles to ensure high calibre applicants with as widely diverse experience as possible, in order that NHS organisations may benefit from the broadest possible spectrum of available knowledge and talent.

Both Health Boards and Trusts would benefit from consistency of key positions at executive level, recognising the need for maintaining flexibility dependent on organisational profile and need.

In considering these core roles, one would expect to see as a minimum Executive Directors of Finance, Workforce and OD, and Nursing/Midwifery, coupled with an Executive Medical Director. One Executive Director role should encompass the quality agenda.

The issue of whether a Chief Operating Officer should have an Executive role (Executive Director of Operations) is a moot point. Given the significance of the role

and the weight of responsibility accorded to it in the majority of organisations, it seems odd not to include it as a potential Executive role, a status which, in the main, it does not currently enjoy.

It is important that the role of Executive Directors and their accountabilities are clearly understood, and that, once agreed, such roles are not diluted. Similarly, it is important that Executive status is accorded to those roles which bear significant organisational responsibility, rather than those which have a more representative role. For example, a Director whose portfolio includes the quality agenda might come from any specific background, not necessarily clinical. There are no clear cut answers here, but what is clear is that the current model warrants revision in order that roles, accountabilities and areas of priority are clearly demarcated through an Executive Director role, with the level of scrutiny and responsibility such a role brings.

Board Secretary
The Welsh Ambulance Service agrees in principle with the safeguarding of the Board Secretary role. Indeed, the role of the Board Secretary is already clearly defined in model standing orders (updated March 2014) but has, in some cases, become diluted over time.

While the Trust recognises the need for the role to be protected, this does not necessarily need to be enshrined in primary legislation, when an acceptable secondary legislative option e.g. regulation/revision and/or strengthening of standing orders, provides well for such protection to be afforded to the role.

It is important to note that the Board Secretary's role to challenge the Chief Executive or Board more widely is one which, were it to be exercised more than rarely, would suggest that the Board was already failing and that other measures would need to be taken to secure the performance of the Board and/or the organisation.

However, it is acknowledged that there could be occasions where individuals attempt to manoeuvre in such a way as to side-step the principles of good governance and, as such, the need to support and protect the independence of the Board Secretary is recognised.

The concept of the "Monitoring Officer" as in local government provides a model as to how such a role might operate in practice.

Similarly, Welsh Government will wish to consider the competencies required in discharging such an important but complex role and reflect on how such competencies might be further developed in NHS Wales.

Duty of Quality for the Population of Wales
The Welsh Ambulance Service supports the proposal that the duty of quality be updated and enhanced better to reflect the integrated system in Wales.

While the Trust notes the need for NHS bodies to placed under a reciprocal duty with local authorities to co-operate and work in partnership to improve the quality of services provided, there is already significant legislative architecture to support this, for example the Social Services and Wellbeing Act (Wales) 2014 and the Wellbeing of Future Generations Act 2015.

While further "legislating for quality" is likely to be problematic and not guaranteed to deliver the intended outcome, the Trust accepts that a strengthened and updated duty of quality may still be required, noting the recent establishment of regional planning committees as vehicles for cross-organisational, pan-boundary planning of services delivered across a wider footprint than individual health board areas.

Duty of Candour

In light of recent concerns across the NHS about governance, accountability and openness, this is broadly welcomed.

However, such a duty has to be taken together with the need to support the development of a culture of transparency and authenticity. The reason for this lies not in a lack of support for the principle of candour, but in a belief that the ability to demonstrate candour, openness and transparency is predicated on developing the culture and demonstrating the values of an organisation, such that colleagues feel able to act honestly and openly, without fear of retribution.

This type of culture is one which the Welsh Ambulance Service is working hard to deliver, having made significant progress in the last three years, but recognising the distance yet to go and the commitment it requires from leaders and others to build trust and momentum towards a shared goal of a better organisation.

On the basis of this, and of the organisation's recent experience, legislating for candour may not deliver the required outcome unless there is equal, if not greater focus on the cultural landscape and leadership at all levels of the NHS.

It is also to be noted that professional groups already have a duty of candour placed upon them.

Setting and Meeting Common Standards

The introduction of a common set of standards across health and social care, regardless of the location of care, is broadly welcomed.

26. While, with proper implementation, the existing 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 a common approach across health and social care.

27. However, regardless of the standards adopted, a more concerted focus on their implementation is needed if there is to be significant progress in the quality agenda. Welsh Government will wish to consider the clarity with which any new standards are articulated and agree how best to evaluate the consistency of their application.

Joint Investigation of Health and Social Care Complaints

This proposal is supported as the concept of joint investigation is particularly pertinent to the Welsh Ambulance Service. Many of the concerns the organisation receives straddle both the Trust and other healthcare organisations, health boards in the main, often as a result of handover delays, the latter either delaying initial response or patients being delayed on their arrival at hospital.

Again, clarity of requirement and expectation will be important, as will simplicity of use for the complainant, but delivered properly, such an approach has the potential both to provide a better service to those who have cause to express concern, while also enabling organisations to share understanding and learning.

Representing the Citizen in Health and Social Care

The Welsh Ambulance Service is committed to the principles of citizen engagement and of co-production. It works hard with local communities and patient groups to understand their experience of care and their expectation about the ambulance service so that we can listen, learn and inform.

As an all-Wales Trust, and one with a sharp focus on operational delivery, managing relationships with seven Community Health Councils is challenging, although relationships have, and continue to improve.

The Board of CHCs has, unfortunately, not been in a position to play sufficiently strong a role in acting as the focus of the Trust's strategic engagement with CHCs, largely as a function of its recent difficulties over the last 18 months, which have coincided with a renewed commitment to engagement and partnership across the ambulance service.

That said, the Trust recognises much of the good work that the CHCs have, and continue to do, as the voice of the patient, whether that be in terms of advocacy on individual cases of concern, or in terms of service change.

The inspection landscape is rather cluttered and the Trust remains of the view that the focus of CHCs, and any other similar construct, should be firmly as a citizens' advocate.

On this basis, the Trust is largely supportive of either the retention of CHCs, but with a revised and strengthened "patient voice" remit or, alternatively, of the creation of a new pan-Wales body as outlined in the White Paper.

Given the national perspective of the Welsh Ambulance Service, it would be helpful if any replacement body also had a national arm, which would facilitate easier engagement on pan-Wales issues.

In abolishing CHCs, one of the important factors which Welsh Government will wish to consider is the recruitment of a truly representative cohort of people who wish to act as the citizen voice in any new organisation.

This is one area where, for any one of a number of understandable reasons, CHCs have not succeeded in making sufficient headway. It is, therefore, important, that consideration is given to the recruitment and role of representatives in a new national organisation, in order that it has credibility not only with health organisations, but with the wider public it is there to represent.

In addition, careful thought needs to be given to aligning the organisation representing the voice of the patient with inspection bodies to ensure that there is no conflict of interest and that any new organisation is not "swallowed" by the inspection regime.

Co-producing Plans and Services with Citizens

While absolutely acknowledging the need for clinical input and independent clinical advice in matters of contentious service change, it is difficult to understand at this stage how such a mechanism might work, given the diversity of service change planned or underway across Wales and the need to ensure that any "independent" clinical advice is sourced from those with specific clinical knowledge and experience.

On that basis, while supportive in principle, the Welsh Ambulance Service will observe with interest how this mechanism is to be established and function.

The Trust is supportive of assurance on citizen engagement being provided by any new citizen voice body.

Inspection and Regulation and single body

The Trust is supportive of, longer term, the creation of a single regulatory body. However, as outlined in the White Paper, as a minimum, the overhauling of the underpinning legislation for Health Inspectorate Wales to ensure it has a single legislative framework to work to is supported.

Given that any abolition of the CHCs will mean the loss of a discrete lay perspective in inspection, Welsh Government will wish to consider how best to ensure such a lay perspective is maintained in any new inspection body.

In this respect, the concept of any new body operating as a Welsh Government Sponsored Body to provide more independence in regulation, inspection and citizen voice is welcomed.

Closing Observations

The Welsh Ambulance Services NHS Trust welcomes the broad thrust of the White Paper and recognises the benefits to both the health and care system and, more specifically to citizens, of a more streamlined approach to citizen voice, complaints management, inspection and regulation, together with the strengthening of governance within NHS organisations.

However, it is important not to lose sight of the need to continue with the cultural journey on which the NHS and social care are embarked, to inculcate a confidence and set of values that support openness and transparency, both of which contribute greatly to improvements in care for the citizens we serve.

WGWPMB208: Directors of Planning, Welsh NHS
Location: All Wales

General Comments

This response has been prepared by Directors of Planning in Health Boards and NHS Trusts in Wales. Whilst recognising the importance of all of the elements within the Consultation, the focus of this response is those areas which specifically impact upon the responsibilities of Directors within their specific organisations and where as a group the Directors consider there is a professional response to offer.

Chapter 1 - Effective Governance
The measures set out in the White Paper which offer Boards the flexibility to tailor certain elements of their membership to meet organisational need are welcomed. This is considered to be of potential significant benefit to the smooth running and effective governance of organisations. In welcoming this potential flexibility, it is important that such approaches are clearly set in the context of the Board's broad statutory duties.
The Wellbeing of Future Generations Act has brought a requirement for Boards to think, plan and deliver services in a far broader context than NHS organisations have previously operated within. In a system that is often characterised by short term pressures and immediate service delivery requirements this brings particular challenges. These must be held to the fore in Board's strategic thinking if the NHS is to respond effectively to the challenges laid down by the Act.

In addition, Boards are now under a legal duty to prepare three year Integrated Medium Term Plans, setting out how they will deliver improvements in health and health services within the resources available. Boards in Wales have the advantage of being able to deliver this requirement within an integrated health system with one organisation responsible for commissioning care to meet the assessed needs of its population and also for the totality of provision to its population from primary care through to secondary services. Different arrangements apply for the commissioning of specialist services, and only some Health Boards provide tertiary services. The absence of artificial barriers which are created in other systems by markets and competition means that Boards in Wales have flexibility to respond, but face the potential pitfalls of a lack of challenge and tension in setting their priorities. This challenge has to be generated from within and requires the Board to maintain focus upon a balanced set of priorities and long term health outcomes whilst also dealing with the day to day delivery of high quality care which meets agreed performance and outcome measures

If Boards are to respond effectively to this challenge then it is critical that Board Membership reflects these requirements explicitly and that there is an Executive portfolio within the Board that has a clear focus upon the long term, system wide transformation (including external relationships) which is required to enable the NHS in Wales to deliver to its full potential. We consider that this focus cannot be optional for Boards in building their Executive portfolios and would urge that any change to membership reflects this clear requirement.

Chapter 2 - Duties to promote Cultural Change
We welcome the references within the section relating to “Duty of Quality for the Population of Wales” to the need to work collaboratively with Local Authorities, other statutory agencies with Public Service Boards and the third sector. This is considered critical if we are to effectively respond to the requirements of the Wellbeing of Future Generations Act and the Social Services and Wellbeing Act in particular.

We welcome the prospect of strengthening the planning duty and would encourage the development of specific measures of progress in these areas in support of this, which are applied to both NHS organisations and , in particular Local Government. In our view, there needs to be a more consistent expectation and performance framework between these two sectors which has at its heart the requirements to plan and deliver services in a more integrated manner, driving up quality and the experiences of those who access services.

Connected with the above, the commitment to setting and meeting common standards is welcomed, however there is an opportunity to frame these commitments in terms of experience and outcomes for individuals as opposed to service standards which we consider would be beneficial. The Public Health Outcomes Framework for Wales and the indicators developed to support the Wellbeing of Future Generations Act offer a good starting poit to set clear outcome based expectations upon Health and Local Government which can guide long term thinking and service delivery. We would encourage this focus on outcomes in addition to the development of individual service standards.

Chapter 4 – Effective Citizen Voice, Co-production and Clear Inspection
We welcome the focus upon citizen engagement and co-production in the planning and evaluation of services. This area of work requires significant enhancement. Our experience is that we should not under-estimate the potential benefits of this approach, but in doing so we must recognise the time and skills investment required if we are to deliver this effectively.

The proposals to refresh the approach to reflecting the citizen voice within the NHS are welcomed as we consider that improvements can be delivered in this area. We are however concerned that in doing this we should not lose some of the very positive aspects of the roles CHCs have performed in recent years. From a planning perspective CHCs have played an important role in testing proposals, advising on approaches to engagement and acting as a critical friend to the NHS planning process. Much of the benefit of this has been derived from consistent relationships over time with people who know and understand local services and populations. However the system is designed going forward these informal aspects of ongoing engagement are considered essential to reflect in new arrangements alongside formal reflections of citizens views.

The role and benefits which have been derived from Service Planning Committees to date should not be forgotten. These Committees, formed under a statutory duty placed upon Health Boards and CHCs to work together, have provided an effective mechanism for joint working in shaping service planning activities and engagement.

Future provisions will benefit greatly from such an arrangement for ongoing dialogue regarding service planning and potential service change.

One of the areas where CHCs have perhaps struggled given their specific local responsibilities and governance structures has been in responding to broader multi organisational or regional service change. This is a factor which needs to be addressed in any new arrangement, especially given the focus within the NHS and in the Consultation upon NHS organisations working more effectively together to plan services for larger population bases. The new system must be capable of flexing its focus from local service issues, through regional layers and ultimately to national services in a way that is consistent and constructive.

With regard to the proposals to establish an independent mechanism to provide advice in relation to substantial service change, we consider that this has some potential benefit. We would expect strong relationships between Health Boards and the new "Citizen Voice" organisation to deliver a mature approach to considering service change whereby the need for third party review is diminished. If this does not arise then we would consider this to be a significant failure of the new system. Therefore use of an independent mechanism should be seen as not routine for our planning process.
Where such a mechanism is required, we believe that its membership should be broader than simply a clinical focus. If we are to move to a system which is truly integrated and works through a co-productive approach then some of the voices which are key to this approach should, in our view, be represented in the independent mechanism. We consider that the patient voice should be represented in all considerations and depending upon the nature of service change being considered there may be merit in including Local Authority or 3rd sector inputs in some instances.
There is one area where the consultation is silent, yet there are considerable issues to address and this relates to cross border matters with the NHS in England. Some Health Boards have significant relationships across the border, commissioning services on behalf of their local population and therefore need the right levers to be able to influence decision making and strategic planning. The current guidance on engagement and consultation in Wales, along with the role of the CHCs has been helpful in influencing strategic change to date. There is no reference to how this would be achieved within the current consultation and this is considered to be a significant omission.
In relation to the proposals for Inspection and Regulation, we welcome the proposal to bring the work of HIW and CSSIW closer together. If the ambition to deliver more integrated care is to be realised, then having a regulation system that is fit for purpose in responding to such service models is a pre-requisite.

The Consultation proposes that the Citizen Voice organisation and the regulators should collaborate and work more closely and we believe that this could add distinct benefit. There is however a potential tension which will need to be addressed at the outset in finalising these proposals. This relates to the interface between the Citizen Voice role in co-production and potential alignment with regulation and inspection. If an organisation is to be genuinely influential in the design of services through co-production then we must recognise that there should be some distance between that role and integration with regulators who will ultimately assess the impact of those

services and their ability to deliver against expected standards or outcomes. We consider that this demarcation should be explicit in any new arrangement.

WGWPMB209: Cwm Taf University Health Board
Location: Abercynon

General Comments

The Health Board took the opportunity to discuss the 'White Paper' at its Board Development meeting in August 2017. In addition broader engagement and discussion with Committees of the Board in relation to the 'Green Paper' that informed this publication have been taken into consideration, which helped to generate a range of comments and feedback which have been summarised within this response.

In discussions held by the Board, the following key general points were made;

- It will be important to ensure that any legislation being considered as a result of the White Paper will not be developed in isolation and will align and supplement other legal frameworks (for example the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations Act (Wales) 2015). The importance of strengthening arrangements for partnership governance should not be missed if we are to encourage the delivery of an integrated health and social care system across Wales.
- It will be important to consider the legitimacy of any proposed legislative change in the context of whether change can be delivered without it. Current planning cycles within both health and social care are not fully aligned and the requirement for legislation where considered necessary should be fully explored, if change at pace is to be a requirement.
- Culture, values and behaviours cannot be driven by legislative change alone, it's important to ensure ongoing engagement of patients / service users and stakeholders in the planning and provision of health services.
- There is a need to strengthen inspection and regulation with a more robust and consistent system of inspection, which would be welcomed by the Health Board and provide our citizens with assurance on the quality and safety of services. There is general support for a stronger and more integrated regulator aligning health and social care inspectorates with integrated service standards that could also align with professional standards.
- The proposal to bring forward legislation regarding a duty of candour is supported. Should a duty of candour be introduced, it must be recognised that there will be training and culture implications that would need to be considered and addressed and the relevant professional bodies would also have to recognise such a duty in their own standards.
- There is a need to review the current size and configuration of Health Board membership, which if too large can inhibit the quality of the Board's deliberations and decision making, but conversely if too small, can stretch the resources of the Board to span the many competing demands placed upon its members. 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 of 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. Being an Independent Board member requires a considerable level of skill and knowledge to effectively scrutinise, challenge and support the delivery and improvement agenda. Consideration should therefore be given to the preparation, induction and ongoing development of individuals undertaking these roles.

The Board is broadly supportive of proposals relating to the CHCs. Their role in advocacy, supporting local dignity and partnership visits and as a community voice in early thinking about service planning and development is highly valued by the Board. However, it is recognised that the role of the CHC in public consultation on service change, particularly in the context of cross-LHB developments needs to be reconsidered. In particular, an improved referral mechanism is needed if Community Health Councils (CHC) wish to challenge service change proposals. There will be a need to reconsider the role of the Cabinet Secretary if areas of dispute cannot be resolved by the Director General / Chief Executive NHS Wales.

Response to Specific Questions

Board Membership and Composition

Do you agree with these proposals?

What further issues would you want us to take into account in firming up these proposals?

The Health Board agrees that there should be shared key principles for Health Boards and Trusts, as outlined in the White Paper. This would provide greater coherence between NHS bodies in the pursuit of improving health and health services across Wales.

The Health Board supports the formal appointment of Vice-Chairs to Trusts, which will assist the underpinning of good governance arrangements in Local Health Boards.

The Board must have the means and skills to lead the organisation so that decision making is effective and the right outcomes are delivered for citizens.
The Board is supportive of the proposal that the Cabinet Secretary is authorised to appoint additional Board Members to Boards, in the circumstances outlined. It will be important to be clear on the roles such appointments undertake, with clear terms of reference informing their work. It will also be necessary to ensure if appointees have Board Member status that that this is clarified in the context of the existing Board membership and composition of the Board. e.g. Associate ex officio Members.

In relation to Board Membership and size of Health Boards, there is some evidence that suggests smaller Boards are more effective than large Boards. The important consideration is that the Board is populated with the right skills and expertise to

deliver its agenda. If a smaller board composition was the chosen way forward, it will be important to clarify the roles and time commitments of Independent Board Members who contribute far in excess of the current notional time commitment and also undertake champion role(s), which will also require significant review and adjustment.

The Board believes that the current size and configuration of Health Board membership as set out in the model Standing Orders has not from its experiences to date, inhibited deliberations and decision-making. Reducing the membership may provide an opportunity for Boards to become more agile, streamlined and responsive, which would in turn enable the Board to function with a greater strategic focus. However, this needs to be balanced against the scale of the agenda and the time commitment requirements of Board members. In respect of the composition of boards, the Board believes that generally, there should be consistency in some key positions for Executive Officers but also allowing some local flexibility to appoint based on local priorities.

The balance between Executive and Independent Membership, with a greater number of the latter, should be maintained in order to ensure the challenge and holding to account that Independent Members bring is maintained, which are cornerstones of good board governance. Boards should also have greater flexibility as regards determining best fit of skill sets when appointing Independent Members. In respect of succession planning and Board stability and to avoid recent experiences where a large number of very experienced Independent Members completed their maximum term of appointment at the same time, appointments should be staggered to avoid this.

Whilst there is support to change the title of Independent Members, the proposed 'Public Member' is not supported. The current regulations refer to Non Officer and Non Executive Member and these are known, well recognised and broadly understood across sectors.

There will be a need to consider Board composition within the current context of representative membership as a smaller Board cannot (and nor does it now), represent all areas of a large and diverse Health Board area. If there is a shift to smaller Boards the current approach will have to be changed significantly but be able to demonstrate knowledge, understanding and awareness of issues, to fully take account of all relevant interests. The Board is strongly supportive that the staff voice at Board level should be maintained.

The Board is supportive of ways to ensure that diversity is strengthened amongst Board members, it will also be as important to ensure time commitments are more transparent and open from the outset, to those wishing to take up such posts, current commitment on average can be at least twice the advertised notional estimate. A review of associate membership would also be welcomed as part of any proposed changes to Board membership.

Adequate Board level resources and skills covering the range of clinical and professional issues should be in place to allow members to fulfil their portfolio obligations and accountabilities.

Board Secretary

Do you agree with these proposals?

What further issues would you want us to take into account in firming up these proposals?

There is increasing recognition that robust and effective Corporate Governance is integral to high-performing organisations. Since the inception of Health Boards in 2009, the role of the Board Secretary as Corporate Governance Adviser has evolved and matured. Cwm Taf UHB recognises the important role that its 'Board Secretary / Director of Corporate Services & Governance' plays in relation to the Governance of the Board and the guardian of a strong governance framework.

Whilst the role of the Board Secretary should be specified, strengthened and clarified in regulations setting it in place on a statutory basis, it will be important to ensure that any legislative change does not isolate the post holder from their integral role as a key member of the Executive team and more broadly but specifically, governance advisor to the Board.

The model job description for the role, incorporated into the original 2009 Model Standing Orders, requires updating to reflect the evolution of governance arrangements that has taken place during the intervening years. To reduce the potential for conflicts of interest to arise, it is important to ensure a clear, corporate portfolio of responsibilities is adhered to, ensure an appropriate balance between the key requirements of the role and where appropriate, but limited operational elements of the role. It will be important to ensure the post holder is enabled and appropriately supported to discharge their role.

The current NHS job evaluation and grading system for NHS Directors and Very Senior Managers whilst generally flawed and somewhat outdated, doesn't fully recognise roles of this nature that can impact on the perception that the role, whilst important, may not be seen as important as other Board Directors.

The strengthening of this role provides an opportunity to correct long standing misperceptions as regards the seniority and status of Board Secretaries. Formally re-naming the role 'Director of Corporate Governance' and emphasising that the post-holder should be seen as a member of the Executive Team would perhaps provide the necessary clarification, which would require direct reporting to both the Chair and Chief Executive of the Board, but also ensure retention of its unique position of trust as an independent adviser and mediator, providing statutory protection to allow the role to challenge the Chief Executive of an NHS organisation more widely, may be better discharged through other existing mechanisms rather than statute.

The Board Secretary should be directly accountable for the conduct of their role to the Chair and Chief Executive, with day to day reporting to the Chief Executive. This is the model which has been in place in Cwm Taf UHB for the past 4 years. It is reflected in the Board Governance and Assurance Framework and serves the organisation extremely well.

The Board feels very strongly that the ability of the Board Secretary to constructively challenge the Chief Executive, Chair and the wider Board is as much about organisational culture and leadership as it is about any statutory protection. Further consideration should be given to the personal and professional attributes required to demonstrate an 'Executive Presence', backed up by solid communication skills to build trusted relationships which need to be exercised within the context of confidentiality, objectivity and sensitivity. Eligibility for the role of board Secretary should not be solely reliant upon a specific professional qualification.

Duty of Quality for the Population of Wales

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

The Board recognises the need to ensure that honesty and transparency are the norm in all health and social care organisations and supports the introduction of a statutory duty of candour to strengthen the expectation for openness that currently exists. The principles of openness and candour would need to extend beyond the current requirements set out in Putting Things Right regulations, to the design of care plans as well as the delivery of health and social care. Whilst professional groups already hold a duty of candour, it would be powerful if this was extended across the NHS. Introducing a legal requirement would enable inspection to take place, though this would be dependent upon clarification as to what would count as evidence of being open and transparent. Any such duty introduced within Wales will need to be aligned to the regulations introduced within NHS England in 2014, in regard to the thresholds in place to measure the consistency of standards. This will be important to ensure there is a common basis for proportionate regulatory action if required.

The importance of organisational leadership, values and culture cannot be understated in the context of being open and transparent and reliance on statutory duty alone, will not bring about the plausible change intended by this proposal.

Duty of Candour

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be important to ensure there is a common basis for proportionate regulatory action if required.

The importance of organisational leadership, values and culture cannot be understated in the context of being open and transparent and reliance on statutory duty alone, will not bring about the plausible change intended by this proposal.

Setting and Meeting Common Standards

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

The Health Board supports the concept of having in place consistent standards, which should be integrated with social care, the third sector and the independent sector.

This common set of requirements should not only set out a clear description of safe and acceptable quality but should also be used as the framework for continuous improvement so that a measureable rise in achievement can be tracked. Associated monitoring arrangements would need to be similarly joined up. The Health Board believes that a review of the Putting Things Right regulations would be timely and helpful, particularly in light of the suggestion to introduce a duty of candour, as its important to recognise that there are significant differences between in-hospital care, community care and care at home.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

The Health Board believes that the complaints process should be more integrated, to include secondary, primary and social care and more responsive to citizens regardless of their setting of health and social care. Any revised system needs to consider the opportunity for citizens to raise concerns at any point and without being over burdened by multi touch point bureaucracy that takes an excessive amount of time to navigate and can often result in disillusionment on the part of those involved. Statutory guidance should set out a transparent joint complaints process for service users who wish to complain about health and social care, where their package of care includes both. Cross border cases would also benefit from better transparency and communication systems. All opportunities to support and encourage organisations to learn lessons to improve their services would also be embraced.

Representing the Citizen in Health and Social Care

Do you support this proposal?

The Health Board fully supports the proposal that Health and Social Care organisations should be working with its communities to co-design and co-create services and that mechanisms need to be reviewed, considered and established to monitor the effectiveness of these arrangements. There is support for ensuring that

systems are strengthened to improve the effectiveness of the Citizen voice in the development of Health & Social Care services, inspection and regulation.
The Health Board has benefitted from a strong and constructive working relationship with its local CHC for many years and have also developed locality specific engagement fora with citizens to discuss and consider service change and service developments. However, the Board recognises that such processes need to be constantly reviewed and where possible strengthened, aligned with other engagement opportunities.

The Health Board, whilst welcoming and supporting any opportunity to strengthen the patient / citizen voice in health and social care, airs some caution with regards adopting or modifying other home nation models, when these are also being changed to improve their effectiveness.

The current role of the CHC in providing advocacy support at a local level for patients and carers is very much welcomed and valued. However, a review of these arrangements, aligned with other proposals around concerns management across the Health and Social care service would be necessary and timely.

There are strengths associated with the independent inspection of Health Board services and facilities undertaken by the CHC and local knowledge and relationships often make this process more effective. However, the broader issue of who inspects what would benefit from being clarified and strengthened further in consideration of proposals within this section of the 'White Paper', particularly in relation to the proposed role of a new Regulatory body across Health & Social Care, who currently undertake elements of this function against any proposed new body to take forward the patient voice.

A further area of the current role of CHCs that will require review and clarity in any new body, is in relation to engagement and consultation of service change and service re-design. We have very good experience in Cwm Taf of effective working with the CHC on matters of service change that ultimately do not require formal public consultation. This has often been extremely helpful in identifying small but significant issues we can address as part of any change process.

Over and above this more local activity, Health Boards are required under the NHS Act to ensure local populations are formally consulted and engaged in proposals regarded as substantial service change and if the NHS is to embrace co-production more fully this will need to be strengthened, along with a sound evidence base in support. However, at the time when health and social care partnership planning and working is being strengthened, indeed as it is with other statutory and third sector partners, there will be a need for clarity in this important and increasing area of business.

This is becoming increasingly significant as service change spans more than one Health Board or at Regional level. The current arrangements do not lend themselves well at all to the complexity of engagement and consultation at this wider level.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

What further issues would you want us to take into account in firming up this proposal?

The Board is supportive of ensuring service change proposals are informed by robust clinical evidence which on times in relation to substantial service change, will need to be sourced independently and considered with views from citizens and the new citizen voice body.

Clarity of process if there is disagreement between the evidence base and the citizen voice will be required, to avoid any excessive referrals to the Cabinet Secretary. Again, this is particularly significant iin areas of supra-health Board change where different Boards may come to different conclusions on the best way forward. The Health Board fully supports the move towards co-production. This is not yet happening on a widespread basis, although evolutionary change has commenced. Additional legislation should not be necessary given that the duty to consult is already covered in the NHS (Wales) Act 2006.

Inspection and Regulation and single body

What do you think of this proposal?

Are there specific issues you would want us to take into account in developing these proposals further?

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?

What issues should we take into account if this idea were to be developed further?

The Health Board agrees that there should be underpinning legislation for integrated inspection and regulation, leading to the development of a single regulator for health and social care, which should be independent of Welsh Government. Regulators need to be robust and have appropriate resourcing, skills and system knowledge so that they can maintain their independence and have clear boundaries so that the public can have confidence in the Regulator.

WGWPMB210: Cardiff Third Sector Council (C3SC)
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
We agree with the proposal that all Boards of health boards and NHS Trusts should share some core key principles including strong governance and delivering person centred care in partnership, providing that this partnership includes service users and third sector organisations and not just other statutory health services and local authorities; it should also include social care given the recognised importance of integration and other key activities and policy strands – such as wellbeing, sport, educators and housing providers.

We agree that all Boards should have a Vice Chair given its role in strengthening governance. Cardiff and Vale University Health Board (UHB) have had a very active Vice Chair who has engaged with partners and across the UHB. He has recently moved on to a new role and we look forward to his replacement being appointed.

The Welsh Government should have the authority to appoint additional Board members on time limited appointments to support – and lead where relevant – improvements in key performance areas, whether these be financial, clinical or any area covered by the core key principles. These should be independently scrutinised and their effectiveness monitored. They should fill specific gaps and not duplicate, and should be in agreement with the strategic directions of the NHS Board/Trust and have the same level of power and influence as all of the other Board Members. Boards should also be able to request this support from Welsh Government, preventing under-performance.

There are a limited number of positions which are consistent across local health boards and these change as structures change. Beyond the Chief Executive and Director of Finance these should mostly be agreed at a local level. However, we propose that Board's should account for how the make-up of the Board allows them to discharge their governance function and comply with the key principles, and we also propose the need to include Public Health, the third sector and citizens on Boards. There is a risk without this that the Boards becomes too insula and do not benefit from wider health remits and opportunities for prevention to reduce ill health in the general population, promoting new thinking and innovation. The third sector has an especially important role in social interventions that improve health, such as reducing social isolation, across all ages and protected characteristics. It is therefore essential that the third sector has representation at Board level, particularly as more evidence is coming to light of the impact on health caused by social issues, such as isolation.

We support any principles that enhance governance and deliver preventative person-centred care; we think that these changes would enable a move in this general direction.

What further issues would you want us to take into account in firming up these proposals?

The importance of the citizen's voice being heard at Board level. The Cardiff and Vale UHB begin each Board meeting with a patient telling their story. This helps to focus the attention of the Board on the fact that services are for individuals, and also allows for this perspective, innovative ideas and improvements to be heard directly. We think that it should be a requirement for all Health Board and NHS Trusts to support self-advocacy by having this feature as the first item on the agenda. County Voluntary Councils could support meeting of this requirement if help were needed.

We do not agree with the change of title of an Independent Member to 'Public Member' as this could be misleading and confused with the citizens voice.

Each Board should be required to have a Board Member who has a specific lead on Equality and Diversity, especially in regards to ethnicity. There is a risk in the current arrangements that equality and diversity is seen as everyone's business, which means it is no one specific person's focus, which risks the possibility that no one takes responsibility for it. Given that Health touches on all people's lives across all protected characteristics, we think that this is essential to support a genuine commitment to inclusive and effective person centred services.

Board Secretary

Do you agree with these proposals?

There is a risk that the role of Board Secretary will become a very confused role unless the role is specified very clearly together with their right and responsibilities around challenging the Board. A secretary of a Board in the third sector is normally the person who is responsible for accuracy and submitting reports required to meet legislation and regulation. The anticipated role that is being proposed is not about that but about holding the Board to account and to challenge the Chief Executive – which is a role that the Chair and other Board members should be undertaking, and if they are not then they are not carrying out their duties of governance. To have the Board Secretary take a specific role in challenging the Board could make the relationship awkward and displace what should be a shared responsibility; they should have the same opportunity and responsibility of challenge as all other Board Members.

It may be more appropriate to have an appointee on the Board who is from the third sector who is able to act as a critical friend and deliver this role from a position of independence rather than complicate the role of the Board Secretary. An appointee or observer from the Wales Audit Office or the Welsh Government could also help to fulfil this function.

What further issues would you want us to take into account in firming up these proposals?

The current proposals risks an over-reliance and level of responsibility for the Board Secretary, potentially amounting to more power and influence than the Chair or any other Board Member unless the role and its powers and limitations are properly described. It would also be essential to make clear who will have responsibility to challenge the Board Secretary to achieve greater balance. It otherwise risks one

person having the power to overly influence decision making without giving due account to other people's views and opinions and the best evidence for delivery of services for citizens.

Health Boards and Trusts should be held accountable through robust governance requirements and their responsibilities to funders and commissioners, which for health is often the politicians and staff working in Welsh Government. The third sector have Boards who are held accountable through charity regulation and to a number of different funders, whether these are grant funds or commissioned services. Having similar arrangements for public services would match the good governance arrangements already in place for charities.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

Integration at a regional level can be time consuming and challenging, to do this across the whole of Wales would be even more so. If all 22 Local Authorities and all of the NHS bodies have to sign up to something there is a real chance that nothing would ever be achieved as there will often be at least one who doesn't want to sign up for a reason specific to their area. Integration would need to be left to be resolved at differing geographical levels for different services in response to citizens' needs, allowing the necessary level of flexibility and responsiveness. The risk otherwise is that the bureaucracy becomes greater and could also stifle innovation and options to meet the needs of citizens at local, regional and Wales wide. However, where it is clear that a direction betters outcomes for citizens, LA's and NHS bodies should be required to submit the proposal to WG, with the party not wanting to support the approach putting forward the rationale for not moving to working to a more appropriate geographical arrangement. The rationale should focus on assessing the impact against the needs of the local population.

We agree that there should be an increased duty around quality and that quality should have an equal value with cost when commissioning practices are being undertaken. We think that legislation should specify that at least 50% of commissioning scores must be weighted on quality.

The Social Services and Wellbeing (Wales) Act 2014 and the Wellbeing of Future Generations (Wales) Act 2015 already place a duty on the NHS bodies to work in partnership. This should therefore be in place and would only need to be referenced; to add this to more legislation would appear to be a duplication.

We agree that there should be a strengthened planning duty to work together. There is an issue in that the current system that operates still puts health boards in competition with each other for certain aspects. Commissioning of services especially between health boards needs to be simplified with services commissioned that promote collaboration and meet the local needs and national needs where appropriate. The local needs and national needs can be different but the health boards should have the flexibility to accommodate this. Where a service is being delivered in partnership then there should be a fair funding formula which funds the cost of running the service to NICE standards and not to the lowest possible cost - this will ensure quality and consistency for patients.

What further issues would you want us to take into account in firming up these proposals?

Promoting good health and wellbeing (paragraph 43, page 18) is a welcome addition in the consultation document. The lack of inclusion in the duty of care is disappointing as this is important for the prevention of ill health in the future and for reducing the impact of ill health. The third sector alongside Public Health have the potential to work in partnership with the Health Boards/Trusts to positively influence healthy lifestyle choices, but this needs political support. There will be an unfortunate impact through the loss of Communities First on promoting positive lifestyle choices amongst Wales' poorer communities, the full implications of which will not become clear for a number of years. The evidence for inclusion and its impact on healthier lifestyles is already in place. The removal of health related aspects of the Families First programme and reduced levels for Flying Start risks having further negative impacts on people, with services focussing more on reactive rather than preventative responses - not dealing with the causes of ill health, but managing it when it occurs – which is the more costly option both financially and on a number of other social levels.

Quality in terms of meeting the needs of those with protected characteristics should also be added, for example those from minority ethnic communities may require variations in how a service is delivered. These may be known locally but if services are looking only at the general population across the whole of Wales then these elements may be missed, especially away from the metropolitan cities. The framework should reflect this requirement.

Duty of Candour

Do you support this proposal?

In principle, we agree that there should be one set of common standards. There are already a number of national standards though that are being applied and consulted on as a result of the Social Services and Wellbeing (Wales) Act 2014, Wellbeing of Future Generations (Wales) Act 2015, and the Regulation and Inspection of Social Care (Wales) 2016. Public Health Wales have also issued their Outcomes Framework and are continuing work on developing national indicators. It would be more beneficial if Welsh Government was able to work across its departments to discuss this option ahead of all the different parts of legislation being written and released. Social Care therefore already have a set of common standards, so there is going to be more bureaucracy where providers have more standards to comply with at a time of already increased bureaucracy as the regulation across domiciliary care comes into place – providers are already struggling to keep up. Any new standards need to be specific to health and at a later date both health and social care standards need to be reviewed with the specific aim of them being merged into a common set of high level standards.

Standards should be a common set of requirements which can be used as the framework for continuous improvement, which can be directly reported and monitored.

What further issues would you want us to take into account in firming up this proposal?

If you are looking to put more regulation into social care on top of what is already proposed under the Social Services and Wellbeing (Wales) Act 2014 and Regulation and Inspection of Social Care (Wales) Act 2016 then there needs to be core funding for services within organisations to be able to put in place the governance and other systems to record and monitor this information. This money should be made available directly to third sector providers and should be ring fenced so that the money must go directly to providers and cannot remain within the statutory bodies. It should be managed directly by the third sector infrastructure organisations (TSSW), or alternatively by Welsh Government.

Independent Professional Advocacy (paragraph 66, page 24) across health and social care is already covered in the Social Services and Wellbeing (Wales) Act 2014. Though there has been very little engagement in the commissioning process from the Community Health Council in our area in the process. Therefore the inclusion of it again in the health legislation would appear to be a duplication.

Setting and Meeting Common Standards

Do you support this proposal?

Yes, we support joint investigation of health and social care complaints. The joint investigations should not be limited to health and social care statutory bodies, when appropriate they should include other statutory bodies, such as the police and fire service, and service providers such as the third sector. The third sector can bring in a different perspective, provide different and innovative solutions and help communicate changes to the wider sector as well as to citizens if change needs to take place due to a complaint.

What further issues would you want us to take into account in firming up this proposal?

There is a risk with introducing a joint complaints procedure across health and social care which only applies where both are involved. As a service user the citizen will have three different complaints procedures – one that is just for health, one that is just for social care, and one for if it is both health and social care. How is a citizen meant to know which of the complaint procedures applies to which service? Especially as they may receive support from three services, one from health, one from social care and a joint one. There should be a single point of contact for complaints, these should then be triaged so that they follow the correct route through the complaints procedure; it should not be for the citizen to decide which complaint pathway they should be following. The triage of complaints could be managed outside of the statutory bodies, by the third sector through the WCVA or other infrastructure body which can provide independent advice and information and ensure consistency across Wales.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

We agree that the public should be involved in the work to co-design and co-create services and that this should be independently monitored. We think that the CHC

supported by an appropriate possibly revised structure should have the independently monitoring role, to make sure that the public have been involved in all decision making. We think that having the monitoring role would mean that there would be a conflict of interest for the CHC under the new arrangement to also be the citizen voice.

The duty should be placed on all health and social care bodies that they must engage with citizens from across the area of benefit for a service and have a clear co-produced strategy to give this effect. This should include engagement with those with protected characteristics. The third sector is able to support this area of work for the statutory bodies through the Third Sector Support Wales (TSSW) partnership of WCVA and the CVC's. TSSW would also bring the benefit of connections through its membership with national and regional organisations that work with specific groups with protected characteristics, such as Diverse Cymru, Race Equality First, Stonewall, Age Cymru and Barnardos, as well as more local groups. This approach will ensure that everyone has an equal chance to be heard, even from the 'seldom heard' groups and that more of the population have opportunities to be involved. This approach would also release CHC to undertake a robust monitoring role.

Can you see any practical difficulties with these suggestions?
At a local level engagement is increasingly being carried out by the local authority and the health board already, therefore there is a risk that saying that engagement needs to just go through the new body will reduce the options and opportunities for direct engagement, which may stifle innovation and add in bureaucracy into a process which is already under development. TSSW would be a valuable option for facilitating inclusive engagement.

Cardiff and Vale UHB already has a very proactive and engaged patient engagement team which reports every quarter to the Board. Is there a risk of duplication from the new CHC with this, leading to delays and only a focus on issues and not including good practice which can help with staff morale, which could be addressed by the CHC role being a monitoring one that would fit with current and emerging arrangements.

The citizen voice must be equal to the inspectorate bodies, and must offer a variety of different pathways and methods of engagement. To enable a diversity of people to be involved will require resource, and therefore if there is to be a citizen voice body it must be staffed and led by passionate people who are skilled and developed in enabling all voices to be heard. Existing funding to TSSW could be enhanced for this function, adding value through its current pillars of activity.

All language needs would need to be integrated together with English and Welsh if marginalisation is to be avoided.

Representing the Citizen in Health and Social Care
Do you agree with this proposal?
We agree that continuous engagement is important, however as mentioned earlier we do not think that this should be through a new citizen voice body that replaces the

CHC as this limits opportunities for direct engagement. The engagement should be direct between the statutory body and the citizen, with the new body monitoring compliance with this. We however recognise that not all citizens will be aware or feel sufficiently confident to engage effectively. TSSW already plays an important role in enabling citizen engagement, providing the opportunity for this arrangement to be strengthened under these plans.

Co-production needs to be integral to the process of change. Information from citizens must not be a 'tick box' exercise that the NHS bodies have to comply with, but must be an equal part along with all the other elements involved in evolving and implementing change. TSSW can enable this process.

Cardiff and the Vale UHB already have an active and engaged Stakeholder Reference Group (SRG) with representation from the local government, carers, private and third sectors with a range of specialities including equality and diversity. The SRG does not replace citizen voice but is an additional route for input which is effectively utilised in Cardiff and the Vale alongside gathering information from citizens and members of staff.

What further issues would you want us to take into account in firming up this proposal?

Paragraph 95 (page 32) specifically mentions digital methods for engagement; we do not think that any one method of engagement should be highlighted in the legislation. Engagement should use traditional methods alongside digital methods and any methods which may come along with technological advances. There are still many people who remain digitally excluded, especially older people, those from deprived areas and those in remote geographical areas, therefore it is important to not over rely on digital with its potential for further marginalisation. In addition, there is some evidence that only certain people engage with digital survey's so an over reliance could result in misrepresentation and an appearance of an evidence-base which is not really inclusive.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

We agree that continuous engagement is important, however as mentioned earlier we do not think that this should be through a new citizen voice body that replaces the CHC as this limits opportunities for direct engagement. The engagement should be direct between the statutory body and the citizen, with the new body monitoring compliance with this. We however recognise that not all citizens will be aware or feel sufficiently confident to engage effectively. TSSW already plays an important role in enabling citizen engagement, providing the opportunity for this arrangement to be strengthened under these plans.

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Inspection and Regulation and single body
What do you think of this proposal?
Improved integration and joint working between HIW and CSSIW would be welcomed as many services providing both health and social care services are registered with both. We agree therefore that legislation should be clear and enable joint working, especially around dealing with complaints and compliance of providers.

Are there any specific issues you would want us to take into account in developing these proposals further?
Social Care Wales will also be carrying out regulation and inspection duties, it is important that they are included alongside CSSIW and HIW in considering how services are inspected and regulated in partnership.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?
In principle, we would agree with having one body for regulation and inspection of health and social care. However, with Social Care Wales only just being formed and the Regulation and Inspection of Social Care (Wales) Act 2016 only just being implemented this needs to be allowed to be embedded before there are more changes. This could be a long term aim, which could be looked at once the current priorities for Social Care Wales and the Act 2016 has been given a chance to be implemented and embedded. This will allow both capacity and learning – allowing gaps and issues to be identified which could then be resolved as the combined body is formed.

Monitoring of the citizen voice does not easily fit with the regulation and inspection of services. However, there should be benchmarks based on best practice and clear, inclusive and accessible mechanisms whereby service users are included in reviewing and monitoring of services. This is already a requirement for commissioned services and could be measured.

What issues should we take into account if this idea were to be developed further?
The timing of any future developments would need to cross over Welsh Government departments, which often feature silo'd ways of working. Health and Social Care do not operate in isolation, housing, education and other provision also have direct impacts on these services, so there could be potential to look in a much more holistic manner at what truly impacts on health and social care and not just be limited to those who are known to the two service areas. This would also further enhance the focus on prevention.

WGWPMB211: Powys teaching Health Board
Location: Llandrindod Wells

General Comments

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
What further issues would you want us to take into account in firming up these proposals?
In general, Powys Teaching Health Board (referred to throughout the remainder of this response as the Board of PTHB) agrees with each of the proposals set out in the White Paper that relate to the membership of NHS health board and Trust Boards.

The Welsh Government's view that the Boards of NHS health bodies should share some core key principles, as outlined in the White Paper, is a sensible one. Such an approach would provide greater consistency across Welsh NHS bodies and promotes a one Wales approach.

PTHB also agrees that all Boards should have Vice-Chairs. This model has underpinned good governance arrangements in health boards and should be incorporated into the membership arrangements of Trusts. Careful consideration should be given as to whether on balance the attribution of specific service areas to the Vice Chair (community and mental health) is helpful or detracts from all Board members having a keen input in that area. A more flexible approach may be helpful.

PTHB understands and fully accepts that when an NHS body is underperforming Ministers need to ensure that the Board has the means and skills to drive improvement, make effective decisions and deliver the right outcomes for its population. The view that Ministers should have the authority to appoint additional Board members under the circumstances described in the White Paper is therefore supported. Careful consideration should be given to whether individuals brought in during times of concern should be full or associate Board members. In addition, it should be recognised that additional support may be appropriate when there are no escalated concerns or evidence of poor performance, for example, when there are a number of changes at Board level and support is needed to help new Board members settle in.
The Board of PTHB believes that there should be a consistent 'core' Board Executive Officer membership across NHS Wales, and there should also be some local flexibility so that appointments can be made in alignment with local priorities. Boards should be able to determine the Executive structure and Board membership that best meets its local requirements. The complexity of the remit of an organisations, and not just the size of the organisation should be taken account of when considering the membership of the Board and Executive structure i.e. the size and membership of the Board should support the business of the organisation. Any new proposals should aim to strengthen the role of 'Clinical Executives'

demonstrating a clear commitment to the embedding of clinical leadership, being cognisant of legislation (e.g. Nurse Staffing Act).
PTHB recognises the importance of a diverse Board membership, however believes that caution is needed to ensure that the membership is not overly large. The Board should not have a membership of more than 20, but when considering the size and membership of Boards consideration must be given to the resource needed to meet the range of roles and responsibilities required to deliver the organisations

The Board of PTHB supports a change of the title 'Independent Member', so that the role they play on behalf of the local population and stakeholders is better understood. The appropriateness of the title 'Public Member' is questioned as it is likely to be misleading. The terms a 'Non-Officer Member' and 'Non-Executive Member' are used across both the public and private sectors and may be more appropriate terms to use.

The Board of PTHB would like the following additional issues taken in to account as part of the process for firming up the proposals set out in the White Paper:

- Independent Member appointments should be staggered to ensure Board stability. The appointment process should also be reviewed.
- The development of core competencies and skills for all Board Members is critical; these should include reference to emotional intelligence and behaviours.
- Ways of increasing diversity amongst Independent Board Members in particular, those with protected characteristics would be welcomed. The Independent Member appointment process needs to be more efficient and better designed to engage individuals from different backgrounds, age groups and ethnic backgrounds. The current process is to onerous and deters many suitable candidates from applying.
- The time commitment required of Independent Members is significant (far greater than four days per month as set out in current IM recruitment adverts). Most IMs sit on more than one Board Committee and have a Board Champion role. If the number of Independent Members was reduced there would be an impact on the Board Committee and Champion arrangements.

Board Secretary

Do you agree with these proposals?

What further issues would you want us to take into account in firming up these proposals?

Board of PTHB considers the role of the Board Secretary to be key and recognises that greater clarity and protection of the role is needed. It agrees that the role should be place on a statutory basis and of equal standing to other professional roles such as Nurse Director, Medical Director etc. As such the role would have unfettered access and provision of professional advice to the Chair and Board, being directly accountable to the Chair and indirectly accountable to the CEO.

While the role could be set out in regulations, what is urgently needed is greater clarity in relation to the Board Secretary remit, and where the role sits in relation to the Board, and the Executive in particular.

Since the role was introduced in to NHS Wales in 2009, it has evolved, and there is variation in the post holders' responsibilities across organisations. The role as set out in Standing Orders and in the model job description issued by the Welsh Government needs to be reviewed and operational responsibilities avoided.

The title of Board Secretary is an issue, as it can lead to the status of the role not being fully recognised or understood. The Board of PTHB is of the view that the importance of the role would be strengthened if it were renamed to fully reflect the role and the fact that it is a director level position, for example Director of Governance. Further, consideration should be given to the personal and professional attributes required to fulfil the role of the Board Secretary, particularly if the role is to be strengthened.

The Board Secretary role should advise the Chief Executive, Chair and Board and proactively develop good governance systems, processes, practice and behaviours. Care should be taken for this role not to simply be a 'policing' one but positive and proactively support the building of effective and enabling governance. Adequate resources and staff must be made available to support the role of the Board Secretary and operate the governance and assurance arrangements of the organisation.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

What further issues would you want us to take into account in firming up these proposals?

The Board of PTHB agrees that the duty of quality should be updated and enhanced to better reflect our integrated system, that this should be sufficiently wide in scope, and aligned with the Well-Being of Future Generations Act and the Social Services and Well-being Act to enable a greater focus on quality.

While recognising that a duty of quality is fundamental to the delivery of health and care services focused on the needs of the population, we do not consider further changes to legislation to be necessary in order to strengthen collaboration and improve the planning and delivery of quality services. Legislation (Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015) already places a duty on organisations to undertake joint needs assessments, and plan the delivery of quality health and care services together. Further, the Social Services and Well-being (Wales) Act 2014 sets out the requirement for a citizen centred approach and how this can be achieved through partnership working and integration. The Board of PTHB suggests that time is needed for these new pieces of legislation to be implemented, embedded and their impact evaluated before further layers of legislation are considered.

PTHB does not operate District General Hospitals and therefore recognises, more than most NHS organisations, that services cannot always be delivered in Powys. As part of the development of our Integrated Medium Term Plan (IMTP), we collaborate with other Welsh and English organisations so that they can inform our IMTP and we can influence theirs. Further, the health board and Powys County Council recently published a Health and Care Strategy for Powys. The Strategy, is the first of its kind

to be published in Wales, and demonstrates that where there is a willingness to collaborate and work together at a senior level legislation is not needed.

It is vital that existing systems are built upon and consideration given to quality and standards that are consistent across health and social care. Any proposals need to drive a culture of continuous improvement and ensure that there is a clear understanding of what quality means and how it is measured. Many of the current Welsh Government quality targets and measures relate to access times and if quality is really to be at the core these will need to be reviewed; the public of Wales need to be engaged in the development of measures that reflect what they see as being central to a quality service

The Board of PTHB is supportive of the emerging ways of working as part of Regional Planning Boards. Any proposals need to take in to consideration the learning from the South Wales Programme and the Mid Wales Health Collaborative.

Duty of Candour

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

The Board of PTHB agrees that a statutory duty of candour across health and social care should be developed, and that this would be in the interests of a person centred system. In addition, it believes that consideration should be given to how such a duty may be applied to the third sector. Such a duty would need to be aligned to the regulations introduced within NHS England in 2014. This will be important to ensure a common basis for regulatory action.

The principles of openness and candour must extend beyond the current requirements set out in 'Putting Things Right' regulations, and include the design of care plans as well as the delivery of health care, building upon the duty of candour already held by registered health professions. It would be beneficial for Wales to have an NHS Constitution, like that in NHS England, that establishes the principles and values of the NHS in Wales, sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

We consider that a full review of 'Putting Things Right' is required to ensure transparent processes are in place for people to express views about services. There should be one process for health and social care organisations and the architecture for raising concerns needs to be reviewed and strengthened.

Setting and Meeting Common Standards

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

The Board of PTHB supports the development of common high level standards that can be applied to health and social care, and agrees that they should be applied

wherever care is provided. These standards should be applied to statutory bodies, the independent sector and third sector providers.

A common set of standards will provide clarity to staff as to what standard they are expected to deliver services and hence drive consistency and better outcomes. They will also provide patients and service users with clarity as to the service/care they can expect and help drive quality. Such standards should not only set out a clear description of safe and acceptable quality, but should also be used as the framework for continuous improvement. There is a danger that 'common standards' would mean different things to different individuals/organisations and so clear definitions will be needed.
Health and Care Standards have been in existence, in various iterations, for a number of years and as a precursor to the development of any new set of standards we need to honestly assess whether they have resulted in the level of consistency, impact and outcomes that they were developed to deliver. Further, in developing a common set of standards, there will be a need to ensure alignment and reference to the professional standards that staff must adhere to. Care will also need to be taken to ensure that standards are expressed in a way that will drive improved outcomes and quality services. The standards need to be developed in collaboration with patients, service users, the public and staff. Honest conversations in relation to the cost of compliance with standards need to be held.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
What further issues would you want us to take into account in firming up this proposal?
The Board of PTHB agrees that different organisations should be required to work together to investigate complaints. Making a complaint can be stressful and the process needs to be made as open, transparent and simple as possible. The process should be integrated so that the same principles are applied, and processes followed by health and social care commissioners and providers. We suggest consideration is given to whether there is a role for a single public services complaint function, this should determine how and by whom the complaint should be investigated, for example, by health, social care or jointly.

Joint investigations of complaints take place currently and under the redress system health boards work together, with a lead organisation being agreed. Consideration should be given to extending the NHS re-dress process to social care providers.

Cross border issues should be considered as part of these proposals to ensure that there is the same level of openness, transparency and information sharing between English and Welsh organisations.

These proposals, together with the proposals in relation to a duty of candour, suggest that a review of the 'Putting Things Right' regulations would be timely.

Representing the Citizen in Health and Social Care
Do you support this proposal?

Powys Teaching Health Board has an extremely positive relationship with the Powys Community Health Council. That said we recognise that this is not the picture across Wales and that there is inconsistency in approach. We consider the current arrangements to be no longer fit for purpose as a more integrated approach that reflects the health and social care integration agenda is now needed. We therefore support the Welsh Government's proposal to replace the current statutory CHCs and their functions with a new national arrangement.

In taking forward this proposal the importance of the work that CHCs take forward at a local level should not be forgotten. The advocacy services provided by the CHC for patients across Powys, its constructive challenge and input into shaping and improving services is of great value. We would want such strengths to be built upon in order to ensure strengthen the citizen voice.

We would recommend that in establishing the new national arrangement the opportunity is taken to review the membership profile and ensure that it is more diverse and reflective of the population of Wales.

The strengthening of the alignment of the new body with Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales is welcomed. There have been occasions where there has been a lack of clarity in relation to roles and remits, particularly in relation to inspections and reviews. Further, there as been a sense that inspection activity (not in Powys) as been taken forward at the expense of more meaningful activities, for example advocacy. Inspection and regulation requires transformation to ensure an evidence based, impartial and objective basis that promotes public and professional confidence. PTHB supports the development of a combined inspectorate function for health and social care.

The proposed arrangements should help to raise the profile of the type of work currently undertaken by CHCs, reduce duplication and ensure a health and social care focus.

It should be stressed that for Powys Teaching Health Board the role of the CHC in supporting cross border strategic service change has been invaluable in ensuring the voice of the people in our county is heard. It is therefore essential that any new arrangement only builds on that success and suggest that this type of working is an exemplar of good practice that should be taken into any new arrangement. The complexity of cross border arrangements must be managed in the any changes in approach.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

The Board of PTHB supports the need to have appropriate clinical input to substantial service change decisions. It also recognises the need for a mechanism to encourage continuous engagement and increase the pace of strategic change. There is a need to ensure that such arrangements do not add unnecessary layers of bureaucracy or lead to the inadequate reflection of local circumstances and local citizen voice.

Further consideration should be given to the role of the advisory committees required by Standing Orders and how these may be better utilised. In addition, consideration should be given to an alternative approach for ensuring clinical advice is provided on substantial service change that involves the establishment of a specific Expert Panel for each significant service change.

Inspection and Regulation and single body

What do you think of this proposal?

Are there any specific issues you would want us to take into account in developing these proposals further?

However, we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?

What issues should we take into account if this idea were to be developed further?

We support the need to review and update the underpinning legislative framework for HIW to ensure closer integration and joint working with CSSIW. However, we believe that the best way forward would be to establish a new single health and care inspectorate. This would better reflect the work being taken forward across Wales to integrate health and care services and ensure a more transparent, stronger and less complex inspection approach. There would be greater public confidence in an integrated inspectorate that is independent of the Welsh Government.

WGWPMB212: The Association of Directors of Social Services
Location: All Wales

General Comments

The Association of Directors of Social Services (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.

ADSS Cymru welcomes the opportunity to comment on the proposals contained in the Welsh Government White Paper: Services Fit for the Future, which builds on the Government's Green Paper, Our Health, Our Health Service, published in 2015, as well as the reforms that have been made through key pieces of Government legislation, namely the Social Service and Well-being (Wales) Act 2015, the Well-being of Future Generations (Wales) Act 2015 and the Regulation and Inspection of Social Services (Wales) Act 2016.

Given the challenges being faced by public services of an aging demographic, increase service demand, greater complexity of service user need, coupled with reduced financial resource, the increasing focus on integrated approaches is necessary and that is why it is appropriate that there is serious reflection on the issues and proposals outlined in the White Paper.

However, there are elements within some of the chapter headings as set-out that require more detail, like the merging of inspectorates for example, to allow our members the opportunity to properly analyse and examine how some of the proposals would work in practice. While the proposals in the White Paper are an opportunity for the Government to set out its strategic thinking on how it believes governance and quality can be improved, it is the detail that rests behind those proposals which is critical. There are some significant proposals set out in the White Paper, which will have a resource implication for our members in local government, both in terms of time and funding and given the increased pressures already being faced in local government, a greater level of understanding of any additional resource implications is extremely important, as well as the further benefits that might accrue in successfully implementing those proposals.

It was made evidently clear in the recent publication of the Interim Report of the Parliamentary Review into Health and Social Care that the case for further change in both sectors is required and that the evolutionary work that has already taken place in those sectors, must be aligned and harmonised as much as possible to achieve a truly integrated public service approach that Welsh citizens are asking for. Our members support the move towards a more integrated system with public services working together and that includes the enhancement of honesty, openness and transparency throughout the NHS. When we look towards what changes need to be made to support some of the proposals within the White Paper however, 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, consistent, outcomes-based

approach across all public services in Wales. Moreover, we should not lose sight of the resonance that strong community engagement and advocacy has in ensuring that the patient voice is heard and understood. If we are to truly deliver an outcomes-based approach that will enable the improvement of service quality and governance, we cannot afford to create an inflexible system that discounts that involvement. Therefore, we believe local government has a strong function to perform in this area to prevent any local or democratic deficit.

There are already significant amounts of work being undertaken across social care which cross over some elements of the proposals. For example, the Social Services and Well-being Act already places a duty to involve people in the design and provision of services; the social care complaints process is being reviewed in light of the Act; the National Outcomes Framework for social services has been developed and is being implemented; and there are already responsibilities placed on social care workers around openness and honesty. It is essential that we neither duplicate nor disrupt work that is already happening but that we allow sufficient time to enable these new systems to bed in.

Moreover, given the full recommendations of the Parliamentary Review of Health and Social Care will not be published until the end of 2017, it is essential that those findings are properly considered before any further significant changes are made, so that any proposals support and dovetail with the future direction of health and social care services in Wales.

ADSS Cymru fully appreciates that the White Paper is the start of the discussion and the issues are open for debate and we would welcome working jointly with Welsh Government and NHS Wales, to discuss the proposals further in a bid to help inform and shape the next steps required to implement positive change in the governance and quality of health and care in Wales.

Chapter 1: Effective Governance

ADSS Cymru broadly agrees with the proposals set-out on Chapter One and support the need for the boards of both health boards and NHS trusts to share some core key principles, including delivering in partnership to deliver person-centred care and a strong governance framework, to enable the board to work effectively and meet its responsibilities. We would welcome though, further discussion on the determination of what those core principles should be. Moreover, we would also advocate that those principles should be kept to a minimum, with a need for some flexibility, to allow health boards to determine how best to meet local needs and priorities.

In terms of the board, it is important that the roles and responsibility of board members are made clear. Given the resources pressures across public service in Wales attendance at board meetings by Elected Members or Directors of Social Services for example, would be another commitment that would need to be managed. While the involvement of both Directors of Social Services and Elected Members is essential to support the work of and make appropriate links across both the NHS and local authorities, particularly around the integration of services, the determination and benefits of membership must be clear to ensure there is no duplication of effort by which input is already being obtained via other interfaces. ADSS Cymru would want to ensure that any change to board membership fits with

other changes, such as the Public Services Boards (PSBs) under the Well-being of Future Generations Act and the Regional Partnership Boards (RPBs) under the Social Services and Well-being Act to ensure consistency, alignment and effective use of resources.

Chapter 2: Duties to Promote Cultural Change

It is critical that when considering a duty of quality that due consideration is given to the regional work being undertaken and the partnership arrangements and duties already in place under the Well-being of Future Generations Act and the Social Services and Well-being Act. We would welcome any steps that emphasise the importance of person-centred care and how this can be facilitated by closer working within the region and across Wales. This would be consistent with activities already being taken forward through the RPB and PSB and this should be reflected in any changes to the duties on local health boards/trusts to ensure that we build on the current momentum of the Area Plan and Well-being Plans and our joint commissioning arrangements. The duty of quality must be consistent across the health and social care sectors and also recognise the role of the Third sector.

However, we must also be mindful that legislation on its own, is not the panacea to addressing the challenge of improving service quality. The main issue related to quality is primarily cultural, developing an ethos of honesty, openness, sincerity and empathy, which is then coupled with elements of continued professional training and development, well managed resources and improved awareness and education. In order to improve quality, any legislation needs to be supported with the promotion and adoption of best practice, ensuring more involvement of staff and most crucially that strong professional leadership is directing that positive cultural change agenda.

There are also practical implications over how feasible it will be for regulators to monitor behaviour under a regime of mandatory disclosure for serious adverse events both consistently and effectively and how regulators will enforce any prescribed sanctions for non-compliance with a disclosure.

We support the intention that 'We want to ensure that all health and social care organisations and providers are under similar duties to be open and transparent, because then the public will know what they should be able to expect.' We agree that this would be consistent with a more person-centred system and this is something that should be progressed. However, ADSS Cymru has some reservations regarding how this might work in practice where different organisations have different policies and procedures, which may hamper any joint investigations and where there are different lines of accountability for different professions.

Chapter 3: Person-Centred Health and Care

ADSS Cymru recognises that for service users, their family/carers and service providers, the separate standards which exist for health and social care creates issues when care arrangements transfer from one organisation to another. We would therefore support the proposal to have a common set of citizen and outcomes-based standards, regardless of the location of care and welcome changes which enable integrated, seamless care to be provided for individuals. Any changes should lead to greater levels of choice and control over care arrangements.

We also agree that it is far too complex for our customers when separate complaints processes are followed for health and social care. There must be greater collaboration to investigate complaints and it is hard to understand why two separate complaint regulations are required. If they remain separate, then there will always be the potential for divergence despite any requirement to work together. A single process with a requirement for joint investigation when needed and perhaps a lead agency depending on the primary nature of the complaint could resolve this and also address some of the issues raised earlier in response to the duty of candour proposals.

However, we must be mindful that there are already significant amounts of work being undertaken across social care which cross over some elements of the proposals in the White Paper. For example, the Social Services and Well-being Act already places a duty to involve people in the design and provision of services; the social care complaints process is being reviewed in light of the Act; the National Outcomes Framework for social services has been developed and is being implemented; and there are already responsibilities placed on social care workers around openness and honesty. It is essential that we neither duplicate nor disrupt work that is already happening but that we allow sufficient time to enable these new systems to bed in.

Chapter 4: Effective Citizen Voice, Co-production and Clear Inspection

We fully support the need for meaningful engagement with the public and communities, with the voice of the citizen a crucial element in supporting the way in which health and social care is planned and delivered – it is essential that we enable the views and concerns of patients and service users to receive maximum prominence throughout the systems that we operate.

The proposals set out in this section are of particular interest in terms of our members work within the RPB and PSB, to ensure citizens are more involved and how we make sure their involvement is meaningful for them and adds value to the work we are undertaking.

Citizens are already involved in the planning of services through our citizen's panels etc., stakeholder engagement and representation on the RPB. Therefore, ADSS Cymru believes it is important to distinguish between involving citizens in the planning and co-production of services and their involvement in assessing the quality of services. Although there is clearly a link and one may lead to the other these are distinct functions. The proposals seem to be asking citizen representatives to be able to encompass a wide remit (locally and nationally) and some of this would require specific skills, experience and capacity which go above what may be reasonably asked of a volunteer/lay person. We need to be clear what we are asking people to do, the commitment we expect from them and what we will offer in return.

In terms of the proposals around disbanding Community Health Councils (CHCs) and strengthening the citizen voice with a new national organisation, ADSS Cymru have some reservations about whether the proposals will lead to more effective engagement. It is important that there is clarity about the purpose of involving citizens, at what point this is considered to be meaningful for all parties, as well as

issues around representation and accountability as highlighted earlier and how this might sit with the work already being undertaken in response to the Social Services and Well-being Act.
ADSS Cymru does believe it is right that we examine whether this model not only adequately represents patients' interests but whether it is also enacting effective outcome change. A considerable piece of work was undertaken by Professor Marcus Longley in 2012. In his report 'Moving Towards World Class? A Review of Community Health Councils in Wales', he identified principle 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. He also highlighted that there we many elements of work that CHCs were conducting, like inspections that were being undertaking more comprehensively by other bodies; that element of work duplication has not changed in the past five years.

ADSS Cymru supports the need for change and believes that this is an opportunity to ensure greater democratic oversight of the NHS by improving the current framework under which CHCs operate and through locating some of the existing powers of the powers of CHCs within local government. We note that the White Paper is quiet on what will happen to some of the existing responsibilities of the CHC if they are to be replaced, in particular around their current scrutiny role.

If CHCs are to be replaced, then ADSS Cymru believe that those functions should not be centralised but rather, they should be allowed to remain at the local community level and local government could have a significant role to enable that by examining how far its 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 Members would be able to voice the views of their constituents and hold relevant NHS bodies and relevant health service providers to account.

A refocusing of CHCs to represent the voice of the patient and user, while local authorities scrutinise the overall service, is a potential way forward and should be given serious consideration. Moreover, ADSS Cymru would welcome working with Welsh Government and NHS Wales, to discuss this proposal more fully. In looking at this refocused role we need to be mindful and give careful consideration as to how this new arrangement would fit into existing arrangements in place, particularly across social care, complementing rather than duplicating effort.

In terms of the merging the functions of inspection and regulation into one single body, in keeping with the move towards greater integration, we would support a feasibility study regarding an amalgamation of CSSIW and HIW. The introduction of the Regulation and Inspection of Social Care (Wales) Act has created a clear statutory framework for CSSIW that is centred around people who need care and support and the social care workforce. There are differences in the way in which services are currently regulated across health and social care, for example services being regulated and inspected on an establishment rather than service basis, which means that it would make sense to bring the underpinning legislative framework for HIW in line with that of CSSIW. Moreover, a single inspection body could potentially

be more efficient and bring together a range of expertise across the health and social care sector and take a more holistic view of these services and the experience of our service users.

However, far more detail would be required to understand the implications of the proposal. Whilst a new independent inspectorate covering both health and social care, working to common framework and standards would be easier for both service providers and users to understand, there could be potential unintended consequence of such a merger. These include the fact that the process of merging can divert resources and attention away from inspections and that integration could lead to an organisation which is too large and unwieldy with a loss or imbalance of specialist expertise.
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 Social Care Wales, Estyn and the Wales Audit Office and it will be important to fully consider the implications on all partners.

WGWPMB213: The British Medical Association Cymru Wales
Location: Cardiff

General Comments

Owing to the wide-ranging nature of the proposals in this White Paper, this response does not seek to address every issue raised. Instead, we have concentrated our submission on the issues which are of most relevance to our membership and which build on our response in 2015 to the Green Paper: Our Health; Our Health Service.

Response to Specific Questions

Board Membership and Composition/ Board Secretary

As recognised by the 2016 OECD report, there is clearly a case for change in the governance of NHS organisations in Wales. The report observed that local health boards are showing less signs of innovation and fewer radical approaches to quality assurance and system change than would be expected at this stage, it also made a number of suggestions which set out how government and NHS organisations might make further progress.

One suggestion was that centre (i.e. Welsh Government) should "play a more supportive – and prescriptive – role" and that there should be "an ambitious workforce strategy, which includes planning, piloting and evaluating innovative staffing models". We are not persuaded that the proposals in the White Paper go far enough to deliver on this. We also do not feel that the current planning process, via the Integrated Medium Term Plans (IMTPs) is prescriptive enough, given their variability in both detail and quality. In our view, each should contain detailed data on the workforce (including primary care) and clearly outline how the local work and analysis by primary care clusters has informed both strategic decisions and strategic direction – this should include how the boards will support innovative and collaborative working at cluster level. We believe that IMTPs should be subject to more effective scrutiny at both national and local level (including by cluster), with an agreed format and standard of data sets to enable effective national monitoring and allow for continual improvement, shared decision making and joint working. There are obvious benefits to be gained from joining up the planning processes, especially in aligning the term (e.g three years) over which they run. We also question the amount of all-Wales planning which currently takes place – particularly in relation to workforce planning and service sustainability.

Whilst the make-up and constitution of the board is obviously important, for us an engaged and transparent leadership is paramount. We welcome the proposal for Core Key Principles for NHS Organisations outlined on page 13 of the White Paper; the focus on openness and transparency in the first principle is particularly well-placed and reinforces the, already agreed, NHS Wales Core Principles. Indeed, it seems an omission not to incorporate the existing Core Principles directly.

The principles on leadership, quality improvement, and partnership working are equally welcomed. However, we feel that the principles for staff engagement are not sufficient:

- ‘the board to involve and are supported by the senior management below the Executive Directors to ensure wider professional and staff engagement’.
- ‘a well-functioning and supporting committee structure that ensures it involves and receives views and input from a wide range of stakeholders including the professions and patients’

It is well-recognised that high-quality patient care goes hand in hand with a highly-motivated and committed workforce. As we said in response to the Green Paper, the reality reported all too often by our members is that they feel increasingly de-professionalised, devalued and isolated. It is therefore essential that the Welsh Government provides the resources, policy and structures for professionalism and engagement to flourish.

When looking at governance arrangements - legislative or otherwise - for NHS Wales organisations we believe that the opportunity to improve engagement with staff should not be lost, and that mechanisms to reduce the ‘board to ward’ gap should be firmly embedded in any changes. We view this as particularly important given the evidence of the correlation between medical engagement, patient care and organisational effectiveness:

“There is clear and growing evidence supporting the hypothesis that there is a direct relationship between medical engagement and clinical performance. The evidence of that association underpins our argument that medical engagement should not be an optional extra but rather an integral element of the culture of any health organisation and system. It should therefore be one of the highest priorities for NHS boards and leaders” .

As such we believe that there should be more effective clinical engagement in the day-to-day running and planning of health and social care in Wales, and that frontline clinicians should play a greater role in developing the strategic direction and delivery of services; in turn therefore boards should be better appraised of what is happening on the ground. To reiterate a suggestion made in our response to the Green Paper, those in senior management positions, including those serving as board members, could spend a proportion of their time (e.g. one day a week) working at the frontline. This would give them a genuine opportunity to experience first-hand the provision of patient care in their health board – engaging closely with patients and with staff.

The findings of the Medical Engagement Surveys carried out in 2016 for all NHS Wales organisations (except Powys) painted a poor and patchy picture across Wales. The results prompted the passing of the following motion at the BMA’s annual UK policy making meeting earlier this year:

That this meeting recognises the acknowledged links between poor medical engagement with risks to patient safety and poor outcomes for patients and:-
i) recognises that promoting greater medical involvement in the design and planning of healthcare is crucial in ensuring that improved patient services are properly designed and effectively implemented;

ii) calls for radical change of the management culture in the NHS from the current hierarchical focus on narrowly based targets towards a clinically based system adapted to the needs of patients;
iii) calls for all NHS organisations to agree and sign up to a new medical engagement charter that will facilitate the positive involvement and engagement of doctors who are willing to work in close cooperation with other clinical and non-clinical healthcare staff.

At a joint event between BMA Cymru Wales, the NHS Wales Confederation and NHS Wales Employers in May 2017 it was agreed with NHS organisations would develop - working with the local medical profession via LNCs - action plans to address the poor survey findings, and also that the survey would be repeated at an interval of three years. We remain committed to working in partnership to deliver measureable improvements in this important area, and thus in the culture of the NHS in Wales. To that end, a further joint event is currently being planned with the additional involvement of the General Medical Council.

The lack of primary care representation at board level is very concerning and not reflective of the 'integrated' way in which health boards should be working and constituted. We have raised the fact that this oversight is to the detriment of strategic planning and decision making on a number of occasions with Welsh Government and with health boards. The 2016 OECD report also recognised this where it concluded: "to ensure high quality health care at every encounter and continuously improving care across the system, Wales should put primary care front and centre as a force for dynamic system change". It goes on to make a number of specific suggestions, including that "a robust and high quality primary care sector is needed to effectively manage patients in the community" and that Wales' Primary Care Clusters have the "potential to be an important resource" in developing ambitious new models of care – an observation which resonances with our own, well documented, views.

We are keen to support stronger and improved governance mechanisms for NHS boards. Broadly, we would support the concept of there being a number of 'fixed' positions on the membership of boards, one being the position of vice-chair, and for the specific position (and function) of board secretary to be independent. There is an obvious requirement for consistency in certain 'core' positions across organisations. As a minimum we would expect there to be specific representation for both the medical and primary care directors; and would strongly support independent professional members from within the health service having a fixed input at board level. For the position of board secretary in particular, and as guardian of good governance and principal advisor to the board, we would support a strengthening of the statutory protection around this independent role to provide consistency and since so little is known or understood about the role currently. For significant issues of concern we believe that the Board Secretary should have access to more avenues where these can be raised – i.e. the ability to report to the Chief Executive or Board Chair is not sufficient. There is certainly a strong case for improved and more visible accountability of organisations, for which this role should be central.

For time-limited periods, and in specified circumstances (where an organisation is underperforming or under escalation procedures, as suggested) Welsh Government

Ministers should have the authority to appoint additional members to the Board – for those specific purposes only.

Finally, many of our members report a degree of frustration when individuals in key health board posts change regularly or are retained on an 'interim' basis and that this can lead to a loss of momentum and loss of focus, as well as a degree of uncertainty around future service planning or strategic direction. Whilst recognising that such circumstances are sometimes unavoidable, we would wish to see this considered and addressed where possible (in operational guidance for instance). Like with the ability for Welsh Ministers to appoint additional members for time limited periods in specified circumstances, the number of interim or transient post-holders in key positions may indicate that more rigorous care should be taken in the initial recruitment process – i.e. to get the right people into substantive posts, and retain them.

Duty of Quality for the Population of Wales

The BMA strongly supports the pursuit of the highest standards of care for patients and the important role which clinicians play in this. Quality, and subsequently quality measures, should represent what is important, as well as the challenges, in a health service.

Rather than measure performance against centrally imposed targets which can have unintended consequences, distort clinical priorities and harm patients, the BMA believes that NHS performance should be measured against quality, equity and outcomes of patient care. Together these inter-related areas build a picture of how well the NHS is performing and the NHS needs to balance all three areas in order to deliver the highest standards of care.

We acknowledge that a duty of quality already exists for NHS bodies in Wales. However, aside from noting that the legislative underpinning around this duty as it currently stands is in need of review, the White Paper does not appear to consider why this existing duty has not worked, why it is not adequate, or what more could be done to make the current duty effective.

We would certainly support any moves which would require health boards to work in partnership across their geographical boundaries when planning care and care services. We would also support a broader focus so that a duty of quality would cover entire services and entire populations (local, regional, or all-Wales). By way of example, many of our GP members, report frustration that when referring patients into secondary care that they are not always able to refer to the nearest hospital or service (i.e. one which would be most convenient to the patient) as this would require referring into a neighbouring health board area and that a degree of patient choice would be welcome.

However, there is a notable lack of detail in the White Paper about what the proposed new duty of quality would look like, and particularly what would be put in place to ensure that the co-operation between organisations occurred, what that could deliver, and what the relationship with national level service planning would be (including workforce planning).

Overall, we believe that this duty to co-operate is not sufficient as a marker of quality; and that other markers, in a broader setting of care and wellbeing, need to be considered. The OECD definition of quality, for instance, focuses on effectiveness, safety and patient-centeredness . This definition recognises that quality is part of a wider context, as it includes areas such health determinants, access and cost. We therefore consider that health and social care in Wales is in need of a robust quality management system (and that such a system would, as a number of reviews and publications attest, have staff engagement and improved organisational culture at its core). We note the recent publication by the Bevan Commission calling for a universal and mandatory quality management system which would "ensure that should reforms, management changes and reorganisations supervene (as they have in the past) the quality of care is not adversely affected" we look forward to engaging as the debate around this proposal develops pace.

The work of the joint research programme between the Nuffield Trust and the Health Foundation in England, QualityWatch, is relevant when considering quality measures – it has identified over 300 care quality indicators to monitor the standards of the NHS and social care. These quality indicators are subdivided into six domains (safety, patient centred care and experience, equity, effectiveness, access and capacity) and are tracked to find out whether health and social care quality is improving or getting worse.
We believe that a duty of quality would need a robust mechanism to monitor and evaluate effectiveness (to include quality, equity and outcomes) and manifestly facilitate engagement - so that the duty delivers genuine change (not only expanded workloads and 'box-ticking').

More detail on the proposed duty of quality is needed in order to form a view on the likely impact on service planning and delivery.

Duty of Candour
We support the principles underlying the proposed duty of candour across health and social services in Wales. Such principles already underpin the existing professional duties on doctors to be open and honest with patients about their care through 'Good Medical Practice' , which describes what is expected of all doctors registered with the GMC. A failure to follow the principles and values set out in this guidance will put a doctors' licence to practice at risk.

We support a statutory duty on organisations aligned to, and complimentary of, existing professional duties; this is important for delivering positive cultural change at all levels. Annex 1 outlines the relevant extracts of the GMC's Good Medical Practice relating to the duty to be honest and open – as this shows, being open and honest will be second nature to most doctors.

The BMA believes that in order to change the underlying culture that discourages people from speaking up, there should be a new duty on employers and NHS organisations to listen to staff when they do report concerns, and to protect them if necessary. Staff should be encouraged and recognised for following their professional guidelines, and more training may be necessary to help doctors

communicate more effectively with their patients about when, for example, treatment has not gone as well as expected or an error has occurred in the process of their care. More effective policies preventing and addressing incidences of bullying may also be necessary.

As Keith Evans reported there is also a need to "address the lack of infrastructure to accommodate the current levels of concerns and complaints that have positively increased through the intention of the Putting Things Right process when launched in 2011. I have seen very committed staff attempting to maintain responses in the face of growing demand; however, I do not think the resources have yet been aligned to allow this to be undertaken in a personal, compassionate and comprehensive way" .

There is no detail in the White Paper about how the duty will operate or how it will be enforced – for instance: What will the sanctions be for any breach? Will the duty apply to all 'adverse events' or will there be a 'threshold' for when the duty applies? What will the duty stipulate in terms of process? how will adherence to that be monitored? Is it to apply in general practice settings (and dentistry / pharmacy) and then how will that transition be managed in terms of meeting any new administrative requirements of compliance? These are high-level questions which need answering – for the more detailed questions it is worth looking to the Scottish Government's Duty of Candour FAQ's .

Setting and Meeting Common Standards

As we have set out above, the OECD definition of quality focuses on effectiveness, safety and patient-centeredness. Our response to question 2.1 on a proposed Duty of Quality should therefore be considered as part of our response to this section on setting common high-level standards across health and social care.

We would be supportive of common high-level standards being established across both health and social care, in order that service users can expect to receive the same high-level standard of safe and quality care regardless of where they receive it. It is important to note that any standards will need to be supportive of the principles of prudent healthcare, co-production and patient-centeredness (which dictate that standards and experiences cannot be the same in every environment or encounter).

We look forward to engaging with Welsh Government and fellow stakeholders on what these standards will look to provide; and on what mechanisms will be developed to measure and evaluate their continued effectiveness (it is essential that health and social care professionals are included in developing the common standards so that they are aligned to professional regulations, and that they carry the support and confidence of those working to them).

Joint Investigation of Health and Social Care Complaints

We largely agree with the findings and recommendations in the Evans report in this area – in particular that there is a need for "all of the various aspects of social services, primary and secondary care, the ambulance service, Community Health Councils all need to be organised to provide a seamless experience." We would therefore support health and social care organisations working together when

investigating complaints, and when putting them right – so that complainants only need to complain once. Joining-up the different complaints systems which currently exist into an operationally effective, and user-friendly, single process is a complex task; and more detail around how this will be achieved is needed.

We are aware that there are some pockets of joint work in Wales, and operational agreements between HIW and the board of CHCs for instance, however, the OECD report noted that some of the work by CHCs duplicated the activities of other bodies and organisations, such as inspections.

Importantly, if organisations are to work together, the observations in the Evans report about the wide variations in the reported experiences from users despite the intentions of the Putting Things Right process and guidance will need to be addressed. The report also highlighted the need for NHS Boards to have clear lines of accountability in place so that they are sighted on - and can act on - patient feedback, complaints and concerns. These wider concerns should be considered in detail as part of the proposals for joint investigations. Any new joint working arrangements would need to be clearly set out and communicated to organisations, staff, patients and relatives, and be appropriately resourced.

We would broadly be support a joined up system, and as we mentioned in response to section 3.1, this would need to be consistent with existing professional regulatory bodies in the UK so that professionals can be confident in the system and that lessons are learned, at all levels, as a result – i.e. not lost in the myriad of organisations. Professionals need to be assured that complaints, and the provision of timely feedback, are handled in a consistent and fair manner, preferably with one owner, rather than via multiple routes.

Representing the Citizen in Health and Social Care

We agree that the views of patients and the public should inform service design and delivery. We also believe that the time is right, as a number of commentators and reports have suggested, to review the effectiveness of current arrangements for the provision of this.

Since Community Health Councils (CHCs) are organised along geographical lines, coterminous with health boards, this causes potential problems for service pathways which operate across health board boundaries – and, as the White Paper identifies, when service change from one health board area to another is proposed. Our members report that CHC co-ordination at an all-Wales level has, to date, largely failed. We would therefore be supportive of a new national arrangement to represent the citizen voice, so that the realities of the regional and national needs of individuals are recognised and catered for but whereby local engagement and advocacy is also effective. This is an importance balance, and supports other proposals in the White Paper, such as the ‘Duty of Quality’, which requires Health Boards to work together across their geographical boundaries. We note the reference within the document to the new body potentially having some similarity to the Scottish Health Council (SHC). The SHC “promotes patient focus and public involvement in the NHS in Scotland “and exists structurally as an arm of Health Improvement Scotland. The SHC was criticised by the Scottish Parliament’s Health and Sport Committee for being

insufficiently independent in scrutinising major service changes . Lessons should be learned from the SHC when considering the structure and governance of any new Welsh body.

In our submission to Ruth Marks' independent review of Healthcare Inspectorate Wales (HIW) , and also in our response to the Welsh Government's 2015 consultation on the future of Community Health Councils , we noted that a growing number of activities within general practice around areas such as inspections, appraisal and revalidation – when taken together – were leading to a real risk of over-inspection and duplication. We went on to call for organisations such as CHCs and HIW to work better together and for their remits to more appropriately complement each other so as to avoid duplication and embed the patient voice.

We would therefore broadly support the proposals in this section of the White Paper.

Clear operational structures and governance arrangements would be needed to guarantee the independence of any new model to replace CHCs, and to balance the various aspects of its work (so that it is not tied to an agenda of inspections) but one which would enable joint working where it is needed. As already noted, we particularly welcome the requirement for the new arrangement to engage closely with local community organisations whilst ensuring national coordination.

The Evans report said: "I was really struck to hear in an evening session set up to share patients' views how many were unaware of the Community Health Councils in Wales and the specific independent complaints advocacy service they lead. In fact many were unaware of the broader role that Community Health Councils play. There may be a need to clarify their role and make them more visible even within the hospital or service space. Communicating the system and its structures is, for me, as important as commenting on the improvements to the system."

As such, we would expect that any new arrangement would work to increase the visibility and voice of the patient voice in health and social care and work to engage more individuals and community groups to shape the design and delivery of services. It would be necessary for the new arrangement to have a variety of mechanisms and resources at its disposal to allow it to balance robust local engagement and accessibility within a national and coordinated framework. The membership of the new organisation must be as diverse and representative as possible and it must be able to operate in a wholly independent way, with clear accountability lines to the public and to local populations.

The White Paper notes that one of the functions of this new national citizen's voice body would be "to monitor and evaluate the way in which health and social care organisations involve local people, probably in accordance with agreed standards" we would suggest that these agreed joint standards are agreed and are clearly specified and communicated.

The important advocacy role currently provided by CHCs should be maintained and protected, with increased visibility; we would support the extension of this to cover social care – which we believe would support the objective of creating person-

centred services. Measures to increase the service's visibility, and also its remit, will need to be appropriately resourced.

Co-producing Plans and Services with Citizens

The White Paper proposes "to establish an independent mechanism to provide clinical advice and assurance on substantial change proposals" and yet gives no further details as to what this might look like, how it might function, where it would sit, its relationship with existing bodies and structures for the provision of professional and clinical advice – such as Welsh Medical Committee and other local and national advisory structures. It would, for obvious reasons, not be acceptable for NHS organisations to be involved in constituting a body for the provision of medical advice.

We would support health boards being required to demonstrate that they have listened to clinical evidence and to the views of citizens and staff in any proposals for change. We feel that a standardised approach to this would be beneficial, including clear and agreed thresholds for what would constitute a 'substantial' proposal. Listening to the views of clinicians and citizens should be part of a continuous process, and in our view is a keystone of everyday good governance (i.e. not only required in exceptional circumstances or when a threshold of a proposal has been met).

We note with concern that, should a new national citizens voice body be established to replace CHCs, this proposal could affect the mechanism by which disputed service changes proposals are referred to the Cabinet Secretary – this mechanism, or a robust and independent alternative to it, needs to be put in place as part of any new arrangements for the citizens voice. Based on the limited details of this proposal in the White Paper, we believe that it is not adequate for Welsh Ministers to only intervene as a 'last resort' when health boards are unable to reach a decision on proposals for service change.

We also believe that requiring heath boards to decide if their own proposal meets the criteria of being 'substantial' enough (a clear and agreed definition for which would be needed) in order that the independent scrutiny mechanism is triggered, is far from adequate - checks and balances on the meeting of the criteria, and the triggering of appropriate further scrutiny, would need to be established. There is no mention of how the meeting of this criteria will be monitored or scrutinised which is unacceptable, potentially dangerous and undermines efforts to embed co-production, transparency and openness. All partners must have confidence in the process by which decisions are reached.

We believe that clinical evidence must be the guiding principle when considering options and proposals for service change and reconfiguration; and we would agree that engaging and involving the public from the start, in an honest discussion, gives such proposals a greater chance of success. It is notable that there is no mention of engaging with staff or local healthcare professionals in relation to any substantial proposals for change (other than in figure 1 on page 34 where the health board sets out its plans). This very unfortunate oversight undermines efforts to realise coproduction, promote professionalism and embed the Core Principles. Our

response to question 1.2, on the importance of medical engagement, is relevant here.

We would also suggest that any proposals for substantial service change undergo a Health Impact Assessment (HIA), which – if well performed – would offer a robust options appraisal process and would inform any formal consultation process (since most areas of controversy will have been covered and addressed, with reasonable solutions developed to problems identified). Public Health teams may be well placed to assist with the conducting of HIAs, and with the involvement of stakeholders.

There are many unanswered questions in this section, and a need for further clarity.

Inspection and Regulation and single body

BMA Cymru Wales provided evidence to both the Marks Review of Healthcare Inspectorate Wales (HIW) and the Green Paper: Our Health, Our Health Service outlining the views of the medical profession across a range of HIW's regulatory and inspection functions. Those papers should therefore be read in conjunction with our response here – however, the specific points we would like to make are outlined below.

We would support an aligning of the system of regulation and inspection across health and social services, and we are also supportive of steps being taken which increase the alignment between sectors. We have previously expressed the view that a full merger of the functions of HIW and CSSIW might work to re-focus the inspectorates to better reflect the reality of patient pathways (although services are far from fully integrated) but we have also highlighted that rearranging organisational structures through mergers is often not absolutely necessary, or even sufficient, to produce genuine joint working and increased coordination. Instead, we believe that the emphasis is often better placed on good information sharing and effective, professional relationships across disciplines and organisations. The White Paper appears to support that approach, but does not clearly outline what is preventing HIW and CSSIW in particular from more effective joint working presently – and if, for instance, a revision of the legislative underpinning for HIW might offer an opportunity to facilitate that.

We would strongly support the proposal to ensure HIW has a clear, single legislative framework to work to. In relation to the proposal to overhaul HIW's underpinning legislation we would reiterate what we have previously said on this matter, i.e. that: "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 and Community Health Councils (CHCs)"

We have also previously expressed the view that HIW requires more capacity and resources. It is not clear in the White Paper if "a pooling of significant exiting

resources" would deliver what is required to balance HIW's workload and functions, support it to identify priorities, better engage clinicians at the coal-face when inspecting or responding to a concern and undertake joint work with CSSIW and the new national citizens voice body. If the proposal to establish a new Welsh Government Sponsored Body were to be taken forward - which would include HIW, CSSIW and the new citizens voice body - then a full analysis of the resourcing requirements and options would be needed which could look at combining certain functions. This arrangement may also help to address the concerns about their independence from Government and could possibly improve the overall visibility and understanding of inspection and regulation of health and social care in Wales. It might also be judicious to consider other options for reassuring the independence of regulation and inspection – such as increasing the level of public scrutiny these bodies are currently subject to.

Regulators and inspectors are often said to be the 'third line of defence' against serious failures, but it also 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 there is good quality care. Each of the partners across the three lines of defence must work together, seamlessly and provide the leadership needed in order to drive shared learning and particularly to establish a culture where staff, patients and relatives 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 and CHCs in particular, the potential for them to play a positive role in 'culture-setting' in NHS Wales organisations should not be overlooked.

There is certainly a strong case to be made for further consideration of how HIW, CSSIW and the new citizens voice body could offer reassurance and scrutiny with regard to the governance of health boards, by ensuring parity with the standards and scrutiny to which health and social care professionals are subject.

ANNEX 1 Extracts from GMC Good Medical Practice

Contribute to and comply with systems to protect patients

22. You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:
a. taking part in regular reviews and audits of your work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary
b. regularly reflecting on your standards of practice and the care you provide
c. reviewing patient feedback where it is available.

23. To help keep patients safe you must:
a. contribute to confidential inquiries
b. contribute to adverse event recognition
c. report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another person, at risk
d. report suspected adverse drug reactions

e. respond to requests from organisations monitoring public health.

When providing information for these purposes you should still respect patients' confidentiality.

Respond to risks to safety

24. You must promote and encourage a culture that allows all staff to raise concerns openly and safely.

25. You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.
a. If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.
b. If patients are at risk because of inadequate premises, equipment* or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken.
c. If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.

Act with honesty and integrity

Honesty

65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

66. You must always be honest about your experience, qualifications and current role.

67. You must act with honesty and integrity when designing, organising or carrying out research, and follow national research governance guidelines and our guidance.

Communicating information

68. You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

69. When communicating publicly, including speaking to or writing in the media, you must maintain patient confidentiality. You should remember when using social media that communications intended for friends or family may become more widely available.

70. When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit patients' vulnerability or lack of medical knowledge.

71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents You must make sure that any documents you write or sign are not false or misleading. a. You must take reasonable steps to check the information is correct. b. You must not deliberately leave out relevant information.

WGWPMB214: David T C Davies MP
Location: Monmouthshire

General Comments

The Welsh Government should invest in building on Community Health Councils (CHCs) rather than abolishing them.

Proposals to scrap CHCs in Wales are a retrograde step and an attempt to stifle the voice of patients. I believe the big issue here is that not enough people know about the work of the independent NHS watchdog and money should instead be spent on raising the profile of local CHCs.

CHCs have an important role to play in ensuring that high standards are always maintained within the NHS. Their complete independence means public and staff alike can have confidence that complaints will be dealt with properly.

Voluntary members of CHCs often have a background that enables them to get the information they need, which can then be passed on to the appropriate authorities.

In a typical example outlined to me by Aneurin Bevan Community Health Council, CHC members visited a hospital in Gwent to check on the hygiene of linen following a tip-off that it was not being cleaned.

The resulting inquiry led to an immediate and successful conclusion.

WGWPMB215: R Ebley
Location: Unknown

General Comments

In order that change is effectively undertaken all levels of government and other public funded organisations need to demonstrate good management

I suggest ISO 9001 to achieve this

WGWPMB216: P Gripper
Location: Unknown

Response to Specific Questions

Board Membership and Composition
It is critically important that membership of the health board includes representation of service users and carers who frequently use services and have long term health problems of sufficient severity to ensure that that they have higher than average experience of the service and are more likely then to have experienced the range of good and bad experiences possible. It is critical that this representation is from people whose difficulties are severe enough to have led to fewer life chances and the inability to use their talents, often due to discrimination, where lack of work history makes current entry at board level impossible. This would require a recruitment process based on assessment of ability and talent and work on committees and not on paid work history. The reason it is important to have this voice at the table is that they will be more aware of the disadvantages faced by those worst affected by their health, and hence the access problems associated with poverty and not having independent transport, as well as difficulties in complying with treatment requirements which their disability or circumstances make difficult. Such people will have more credibility as representatives of the service user and carer voice, with service users and carers, and their place on the board would demonstrate a real commitment to co-production and ensuring that the service user and carer voices are heard.

It is critical that at least one service user and carer come with a mental health back-ground to ensure the visibility of this neglected group and service on the board.

Preferably this needs to also be strengthened by a service user and carer stakeholder group, who would act as a sounding board for health board papers and agenda items and would also be able to feed in matters of concern that need to be considered, priority issues, and ideas for change that would improve services. The board members and stakeholder group would need to sufficiently resourced to maximise how many people can bring their experiences of services, and also to ensure that the members, and through them service user and carers more widely, have access to on-line peer reviewed research to inform their contributions to ensure that they are of the highest standard, and hold excellent credibility as a result with staff and management.

As for other members it is also critical that the membership from primary care and mental health remain strong, or are made stronger. This would require at least one executive member to be a senior manager in mental health.

This needs to be strengthened with a commitment to have at least one agenda item at every board meeting which deals with mental health service issues at all tiers of service including primary and specialist care, and at all ages

Room for flexibility, if introduced needs to be monitored to ensure effectiveness and that agendas and priorities are not skewed by this, so that service quality in some

areas is not comparable across Wales. If service quality across all areas is not consistent as a result of giving flexibility then the regulations will need to be reviewed. This could be covered by ensuring a legal duty to review after a settling in period. As a result of this board membership and composition needs to be in secondary regulations so that it can be more easily changed.

Duty of Quality for the Population of Wales

In section 3 you talk about people having a right to receive excellent care. However, there is no mechanism through which to enforce this right, and hence there is no right. Without legal force, there is no such thing as a 'right'.

A critical issue is 'whose quality is it?'

Something I was part of exploring when a member of the Royal Society of Medicine.

Quality is a matter of values and hence of ethics, and culture. It needs to be recognised that the culture of health board staff, management and governance boards are fundamentally different to the values, culture and risk appetites of most of the people who use services, who come from all kinds of backgrounds.

Currently the views of professional bodies such as Royal Colleges dominate ideas about what 'safety standards' should be, often in terms of the ratio of staffing required in different services. Because there is a shortage of such staff this emphasis is leading to services becoming centralised and moving away from where people live. This is not a technical issue but one of appetite for risk.

It is also clear that those that state the need for experts, are experts themselves, and hence, perhaps the possibility of conflict of interest should be considered.

There have been many difficult battles between health boards and the public regarding withdrawing local services and moving them away to bigger centres. The balance that has to be drawn is between risks associated with access to experience and expertise and risks associated with additional travel time. This is an ethical decision based on individual priorities and preferences, and one that should be made by service users with full information from professionals and not by health boards. People should have access to the option of signing informed consent, either to the risks of travel time on health outcomes, or the risks of not being able to access expertise on health outcomes. As an example I refer to the issue of the maternity unit being moved out of Haverfordwest, so that people now have to travel all the way to Carmarthen. It is often clear before birth who is most at risk and decisions about where people go should be underpinned by such assessments so that the parents are making their decisions on the basis of the best information about risks and benefits. For the people in Haverfordwest local access was a very clear quality preference.

In a rural community such as much of Wales, people may well prefer less expert services that are local, rather than more expert services that are further away. In addition, with the benefits of technology, it is perfectly possible to enhance expertise through telemedicine, with consultants seeing people remotely, and

advising local staff on assessment decisions, risk assessments, and treatment interventions, including guiding staff through surgical procedures.

Because of staff shortages and economic pressures we need to take a different look at how to manage risk and safety, including focusing in on the skills and knowledge that provide the most impact, and training people only in that, so that the training is much faster and people can be increasing safety much more quickly. We have to leverage the time of expensive professionals, to ensure that everything that can be done by less expensive staff is done by them. Reducing the ratio of professional to junior staff is an important way of reducing costs and maintaining services and with the effective training and support of junior staff, may actually increase the quality of service.

At present professionals driven by 'quality' targets, are so overrun with these priorities that they are no-longer able to work reflectively and be either critical of systems that are not working, learning from what is working or of being capable to act creatively to improve services. They are also suffering from severe stress and low morale which is leading to staff leaving the service, further exacerbating shortages of professionals. A local exercise on a physical health ward, demonstrated professional staff suffering considerable compassion fatigue, picked up as a result of high frequency of patient dissatisfaction. The more junior staff such as health and care support workers were notably better at acting with compassion and supporting patients. Such situations demonstrate that high ratios of expert professionals alone are not going to improve the quality of care, or make it any safer. In fact the opposite seems to be happening. It is urgent that we take the pressure off professional staff, so that they can practice more safely and have enough spare capacity to deliver continuous service improvement in response to outcomes and patient satisfaction feedback.

It is critical that there are processes in place to hold services to account for not meeting any duties. At present there are no clear mechanisms to do so. For instance the duty not to threaten service users to prevent them from complaining cannot be addressed, especially if it leads to time gaps between the threat and the service user having the confidence to challenge it. This does not come under the remits of either the ombudsman, because it is an individual staff matter, or the HIW, because they don't deal with complaints, or, of the staff regulators, as they do not deal with non-clinical matters, that are not about fitness to practice, so they would not deal with issues of staff not following an employer's human resource standards. There is no point having a legal right to access an impartial complaints process, if there is no mechanism to hold an organisation or individual to account for delivering on this.

For the same reason there is no point in have a Duty of Quality if there are no mechanisms to hold organisations to account.

However, for accountability there need to be clear standards that can be both evidenced and measured, so it is possible to see when the standard has not been reached. For this reason, we must have co-production of health care quality standards with the people most affected by them, who are services users/patients, carers and families. There need to be reference to standards that are regularly

updated as services, knowledge and policy change, as sub-ordinate legislation. These standards should be things like the NICE guidance; Matrics Cymru; National action plans relevant to different services or patient groups, Policy implementation guidance and delivery plans; Strategies for specific services; relevant legislation (eg POVA, Equality Act), National Occupational Standards; Standards for behaviour, ethics and conduct, and for 'proficiency' or competence, produced by Regulatory Bodies.

However legal regulations need to be in place to require the involvement of service users and carers in a co-productive role in all of the decision making processes at all levels in the production of all these standards. Those service users and carers must be users of the services to which those standards apply, and not people who use different services who won't have the credibility or experience to truly provide the perspective and reality check needed to make standards that are appropriate and fit for purpose.

This will require a clear definition of both 'service user or carer', and of co-production.

Within the mental health service and in Social Care Wales, a service user is someone who:

Is using the service relevant to the decisions discussed now.
Is using them frequently (eg 25 or more contacts a year – although in some services this frequency will depend on the condition, eg maternity services, might be seeing someone less frequently – but for instance you would go for someone who has had multiple pregnancies with significant complications requiring a high level of intervention – eg eclampsia, placental insufficiency, complicating health condition eg diabetes, etc.)
Has been using services for at least 5 years, preferably more, and at many different levels, and tiers of service (ie primary care, self referral tier zero, secondary care, out-patient, in-patient, specialist)
Has been affected sufficiently by their health condition to be unable to work full time, and probably due to the condition or discrimination will not have been in paid work for some time, or have had high level paid work experiences
It is desirable that they:-
have experience of being dependent on public transport, or on people outside of their own household for transport, and of having a low disposable income, so that they understand and can convey the difficulties faced by people with these disadvantages.
Come from groups with additional protected characteristics
Have more than one health condition, so understand co-morbidity issues

Carers are people who care for people with this level of health difficulties 35 or more hours a week.

"co-production", requires the equal status of service users and carers in all decision-making processes, first in their own care, and for those with appropriate backgrounds, skills and knowledge in all decision-making processes in the strategy and policy development at government level and below, governance, commissioning,

planning, service design, standard setting, workforce issues, including standards of competence, curriculm design, and standards of ethics for staff, complaints investigations and audits of service quality, design, delivery, and management of staff training, including involvement in student and staff selection, assessment, recruitment and promotion of staff and in conduct panels, evaluation of services, informatics, research and development, implementation of service change, design and delivery of consultations and service user and carer engagement processes, inspection, serious incident investigations, operational management and delivery of services. It must be possible to provide an audit trail of the contributions of service users and carers, and to demonstrate how these have made an impact on decisions, and contributed to service improvement.

Co-production is ensuring that there is no restriction beyond imagination to how service users and carers can tell the service how they feel about it, or engage in discussions about it.

Clinically led service is not compatible with co-production. Professional autonomy is not compatible with co-production, where it takes precedence over service user/patient autonomy.

“co-production” in your own care is being provided with information about the resources available, including the risks and potential benefits of those options, being given choices within that resource bracket, being given choices about who is involved in your care based on both relationship - especially where face to face contact and hence relationship is particularly critical – and on professional reputation, on performance information where available and relevant, and on regulation status. It is enabling service users to make their own decisions about what care they receive and not professionals making those decisions on their behalf, unless statutory exceptions apply, where independent advocates must be involved. It is about accepting and respecting service user decisions about what risks they do or do not tolerate, or what treatment they do or do not prefer, including respect for advance directives such as do not resussitate requests.

Co-production is not – having staff representing service user and carer views, on any committee, board or working group, whether they be from the health service, or from the voluntary sector, or from any other voluntary or statutory agency. This includes Public and Patient Involvement workers, or community development workers, or ‘independent’ consultants.

It is not having any volunteer representing service user and carer views who meets the service user or carer criteria for one health condition, but not for the condition being discussed, or not for the condition at the severity being discussed.

It is not having service users and carers who have a health professional background for health service issues, or a social care professional back-ground for social services, or a background as a research or teaching academic in health professional, clinical subjects for health or of social care professional practice for social care. This is because the majority of people who use services do not have the advantages of understanding how the service works, the underpinning skills, the hierarchy or culture, and would not normally experience being seen as an equal by

clinical staff. They need to understand the vulnerability of not knowing what will happen to them, and not being in tune with the values and priorities of staff. They also need to not be a part of the clinical professional culture in order to ensure those non-clinical values and distinctive perspective can have a significant impact on decision-making.

It is not restricting involvement to one off events, consultations, panels, whether face to face or virtual, surveys, questionnaires, tick box or scored satisfaction measures, involving in some levels of service and not others. (eg scrutiny but not operational).

It is not: tokenistic, So it does not have anyone on a committee or group who is not willing or able to speak out; not listening to or recording service user or carer perspectives; writing off or undermining service users and carers by trying to isolate them, implying they are a lone voice, requiring them to provide statistical evidence or names to prove the issue they are raising, (Confidentiality for people sharing their experiences with service user and carer representatives must be maintained); having a minority of service users and carers on a decision making body and then making decisions by majority vote; restricting terms of office of service user or carer reps to less that the terms of other members of the decision-making group so that they never develop effective working relationships with the committee, develop enough understanding of the business to be effective, or have enough time to become available and familiar to other service users and carers to enable them to gather wider views; selecting people who always bow to professional opinions, or people who can only deliver their own view, and not respect the voice the range of views of service users and carers; hand picking people staff or managers know rather than selecting through open recruitment; providing information or papers for meetings in an inaccessible format too soon before a meeting or in a meeting, so that the representative has not time to study and effectively respond to it; choosing people on the basis of their being popular or dominant in a service user group; (a risk of elections); only seeking views from people who belong to voluntary organisations;

It is also not expecting a professional job from service user and carer reps, without providing them with the resources to deliver at a high quality, ie office facilities, telephone, email and computer access specifically for the role, support to engage with service users and carers through social media, access to on-line peer reviewed evidence base.

Co-production in a service user's own care is not discussing service users and carers when they are not in the room.

It is not making decisions for service users and carers.

Any planning duty needs to incorporate co-production with service users and carers. However the level of understanding of co-production in local health boards is very poor, and engagement is frequently inaccessible and fails to produce information that can be used to deliver improvement. For instance satisfaction scoring based on numbers or smiley faces does not give enough information to change anything, but only raises matters of concern once the level of dissatisfaction becomes extreme. However, feedback mechanisms which enable a narrative response, or specific

comments about particular aspects of the service, give clarity about what is good and what needs to change.

Committee ability to engage service users and carers and to give adequate weight to what they say is also very variable. There need to be mechanisms for setting standards on co-production, requiring a duty to report on and demonstrate how the service user and carer voices have changed services, which have to include service user and carer satisfaction feedback. Too often boards say that services are better, when the lived experience of service users says otherwise. Those staff, usually 'the converted' whose practice is changed, tend to be a minority, so we need much better mechanisms for change at the level of individual staff performance.

To date the majority of Patient and Public Involvement officers have not been people with significant lived experience and resultant social deprivation, so they do not understand what is required to engage such people. It is essential that this changes.

Duty of Candour

Again this depends on what staff are being candid about, how that impacts on individual care, and how they can be held to account. If all mistakes have to be outed, unless there is also a culture of no-blame error management focused on developing patient safety procedures, rather than on punishing individual staff, staff will be motivated not to be open and candid, and to deny any errors.

It is critical that any duty is balanced by an understanding that errors are usually the result of a cascade of events and often of system and process inadequacies. They are common and inevitable. No system is ever perfect, the critical thing is to learn from error and change the way things are done to minimise future problems.

Supervision, training, case loads, under-staffing, all have a part to play in the capacity and willingness to be candid.

It is critical that problems are not faced with defensiveness, and that the old pattern of investigations to determine whether or not something happened, or who was responsible, needs to be replaced with a culture of investigation resting on the experience of service users and carers and why they felt something went wrong, and the consequences they are dealing with, with the process drawing learning from the situation, whether or not it actually did happen. The current system is adversarial and encourages denial, and avoidance of challenge, and creates deep distress and conflict both for those who have been through enough in suffering as a result of using the service, and for staff who feel under attack. A focus on defending against complaints underpinned the mid-staffs issues. However, at least the complaints were made. We need to be thinking also about what happened at Tawel fan, and the fact that people with mental health problems often are too afraid to complain and with very good reason, so that abuse bad practice and error frequently go below the radar.

One of the problems is that it is not safe for service users and carers to complain, as services can be withdrawn and leave them without access to any care at all. Since professionals are able to withdraw service on the basis of a 'breakdown in

relationships', you cannot stop them excluding people from service following a complaint. The CHC is currently advising people in rural areas where there is only one GP available in the catchment, not to complain because of the risk of this withdrawal of care. This raises the risk of serious malpractice in rural areas or shortage services, going undetected and causing extensive harm to a lot of people.

It is critical that the duty of candour is accompanied by stronger legal protection from loss of services if someone complains, and also from relationship breakdown, where information about complaints is inappropriately shared with staff across the clinical team who were not directly implicated, leading to defensive practice, and prejudice against the complainant.

I have experienced this issue personally. It caused years of aggressive treatment of me by some staff, often from first introduction or the point at which I gave them my name, with clear and frequent reference in my notes to my having complained and/or judgements about my character directly traceable back to those complaint references, for at least a decade after the complaint was made. At present I do not feel safe to complain again, however bad the incident was.

Before candour will work there needs to be adequate mechanisms for identifying the problems, such as medical error and neglect, that organisations are required to be candid about.

At present it is impossible to hold staff to account for individual clinical decisions. There is no process for investigation, no requirement for staff to explain their decisions to service user or carers, or to answer any of their questions, or respond to any challenges. They can refuse a request for a second opinion and hence avoid the scrutiny of their decisions that would reveal error or bad practice. I experienced a refusal to offer a second opinion on the basis that I would not tell the second opinion giver the truth, and hence the team would not be able to act on the second opinion, which would cause me harm, and they couldn't cause me harm. This they did not discuss with me. I found it in my notes, in a letter from a Dr who I had complained about 4 years earlier, who had no clinical role in my care, and yet, despite my request for him to be excluded, continued to have an influence over my care. The anger in the letter clearly raises the question as to his motives for remaining involved, given that his input was for the most part negative, and denying me access to services. At a later date this involvement was described by one of his colleagues as 'unprecedented'.

Without access to a second opinion decisions are not quality assured and mistakes cannot be found. Prejudice and bias in mental health are particularly entrenched and can ensure that errors persist for decades unacknowledged, as they are handed down from one group of staff to the next, and immortalised in clinical notes. It is critically important that evidence has to be provided to support claims that a service user is being dishonest, because the risk that they are not dishonest and hence the treatment and diagnosis are inappropriate is very high. I cannot see how cover ups can be avoided or errors found unless service users and patients have a legal right to have a second opinion, where a thorough face to face clinical investigation is made and a search for new evidence to fill gaps in the information upon which decisions have been made is done. Where the second opinion differs to the first

opinion, as a result of the additional evidence, the service user or patient must have the legal right to have their treatment and diagnosis changed in line with it.

It is also critical in mental health that staff have a legal duty to reality check their beliefs about service user behaviour, with people in the service user's social circle who know them well, in a number of different contexts. Otherwise, being misunderstood by staff making unrealistic assumptions causes extreme distress which manifests in behaviours that are specific to the difficulty of that circumstance, which over time become assumed by staff to be the service users behaviour in all situations. Without reality checking this can lead to serious and long term, very damaging and harmful errors, and treatment that verges on abuse of the service user.

For effectiveness of candour, staff must be required to explain their decisions more clearly in clinical notes, and to service users and carers, and to actively record the risks of clinical error or neglect, when making any decision. Just as clients need to understand the risk of different treatments, and their consequences, so that we can weigh up our decisions and be prepared for things if they do go wrong, it is equally important to inform clients regarding the risks and possible consequences of mis-diagnosis, the relative accuracy of different diagnostic tests and processes, so we can be prepared that things could go wrong, and also informed about what to look for that would indicate an error as soon as possible. An error identification and mitigation plan, also needs to be records on records, so that failures to respond to treatment or sequelae of inappropriate treatment are very quickly picked up, so that errors can be found, corrected and damage minimised by instituting appropriate treatment quickly.

Another problem that needs to be addressed in order to identify error and the quality of information which underpins decisions, is to improve the quality and completeness of clinical records. Given the complexity of information and the difficulty writing notes contemporaneously before distraction will compromise their accuracy, more needs to be done with the use of technology to audio record contacts with service users or patients, especially in mental health. Without good records, you cannot hold people to account for candour, because you cannot prove that there is anything to be candid about.

In summary, a Duty of Candour, must be underpinned by robust mechanisms to risk assess for error and to discover it. This will require legislation.

Staff must have a legal duty:

- to explain their clinical decisions to service users, patients or family,
- explain the evidence used (eg clinical tests, symptoms observed), to inform the decision
- to collect additional information from families or close social contacts of people with mental health problems, or communication problems, to clarify or provide additional information about the service users symptoms within normal social contexts,
- and to have a legal duty to answer service user, patient and in some circumstances family or carer questions, in as much detail as the questioner requires.

There must also be a legal duty on all clinicians to offer a second opinion, (including psycotherapists) where the service user, patient or their representative feels a mistake may have been made, and a legal right for service users or patients to have a second opinion in any circumstance where error is at all possible.

Without this, candour is meaningless.

Person Centred Care

People have no right to have a mental health service of any kind, excellent or otherwise. In fact figures from Cardiff and Vale show that 70% of people referred for care fall between primary and secondary care and hence get no service at all.

There is plenty of evidence, as a result of this, and for those who do get a service, that they do not get the right care, at the right time, by the right staff in the right place. And there is nothing service users or carers can do about it.

This is a budget issue. There really needs to be a consideration on equity of funding given how many people suffer from mental health problems compared to how many suffer from physical health problems, to ensure that the limited resources are more fairly distributed. The inequity of care in mental health cannot be plugged without additional investment, including investment for change so that services do not have to be cut to fund service improvements in other parts of the mental health system. The cutting beds to fund change mechanism has only made the resource difficulties and levels of untreated mental health problems worse in the past. It is essential to improve earlier intervention, and more comprehensively available mental health care first, and to only cut beds once more effective services leave them consistently empty.

There is a significant schism in the understanding of 'person centred care' from the person's perspective, and of the same phrase from the professional's perspective.

Where I am the person, it means I make the decisions about my own care, about what my best interests are, about what risks I do or do not take with my health in choosing a treatment (or no treatment) option, about what my treatment goals are and how good a possible outcome of treatment is in my opinion, and if it is good enough weighed against any pain and risks of the treatment to justify my preference for that treatment. I expect my preference to be respected. I expect to be offered a choice of all available treatments for the condition which are possible within the resources available, including the opportunity to travel to a different team if it would, in my opinion, be better for me. I expect to be given all the information I need to make an informed choice, and to have the option to delegate the decision to the professionals if I choose. I expect to be told what can be done within prudent health care principles (especially 'first do no harm'), and not to have to tell staff on their request, what I want in order to then be told it is not possible.

What professionals appear to mean by this phrase is that they use their technical knowledge of the available options and possible outcomes, and choose a treatment on the patient's behalf which delivers the outcome the professional thinks is best for the patients, based on the professional's values and view of what a good outcome

looks like, and the professionals values and view of what is an acceptable risk. They then offer this treatment alone, and give information so that people can give informed consent, without having to think about any of the alternative treatments. Because professionals think that they are helping by simplifying the decision through reducing choice. Maybe they are also trying to save time. The professional wants to use their autonomy to make the decisions, and then tell the service user what will happen, and because their decision is based on the individual's symptoms, they see that as making the patient/service user central'.

As you can see these two viewpoints are very different. We clearly need to come together to define 'person centred care' and ensure that professionals and service users/patients/carers/managers/politicians all understand the same thing by the phrase. Clearly I want the former and get angry about the arrogance of the latter, even though I recognise the good intentions.

Setting and Meeting Common Standards

This rather depends on what the standards are. If the standards are low, then all the services are poor quality.

Having worked with both social care and health, I am sure they cannot be measured against the same stick.

There are some standards that do need to apply across both, such as quality of information for service users/patients/carers/families; dignity in care, including psychological dignity (especially needed in health – see mental health dignity pledge); standards for informed choice and consent; standards of record keeping and confidentiality; protection from abuse by staff; application of the requirements of the equality act including improved equality impact assessments, better understanding of indirect discrimination and the public equality duty including reasonable adjustments (especially in health care as this is much better covered in social care); standards of co-production need to apply equally to both health and social care, but I think require additional legislation to enforce.

There are additional requirements in health due to the manual skills required, and technical knowledge, which do not apply in social care. In addition the complexity of assessments and diagnosis are very different to the need for assessing people in their own homes and social environments. The size of the knowledge base is much greater as is the range of specialities and the complexity of training and research. The physical damage that can be done by health staff is also much greater than social care, although the psychological damage that can be done through abuse in both services is extreme.

The people skills required in social care are much more sophisticated, that those in physical health, although mental health would benefit from the same skills.

There need to be explicit legal rights, such as right to justice and not having allegations made in notes or verbally without the service user having a process enshrined in law through which the service has to provide evidence of their accusation and hear the counter evidence of the service user's defence, in an impartial proceeding overseen by an independent official, based on the basis of

innocent unless proven guilty. Staff have these rights in their employment contracts. Service users currently have to put up with abuse and accusations without any come back at all. There is no innocent unless proven guilty. And abusive comments and accusations are immortalised in records, where they cannot ever be changed. There need to be clear standards about clinical opinions on records and what counts as 'clinical' and what counts as 'accusation' or 'abuse'. Writing in the notes that someone is not being honest, is both accusation and abuse. It is not a clinical opinion. It would be honest and more accurate for staff to record 'I didn't believe the service user', or 'I thought there might be more she wasn't telling us' but only if they add why 'because she didn't describe the symptoms consistent with the diagnosis we made'. Then it is a clinical opinion, and is about the views of the writer and not the qualities of the service user. And by giving the reason for the judgement, another clinician can review the evidence and come to a different conclusion, eg, 'she was describing her situation accurately and fully but the previous clinician got the diagnosis wrong'

We also need to have a right to privacy, which means that information cannot be shared with other clinicians, even within the service without our permission, except in exceptional circumstances where there are risks of abuse or physical danger, or legal requirements for reference to records for legal proceedings, and even then information must be on a need to know basis only. Currently the boundaries of confidentiality are constantly being stretched through service 'integration', multi-disciplinary and multi-agency working, and working with the voluntary sector. Shared databases and information sharing protocols which don't require patient consent are not acceptable. All information sharing protocols and confidentiality boundaries need to be conveyed to all service users and carers so they can choose to edit information if they cannot prevent it from being shared. It is extremely counterproductive to have leaky boundaries between clinical records by different clinicians, agencies, services or organisations as it will encourage people to hold back information which could have helped to address their health or social care problems. This is especially the case with psychotherapy, where issues that may be extremely sensitive, personal and embarrassing may be discussed, or in services which deal with health problems which carry any kind of stigma or cultural taboo.

We need to have a right to family life, so that services must be placed where families are able to visit, especially for people in long term care, and if necessary provide transport and accommodation to facilitate visiting.

We need to have a right to freedom from abuse and harm, including neglect and punitive withdrawal of services.

Access to advocacy is also pointless if services are not legally obliged to take account of what the advocate says. At present they are just as unlikely to listen to the advocate as to listen to the service user. In addition it is not clear how to deal with a situation where the right to advocacy is denied.

Again, standards that cannot be upheld through legal processes, are meaningless.

Common standards also need to be underpinned by common training and performance management. Unless front line staff have training to equip them to

meet the standards, and common performance processes to ensure that they do, and standards are meaningless.

Joint Investigation of Health and Social Care Complaints

Different people find different things simple or complicated, and the cross over in health and social care very much depends on the service context. For me the less an organisation or process does, the easier it is to understand. So separate complaints processes for health and social care are so much easier for me to understand. I very much keep different roles in different boxes, so I have no difficulty separating out and distinguishing from health and social care. I get very upset if a health worker starts to do social care or vice versa. I know the label on the box, and I want the people in the box to stick to that role.

I would prefer to have a separate complaints process for each service. If there were two involved I would prefer to make 2 complaints. I think that increases the chances of a positive outcome. It also increases the possibility of finding an investigator who understands my distress and treats me with respect.

At present the social care complaints process is far superior to the health complaints process. Whilst these processes are different the complainant should have a choice about who the investigating organisation is when there is a dual complaint and hence under which process the complaint will be investigated. The organisation who is not leading on the complaint will have a legal duty to cooperate with the lead organisation's process.

Do not assume that service users and carers are unable to understand that there are different processes for health and social care or that they are not able to appreciate and decide which is better, or which refers to which part of their treatment. If there is a joint investigation it is important that the complainant has options, and if they choose to make separate complaints, that they are allowed to do so.

The current 'Putting Things Right Process' is not fit for purpose, so if joining up with social care processes – which are much better- leads to fundamental change in the direction of the social care process then this would be excellent. However, there is the risk that it will go the other way and the social care process will be compromised. The recent up-date of the Putting Things Right process was inadequate and did not have sufficient any co-production with service users. It was impossible to find out how service users could be involved, and took extreme measures and persistence in the face of very distressing blockades and extremely rude responses and intrusive enquiries from government, to finally find out that the CHC was supposedly representing us, by which time the process had finished and clearly our concerns had not been addressed. It appears that the CHC were not aware of the mental health service user and carer representative arrangements and hence did not set up any processes through which they could be involved. Another CHC staff member told me at an event that they thought they were involved due to their complaints advocacy role alone, and not as the service user and carer voice – so even between the CHC and the government there appears to be a difference about co-production and service user voice in this highly crucial piece of work.

On the other hand the complaints process in the social services was designed with good service user and carer involvement without proxy representation, and is hence a much better piece of work. It is essential that the government understands that proxy representation through any body, including the CHC is not co-production, and does not break down barriers between professionals and service users, but creates additional barriers and hurdles between service users and the CHC, or other organisations chosen as proxy. If there is any area where co-production is most important it is in the sensitive issue of designing complaints processes.

I was horrified that the government sought to interfere in my own (old) confidential complaint when I asked on behalf of the mental health forum for how we could be involved in co-producing change to Putting Things Right. I feel my right to privacy and my confidentiality was fundamentally breached, and any opportunity to influence the process was blocked for all mental health service users and carers as a result of this abuse of position.

It will not be possible to complain jointly or through Putting Things Right, and certainly will not be easy, unless the Putting Things Right process is fundmentally changed. As it stands in mental health complaining threatens access to any care, and discharge following a complaint is common-place. For those not discharged, widespread discussion of complaints within clinical teams breed resentment and poor treatment of people who have complained, which is judgemental and punitive and borders on abusive. A service user who has complained can phone the service and speak to someone they have never met, get a sympathetic response until they give their name and then get a very judgemental and abusive lecture about their behaviour that is entirely unfounded, and can only be based on second hand gossip. Staff are quite happy to tell people that if they complain they will be discharged (because of breakdown of relationship) and managers are not willing to enforce any disciplinary action when they do so. The widespread knowledge that people have complained leads to defensive practices such as over whelming service users with numbers of staff in clinical meetings. It also leads to diagnosis based on the behaviour of complaining, whether or not the complaint was justified, and often that diagnosis is misplaced and leads to ignoring of the real problems. The effect of a complaint impacts negatively on care for many years and can be brought up in clinical discussions with the service user over 10 years later. Material about complaints is put on clinical records and staff refuse to take them off even when required to do so by senior managers. Staff who feel angry with the complainant can remain involved in their care, even if the service user requests that they not be, and even when they have no clinical role. They can write letters raising the history of complaining which compromises care years later. Complaints investigation through the concerns team is rare and only happens if an investigator is appointed and a reasonable response is very rare within 30 days. Investigators come to clinical meetings and discuss the complaint and are then delegated a clinical therapeutic role with the service user which is completely inappropriate and designed to divert them from any resolution or effective investigation, and assumes the problem lies with the service user and not with the staff. Staff refuse to meet service users to discuss complaints so the first step of talking to local staff is impossible. When they refuse to engage with the service user during any investigation things tend to escalate. It is rare for a service user to have any involvement at all in investigation. They have one chance to put their case in a letter of complaint and are not

requested to provide any further information or to respond to the claims of staff which arise during the investigation. Records and staff testimonials are the only sources of evidence used, and the evidence of witnesses from the complainants side is not asked for or taken seriously. Managers will engage in drawn out processes to divert service users from complaining until they are timed out. Frequently because of lack of on-going engagement of the complainant in the process, the complaint is not understood or is re-interpreted and mis-directed.

In order to address this the complaints process must have different steps and create legal duties for front line staff and managers.

Pre-conditions

a) No clinician is involved in any discussion of a concern or complaint unless the complaint or concern is about them.

b) No letters of complaint, process notes from complaints investigations, records of meetings about complaints or references to complaints are ever placed on clinical files, and regular audits take place whenever there is a complaint to ensure that these materials are not accessible to any clinicians involved in the complainant's care, over a period of time. Any such material found is removed

c) Staff involved are under a requirement of total confidentiality and banned from discussing complaints with any other clinician or manager, apart from the complaints investigator, and possibly an independent supporter.

d) The complainant's care is not interrupted, and if necessary their care is temporarily or permanently transferred to another clinician, providing an equivalent service. This service may not be exactly the same, and may need to be provided in another locality.

e) Irrespective of the nature of the complaint, the staff involved will have a legal duty to treat the complainant with compassion and respect, and will demonstrate effort to come to a resolution and ameliorate the complainant's suffering.

f) Staff will be required, without option, to engage in investigation and resolution discussions with the complainant, where the complainant is able to do so.

g) Service users will never be discharged without equivalent alternative care. In a situation where geography means there is no alternative, the clinician will have an obligation to continue care, and may consider options such as transport to an alternative provider, or paying an alternative provider to provide care for the individual from the service's usual premises.

h) The organisation will ensure that no punitive action against a complainant follows a complaint, and will seek feedback from the complainant at intervals to ensure that his does not happen.

i) The organisation will ensure that complaining does not determine diagnosis, unless the complaint is raising a concern that the diagnosis is wrong, and any change in diagnosis is completely independent of the service or staff members in the service user's usual care.

j) The organisation has a duty to follow up to ensure that any actions agreed with the complainant as resolution actions do take place within reasonable timescales.

Process

A) Complainants have a right to rapid local resolution.

Through:-

A supported interview with the staff member/members about whom the service user has raised concerns within 10 days

A legal duty for staff to answer service user's questions and provide detailed evidence for why the events contested took place at this meeting

An approach based on understanding and ameliorating the complainant's distress irrespective of what happened, and establishing what needs to happen to prevent that distress happening again for the service user concerned or others. And not an adversarial investigation to prove what happened or who was responsible.

A legal duty on staff to make a demonstrable effort to restore good relationships with the service user (underpinned by mandatory training in the recognition and repair of relationship ruptures with patients/service user/carers/families)

B) If rapid local resolution fails, as in social care an independent investigator needs to be appointed.

The investigator must consider all evidence with equal weight including that from the complainant, or from witnesses not employed within the health service.

The investigator must focus on explaining the distress and concern of the complainant, and on learning from it to prevent this distress being repeated. This is likely to involve following audit trails of what happened and checking on the reliability of information, including evidence provided by the complainant. It will require seeking additional information and evidence from the complainant. It will require staff to engage with the process and to genuinely consider how they may have contributed to the situation, rather than seeking to disprove that they did anything wrong. This process will be much enhanced if the quality of records were improved with greater use of audio recording to provide impartial and accurate evidence.

The process must also include looking at what is needed to repair relationships and to get treatment back on track, and what can be done to help relieve the complainant's distress. This may require a number of meetings between the complainant and the staff concerned, and potentially additional psychological interventions.

Where a good relationship is not deemed possible by the service user or staff member, an alternative staff member must be offered to ensure continuity of care, even if the treatment they offer is not exactly the same, or if they offer it from another locality, and the staff member against whom the complaint was raised must have no further role or influence over the complainant's care

C) Everyone should have access to an independent and impartial appeal if they are unhappy about a complaint, irrespective of the nature of the complaint. At present there are gaps in the availability of impartial appeal for complaints against individual staff, which are not covered by fitness to practice proceedings, or where the staff member is not a regulated professional, and for organisational performance in the implementation of policy or standards, as the HIW doesn't investigate such complaints and the Ombudsman doesn't have the resources to do so. If a health

board says it has a policy, then the Ombudsman will accept that whether the policy is being implemented or not.

A further gap exists where the health board has created delays which time a complaint out for consideration by the ombudsman, or where the distress caused by the incident has been so traumatic that the complainant has not be able to raise a complaint until they had recovered enough from the trauma, and hence find it is too late to complain.

Representing the Citizen in Health and Social Care
No I do not support your proposal.

I don't think co-production should be monitored, I think it should be held within a legislative framework and enshrined in the structures for the delivery of government policy and services, and that there should be a mechanism for holding organisations to account for meeting their legal requirements.

This starts at government policy level which needs to be co-produced with service users. Social services, on the whole have been better at this level than health. Government strategy, eg together for health, needs to embed real co-production within the implementation and reporting structures, as they have in Together for Mental Health. And create statutory requirements for core funded structures to deliver genuine first person service user and carer perspectives from high intensity , long term users of services and carers of same, in all NHS and social care work at all levels of service on an equal partnership basis, based on open recruitment on merit.

The requirement for service user and carer (with service user permission or where there is incapacity) co-production in their own care also needs a legal framework of rights for people using services. These rights should include
1) The right to information about all available, suitable treatments, including palliative care, and no treatment, including potential range of outcomes, both good and bad, risk of error, length of treatment, pain or suffering expected in treatment, any costs involved, any activities (such as physio) involved, level of support available during treatment, how to recognise treatment failure or indications that the treatment might not be appropriate, indicating the need for a different approach, a different clinician or possible diagnostic error
2) The right to choose which available treatment is preferred, including palliative care or no treatment – within statutory limitations – supported by the right to have advance directives followed.
3) The right to choose who is involved in their care and treatment, at the appropriate level of care within teams, within the boundaries of health boards, or independent of where they live, if they are willing to travel. And also the right to veto a clinician from any further influence over their care. (This would lead to an organic growth of centres of excellence where a department or particular staff gain a reputation with patients and people are willing to travel to see them, without having to create artificial selection of preference sites through centralised decisions which can prove unpopular and divisive – if the funds follow the patients health boards will be encouraged to support their staff to develop, and deliver innovation. Poor

services will wither from lack of support. Within teams staff who are more popular can be rewarded, those who are less popular can be supported with additional training and supervision, and if they remain unpopular moved to less frontline positions. This is the best way to ensure that the patient's values regarding good service are taken on board, and changes the dynamic so that staff motivated to dictate the terms of treatment and put their own autonomy first learn that rewards only come when they keep their patients happy and provide a service that is 'good' as defined by service users rather than as defined by clinicians. Clearly service user/patient/carer etc involvement in staff recruitment and promotion will maximise the likelihood that appointees will meet the expectations and values base of the public)

4) The right to equal access to, and quality of care, whatever your income, whether or not you have a car, irrespective of protected characteristics, wherever you live, whether rural or urban. (this may require providing and/or funding transport for people without access to transport for whatever reason, and will require siting of services in the places which are most accessible to the majority of the target population)

5) The right to co-create patient records in areas where the subjective experience of patients is the only or main clinical measure, eg in mental health and pain management.

6) The right to dignity, face to face and in records, with freedom from verbal, physical, sexual, or written abuse by staff, and a process for innocence unless proven guilty with any opinion related to the moral integrity and character of the patient or carers requiring independent evidence from non-clinical sources, such as witnesses brought by the service user, to be considered and accurately placed on record, before any such opinions can be placed on the clinical records.

7) The right to a second opinion wherever there is any chance of medical error or neglect. The chances of error need to be independently assessed by clinicians not involved in the person's clinical team so that the decision is independent).

8) The right to access to equal quality of service to other patients/service users following a complaint,

Without:

- retribution or revenge by staff,
- added clinical risk,
- reduced likelihood of good clinical outcomes,
- defensive practice,
- reduced quality of relationships with clinical staff not involved in the complaint,
- having to have additional staff to usual services in the consulting room
- gaining a psychiatric diagnosis based only on the fact of making a complaint, without rigorous additional evidence of clinical symptoms required for that diagnosis with external independent witness from the social contacts of the person who has complained
- losing accessible services (eg service withdrawal by a rural GP may leave a patient with no GP service at all – so special arrangements have to be made to maintain the service access).

[GP's and other professionals feel that they can withdraw care if the relationship with the patient 'breaks down' – without having to demonstrate that they behaved professionally in trying to repair the rupture, or having to prove the rupture was in no way down to their own behaviour or preferences (eg they just don't like the

person/personality clash), or that the rupture is not due to prejudice and discrimination, or that it is just a way of covering up error, abuse or neglect, or a way of gaining revenge because of a complaint. They feel they can do this without ensuring alternative, and equivalent appropriate care also of equal quality. It is a loop hole to get around the requirement to ensure the quality of care is not compromised by a complaint, and effectively means that it is never safe to complain when accessing a service which is in shortage, rationed, or has no alternative due to rurality. This is dangerous, and ensures that failure of candour will not be exposed in these situations and the purpose of introducing candour to protect service users will fail.

Justice would require the consideration of evidence of unreasonable or illegal abuse by a patient or carer, with counterevidence from the patient or carer considered equally, by an independent party, with a requirement for the balance of the evidence to be against the service user or carer, before the service can be withdrawn. There would need to also be consideration of medical causes for bad behaviour, such as psychosis, brain damage, or other. Where these are found the service should not be withdrawn unless the difficulties persist after recovery. Otherwise any diagnosis or disability which negatively affects behaviour could lead to exclusion from services, which is unacceptable.]

9) The right to confidentiality of complaints, for them not to be discussed in clinical contexts with staff involved in the person's care but not in the complaint, not to be discussed informally eg in the staff room, with clinicians whether or not they are involved in the person's care, not to have any complaint letters, references to complaint phone calls, references to complaints at all – even obliquely – minutes of complaint resolution meetings, or complaint investigation process notes – placed on the clinical records

Beyond patient care, co-production needs to be strengthened by resourcing opportunities for service users and carers to meet together both locally and Nationally, to identify concerns, priorities, and good practice, and to coordinate access to consultations and opportunities to respond to them. Information about the requirements of co-production and the quality of its implementation can be developed and monitored through these groups. It is important for government officials to engage with these National groups to take action regarding their concerns through the accountability processes with local health boards.

People who are involved in 1st person voice for this work need to be getting equal pay for equal work, unless they opt out of payment, and unless they prefer time credits. Time credits should never be the only option for reward, as they can be an exploitative mechanism to avoid paying the minimum wage, let alone a wage fair for the level of work being done. An effective rep, peer trainer or peer support worker will save the services money, and should be offered fair reward.

The people with 1st Person voice need to be determining the shape of the support they need to deliver their responsibilities, in the form of office facilities, communication equipment and resources, access to research and administrative support. Sometimes co-production involves discussing issues that have caused the

1st person voice real distress and pain, so there need to be resources in place to provide psychological and emotional support in these situations.

It would be best if the local service users and carers appointed to local implementation, planning, commissioning scrutiny, governance, and strategic committees, boards, and working groups, are given the powers and resources to appoint a local organisation to support them on a 3 year tender basis. This will allow them to ensure support organisations are delivering to high standards, and that competitive pressures support high quality services. It will enable them to drop unhelpful organisations if they underperform during the term of the tender, when the tender comes to an end.

Local representatives need a National Forum to share challenges and good practice, and to feed in via representatives they appoint, into National strategic and implementation processes. Again they need to have the resources and powers to appoint a support and admin organisation on a 3 year tender.

This model would be superior to another government sponsored body, as if the support organisation (s) on 3 year tenders are not delivering, they can be replaced, whereas if the sponsored body is not delivering dealing with their performance is more complex and expensive. It is also likely to be less costly.

The appointment of service users and carer reps needs to be to a clear job description and person specification, that ensures adequate scrutiny and challenge and adequate lived experience to ensure a credible and genuine perspective of the widest possible experience of the relevant services. The person spec needs to ensure a critical friend attitude which is not vulnerable to erosion on exposure with acculturation to a group of professionals and managers. Long term involvement with consistent levels of positive challenge and the ability to network and put across a range of views, can be evidenced by candidates, to show that they are not at risk of aculturation. There needs to be National consistency on recruitment, and great care taken to ensure that the organisation doing the recruitment does not have an economic interest that could lead to a recruitment bias, or an organisational/political interest in recruiting people sympathetic to their objectives and point of view. This would rule out many health and social care based voluntary sector organisations, who might be bidding to be support organisations, or who might be seeking voices that back their interests on partnership boards.

It would be preferable for recruitment to also not be subject to NHS and social care government organisations, as they too could have an interest in appointing people who will go along with what they want. The options therefore would be:-

A different government department, eg Sectors and Business
Or sponsored body eg Future generations commissioner
Wales Audit Office

It is critical that representatives do not come from a health or social care professional or public service management career background, in order to reduce the risks of acculturation and insufficient challenge. The most effective contributions are those which bring a completely new eye to the services, not restricted by ideas of custom

and practice and the way things have always been done, or burdened by existing KPIs, priorities and workloads, which have proven to repress creativity and innovation.

As part of an enforcement mechanism, a very small team, something along the lines of a commissioner for co-production with service users/patients/carers and families, could have a role in requiring evidence of compliance from health boards which has to be supported/reality checked by independent reports from local service user and carer reps, and placing duties upon them to fully comply with legal requirements for co-production, with a requirement for a statement of satisfaction from local and/or National reps as appropriate, that the co-productive partnership has been delivered.

This needs to be much stronger and have greater authority than just advising, and should not get involved in any consultations unless specifically requested by local service users and carers on the grounds of specific failings under the standards. The commissioner needs to be able to require health organisations to make improvements to their consultations and co-production through open and flexible discussions and mediation with relevant local service users in the first instance. They should however, not ever, in any circumstances claim to speak for or represent service users.

It would be helpful if they collated concerns raised and best practice, and reported it on an annual basis to government, doing additional research on thematic co-production issues, when indicated.

If you can get the standards for co-production right and regularly review them, giving them a high profile locally and nationally, you will be empowering people with the tools they need to effectively challenge bad practice in co-production, and to take the initiative to develop and deliver good practice.

Waiting until after a consultation process to decide if it was adequate is too late.

We need a clear definition of what is substantial.

We need clear process requirements – eg service user and carer views are separately analysed, themed and reported, by service user and carer analysts from another area, with the same level of experience of service use (or caring for same) as required for reps.

The proportion of responses from service users and carers, compared to those from service providers, must be given.

Any numbers of consultation meetings given, must indicate attendance at those meetings, how many were with a single stakeholder perspective – eg staff only, service user only, and which those perspectives were, how many were with mixed perspectives and what the proportions of service users/carers/staff/voluntary sector, were in each.

How many service users and carers came from groups with protected characteristics.

Any complaints made about the consultation process as it progressed.

Tracking of announcements and public visibility of the consultation process

Any organisations providing consultation advice, such as the consultation institute need to be accredited and licensed by service user and carer reps, to demonstrate that they meet the required standards for co-production, as currently they tend to support the views and interests of the public bodies who commission their services. This is an inevitable business strategy, as they are unlikely to be able to sell their services if they make things difficult for their paymasters.

In addition, it would help to counterbalance such bias, if the commissioning of any such organisation has to be made by a panel with equal membership of public service employees and service user and carer reps with extensive experience of engagement with both good and bad consultation processes.

It is important that the quality of co-production is assessed by the local groups most affected.

It would be helpful if all consultations had a preface explaining how people can complain about a consultation process, and readily available local access to courses in the standards and requirements of consultations so that local people can evaluate them, themselves.

A new organisation is not desirable if it continues with the issues that have undermined the value of the CHCs, including the use of volunteers in the core work of the organisation, too many different roles, and use of proxy. It is critical that a new proxy organisation is not formed and that instead we have paid members who come from a background of high level use of services and unemployment as a result of the health issues that caused the service use, and carers of people in this group. Anyone without this back-ground will not have had intensive enough experience of the service over long enough to have gained experience of the best and worst of the service, and will not have any understanding of the additional challenges that make access to services and engagement with co-production difficult. Without this knowledge it is impossible to design co-productive processes that are truly accessible and representative, in engaging with sufficient numbers of people. It is also essential they have no background in public service delivery to ensure they truly provide a fresh perspective, to facilitate new and better solutions. It is possible to find people in any area at a high level of ability who meet these criteria.

Clearly these reps need to be visible and accessible, so that the whole service user and carer community, including the more privileged individuals, with more high status backgrounds can also feed in their views and insights and any additional ideas, through contacting the representatives in a variety of ways.

The reason that it has been difficult to recruit CHC members, and that the members have not been representative of the local population, is that members are not paid. If members of health boards are paid, making the membership of a service user voice organisation unpaid is demonstrating an attitude of not valuing the time, effort and expertise people put into having a voice, and engaging with others to inform it. You cannot have co-production on the basis of inequality. The voice has to have equal status and equal pay for equal work to those they work with.

Without understanding of the privations and difficulties of those who struggle to be engaged, representation cannot happen, and cannot be effective. Any voice organisation that isn't identifying talented service users and carers to sit on committees and support them, rather than any trustees/staff/or equivalents, sitting on committees as proxy is not providing anything different to inspectors, advocates, or staff trying to present service user and carer views. We need to work to the principle of nothing about us without us. As long as the voice organisation is not us, it cannot represent us.

The document makes the mistake of confusing the visits CHCs make to services in order to gather service user, patient, carer, family views, with inspections. Although it has to be said talking to one person who has never been in your position is very like talking to another. Talking to someone who has been in your position, who really has a much better idea of what you are experiencing is something entirely different again.
Of course as with all areas of engagement with service users and carers not all want the same thing, so it would be helpful to have the possibility of non-service user and carer engagement workers, providing there is always a choice for service users and carers of what kinds of staff or representatives they want to talk to.

The current arrangements for citizen representation in the RPBs are not sufficiently robust, and organisational inexperience in co-production is leading to local RPBs making unnecessary mistakes regarding what does and does not work, massively compromising the effectiveness of the service user voice and making co-production impossible. It is extremely important that the guidance for involvement is more assertive regarding recruitment processes, terms of office and facilities that enable service users and carers on Boards to engage directly with the public. This means ensuring that terms of office are long enough to enable service users and carers to become familiar with the core business of the board, to become established and effective in the team, and to become recognisable and approachable to other service users and carers so that they can feed in views. In addition there is a critical need for citizens' panels that meet in reality and not virtually, to inform service users on the boards. Preferably the panel membership should be open to all through open meetings in big enough venues to welcome all those who have something they want to say. At present not all regions have citizens panels which is a matter of serious concern.

Again it is not appropriate for terms of office on the RPBs to be any different for service user and carer members than it is for other board members. And RPB service user and carer membership should be paid, given that all other members of the board are paid.

The public service boards also must have actual service user and carer membership, and not proxy through any other organisation including the CVS's, condition specific charities or third sector groups or any CHC equivalent.

As for practical difficulties – I think you will have exactly the same recruitment difficulties with your proposal for members of any new organisation. You will only get the privileged do gooders who can afford to do such things for nothing. The majority will be retired professionals, who cannot provide an entirely independent view, and people with an independent income and plenty of time. It is impossible for someone with an NHS or private health service professional background to represent the culture of those who do not. These people should be excluded from all posts tasked with providing voice. The skills and capacity of the local CHC members I have met have been disappointing. In addition you need to watch out for health boards who recommend applicants to their board to first be members of the CHC, so CHC members with an ambition to be on the health board are not likely to rock the health board boat, so that they stand a better chance of getting onto the health board, when they apply. Anyone who is effective at challenging, scrutiny and holding to account the health board is unlikely to be invited to join it. It is critical for conflict of interest issues to exclude any CHC (or equivalent) organisation member, from membership of a health board within 10 years of being on the CHC (or equivalent), to stop this practice.

You will only get good representation and the best talent, if you pay members and recruit on ability and not on work record.

I am not won over on the idea of sitting this with the inspectorates, as that and citizen voice are entirely different roles. Whilst inspectorates would benefit from citizen voice in their governance and decision-making, and operational processes, citizen voice needs to be developed as a separate discipline and structures (rather than organisation), which can indeed also hold the inspectorates to account for the quality of their co-production arrangements. We need to look at the citizen leaders programme in the English NHS, as an idea for improving co-production, as this is based on actual service user and carer input. Nothing about us without us. And us means us, not a proxy.

The model within mental health is not perfect but it is far superior to the CHC or your proposals.

It underpins the ideas I have already suggested, so is a proven and practical alternative.

It combines co-productive requirements for decision making in key bodies within government strategy, with fair merit based recruitment of representatives, with local support for reps through local organisations, a national group including the local reps and others, also with voluntary sector support, direct involvement of government staff in working with the forum nationally, and where necessary follow up on local issues, and also good representation from the forum on the National Implementation body appointed by, and reporting to and from the forum. This

creates a virtuous circle of requirement, structures, debate, networking and outreach, accountability and holding to account.

More detailed description of mental health voice model.
Local service users apply through an open recruitment to a post with a job description and person specification. Other service users and carers can be involved in the recruitment panels. People with the right skills and abilities and with a credible range and length of history of service use (or caring) and evidence of on-going networking with other service users and carers then sit on the Local Mental Health Partnership Board, where they have equal membership status with other partners.

In each area a local voluntary sector organisation 'supports service user and carer reps' and coordinates recruitment of reps. The quality of this is extremely variable and in some areas inadequate. Some areas appoint reps on a long term basis, where they have become effective in their roles. There is a natural turnover as people become more or less ill, or moving on in other ways. However in some areas there is a steady leaching of experience and ability due to limiting terms of office and poor quality of recruitment. Some recruitment is inaccessible to some people with mental health problems who have a lot to offer but who are unable to make a written application or deal with a standard interview process.

The local partnership boards report back to the welsh government and the National Partnership Board in a format that requires service user and carer reps co-producing, co-writing, and in the service user and carer involvement section, exclusively writing, through an annual statement.

All the local representatives are members of, and meet with, the National Service User and Carer forum for mental health and discuss issues of local and national importance. They appoint additional National members again through competitive open recruitment, to balance the range of clinical experience available to the forum and to ensure a fair range of protected characteristics. The forum appoint representative and alternates to sit on the National Partnership Board. They contribute one item to the agenda of each meeting, which often leads to requests for information on progress from the Welsh Government to the local partnership Boards. The forum is supported by an independent mental health charity which deals with the administration, and meeting arrangements, including organising accommodation and expenses. This takes the pressure of representatives many of whom are already working very hard on a voluntary basis, and who have difficulties which would make organisational administration challenging. A member of Welsh Government attends forum meetings and acts as liaison, takes action with Local Boards to follow up concerns about the adequacy of engagement or about the progress of issues raised by the forum.

Currently the forum is funded through section 64 funding, despite the fact the representatives are a required element of structures for government strategy (such as partnership boards, local and national).

The model could be improved by:

Providing core funding from the government that doesn't require on-going applications.
Funding that is sufficient to enable more meetings each year (currently it's 4). We need more because agendas are always tight and we don't have enough time to cover what is needed.
Recruitment processes that support people who cannot access traditional recruitment methods, through reasonable adjustments to ensure they have a fair opportunity to be selected.
Ensuring that all government consultations that are relevant to mental health are flagged to the forum and that there is always a consultation meeting (outside of the core meetings) with the forum to ensure that the mental health view is heard. This obviously includes consultations such as this one, and developing the complaints process.
CHC should have had regular contact with this group
The power for the National forum to choose an organisation to whom they delegate the administration of the group and organisation of meetings and sufficient funding to pay for this.
The power and funding for the National Forum to appoint supporting organisations in the Local Partnership Board areas, and to set working standards and reporting mechanisms for these supporting organisations to ensure that local support and recruitment processes are consistent and fair across the whole of Wales.
Sufficient funding to cover all travel and accommodation expenses for meetings
Sufficient funding to pay representatives for their time doing work at a national level, so they are equally paid to the people they are working with
Sufficient funding to extend membership to retain experience of previous representatives to support the development of new ones, to attract new talent to provide representation on other Government and local groups, working groups, committees and boards
Membership to be widened to include all mental health service user and carer representatives involved in any co-productive public sector work in Wales, to ensure good information flow between representatives and an overview of the whole system and how it fits together.

The model could be improved in the Local areas with access to office space, mobile phone, computer, and NHS email address to enable access through NHS library services to the peer reviewed evidence base, and to enable accessibility by other service users and carers to the reps without having to give out personal phone and email addresses. IT support to have a high profile social media presence, through which to stimulate debate and collect views, and a budget for outreach, engagement events, and project groups. A requirement for PPI budgets to be used to fund the payment of local reps when doing local business, and or central government funding for the role.

I believe this is a model that should be rolled out to other health interest groups, which would ensure a vibrant and diverse representation by people with a genuine perspective of high value in the co-productive improvement of services. This would provide a career structure, succession planning, and the potential for training of both reps and the people they work with in how to make decisions which truly reflect the radical shift in the power balance between service users, carers and the

professionals which is needed to reconnect the direct accountability relationship between service users, carers and professionals which was broken with the formation of the NHS, whilst uniting the expertise of professionals with the value systems and rights of the people they are there to advise and treat.

Biennial conferences to bring together these representatives, across all health groups to share good practice and debate challenges and how to overcome them would develop an opportunity to develop a field of expertise in service user and carer roles in co-production, in how to support, facilitate and improve co-production, and create an evidence base for the effect on outcomes and service efficiency that results from co-produced services, compared to those that are limited by just being clinically led.

It is critically important that voice mechanisms only do voice, so there is never any confusion about their role.

Co-producing Plans and Services with Citizens
I do not agree with the proposal.

In my experience mental health clinicians and managers do not understand the notion of an evidence base. I have investigated the claimed evidence base for change proposals on a number of occasions. On one of which I asked the medical director to provide the relevant references. What he gave me was a list of opinion articles and case descriptions presented by the people providing the relevant service. Hence the existence of bias could not be ruled out. On this occasion it was about the introduction of crisis teams and how it would reduce bed use. However, all the case studies cut beds when they introduced the crisis teams so that the bed use reductions were structural not consequential on the crisis team presence. In addition each case study came from very different systems with very different bed numbers to start with. In some areas the reduction was smaller, usually where bed ratios were already lower, and in all studies the initial and post introduction bed ratios were higher than in our area. So it was impossible to draw any robust conclusions.

In the current Hywel Dda consultation on transforming mental health there is a claim for an evidence base for a ‘single point of contact’. So I did a literature search on that. It turns out that the term ‘single point of contact’ is used in many different ways and never in the context described in the proposal. As before the articles are all case studies, with no before and after rigorous statistics and are not independent, but presented by the people who run the service concerned. In all cases for mental health the target population was limited in some way, whereas the Hywel Dda proposal is for the whole range of mental health from primary to secondary care. The only case study that claimed better outcomes was a social care model in North Wales, but the rigour of the statistics was poor as was the case for the claim that it was the single point of contact alone that improved outcomes. There were no independent trials or rigorous before after methodologies by independent researchers which demonstrated better outcomes. None of the articles described the staffing numbers and qualifications of single points or the costs, or compared the cost effectiveness compared with other models of service.

It is therefore crucial that any panel examining the evidence base includes service users and carers with a scientific background and ability to critically review the quality of evidence according to the Cochrane criteria. A critical issue in much research and evidence bases is that the research is not designed by service users and carers and does not reflect their values and goals, so that 'good outcomes' reflect the values of researchers and staff, and would not necessarily be seen as 'good' by service users and carers. The kinds of research questions service users and carers would ask, the way they would involve people, and the way they would analyse and categorise results are fundamentally different to the perspectives of academically and professionally based researchers. This is why it is critical to have able service users and carers on a group to evaluate studies and evidence.

This also raises the issue of further development of the evidence base doing much more in gaining service user and carer leadership, sign up, and guidance. We need the government to fund service user and carer researchers to design and do research to develop the evidence base from the service user and carer perspective as a specific discipline (like the development of feminist disciplines). Merely encouraging involvement in research led by professionals and academics is not enough.

There is a need for a radical and critical review of advice and standards on how to consult the public, and how to analyse their responses. In the Transforming Mental health consultation of Hywel Dda they claim considerable public consultation and imply the agreement of service users and carers to their proposals. They give numbers of meetings but not who the meetings were with, disguising the fact that the majority were with other stakeholders and not with service users and carers. They give no numbers for the service users and carers involved, and their consultation document also does not ask if the respondents are service users and carers – so the voice cannot be truly identified.

In addition the process was faulty and each stage progressively edited out the service user and carer voice. The initial meetings were accessible and well-attended by service users and carers. They were open meetings with plenty of notice.

However the health board then delegated the analysis and theming of the material to a researcher from the local University, who did not involve service users and carers in the analysis. Hence the emergent themes did not reflect the critical issues for us. Recently a member of staff said that the strong theme from service users and carers regarding choice of who is involved in your care, was subsumed under another heading 'because choice of staff could not be delivered'. A) this is not true, some teams are enabling choice, b) choice of care coordinator is required under the measure, and c) whether you can do it or not consultation is not consultation if you edit out the key stakeholder group's views

A large meeting was then held, with a huge number of people, very few of whom were service users and carers. The process of discussion of the themes at tables for only 20 minutes, without the material which was themed, was designed in a way that objection and change to the themes could not happen. There were very verbal individuals who talked other people out. Excluded contributors included service

users and carers who are not always able to effectively compete in such an environment. When the report back was made by facilitators, the views of service users and carers were not included. They were summarised out. There were no records kept of how many service users or carers were present at any of the events, so the claim for involvement is weak, and because their voice was not identified, it was not given the weight needed, as the louder, more numerous voices of staff, professionals, managers and voluntary sector workers dominated. For the process to be credible, numbers of service users and carers need to be monitored and their voice needs to be separately reported, so that difference in this group can be compared to other stakeholders and given appropriate weight

So the following generation of proposals was underpinned by a non-representative set of themes. Whilst service users and carers were members of the committee generating the options, there were not enough of them to replace the need to ask people more widely about what options they would want considered. Service user and carer reps on the project group commented that because they were unable to get to all meetings, decisions were made that they were not happy with. The options were complex and random, largely with the same elements, and had no rhyme or reason of what was in and what was out. So many variations of details made them incredibly difficult to evaluate and they focused too much on buildings, beds and the number of staff, and not at all on what the staff would be doing and how the service would be better and able to serve more people more effectively. Although the committee worked very hard the whole basis of the process and focus on infra-structural detail without evidence base of the levels of need or of the effectiveness of treatment was based more on what could be afforded than what could develop if the focus was changed to staff approaches, staffing models and the evolution of services based on values and goals, such as increasing access, increasing co-production, improving training, increasing effectiveness and reducing waste.

7 of these options were brought to another very large meeting, again where service users and carers were in a minority and a difficult environment. A very similar process was used, with 20 minute discussions of each option. A none of the above option was not offered, and the differences between the options were so subtle that they did not feel like real choices. Service users and carers made it very clear that they didn't like the options and stated that they did not want a proposal about buildings, and yet that is what we were given. We were promised however, that there would be a real consultation with the opportunity to say that we didn't like any of the components of the options given. But that did not happen. When the consultation arrived it said that the main components were 'givens', and those decisions had already been made.

In the options meeting there was one option which was the best of the bad lot. Most service users and carers had put that first. But when it came to summing up the facilitator said that it was unaffordable and ruled it out without registering our views. If it was not affordable, it should not have been on the table. We were edited out again. To put something on the table which is not possible is going to cause trouble, create resistance and be divisive. It would have been far better to lay out the ideas in the options and check with people whether they liked any of these ideas and if they felt it was appropriate yet to determine where and for how many hours services would be open. It would have been more helpful to have asked what people's

priorities were if everything could not be afforded. So was local more important than 24 hours, was the ratio of professional staff on wards more important than having more beds, or more wards? Would less qualified staff be acceptable if it meant more local services, or more beds? And so on.

It is crucial that a delegated proxy organisation run by local well-to-do do gooders, who are the only people who can afford to do such work without payment, who are never going to be representative of us or understand our perspective, or their paid staff, if they are not themselves from a background of extensive service use and significant periods unemployed, is not given the authority to speak on our behalf about whether a consultation has been good enough.

The rules for consultation need to be more rigorous and include the following.

1) Service users are involved from the conception of proposals – in person, not via any proxy organisation
2) Those service users directly involved are linked to government funded wider groups of service users and carers and are adequately funded to have sufficient depth and spread of engagement to inform their contributions. They will have office facilities, dedicated telephone for contact by the public, dedicated email addresses, access to on line journals free of charge, computer access, a website and appropriate social media addresses,
3) Any engagement counts the numbers of service users and carers and analyses their input separately to other stakeholders, so any differences can be identified. This counting needs to ensure that individuals who go to more than one event or engage through more than one method, are not double counted, so that we get a realistic picture of the opportunity to engage. (It has been argued that we shouldn't ask by Hywel Dda, but it is no more intrusive than asking about protected characteristics. As long as the opinions of non service users don't slip into the service user and carer replies it should be giving a good indication of that perspective)
4) Engagement processes are designed by service users and carers, with at least one month's notice of events and open access, so no barriers are created by booking processes. The consultation is divided up into sections and arrangements are available to only cover one section at a time so that it is dealt with in digestible chunks, if people prefer, so that people feel they have had enough time to consider and respond. There is never only one way to give responses – a decision is never made on the basis of a meeting or event alone - there is always a written option for people unable to deal with being in groups or crowds. Where an idea is being presented for response, it is always provided to people in advance of events, in various formats to increase accessibility.
5) Any event organised for service users and carers in a locality checks for local service user events or committees involving service users and carers before booking a date to ensure that there is no clash
6) Material from service users and carers, is analysed by service users and carers, to ensure the integrity of the message and the values coming through.
7) Consultation documents and questions are designed by service users and carers to ensure that the proposals are clear, understandable, that choices are real choices, that the questions can uncover value priorities and full information is given

about the numbers of people who would be using a service, the range of problems and severity and hence how big developments would have to be.

8) Consultations have to give a risk assessment and invite people to raise other risks.

9) Consultations must include an implementation plan, explaining the order of change, ie beds close first and then money is reinvested into the community, or (better) community services are made more effective and less wasteful, help people better so fewer beds are needed, and then only redundant beds will be closed (and we can't give the number of beds lost until we see how things work).

10) Consultations must include piloting arrangements, review arrangements and contingency plans, committing to halt change if outcomes performance or value for money deteriorates.

11) Consultations must offer references to any evidence base, and not anywhere in written documents, refer people to the internet with a symbol, as this indirectly discriminates against those disability groups less likely to have internet access and the ability to track down documents. Any references in documents to material on the internet must give the full address of the referred document – and where the individual can easily get a hard copy.

12) No consultation is presented as the decision already having been made – ever. Ie, there are no givens. All significant changes to services must be open to being overturned by the public.

13) Consultations never tell people what to think. (In each section of the Hywel Dda consultation there is a part titled 'what to think'. This is leading and inappropriate)

14) No consultation ever takes place between June and September – in the month of December, or over Easter, as people are struggling with the holiday period, child care, family visits, support workers on holiday and so forth. This is an equality impact issue which indirectly discriminates against those with child care responsibilities or those with disabilities who rely on them.

15) Any consultation over a holiday has to be extended to compensate, so that 12 weeks outside of holidays are always given.

16) Any consultation event has to create a written record of all contributions, which need to all be reflected in final reports. The possibility of audio recording needs to be considered for fidelity of records.

17) Information about consultations and communication plans to ensure people know about it and have the opportunity to respond, are planned with service users and carers to ensure that the documents, posters and information are placed in the key places where affected service users and carers are most likely to see them. Consultations are never limited to internet presence only. The public don't visit the public health website or the CHC website, or the government website to check if there is a consultation. They generally hear through word of mouth and networks, or through active promotion and availability and visibility of documents and events.

18) When considering the quality of engagement, it is necessary to look at numbers of service users and carers engaged, range of methods of engagement, notice given and accessibility of events – (eg on the public transport network???) publicity and access to consultation documents and opportunities to engage, as well as methods of analysis, field work to check with service users and carers to see if they feel their views have been recorded accurately and taken into account, and to ensure that the ethics, the competing values and choices for service users and carers are fairly balanced with the risk aversion of organisations, to ensure that the

principle of autonomy of service users to determine the risks they wish to take, is always respected. It is not the job of health boards or staff to impose their own levels of risk aversion, or preferences for outcomes on the people who use their services.

19) At the stage when a decision is dead locked any expert panel needs to be equally balanced with professional experts and experts by experience and have an independent chair. The panel must give equal weight to professional values and technical evidence and to service user values and evidence of experience and be skilled at recognising where technical issues are smoke screening attempts by professionals to impose their own values. The panel must be able to review evidence from all sides with equal weight and be able to assess the views about the quality of the evidence base from professionals and non –professionals by referring to a non-clinical science academic for evaluation of the quality of the studies done.

At the point of deciding whether proposals are evidence based it is critical that service users and carers are involved in reviewing and evaluating the evidence base. To not trust and support patient voice to evaluate and debate the evidence is patronising and not co-productive. There are always different ways to interpret research results and different conclusions to be drawn from studies. It is essential that there is a real dialogue about the evidence with equal input from service user and carers. The current process and the one you are describing is absolutely leaning in favour of services and minimising the possibility of true co-production, in an extremely frustrating way.

It is essential to recognise that dead-locks are not co-productively resolved by focusing only on clinical issues, nor can you rely on expert clinicians to necessarily be good at the evaluation of the evidence base. Too often the views of expert panels refer to the recommendations of Royal Colleges based not on research but on opinions of working groups who place a very high value on their own work and opinions.

Whatever you do on this you need an expert group of service users and carers who have never been health professionals, have a great deal of experience of using services, have experienced the range of good and bad in services, and have significant access problems due to poverty, disability, culture, or caring which throw light on equality impact and access issues, to co-design a process for service user voice, which does not use proxy, is sufficiently resourced, which values the input of service users and carers fairly, and which is not led by privileged and non-representative individuals. Any organisation needs to be designed by them, preferably to provide mechanisms for identification and development of talented service users and carers available to take key roles in co-production, fair methods of recruitment based on talent and committee performance (with opportunities for developing that performance so new people can come on board), access to resources to support representatives and ensure they are equipped to be effective, and to support them in their roles, and ensure back up positions or alternates so that the voice is never lost. In addition you need to ensure there is no exploitation of service users and carers in co-production beyond their own care, and that whatever work they do, they are offered the same level of payment for that work, as other people around the same table.

I have come across many individuals and organisations who claim to be experts in service user and carer, or citizen engagement, who have no experience of being dependent on services or of being excluded due to the additional challenges of their lives, and the quality of their work has always demonstrated their ignorance, and failed to be a beacon of excellence. There is an organisation that professes expertise in this area, but it has no citizens/service users or carers on its board, or on its staff. So it is not walking it's talk. A lot of people from a back-ground of community development think they are experts in co-production because they run meetings. However, the real experts are those who sit on committees and working groups, who are actively engaged in projects and workstreams, and who have spent many years trying to engage meaningfully as a service user or carer, with services to bring improvement. Co-production needs to be the exclusive domain of service users and carers, with involvement of community workers to provide support or co-lead to provide choice, but never to lead on or design co-production instead of it being led by service users and carers.

I cannot make this point strongly enough, service users and carers come from all walks of life, and many are extremely talented. It is both extremely patronising, excluding and frustrating to have our voice silenced by delivery by proxy. Because that is what proxy means. We are perfectly capable of speaking for ourselves and of being extremely effective at doing so. No one who has not had these experiences can possibly understand and convey our perspective. And people who are also professionals have a different perspective again. If you are both service user and professional you have privileged information which makes your engagement with services very different because you understand exactly what you are dealing with and how the system works. You are also on the same values wave-length as other staff, which is not the case for service users and carers who do not have a professional background. It is critically important that there is no repeat of the CHC or anything else remotely like it.

Inspection and Regulation and single body

I agree that HIW needs to be re-imagined, and their role extended. I do not agree with integration with CSSIW, as I think this would be cumbersome and unwieldy and lead to organisational stresses likely to make a combined organisation less effective.

Joint working is already happening and improving this is always going to be helpful. This does not necessarily require legislation.

The critical thing for regulation and inspection in health care is a) more authority to require health board accountability, so that the recommendations of the inspectorate carry real weight, and health boards must comply, and b) a remit to follow up on complaints relating to a health board not operationalising a key policy, such as the complaints process. This would mean that the HIW would have a complaints appeal role where a complaint relates to the operation of a policy, complementing the ombudsmans role which only goes as far as ensuring that a policy exists.

It would help for services such as the mental health service to be inspected separately, and for the inspection priorities to be informed by the pattern of complaints in the area.

I am fundamentally opposed to an inspection and voice organisation in one.

Whilst inspection needs to improve in the use of voice in it's own governance and processes, it is not the right vehicle for patient's voice.

Patients' voice must be completely independent of government, and of any government organisation such as an inspectorate.

Confusion and conflict of roles is one of the problems of the current CHC. To create another organisation with multiple roles will only confuse the public more. The voice needs to be clearly and singularly focused just on ensuring the users of services, their carers and families get heard, with no other ancillary roles.

I do believe that both inspectorates should be independent of government and have their own governance boards with paid service user and carer members on each.

Service user and carer stakeholder groups feeding into the inspectorate, is not robust enough on its own. Service users and carers need to be integral to organisational scrutiny arrangements alongside other key stakeholders. It is critical that there is service user and carer committee and board membership and that it is long enough to ensure competence and performance, and hence at least 3 years and potentially longer.

There needs to be a career structure and fair pay for service users and carers in co-production in order to reward and value their dedication. It is not OK to have someone work their soul out for 3 years getting good at what they do and then throw them on the scrap heap. The glass ceiling for service user and carer progression, to more responsible board and committee roles needs to be looked at. It is very hard for them to work to their potential when the gateways are only open to the privileged who have had access to high level career opportunities, which people with poor health very rarely have access to if they cannot work full time. They have few opportunities to prove their worth. This requires a change to recruitment so that it is not based on paid work history, but only on the assessment of skills and experience in the committee environment alone.

A service user and carer engagement commissioner, who hears service user and carer concerns about engagement processes and does research to investigate involvement and co-production experience, expose bad practice and promote good practice, including co-production in people's own care, and also being someone to whom service users and carers can turn when they feel they are not being heard, or organisations are not meeting their obligations for co-production, especially where this is compromising their welfare, would be a far better model, alongside an autonomous service user and carer led voice organisation that ensures the voice is never silenced by proxy and is always 100% genuine, credible with other service users and carers and relevant to the work being done. An autonomous service user and carer led organisation would be looking at the evidence base for engagement and co-production which is constantly growing, and work to develop and constantly improve standards of engagement. We would be seeking to grow talent and a network of people who want to be involved, seeking always to maximise outreach

and assess the best ways and places to promote opportunities to be heard and to contribute. We would be looking at developing training programmes for managers, policy makers and senior clinicians in the principles of co-production and the latest best practice, as well as constantly updating quality standards for consultation processes and managing and enabling service user and carer voices on committees and boards.

There would be no retired, ex-professional board members, or the great and the good. But only people with genuine hard experiences of life as a result of long term health difficulties or caring for others who have

WGWPMB218: The Royal College of Surgeons
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General Comments

The Royal College of Surgeons (RCS) welcomes the Welsh Government's White Paper consultation on 'Services Fit for the Future'.

- There is a pressing need to address some of the serious challenges facing our hospitals in Wales, such as improving waiting times and access to surgery.
- There is a need to elevate the professional and clinical agenda within the decision-making process in health boards and we would welcome any steps to strengthen the patient voice in the Welsh NHS.
- It is important that appropriate legislation regarding a Duty of Candour is introduced as soon as possible to bring Wales in line with England and Scotland. We would be happy to discuss the College's relevant guidance and experiences of the introduction of legislation in England in further detail.
- We would welcome a more consistent level of care between health and social care. Welsh Government and Health Boards should work closely with medical royal colleges such as the Royal College of Surgeons, to ensure that high standards of care are met.
- We welcome any steps to improve the pace of clinically led service change. Royal colleges have an important role to play in supporting substantial service change decisions in Wales.
- We support any steps to strengthen the regulatory remit and independence of HIW as the independent inspectorate and regulator of all health care in Wales. This includes the idea of a new body to provide more independence in regulation and inspection and citizen voice.

The Royal College of Surgeons (RCS) welcomes the publication of the White Paper consultation on 'Services Fit for the Future'. Outlined in the response below is our position on a number of areas in the consultation document.

It is worth noting the pressing need to address the serious challenges facing our hospitals in Wales and the number of areas which remain in urgent consideration by Welsh Government and NHS Wales.

For example, improving waiting times and access to surgery in Wales are in need of immediate attention. Waiting times for some types of surgery in Wales are too high and the problem is particularly acute in certain parts of Wales. Freedom of Information requests of waiting times data in Wales made by the Royal College of Surgeons have found that in March 2017 the number of patients waiting more than a year for surgical treatment was 3,605 – a rise of over 400% in four years. In March 2013, 699 patients were waiting more than a year for treatment. The data also showed that Betsi Cadwaladr University Health Board and Abertawe Bro Morgannwg University Health Board have seen the greatest increases in patients having to wait longer than 52 weeks to receive treatment ('Wales sees over 400% increase in patients waiting more than a year for surgery,' The Royal College of Surgeons, 30

August 2016, https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/wales-52-week-waits/).

Our view is that it is important to retain focus in ensuring that Welsh patients have timely access to the care they need and that NHS Wales and Welsh Government give renewed focus to policies that will help decrease waiting times and ensure that elective activity is maintained throughout the year.

Response to Specific Questions

Board Membership and Composition
Representing the Citizen in Health and Social Care
The College believes there needs to be greater collaboration between clinical and managerial leaders in the NHS in Wales. There has sometimes been an historical culture of financial priority in decision-making within health boards although the move to a three-year financial planning cycle has helped 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 would welcome any steps to strengthen the patient voice within the Welsh NHS. For example, we believe lay or patient representation should be sought at all levels of the NHS, especially on NHS Health 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.

Duty of Candour
In England, regulations relating to a statutory Duty of Candour were implemented in April 2015. In Scotland, legislation relating to a Duty of Candour was given Royal Assent in April 2016, with an implementation date of 1 April 2018. (http://www.gov.scot/Topics/Health/Policy/Duty-of-Candour)

Our view is that it is now important that appropriate legislation is introduced as soon as possible to bring Wales in line with England and Scotland.

The Dalton/Williams review (https://www.rcseng.ac.uk/about-the-rcs/government-relations-and-consultation/duty-of-candour-review/), stressed the importance of organisational commitment to a culture of safety that understands the inevitability of harm even as it tries to do all it can to avoid it. Medical care is not risk free, and so the aim should not be to eliminate harm completely, but to provide swift, thoughtful and practical response when harm does occur.

The effective application of a duty of candour should not just be a matter of compliance to legislation and regulatory guidance. It can only be part of a wider commitment to safety, learning and improvement.

Leadership is vital for the implementation of the duty of candour. It is essential to have consistent and visible commitment at all levels in the organisation, including at board level, and to support a culture of transparency and safety.

Organisations should actively promote an open and fair environment that encourages the reporting of safety incidents, fosters peer support and discourages the attribution of blame.

Candour also allows the public to understand why decisions have been made, encouraging patients to be involved in their care. Openness and transparency needs to be led from the top of the organisation to engender real culture change and drive professionalism in the NHS.

To help achieve a cultural change of greater openness in the NHS it is essential that any duty of candour enables and encourages doctors and nurses to be open and candid in their own conversations with colleagues and patients. There needs to be greater clarity in how any new duty will be introduced and we would expect to see the NHS in Wales and its Health Boards explaining and educating staff on what the new duty means for their everyday practice. Surgery is reliant on the work of multidisciplinary teams and thought should also be given to how a new duty will encourage and support learning from situations where harm has occurred.

All doctors have a professional, moral and ethical duty to be open and honest with patients at all times. It is the responsibility of the clinical team - led by the most senior clinician involved - to make a judgment about disclosure, which should be personalised according to the needs of the individual patient. The College regards the quality and manner of this disclosure with patients to be a critically important aspect of clinical practice.

The College's guidance, 'Good Surgical Practice' (http://www.rcseng.ac.uk/associates/docs/gsp2008) , (patient communication, section 4.4) states that surgeons must:

- fully inform the patient and their supporter of progress during treatment;
- explain any complications of treatment as they occur and explain the possible solutions; and
- act immediately when patients have suffered harm and apologise when appropriate.

We would expect Health Boards to set up a system to support staff to manage the implementation of any new Duty of Candour, but most importantly, to educate staff meet their individual and organisational duties within that system. Alongside this it is also important that all healthcare staff are aware that non-reporting has significant consequences, but that these can be avoided through full and open disclosure. Only in doing so will a true culture of candour to be brought into the NHS.

Following the implementation of legislation in England, the College published 'Duty of Candour Guidance for Surgeons and Employers'(https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/duty-of-candour/) in 2015. This best practice guide provides a helpful resource for healthcare staff on how to implement the principles of Duty of Candour in everyday practice.
Our document, (https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/duty-of-candour/) outlines the 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. It reflects the profession's commitment towards creating greater openness and transparency in the NHS.

We have also developed a "Duty of Candour" e-learning module, (http://vle.rcseng.ac.uk/course/view.php?id=321) which is available to surgeons and other healthcare staff to use to reflect on and improve their practice in this critical area for high quality patient care.

We would be happy to discuss our guidance and our experiences of the introduction of legislation in England with Welsh Government in further detail as these proposals are finalised.

Setting and Meeting Common Standards
We would welcome any move that encourages a more consistent level of care between health and social care and would therefore support the introduction of a common set of high-level standards applied to health and social care and regardless of the location of care.

In particular, we believe that Welsh Government and Health Boards should work closely with medical royal colleges such as the Royal College of Surgeons, to ensure that high standards of care are met. For example, our service standards and good practice guides, such as 'Good Medical Practice', (https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/good-medical-practice/) offer support to both surgeons working in the Welsh NHS with matters of their daily working practice and Welsh Government and Health Boards in the design and delivery of high quality surgical services.

It is also worth noting that we believe that an equal focus on patient safety and the same high standards of care and should apply to both the private and NHS sectors. In particular, there is poorer availability of patient safety and clinical data from private hospitals. The private sector should report similar patient safety data to the NHS as well as improve participation in clinical audits. (https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/surgeons-call-for-review-of-private-sector-transparency-and-safety-standards/)

Our view is that greater transparency in the health service in Wales would improve governance, drive up performance, and allow us to make judgements about the quality of patient care in Wales. The improvement of data collection and publication is one important area that can contribute to this.

As with many parts of the NHS across the UK, data collection in Wales has been historically poor, particularly for outcomes data. There are a variety of reasons for this, but in Wales outcomes and recording activity in particular have historically not been well resourced. This is recognised by the Welsh Government. The current structures in Wales mean there is not the same imperative for organisations to collect data as there has been in England where 'payment by results' and tariffs for procedures require hospitals to record their activity in order to be paid. While this might not necessarily be the right approach in Wales, we would like to see greater focus on the collection and management of data in Wales in order to focus the NHS on improving outcomes for patients.

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 Government on this.

Duty of Quality for the Population of Wales
Co-producing Plans and Services with Citizens
Our view is that any steps to improve the pace of clinically led service change in Wales are to be welcomed. We would also welcome a more transparent and evidence based process and believe that medical royal colleges have an important role to play in supporting substantial service change decisions in Wales. We would welcome a discussion with Welsh Government about how we might be able to offer more support in making the case for change where there is the potential for clinical benefit to patients.
Our position for some time has been that the configuration of services in Wales still does not make clinical sense in many places and Welsh Government have commendably made this a priority. Centralising complex services can save lives and make services more sustainable by concentrating expertise onto fewer sites. In addition, the recruitment and retention of staff has a major impact on the future configuration of services, particularly for acute services.

We believe there are a number of areas in Wales where clinically necessary service change is urgently required including emergency surgery, vascular surgery and thoracic surgery, to address the sustainability of the current pattern of acute hospitals. One of the major pressures driving the need for change is insufficient numbers of doctors to staff acute surgical services in all of our hospitals. Every Health Board has been proactive in recruiting both at home and abroad and yet every Health Board has to cope with 'rota gaps' which are detrimental to the moral of the medical staff, expensive because of the chronic requirement for locum cover and less than ideal for patient care.

Concentrating staff on fewer acute sites would reduce the need for locum cover, making the service sustainable and improving care. However, we recognise that this would be potentially unpopular and politically sensitive. Rapid progress needs to be made in training and developing clinicians that are not medically qualified, (the extended surgical team including Surgical Care Practitioners, Advanced Nurse

Practitioners and Physicians Assistants), if the reduction in acute sites is to be kept to a minimum.
However, progress on service changes has been too slow, often hindered by a lack of local will and politicians campaigning against clinically necessary service change. Political leaders need to spend as much time engaging with the clinical case for change as listening to public concerns.

In some cases, there has not been enough joined-up working between different health boards. With this in mind, we welcome the proposal for an enhanced duty of quality to facilitate collaborative, regional and all-Wales solutions to service design and delivery. For some time we have been calling for Health Boards to be required to collaborate on their planning and cooperate on the provision of services across health board boundaries.

We also recognise the important role that surgeons have to play in championing service change and the difficulties when individual or groups of surgeons oppose changes. There is evidence from Ipsos Mori that the public trust doctors and nurses more on communicating service changes, than managers or politicians (https://www.ipsos-mori.com/Assets/Docs/Publications/Mumsnet-trust-report-FINAL.pdf). Despite the personal or professional challenges it might pose, it is essential that clinicians provide leadership in the drive to provide the best service for patients. We recognise the role the College has to play in this regard.

When decisions on major service reconfiguration are eventually made, for example with the location of the major trauma centre in South Wales, it is important that appropriate funding is also made available. This is both in terms of capital expenditure to enable new facilities to be established but also ensuring that sufficient funding is made available to meet increasing patient demand.

Separating elective care from emergency pressures through the use of dedicated beds, theatres and staff can if well planned, resourced and managed reduce cancellations, achieve a more predictable workflow, provide excellent training opportunities, increase senior supervision of complex/emergency cases, and therefore improve the quality of care delivered to patients (https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/emergency--elective.pdf).

Inspection and Regulation and single body
Those on the frontline of the NHS ultimately drive up the quality of surgical care. Nevertheless, regulation can help to ensure minimum standards of care are met. We would welcome any steps to strengthen the regulatory remit and independence of HIW as the independent inspectorate and regulator of all health care in Wales. This includes the idea of a new body to provide more independence in regulation and inspection and citizen voice.

While we welcome HIW's steps to introduce a draft surgical inspection regime, we remain of the view that there are significant shortcomings in HIW's approach which need to be addressed. While it is important that any inspection service provides value for money, and The King's Fund have questioned the role regulation plays in

raising standards (https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/reforming-the-nhs-from-within-kingsfund-jun14.pdf), there needs to be a much clearer system of inspection and we believe HIW could play an important role in providing external challenge which is lacking in the health service in Wales. This should continue to include specialist clinical leads in inspection teams and the need to incorporate third party intelligence and data. In England the CQC is moving towards a more data-driven approach to monitoring and identifying problems in the NHS and there may be lessons for HIW here.

HIW's budget is significant lower than other inspection bodies in Wales at £3.4m in 2015/2016 (http://hiw.org.uk/docs/hiw/reports/160727annualreporten.pdf). For example, the education regulator, Estyn, received a total revenue of £11.7m in 2014-2015 (https://www.estyn.gov.wales/faq) and Care and Social Services Inspectorate Wales will receive £13.9 in 2016/2017 (http://cssiw.org.uk/docs/cssiw/general/160824businessplanen.pdf). These severe budgetary constraints result in serious shortcomings for HIW's manpower and resourcing and we believe is an area which should be given urgent consideration.

WGWPMB220: Unison Cymru/ Wales
Location: Cardiff

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
UNISON supports consistency across Wales. Shared key principles across healthcare in Wales would be a benefit. However, there is no point in consistency unless it is of a benefit through proper shared working and cooperation.

What further issues would you want us to take into account in firming up these proposals?
Processes need to be implemented to ensure both good practice and lessons learned can be shared across Health Boards and Trusts.

We support the Vice-Chair position but the Chair and Vice-Chair should not come from the same pool/element of the committee. So, for example, it would not be appropriate for both positions to be filled by executive members.

The positions of Chair and Vice-Chair also provide an opportunity to ensure diversity within the leadership of the committee.

Board Secretary
Do you agree with these proposals?
UNISON supports this principle.

What further issues would you want us to take into account in firming up these proposals?
There will be wider issues of collaboration that will need to be addressed in the long term, including the different culture and employment conditions across health and local government. There is a very real danger of a two-tier workforce.

We have already seen employer failures in addressing these concerns from the outset. Occupational therapists employed by Swansea council received a settlement of thousands of pounds after the authority acknowledged UNISON was correct to insist the therapists were significantly underpaid when compared to NHS peers. The council therapists were working directly alongside NHS therapists and were performing the same duties but were being paid £4,600 less.

Prior to the decision to address the inequity, there was unanimous vote for strike action amongst the therapists. The current rate of pay is now equivalent to the top point of Band 6 of the NHS pay scale. The council recognised that lower pay may have deterred potential applicants from looking for occupational therapist work with them.
The council therapists will receive a pay settlement to address the discrepancy.
As collaboration develops, which we hope it will, we are likely to see more of these types of cases.

Furthermore, collaborative working and integration within public services has been a long-term aim of the Welsh Government. There are examples of good practice, however, overall the progress of the agenda has been limited and there has been significant resistance from decision-makers within public services. This resistance must be addressed.

Legislation by itself will no overcome these challenges. There needs to be a concerted effort to address the cultural differences between organisations and the difficulties these present.

Duty of Quality for the Population of Wales

Do you agree with these proposals?

UNISON supports this principle.

What further issues would you want us to take into account in firming up these proposals?

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Legislation by itself will no overcome these challenges. There needs to be a concerted effort to address the cultural differences between organisations and the difficulties these present.

Duty of Candour

Do you support this proposal?
UNISON supports this in principle.

What further issues would you want us to take into account in firming up this proposal?
Social care services are largely privatised and therefore extremely fragmented. Naturally this will present a challenge when applying common standards across the social care system.

This reinforces UNISON's calls to bring social care services back under democratically accountable public control.

External providers are often contingent upon local authority funding and the recent funding cuts as a result of austerity have also made it difficult to ensure standards are upheld.

The Welsh Government commissioned paper, "Factors which affect the recruitment and retention of domiciliary care workers", lists some of the barriers which prevent a high level of standard being applied.

Again, UNISON believes these issues can be alleviated by ensuring trade union access to the workforce and ensuring the workforce play a key role in discussions about the future of the workforce. Indeed, the ethos of partnership working should be part of the procurement criteria where services have been privatised. 'the Welsh Way' is hailed by politicians and unions alike, when describing good industrial relations, these can only be maintained if all employers have the same commitment to looking after their workforce as well as consulting them as partners.

More widely, the common standards approach should include the ability for staff and trade unions to make complaints as well as families.

Furthermore, common standards should be accompanied with common terms and conditions, and pay, irrespective of where a carer works.

Setting and Meeting Common Standards
Do you support this proposal?
UNISON supports this in principle.
What further issues would you want us to take into account in firming up this proposal?

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Furthermore, common standards should be accompanied with common terms and conditions, and pay, irrespective of where a carer works.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

There would need to be a Service Level Agreement in place, so that employers set out an easily understood and accessible complaints process. The process needs to be transparent and a commitment from the employer would be needed to ensure that time is available to conduct investigations and complaints processes within a reasonable time frame.

This would need an agreed process inclusive of both employers.

What further issues would you want us to take into account in firming up this proposal?

The fragmented nature of the social care system means there is a huge variety of organisations operating within the sector, ranging from large UK wide providers to very small localised providers.

Many providers lack HR departments and experience high staff turnover rates.

These problems would present a barrier to ensuring organisations work together to investigate complaints.

The chaotic nature of the social care system would conspire against these ambitions.

UNISON calls for these services to be brought back under the direct control of local authorities as a means to support the aims of the Welsh Government’s proposal.

Representing the Citizen in Health and Social Care

Can you see any practical difficulties with these suggestions?

Clearly there will be some social care recipients who will be unable to participate in any of these groups, for example, people with severe levels of dementia.

UNISON has also observed that many recipients of social care services are scared of raising concerns or complaints for fear of the service being taken away from them.

Similar problems apply to the care workforce who are often scared to raise concerns.

Despite this, UNISON is supportive of ensuring the voices of services users and the workforce are heard.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

UNISON agrees that an independent review of all change processes is desirable, in the same way as applying an equalities impact assessment allows time and space for users and their families to be consulted and considered.

What further issues would you want us to take into account in firming up this proposal?

The Trade Unions should be allocated time in work to consider all such proposals properly, with their members, and then engage in meaningful consultation discussions.

Inspection and Regulation and single body

What do you think of this proposal?

UNISON agrees.

Are there any specific issues you would want us to take into account in developing these proposals further?

There are a number of new organisations in the Social Care field, and any changes document should also include a list of all bodies in Wales and how they fit together.. This needs to be more widely understood, so should be an appendix in all guidelines.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

UNISON believes that all policies should be accountable to the elected government. The creation of separate more independent bodies, weakens the accountability chain to the electorate. We would like to see any such proposals include accountability and more information before we can comment further on this point.

Would you support such an idea?

Not without more detail.

What issues should we take into account if this idea were to be developed further?

Accountability
Transparency of health and social care provision, and keeping the public informed.

More bodies with part of the responsibility confuses people and can be a barrier to accessing quality care.

WGWPMB221: Powys County Council Adult Social Care
Location: Powys

Response to Specific Questions

Board Membership and Composition
What further issues would you want us to take into account in firming up these proposals?
Too inward looking to the Health Boards and no mention of the statutory roles of partnership groups such as the Public Service Boards and Regional Partnership Boards and how HB's can and should provide leadership as well as draw on the cross sector expertise to help drive integrated strategy and delivery on a 'whole system' basis.

LA / joint scrutiny is another way of engaging and providing challenge to areas of joint interest and LA's and HB's should work together to support each other in relation to scrutiny.

Board Secretary
What further issues would you want us to take into account in firming up these proposals?
The role of the Board Secretary could be developed in partnership / jointly for efficiency purposes. For example LA's have a Monitoring Officer could this role not be built on – does every single HB need its own secretary or could they be developed regionally with a small support team.

Duty of Quality for the Population of Wales
What further issues would you want us to take into account in firming up these proposals?
The infrastructure and process is there via the Population and Wellbeing Assessment – we have had limited success in engaging health colleagues in these processes so would welcome legislative change that would ensure compliance. However, the legislation should make it very clear that these processes are the methodology and that resources should be pooled and aligned to deliver to reduce duplicity and keep a single focus.

Along with the legislation there will be resource implications around training and development (including college and universities) in respect of good leadership and accountability.

Setting and Meeting Common Standards
Do you support this proposal?
Yes

What further issues would you want us to take into account in firming up this proposal?

This is to be welcomed – the single most influential thing that helped with the integration of children's services in England was an integrated inspection regime. It prompts organisations to look outward, work in partnership and draw on external expertise to challenge, scrutinise design and delivery of innovative solutions to meting need.

It will not be easy but could be phased and the first place to start would be prevention and early help where the combination of interventions and any standards adopted would help reduce down the impact of higher cost services – addressing loneliness and isolation is a really good example.

However, the caveat will be the tensions between of social model and medical model of health and additional need. This will also need to be addressed through training and development for staff on all sides.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

Yes

What further issues would you want us to take into account in firming up this proposal?

Again to be welcomed – we already have such an approach in child/adult practice reviews– tracking back and identifying the failure demand or not intervening soon enough to prevent escalation is an essential part of 'Candour' and open learning.

Joint or pooled resources to support such an approach will be essential.

Representing the Citizen in Health and Social Care

Can you see any practical difficulties with these suggestions?

We already have Town and Community Councils who on the whole have a more localised focus. We need to work collectively to build their capacity and understanding about the integrated needs of their population.

They are already beginning to take a more proactive approach to delivering and or supporting local services (locally in Powys in relation to social care), and taking an interest in the interface with Health (particularly around preventing and early help).

Integrating the resources of One Voice Wales and CHC's to create a single entity that build's capacity and helps Town and Community Council's to work to make their citizen's voice heard.

This would link to a community focused approach – something we have been discussing in Powys for some years – this could lead to local area plans on a lower level scale that authority wide, and would inevitably support other statutory planning elements of the Wellbeing Planning regime and the Regional Partnership Board Area Plan.

This would begin to create a truly whole system approach.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes

Inspection and Regulation and single body
What do you think of this proposal?
We agree with this approach and would welcome movement on this.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Would you support such an idea?
Yes

What issues should we take into account if this idea were to be developed further?
It is particularly pertinent in respect of adults and older people. Let's reduce down cost and again duplicity.

Not sure about how it would work for children because the better alignment is to include education, health and social care.

WGWPMB222: TLC Nursing & Homecare Plus Ltd, Domiciliary Care Association Wales
Location: Wrexham

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Mostly

What further issues would you want us to take into account in firming up these proposals?
I agree that the boards should have common core key principles. I dont feel qualified to advise on the make up of the Trust Board but feel that if theChief Execs are under performing then the Ministers should have the power to replace them.

I am confused by the use of the word 'probably', either they should include common key positions or they should not. Probably is neither one or the other.

Board Secretary
Do you agree with these proposals?
Partly

What further issues would you want us to take into account in firming up these proposals?
A Board Secretary independent of whom? If they were Independent sho sould appoint them and who would they be accountable to?

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Mostly

What further issues would you want us to take into account in firming up these proposals?
At present we do not have an integrated system. I agree with this point otherwise.

Duty of Candour
Do you support this proposal?
Agree

Setting and Meeting Common Standards
Do you support this proposal?
Agree

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Partly

What further issues would you want us to take into account in firming up this proposal?
This depends on how well integration is achieved. If integration is only partial then complaints could fall between the two services with health saying this is not our problem it is a Social Services issue and vice versa. This will have the effect of making it more difficult for people to get a resolution to their complaints.

Representing the Citizen in Health and Social Care
Do you support this proposal?
Not really

Can you see any practical difficulties with these suggestions?
So why change CHCs, why not give them the necessary powers. Surely it would be more cost effective to do this than to scrap what is already in existence and replace it with something completely new.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Unclear

What further issues would you want us to take into account in firming up this proposal?
Again why can the 'citizen voice body' not be the one currently in existence. What would the independent mechanism be?

Inspection and Regulation and single body
Are there any specific issues you would want us to take into account in developing these proposals further?
If a single body is to be created it should be instead of not as well as HIW and CSSIW. We do not need an extra strata of administrators with the associated costs that would bring.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
What issues should we take into account if this idea were to be developed further?
Again if it were instead of the existing bodies not as well as.

WGWPMB223: Royal National Institute for the Blind
Location: Cardiff

General Comments

RNIB Cymru welcomes the Welsh Government's aim to develop proposals which focus on the principles of enabling and empowering organisations, staff and citizens. In particular, it looks at ways of unlocking the potential of local health boards to demonstrate that they govern and behave strategically and that quality is at the heart of all they do.

We recognise that the document sets out the systems proposed to support cooperation and governance in Wales; we also see this consultation as a means of supporting 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.

Response to Specific Questions

Board Membership and Composition

Do you agree with these proposals?

We fully support the fundamental core principles that care be delivered to in partnership within a strong governance framework to enable the board to work effectively to deliver person centred care.

We also support the need for NHS trust boards to have a vice chairman to allow for consistency and to improve transparency.

Whilst we accept that there needs to be a mechanism to allow Welsh Government the authority to appoint additional board members if required, to ensure that those areas which may have problems have access to the requisite skills and expertise, this should not be at the expense of independent members, whose local knowledge, experience and skills should be nurtured and developed, to allow an effective 'local' voice to the working of the board.

RNIB Cymru is aware that there is a mixed picture across Wales of how the Partnership Boards embrace and support independent members, although we believe that much more can be done to encourage those with disability to participate in the process.

We would support the recommendations of the Williams Commission (1) 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.

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.

What further issues would you want us to take into account in firming up these proposals?
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 (2) 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.

Board Secretary
Do you agree with these proposals?
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 processes adopted should empower and enthuse the participation of community representatives with their local health board.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
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.

Duty of Candour

Do you support this proposal?

What further issues would you want us to take into account in firming up this proposal?

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.

Setting and Meeting Common Standards

Do you support this proposal?

The Ruth Marks’ review of Health Inspectorate Wales (HIW)(3) 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 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 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.

Joint Investigation of Health and Social Care Complaints

Do you support this proposal?

We would support this proposal if it ensures that the patient voice is heard throughout the process.

If a joint approach is adopted it should be in conjunction with access to independent advocacy for citizens.

Representing the Citizen in Health and Social Care

Do you support this proposal?

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 or any other body 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.

RNIB Cymru supports the recommendations stemming from Professors Marcus Longley's review of Community Health Councils in Wales (4) 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 the current structures 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.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

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.

We believe that Welsh Government has a great opportunity to enshrine the role of the third sector in engaging communities either through the community health councils (CHC)/new national body 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 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.

Inspection and Regulation and single body

What do you think of this proposal?

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.

Are there any specific issues you would want us to take into account in developing these proposals further?

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.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

WGWPMB224: Royal College of Physicians
Location: Cardiff

General Comments

The Royal College of Physicians welcomes the opportunity to respond to this consultation on quality and governance in health and care in Wales. We have worked with consultants, trainee doctors and members of our patient carer network in Wales to produce this feedback, and we would be happy to organise further evidence if that would be helpful.

The RCP also responded to the earlier consultation on the 'Our Health, Our Health Service' green paper which formed the basis to many of the proposals contained in the 'Services Fit For the Future' white paper. In forming our responses to both of these consultations we have focused on the areas which align with the remit and expertise of the Royal College of Physicians.

We have also fed in to the Parliamentary Review of Health and Social Care and hope that the recommendations of that review will strongly impact on proposals for reforming quality and governance, as this consultation has committed to.

1. Measures to promote effective governance

We feel the proposals and core principles set out to promote effective governance could better include both the citizen voice and the leadership skills of the medical workforce. The RCP is fully behind the principle of co-production and breaking down barriers between professionals and those who use services, and recognising the skills and perspective patients and carers can bring to service change where they are empowered to do so. We also believe that leadership from within the medical workforce is a powerful force for quality improvement, and would recommend structural and cultural changes that facilitate this.

There are many cases in which legislation alone will not be enough to deliver large scale cultural change, and supporting innovation and best practice among the medical workforce should go hand in hand with Parliamentary review of health and social care governance reform. Doctors and other healthcare professionals from all parts of the NHS must be empowered to plan services collaboratively at every level – locally, regionally and nationally.

The RCP are also keen for more clarity around how associate membership of boards would address citizen representation, and how this would fit around other proposals focused on the citizen voice. We would support the creation of a job description for the board secretary.

Alongside promoting the role of clinical leadership in health board structure, Welsh Government and health boards should:

> Promote informed public debate on local health service redesign, nationally and locally. Government and the health sector as a whole have a real responsibility to support clinically led, evidence-based change that will deliver better care for patients. Health boards and the Welsh Government must ensure that change is genuinely led

by patients and clinicians, and not presented as a ‘done deal’ at a late stage in the planning process.
> Establish a national programme for sharing good practice. The Welsh Government must support new networks for sharing good practice across the system. This will improve patient care, increase efficiency and support informed local variation. One example is the RCP Future Hospital Partners’ Network, which aims to link together healthcare professionals across the UK in order to promote collaboration and innovative practice.
> Promote clinical leadership and clinically led quality improvement projects. The next Welsh Government should provide public and financial support for professionally led quality improvement projects and leadership work. Such schemes drive up quality and have the potential to transform the NHS in Wales.

2. Duties for health and social care which promote cultural change
The RCP agree that updating the duty of quality to better align it with recent legislation – the Well-being of Future Generations Act and the Social Services and Well-being Act – could be a mechanism for driving up quality, particularly in ensuring that specialist services which are not available widely are delivering adequately beyond their local boundaries. We would also support the strengthening of public health and prevention within the duty of quality.

Openness and transparency are values which the public should expect across health and social care, to consistent standards. 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. As we stated in our response to the original green paper, 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. This should cover all health and social care services.

3. Common processes to underpin person-centred health and care
A clear definition of person-centred care is needed which much be consistent throughout legislation and programmes for change. Change must be patient centred, clinically led and evidence based, and must not be about cutting costs. Reconfiguration should be based on the Future Hospital model of care, in which care comes to the patient and is coordinated around their needs.

Setting and meeting common standards
We would support the creation of 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, and we agree that disjointed standards across different providers can cause confusion for those using services.

Joint investigation of Health and Social Care Complaints
For many people, making a complaint about the quality of care they have received can be a traumatic experience, in which they have to relive events that were distressing for themselves and their carers/support networks. As the consultation document recognises, advocacy services can support the delivery of person-centred

care, but they can also support people to understand their rights and where standards have not been met, and this should be recognised within complaints systems.

As the integration of health and social care continues to develop towards a vision in which people are treated in a more seamless and community-focused way, separate systems for raising concerns about care will become more and more disjointed and difficult to navigate for patients and their carers. People should be able to expect the same standards and rights from a complaints investigation process from any service they receive within health and social care. We support the view that we need a complaints service that is “people centred not service centred”.

The white paper does not set out the proposed time frame for responding to complaints under a new joint complaints process. As the current systems for health and social care carry differing response time targets, it is important to ensure that changes to the system do not result in a diminished standard of efficiency for complainants.

Clarity about the next steps for a complainant who is unhappy with the outcome of the process under a joint system is however needed. It is also not yet clear how lessons for service improvement would be learned although this is recognised as a potential benefit of the system.

4. Focus on promoting citizen voice and clarity in inspection and service change
A priority must be improving the level of knowledge and understanding among the public of the Community Health Council model and any future body that replaces it. Poor public awareness is one of the most obvious and significant barriers to representing citizens.

Although the document recognises that a lack of diversity from the current model is an issue, it is not entirely clear from the proposals how they will actively ensure the voices of a diverse range of citizens are heard, and will broaden out citizen engagement from the current model. It will not be enough to move from the current appointments process alone – there must be robust measurements in place to ensure that the diversity within communities in Wales is reflected in new structures.

In functions such as visiting premises in which services are delivered to gather feedback on experiences, the role of peer engagement, in which feedback exercises are led by service user/citizen representatives, should be recognised and supported as a way to break down barriers between professionals/staff and patients.

It is difficult to comment on any proposals for changes to HIW with limited detail on what those changes would be. 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. For any inspectorate to be effective it needs to be perceived to be independent of governments’ influence and intervention whilst also having the necessary resources and expertise to undertake its remit and meet expectations.

WGWPMB225: Councillor Mabon ap Gwynfor
Location: Corwen

Sylwadau cyffredinol

Diolch am y cyfle i ymateb i'ch Papur Gwyn, Gwasanaethau Sy'n Addas I'r Dyfodol. Mae llawer o'r Papur yn ganmoladwy, ar yr wyneb.

Mae'r Papur yn nodi rhai o'r gwendidau sydd yn y drefn bresennol, megis y ffaith fod sefydliadau yn gweithio yn annibynnol o'u gilydd heb gydweithio. Mae'n nodi'r angen i rymuso'r staff a dinasyddion, a bod pobl yn cael dweud go iawn yn yr hyn sy'n digwydd iddynt.

Mae'r pwyslais ar dryloywder yn gaboledig.

Bydd llwyddiant yr uchelgeisiau yma yn ddibynnol, i raddau helaeth, ar y dehongliad o unrhyw ddeddfwriaeth newydd a ddaw allan, a hefyd ar y ffordd mae'r dehongliad hwnnw yn cael ei weithredu ar lawr gwlad. Mae 'ysbryd' rhywbeth yn medru bod yn dra wahanol i'r realiti oer pan ei fod yn cael ei weithredu.

Wrth feddwl am yr uchelgais i dorri i lawr y ffiniau rhwng sefydliadau, rhaid bod yn ofalus nad esgus mo hyn i ganoli gwasanaethau ymhellach.

Byddwn yn gwrthwynebu unrhyw gamau fyddai'n golygu fod gwasanaethau elfennol yn cael eu canoli, ac a fydd yn golygu fod pobl, yn enwedig yn ein hardaloedd mwyaf gwledig, ymhellach fyth o'r gwasanaethau hwnnw.

Fel cynrychiolydd i ward wledig iawn yn ne Sir Ddinbych, rwyf eisoes wedi gweld nad ydy'r GIG yn deall sut mae mynd i'r afael a chefn gwlad Cymru. Felly tra bo'r egwyddor o dorri ffiniau rhwng sefydliadau i lawr i'w groesawi, rhaid gofalu nad pen draw hyn mewn gweithred fydd ymbellhau gwasanaethau ymhellach i ffwrdd o bobl. Rwy'n bryderus iawn am Bennod 4, sy'n cyfeirio at y pryderon sydd yna am y Cynghorai Iechyd Cymunedol (CIC). Mae'r rhesymeg yn ffaeledig yma.

Mae'r papur yn cyfeirio at adroddiadau gan Marcus Longley ac Ann Lloyd fel rheswm dros ddiddymu'r CIC. Rwyf wedi darllen y ddau adroddiad yma, ac nid ydynt yn son am ddiddymu'r CIC. Maent yn mynegi pryder am aelodaeth y Cynghorau, ond ceisiodd Llywodraeth Cymru, o dan reolaeth Lesley Griffiths, fynd i'r afael â hyn rhai blynyddoedd yn ôl. Os nad yw'r drefn newydd yn gweithio, yna rhaid holi cwestiynau o'r Llywodraeth, nid cael gwared ar y corff sy'n cynrychioli llais y cleifion a dinasyddion.

Rwy'n cytuno gyda rhan gyntaf paragraff 84 fod angen cryfhau llais ein dinasyddion ymhellach, trwy gynnwys gofal cymdeithasol fel rhan o waith y CIC. Ond mae'r cynnig ym mharagraff 85 i sefydlu corff yn ymdebygu i'r un sydd yn yr Alban yn wallus. Mae Cyngor Iechyd yr Alban yn wan, ac yn methu a herio'r Byrddau Iechyd yno. Yn wir mae'r Alban yn adolygu'r Cyngor Iechyd yno oherwydd ei wendidau. Credaf fod angen cynnal y CIC, gan sicrhau eu pont yn annibynnol o'r Llywodraeth a'r Byrddau Iechyd, a chyda'r grym i herio penderfyniadau ac i sicrhau atebolrwydd gan y Byrddau Iechyd.

Ymhellach i hyn, credaf fod yr awgrym a geir ym mharagraff 84 i greu corff cenedlaethol newydd yn beryglus. Mae'n anochel y byddai hyn yn canoli'r corff newydd a ddaw yn lle'r CIC mwy na thebyg yng Nghaerdydd, gan olygu llai o atebolrwydd, bod yn llai tryloyw, a chynnig llai o gyfle i'n dinasyddion ymwneud a'r corff. Mae hyn yn mynd yn gwbl groes i ysbryd y Papur Gwyn, sydd hefyd yn profi fod y pryder y soniais amdano ynghynt sef y peryg o ganoli gwasanaethau.
Ni fedraf gefnogi unrhyw gynnig sy'n mynd a gwasanaethau a chyrff ymhellach fyth i ffwrdd o'r bobl yr ydwyf yn eu cynrychioli.

Gobeithio y byddwch yn dehongli fy sylwadau yma fel rhai adeiladol wrth i chi ystyried eich cynlluniau ymhellach.

WGWPMB226: C Phillips
Location: Unknown

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Agree

What further issues would you want us to take into account in firming up these proposals?
Ensuring there are robust arrangements for suitably qualified and experienced board members in the first instance – thereby acting to raise issues and prevent poor performance.

Individuals who are willing, able and experienced in raising concerns should be a valuable asset to the Boards – as it is careers are stalled as 'problems' are not addressed at an early stage.

Board Secretary
Do you agree with these proposals?
Agree

What further issues would you want us to take into account in firming up these proposals?
As above Board Secretary need to have the personal integrity to challenge cultures/ Chief Executives and others

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up these proposals?
There is a gap (abdication of responsibility) in provision as the NHS in Wales seeks to deliver 'more for less' for people with learning disabilities, whilst the definition remains within the auspices of NHS (Wales) Act 2006 the delivery of services is markedly poor/ absent and needs analysis and addressing.

Duty of Candour
Do you support this proposal?
Agree

What further issues would you want us to take into account in firming up this proposal?

There has to be clear culpability by senior managers where the ‘culture’ of poor/abusive/ criminal practice has been enabled to perpetuate – e.g. Kris Wade report where:

The Action Plan failed to mention the HB has had a legal duty to report to the Local Authority since April 2016 and therefore left them disregarding their legal duties to the vulnerable and at risk individuals and outside the law- this omission has been 'signed off' at the top it would seem? (Part 7 Social Services and Well-being (Wales) Act 2014 requires HB to refer to the LA in the area the abuse has occurred.ie Cardiff and not ‘Western Bay’

The role of HIW in Inspecting this service needs to be reviewed as I cannot see they have reviewed risk or patient safety in respect of recruitment nor are they being informed of abuse when it has been alleged it would seem.…??

Finally, the ABMUHB report indicates that KW was a 'support worker' prior to his employment on Rowan Ward - there maybe be other victims in that employment less able to articulate the alleged abuses - without responsible reporting there cannot be a comprehensive investigation.

Can the public be confident that all the professionals will act professionally in such situations, if not why not?

Setting and Meeting Common Standards
Do you support this proposal?
Agree

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
Agree

What further issues would you want us to take into account in firming up this proposal?
Local Authorities, Health Boards and HIW/CSSIW having co-terminus boundaries, therefore ensuring a picture of concerns are shared, understood, effectively investigated and ‘held to account’ when necessary.

Representing the Citizen in Health and Social Care
Do you support this proposal?
Agree

Can you see any practical difficulties with these suggestions?
As Above and engagement of the workforce, there is considerable research depicting the positive impact that a fully engaged workforce can have on innovation and change. However as with Culture and Candour the Inspectorates in 2017 appear to be floundering to hold HB and LA to account or the investigate robustly on occasions (Bestsi Cadwalidor and ABMU)

CSSIW Report 2016 (PCC) P.18
'Individuals (staff) described a feeling of disempowerment from a lack of consultation about changes / progress/plans for filling vacancies. Some (staff) talked about an 'autocratic style of management' ' if the LA wants its staff to consistently respect and value the people they help and support….then it needs to do the same for them'

Up-date Report CSSIW June 2017 P.17
'The lack of agreed protocols for the new models of working between health and social care… this shortfall MUST be addressed'

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Agree

What further issues would you want us to take into account in firming up this proposal?
See above

Inspection and Regulation and single body
What do you think of this proposal?
Agree

Are there any specific issues you would want us to take into account in developing these proposals further?
Co-terminus boundaries – which would also mean re-visiting the Williams Report in respect of LA Boundaries – 22 are too small and permeate with poor cultures/ absence of condour

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Would you support such an idea?
Who regulates the regulators?

WGWPMB227: Cyngor Gwynedd Council
Location: Caernarfon

Ymateb i Gwestiynau Penodol

Aelodaeth a Chyfansoddiad y Bwrdd
A ydych yn cytuno â'r cynigion hyn?
Nid ydym o'r farn bod Llywodraeth Cymru yn mynd yn ddigon pell o ran sicrhau bod y Byrddau Iechyd yn gyrff democrataidd. Nid ydym yn teimlo bod y drefn bresennol yn ddigon cryf o ran atebolrwydd lleol.

Mae'r Llywodraeth eisoes wedi datgan bod angen creu Cyd-Bwyllgorau Rhanbarthol, onid felly yw hi'n rhesymol i ddisgwyl i Fyrddau Iechyd fod yn atebol i'r Cyd-Bwyllgor?

Pa faterion eraill hoffech i ni eu hystyried wrth ddatblygu'r cynigion hyn?
Beth bynnag y trefniadau atebolrwydd, rydym o'r farn y dylid cynnwys dwy ffactor ychwanegol yng nghyswllt cefndir, sgiliau a phrofiad aelodau'r bwrdd. O ystyried y ffocws o fewn y Papur Gwyn ar fod yn agos at y dinesydd gan fod yn agored ac yn dryloyw, credwn mai ffactor allweddol i'w sicrhau yw'r angen i Aelodau'r Bwrdd fod yn unigolion sy'n byw ac yn defnyddio'r gwasanaethau y mae'n eu darparu.

Dylid hefyd cael ymrwymiad clir i arddangos sgiliau iaith Gymraeg Aelodau'r Bwrdd.

Drwy gyflawni hyn, credwn y bydd y Byrddau Iechyd mewn gwell sefyllfa i lywodraethu'n effeithiol.

Ysgrifennydd y Bwrdd
A ydych yn cytuno â'r cynigion hyn?
Dylid ystyried yr uchod mewn cyd-destun yr ymateb i 1.1 uchod, ond gan edrych ar drefniadau democrataidd llywodraeth leol, byddai'n rhesymol disgwyl bod gan un rôl o ran y Bwrdd fod yn gyfrifol am briodoldeb a dilyn cyfraith gwlad.

Pa faterion eraill hoffech i ni eu hystyried wrth ddatblygu'r cynigion hyn?
Mae angen sicrhau bod unrhyw ofynion statudol a roddir ar swydd unigolyn wedi'u cefnogi gan y dulliau cefnogi angenrheidiol.

Byddai gofyn i sgiliau a phrofiad deiliaid swyddi fod yn ddigonol i ymgymryd â rôl o'r fath yn effeithiol a dylid ystyried rôl Swyddogion Monitro Awdurdodau Lleol wrth lunio'r cynnig hwn ac yn enwedig cymhwyster cyfreithiol rolau o'r fath.

Dyletswydd Ansawdd i Boblogaeth Cymru
A ydych yn cytuno â'r cynigion hyn?
Mae cytundeb cyffredinol i'r cynnig roi dyletswydd ar y GIG i gydweithredu a gweithio mewn partneriaeth yn yr un ffordd ag y mae'r un ddyletswydd ar awdurdodau lleol. Dylid cyfeirio eto at ein hymateb i 1.1 uchod yn ogystal.

Ar hyn o bryd mae cyfrifoldeb unigol ar Gyfarwyddwyr Gwasanaethau Cymdeithasol o ran cydweithio o fewn llywodraeth leol, a dylid sicrhau bod rôl benodol o fewn y Byrddau Iechyd yn cael eu henwi er mwyn cyfateb i'r trefniant statudol o fewn llywodraeth leol. Heb hyn mae'r drefn yn gwbl anghyfartal ac annheg.

Rydym yn croesawu'r ffocws ar y person yn hytrach na'r sefydliad.
O fewn paragraff 48, mae'r ffocws ar safbwynt poblogaeth ranbarthol neu Gymru gyfan. Ond mae hi'n bwysig ac yn hanfodol sicrhau bod penderfyniadau yn cael eu gwneud ar sail ardal leol - oherwydd po agosaf at yr unigolyn y gwneir y penderfyniad, y mwyaf tebygol yw hi y bydd penderfyniadau'n effeithiol a'r hyn y mae unigolion ei angen. Mae pryder gennym bod y Llywodraeth yn gweld gweithredu'n rhanbarthol yn effeithiol ymhob cyd-destun, ac yn sicr nid yw hyn yn debygol o fod yn rhoi y person yn agos at y penderfyniadau.

Dyletswydd Gonestrwydd
Ydych chi'n cefnogi'r cynnig hwn?
Cefnogwn y cynnig hwn.

Gosod a Bodloni Safonau Cyffredin
Ydych chi'n cefnogi'r cynnig hwn?
Er yn cytuno gyda'r egwyddor o osod safonau, mae gennym bryder bod safonau yn cael eu gosod yn bell o'r unigolion a heb eu seilio ar dystiolaeth. Byddem felly yn dweud bod angen bod yn wyliadwrus iawn o osod y safonau hyn heb dystiolaeth o'r hyn sy'n bwysig i ddinasyddion.

Pa faterion eraill y byddech am inni eu hystyried wrth fynd ati i ddatblygu'r cynnig hwn?
Fel awdurdod, rydym wedi bod yn gweithio o fewn dull meddylfryd systemau ac rydym wedi dysgu bod rhaid i egwyddorion a safonau ddod o'r hyn sy'n bwysig i unigolion. Fel arall, y peryg yw na fydd y safonau na'r egwyddorion, waeth pa mor dda y'u bwriadwyd, yn adlewyrchu'r hyn mae'r dinesydd yn ei gredu sydd fwyaf pwysig.

Ymchwilio ar y cyd i Gwynion Iechyd a Gofal Cymdeithasol
Ydych chi'n cefnogi'r cynnig hwn?
Rydym yn cefnogi'r cynnig i gael trefniadau ymchwilio ar y cyd ar gyfer cwynion sy'n croesi iechyd a gofal cymdeithasol oherwydd credwn y byddai dinasyddion/achwynwyr yn derbyn ymateb llawer mwy effeithiol.

Pa faterion eraill y byddech am inni eu hystyried wrth fynd ati i ddatblygu'r cynnig hwn?
Yn ogystal, wrth i ni symud ymhellach tuag at wasanaethau integredig, mae hyn yn ddilyniant naturiol. Yn amlwg, bydd angen cyfarwyddyd cyfreithiol er mwyn sicrhau bod y ddau sector yn glir ynghylch rolau a chyfrifoldebau. Ar hyn o bryd, mae gan y Cyfarwyddwr Gwasanaethau Cymdeithasol ddyletswyddau penodol ynghylch ymateb i gwynion. Eto, byddem yn gofyn un unigolyn o fewn Iechyd gael yr un ddyletswydd.

Cynrychioli'r Dinesydd ym maes Iechyd a Gofal Cymdeithasol

Ydych chi'n cefnogi'r cynnig hwn?

Rydym yn gryf yn erbyn y farn y dylid ddisodli'r Cynghorau Iechyd Cymuned statudol presennol. Maent yn lleol eu natur ac yn chwarae rhan bwysig yn yr her annibynnol i Fyrddau Iechyd. Efallai bod modd cryfhau y trefniadau presennol gan edrych ar sut y gellid eu gwneud yn fwy gynaliadwy, ond rydym yn sicr yn erbyn creu corff cenedlaethol, sydd yn amlwg wedyn yn bellach o'r bobl.

Rydym yn cefnogi'r farn y dylid dod ag Arolygiaeth Gofal Iechyd Cymru ac Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru yn agosach wrth i'r daith o integreiddio fynd yn ei blaen.

Allwch chi weld unrhyw anawsterau ymarferol gyda'r awgrymiadau hyn?

Gweler uchod – rydym yn erbyn y bwriad o ddisodli'r Cynghorau Iechyd Cymuned.

Llunio Cynlluniau a Gwasanaethau ar y cyd â dinasyddion

Ydych chi'n cytuno â'r cynnig hwn?

Yn sgil ein barn ar 4.1 uchod, rydym o'r farn y dylid gadw cynllunio mor lleol a phosib.

Pa faterion eraill y byddech am inni eu hystyried wrth fynd ati i ddatblygu'r cynnig hwn?

Ym mharagraff 91, amlygir yr angen i ganiatáu i benderfyniadau gael eu gwneud yn lleol. Cytunwn yn llwyr â hyn ac anogwn gynhyrchu canllawiau a threfniadau i adnabod yr ardaloedd lleol. Mae peryg yr ystyrir mai trefniadau rhanbarthol fydd yr ôl-troed lleiaf posib. Ar gyfer rhai rhanbarthau, a Rhanbarth y Gogledd yn benodol, mae'r ôl-troed rhanbarthol yn rhy fawr i ganiatáu i gynlluniau a gwasanaethau gael eu cynhyrchu'n effeithiol ar y cyd â dinasyddion. Ym mharagraff 95, mae'r Papur Gwyn yn cyfeirio at 'bwysigrwydd gweithio'n rhanbarthol ac yn strategol' yng nghyswllt 'gwaith ymgysylltu ... mwy cynhwysol a chynrychioladol'. Mae'n annhebygol y bydd ymagwedd o'r fath yn effeithiol mewn rhanbarth mawr. Mae'n werth cynnwys ôl-troed lleol ac isranbarthol hefyd, sydd hefyd yn adlewyrchu ôl-troed y Byrddau Gwasanaethau Cyhoeddus.

Archwilio a Rheoleiddio a chorff unigol

Beth yw eich barn chi am y cynnig?

Rydym yn cytuno gyda'r cynnig i ddod ag Arolygiaeth Gofal Iechyd Cymru ac Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru yn agosach at ei gilydd.

A oes unrhyw faterion penodol yr hoffech i ni eu hystyried wrth ddatblygu'r cynigion hyn ymhellach?

Nid ydym yn cytuno gyda'r bwriad o ddisodli'r Cynghorau Iechyd Cymuned a byddem yn ffafrio ystyried gwella'r trefniadau presennol yn gyntaf, ac ni welwn y byddai sefydliad cenedlaethol yn rhoi llais digonol i bobl leol.

Fodd bynnag, rydym hefyd yn credu y gallai fod gwerth ystyried corff newydd - er enghraifft, Corff a Noddir gan Lywodraeth Cymru - i roi mwy o annibyniaeth o ran rheoleiddio ac archwilio a rhoi llais i ddinasyddion.
Mae unrhyw gorff cenedlaethol yn mynd i fod yn bell iawn o bobl leol.

WGWPMB230: Comisiynydd y Gymraeg
Location: Caerdydd

Sylwadau cyffredinol

Diolch yn fawr ichi am y cyfle i ymateb i'r ymgynghoriad hwn. Bydd gan y cynigion fydd yn cael eu datblygu yn sgil yr ymgynghoriad oblygiadau arwyddocaol o ran lle'r Gymraeg o fewn trefniadau llywodraethu system iechyd a gofal Cymru i'r dyfodol, ac o ran canfod ac ymateb i lais a phrofiadau'r dinesydd yn ei holl ymwneud â'r maes iechyd a gofal.
Cyflwynir sylwadau penodol ar gwestiynau'r ddogfen ymgynghori yn adran 3 isod ond nod cyffredinol y Comisiynydd wrth ymateb yw pwysleisio:

- Yr angen i brif ffrydio'r Gymraeg i drefniadau llywodraethu ac ansawdd cyrff iechyd yng Nghymru i'r dyfodol. Dylai hynny gynnwys gosod cyfeiriadau penodol at y Gymraeg ar wyneb unrhyw ddeddfwriaeth, is-ddeddfwriaeth neu ddogfennau polisi fydd yn deillio o'r Papur Gwyn hwn;
- Yr angen i unrhyw newidiadau i'r drefn cwynion iechyd a gofal gydnabod ac adlewyrchu swyddogaethau Comisiynydd y Gymraeg fel rhan o'r tirwedd cyfiawnder gweinyddol yng Nghymru pan fo'r cwynion hynny yn ymwneud â'r Gymraeg, neu gais i ymchwilio i ymyrraeth honedig â'r rhyddid i ddefnyddio'r Gymraeg yng Nghymru;
- Y disgwyl i unrhyw newidiadau i'r trefniadau ar gyfer cynrychioli llais y dinesydd gryfhau'r cyfleoedd i ddefnyddio'r Gymraeg ac i ganfod profiadau siaradwyr Cymraeg wrth gyrchu gwasanaethau iechyd a gofal yn ôl eu hanghenion iaith. Byddai hynny'n darparu tystiolaeth gadarn i Lywodraeth Cymru ac eraill ynghylch traweffaith y fframwaith polisi a deddfwriaeth sy'n cefnogi defnyddio'r Gymraeg ym Is-adran Ansawdd Gofal Iechyd maes iechyd a gofal, gan gynnwys y graddau mae'n rhoi canlyniadau cadarnhaol I siaradwyr Cymraeg o fewn y maes hwn;
- Yr angen i ystyried ymdrechion y cyrff arolygu a rheoleiddio yn y maes iechyd a gofal i ymgorffori'r Gymraeg yn eu gwaith hyd yma fel gwaelodlin y dylid adeiladu arno mewn unrhyw gynigion pendant fydd yn cael eu datblygu ar gefn y Papur Gwyn hwn.

Cefndir
Prif nod y Comisiynydd yw hybu a hwyluso defnyddio'r Gymraeg. Gwneir hyn drwy ddwyn sylw at y ffaith bod statws swyddogol i'r Gymraeg yng Nghymru a thrwy osod safonau ar sefydliadau. Bydd hyn, yn ei dro, yn arwain at sefydlu hawliau i siaradwyr Cymraeg.

1.2 Mae dwy egwyddor yn sail i waith y Comisiynydd:

- Ni ddylid trin y Gymraeg yn llai ffafriol na'r Saesneg yng Nghymru;
- Dylai personau yng Nghymru allu byw eu bywydau drwy gyfrwng y Gymraeg os ydynt yn dymuno gwneud hynny.

Cyd-destun
Yr agenda polisi sy'n sail i'r Papur Gwyn hwn yw bod yr 'her o ddiwallu anghenion pawb wedi cynyddu' yn ystod y blynyddoedd diwethaf (Llywodraeth Cymru. (2017). Dogfen Ymgynghori Papur Gwyn: Gwasanaethau sy'n Addas i'r Dyfodol – Ansawdd

a Llywodraethiant ym maes iechyd a gofal yng Nghymru, t.5); y bu ymdrechion i symud
tuag at fodel o ddarparu gofal sy'n canolbwyntio ar yr unigolyn ac ataliaeth, a bod sawl polisi a darnau o ddeddfwriaeth ac is-ddeddfwriaeth wedi'u cyflwyno i ateb y galw.

Yr amlycaf o'r newidiadau i'r fframwaith polisi a deddfwriaeth ym maes iechyd a gofal yw cyflwyno Deddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014, Deddf Rheoleiddio ac Arolygu Gwasanaethau Cymdeithasol (Cymru) 2016, ac yn ehangach Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015.

Nodaf mai gogwydd y Papur Gwyn hwn yw sut y gall deddfu fod o gymorth pellach yn y gwaith o gyflwyno newidiadau ac y bwriedir iddo hefyd weithredu 'fel llwyfan posibl ar gyfer unrhyw argymhellion a ddaw o'r Adolygiad Seneddol o Iechyd a Gofal Cymdeithasol, sydd yn mynd rhagddo ar hyn o bryd'.

Cyhoeddodd yr Adolygiad Seneddol hwnnw ei adroddiad interim yn ystod mis Gorffennaf eleni. (Adolygiad Seneddol o Iechyd a Gofal Cymdeithasol yng Nghymru. (2017). Adroddiad Interim. Ar gael: https://beta.llyw.cymru/sites/default/files/publications/2017-07/170714-review-interim-report-cy.pdf [Cyrchwyd: 21 Medi 2017]). Cyflwynais ymateb llawn i'r Adolygiad Seneddol ac mae wedi'l gyhoeddi ar wefan Comisiynydd y Gymraeg (Comisiynydd y Gymraeg (2017) Adolygiad Seneddol o Iechyd a Gofal Cymdeithasol Cymru – tystiolaeth Comisiynydd y Gymraeg. Ar gael: http://www.comisiynyddygymraeg.cymru/Cymraeg/Rhestr%20Cyhoeddiadau/Adolygiad%20Seneddol%20o%20Iechyd%20a%20Gofal%20yng%20Nghymru.pdf). Roedd yr ymateb hwnnw yn darparu gwybodaeth gefndirol a chyd-destunol am bwysigrwydd ystyried anghenion iaith fel angen gofal, gan dynnu ar dystiolaeth o Gymru ac yn rhyngwladol. Roedd hefyd yn cloriannu'r cynnydd a welwyd hyd yma o safbwynt y Gymraeg ym maes iechyd a gofal, ac yn tynnu sylw at y bylchau sy'n parhau i fynnu sylw os ydym am wireddu'r uchelgais polisi cenedlaethol o ran y Gymraeg o fewn iechyd a gofal.

Perthnasedd y newidiadau i'r Gymraeg ac anghenion siaradwyr Cymraeg
Yn ei Adroddiad Interim, wrth gydnabod ymdrechion Llywodraeth Cymru hyd yma o safbwynt Mwy na Geiriau..., mae'r Adolygiad Seneddol o Iechyd a Gofal Cymdeithasol yn gytûn â'r farn bod angen gwella 'gwasanaethau dwyieithog er mwyn gwella ansawdd ym maes iechyd a gofal' o hyd (Adolygiad Seneddol o Iechyd a Gofal Cymdeithasol yng Nghymru. (2017). Adroddiad Interim, t.14. Ar gael: https://beta.llyw.cymru/sites/default/files/publications/2017-07/170714-review-interim-report-cy.pdf [Cyrchwyd: 21 Medi 2017]). Mae hynny oherwydd bod 'anghysonderau o ran argaeledd a safon gwasanaethau iaith Gymraeg mewn iechyd a gofal cymdeithasol' yn parhau i fodoli (Ibid, t.60). Rwyf o'r farn y byddai modd adeiladu ar yr hyn a gyflawnwyd a chadarnhau'r dyhead polisi o safbwynt y Gymraeg o fewn iechyd a gofal ymhellach drwy'r Papur Gwyn hwn ac unrhyw gynigion ddaw yn ei sgil.

Mae athroniaeth yr agenda gofal newydd y sonnir amdani felly – canolbwyntio ar yr unigolyn, pwyslais ar ganlyniadau, grymuso'r dinesydd ac ati – yn cyd-fynd â'r ymdrechion diweddar i geisio sicrhau bod gwasanaethau iechyd a gofal yn cael eu

cyflwyno yn ôl anghenion iaith siaradwyr Cymraeg yng Nghymru. Yn wir, mae hynny'n cael ei ymgorffori i wahanol raddau yn y darnau penodol o ddeddfwriaeth a gymeradwywyd hyd yma wrth i Ddeddfau 2014 a 2016, er enghraifft, gyflwyno'r gofyn i ystyried anghenion iaith i wahanol raddau wrth ddarparu gofal. Croesawaf y gydnabyddiaeth hon yn y Papur Gwyn a'r asesiad effaith cysylltiedig, gan hyderu y bydd unrhyw ddeddfwriaeth bellach hefyd yn cyfrannu at y trywydd hwn ac yn cynnwys cyfeiriadau penodol at y Gymraeg.

Newid arall cysylltiedig sy'n ymwneud â'r modd y mae gwasanaethau Cymraeg mewn sawl sector – gan gynnwys y sector iechyd a gofal cymdeithasol yn enwedig – yn cael eu darparu a'u rheoleiddio yw cymeradwyo Mesur y Gymraeg (Cymru) 2011. Yn hyn o beth, rwyf am nodi fod y Mesur ac is-ddeddfwriaeth cysylltiedig yn sefydlu Comisiynydd y Gymraeg fel "rheoleiddiwr perthnasol" ac yn rhoi nifer o swyddogaethau i'r Comisiynydd. Mae'r rheiny'n cynnwys y gallu i osod safonau'r Gymraeg ar nifer o sefydliadau; y gallu i ymchwilio i amheuon ynghylch methiant i gydymffurfio â dyletswyddau iaith a'r gallu i ymchwilio i honiadau am ymyrraeth â'r rhyddid i ddefnyddio'r Gymraeg yng Nghymru.

Mae gwasanaethau cymdeithasol eisoes yn ddarostyngedig i gyfundrefn safonau'r Gymraeg o dan Hysbysiadau Cydymffurfio'r awdurdodau lleol. Yn gyffredinol, rwyf eisoes wedi gweld cynnydd yn ystod ac ansawdd gwasanaethau cyfrwng Cymraeg yn sgil hynny, er bod gwaith pellach i'w wneud. Mae'r rheoleiddwyr iechyd eraill y gallent gael eu heffeithio yn sgil canlyniadau'r ymgynghoriad hwn – sef Arolygiaeth Gofal Iechyd Cymru ac Arolygiaeth Gofal a Gwasanaethau Cymdeithasol hefyd yn ddarostyngedig i'r drefn safonau o dan Hysbysiad Cydymffurfio Gweinidogion Cymru. Fodd bynnag, mae'r byrddau iechyd lleol, y cynghorau iechyd cymuned, Bwrdd Cynghorau Iechyd Cymru, a'r cyrff proffesiynol yn y sector iechyd yn parhau i weithredu cynlluniau iaith Gymraeg o dan Ddeddf Iaith 1993 ar hyn o bryd, hyd nes bydd y Llywodraeth yn cyflwyno rheoliadau fydd yn caniatáu imi osod safonau'r Gymraeg ar weddill y cyrff iechyd hyn.

Cynhaliodd Llywodraeth Cymru ymgynghoriad ar gynnwys Rheoliadau drafft safonau'r Gymraeg ar gyfer y cyrff iechyd yn benodol y llynedd, a disgwylir i'r rheoliadau terfynol gael eu gosod gerbron Cynulliad Cenedlaethol Cymru cyn diwedd y flwyddyn hon.

Mae hyn oll yn perthnasu i'r Papur Gwyn ac unrhyw gynigion a ddatblygir yn ei sgil felly. Disgwylir i'r cynigion hynny gyfrannu at y nod o weld gwasanaethau Cymraeg mewn iechyd a gofal yn gwella; cryfhau llais y dinesydd Cymraeg ac esgor ar drefniadau cadarn i roi sicrwydd i'r Llywodraeth a'r cyrff iechyd ynghylch y graddau y mae eu gwasanaethau yn llwyddo i gyflwyno gwasanaethau iechyd dwyieithog o ansawdd i ddinasyddion.

Ymateb i Gwestiynau Penodol

Aelodaeth a chyfansoddiad y Bwrdd
Fe ddylai'r angen i sicrhau bod dinasyddion yn gallu cyrchu gwasanaethau iechyd a gofal yn ôl eu hanghenion, gan gynnwys anghenion ieithyddol yn benodol, fod yn rhan annatod o genhadaeth pob sefydliad y GIG yng Nghymru. Mae'n hollbwysig

bod hynny'n cael ei adlewyrchu mewn unrhyw egwyddorion craidd terfynol fydd yn gyrru'r gweithredu a fydd yn deillio o'r Papur Gwyn hwn felly.

Mae rhai cymalau yn adran 'Egwyddorion craidd allweddol ar gyfer pob sefydliad y GIG' y Papur Gwyn yn nodi 'canolbwyntio ar yr unigolyn' a 'gwella ansawdd' fel egwyddorion craidd. Mae'r egwyddorion hynny yn sicr yn cyffwrdd ar yr angen i ddarparu gwasanaethau yn Gymraeg ond dylid cadarnhau mewn termau diamwys y disgwyl i holl gyrff y GIG yng Nghymru sicrhau bod y gwasanaethau mae'r corff yn eu darparu yn hybu mynediad at wasanaethau yn ôl anghenion iaith dinasyddion yng Nghymru.

Byddai cynnwys gofyniad o'r fath fel egwyddor graidd hefyd yn gydnabyddiaeth o'r ffaith fod angen perchnogaeth ar agenda'r Gymraeg ar y lefel uchaf un trwy drefniadau rheoli a llywodraethu cadarn os yw corff am lwyddo i ymateb yn gadarnhaol i fframwaith polisi a deddfwriaeth y Gymraeg ym maes iechyd a gofal. Amlygir enghraifft yn Adroddiad Sicrwydd Comisiynydd y Gymraeg ar gyfer 2014-15 o sut mae un bwrdd iechyd penodol wedi gosod y Gymraeg o fewn ei drefniadau llywodraethu drwy sefydlu Grŵp Cymraeg y mae Cadeirydd y bwrdd iechyd, sydd hefyd yn Bencampwr y Gymraeg, a nifer o uwch aelodau staff yn rhan ohono (Comisiynydd y Gymraeg. (2015). Mesur newydd; meddylfryd newydd – Adroddiad Sicrwydd Comisiynydd y Gymraeg ar gyfer 2014-15, t.48. Ar gael: http://www.comisiynyddygymraeg.cymru/Cymraeg/Rhestr%20Cyhoeddiadau/20151022%20DG%20C%20Adroddiad%20Sicrwydd%20Comisiynydd%20y%20Gymraeg%202014-15.pdf [Cyrchwyd: 25 Medi 2017]).

Wrth ddatblygu'r cynigion hyn, credaf y dylai Llywodraeth Cymru ystyried ymhellach sut y gallai fanteisio ar y bwriad i gyflwyno deddfwriaeth fel modd o roi hwb i fyrddau iechyd ysgwyddo cyfrifoldeb corfforaethol ac arweinyddiaeth o ran y Gymraeg – a chyflawni amcanion polisi Llywodraeth Cymru ar gyfer y Gymraeg wrth gyflwyno gwasanaethau iechyd a gofal. Fan leiaf dylai'r cyfrifoldeb dros hybu a hwyluso defnyddio'r Gymraeg, ynghyd â sicrhau cydymffurfiaeth dda â dyletswyddau ieithyddol a'r disgwyliad polisi cenedlaethol o ran y Gymraeg, ar lefel strategol fod wedi'i wreiddio yn nhrefniadau llywodraethu pob bwrdd iechyd ac yn nodwedd gyson ledled Cymru. Dylai Llywodraeth Cymru ystyried y ffordd fwyaf priodol o ysgogi byrddau iechyd i ysgwyddo'r gyfrifoldeb hon drwy'r ddeddfwriaeth arfaethedig.

Rwyf hefyd am bwysleisio yr angen i aelodaeth byrddau iechyd adlewyrchu eu poblogaethau lleol o safbwynt y Gymraeg. Gwyddom fod siaradwyr Cymraeg yn byw ym mhob cymuned yng Nghymru a bod yna nifer o bobl ym mhob ardal bwrdd iechyd sy'n teimlo fwyaf cyfforddus yn defnyddio'r Gymraeg neu'r un mor gyfforddus yn y ddwy iaith (Llywodraeth Cymru (2016), Adnodd data ar y gweithlu a'r iaith Gymraeg i gefnogi cynllunio gofal sylfaenol, t.17. Ar gael: http://gov.wales/docs/statistics/2016/160622-workforce-welsh-language-support-primary-carecy.pdf [Cyrchwyd: 25 Medi 2017]). Croesawaf y gydnabyddiaeth hon yn y Papur Gwyn a'r asesiad effaith cysylltiedig. Fodd bynnag, nid yw'n gwbl glir ar hyn o bryd sut yn union y bwriedir ymateb i hyn yn ymarferol er mwyn cryfhau'r trefniadau presennol.

Gwnaeth y Gweithgor ar y Gymraeg mewn llywodraeth leol argymell y dylai Llywodraeth Cymru ddeddfu i wneud lefel o hyfedredd yn y Gymraeg yn ofynnol i

nifer penodol o swyddi llywodraeth leol er mwyn gwasanaethu Cymru ddwyieithog, ac os nad yw'r hyfedredd eisoes yn bodoli yn y swyddi y dylai hi osod dyletswydd ar gyrff i sicrhau eu bod yn meithrin yr hyfedredd honno. (Y Gweithgor ar yr Iaith Gymraeg a Llywodraeth Leol. (2016). Iaith, Gwaith a Gwasanaethau Dwyieithog, tt.11-12. Ar gael: http://gov.wales/docs/dsjlg/publications/160614-language-work-bilingual-services-cy.pdf [Cyrchwyd: 25 Medi 2017])

Efallai yr hoffai'r Llywodraeth ystyried a ddylid pennu isafswm gallu yn y Gymraeg ar gyfer swyddi gweithredol / aelodaeth pob bwrdd iechyd lleol yn ei gyfanrwydd mewn deddfwriaeth sylfaenol neu is-ddeddfwriaeth fel rhan o ddatblygu'r cynigion. Gellid dadlau y byddai hynny'n sefydlu gwaelodlin ledled Cymru o isafswm y sgiliau ieithyddol mae'n ofynnol meddu arnynt I wasanaethu'r cyhoedd ac i adlewyrchu poblogaeth Cymru. Yn y cyswllt hwn, deallaf bod sgiliau ieithyddol aelodau'r byrddau iechyd presennol yn cael eu cofnodi yn ôl gallu i Ddeall, Darllen, Siarad ac Ysgrifennu Cymraeg ar raddfao 0 i 5; fe allai hyn hwyluso pennu isafswm priodol o sgiliau ieithyddol felly (Papur nas cyhoeddwyd a gyflwynwyd i Fwrdd Partneriaeth y Gymraeg 12 Gorffennaf 2017).

Dyletswydd Ansawdd i Boblogaeth Cymru
Nodaf y cynnig a'r rhesymeg ynghylch cyflwyno dyletswydd ansawdd o'r newydd i boblogaeth Cymru. Wrth dynnu sylw at berthnasedd y newidiadau hyn i'r Gymraeg ac anghenion siaradwyr Cymraeg yn yr adran flaenorol, rwyf yn nodi bod nifer o'r newidiadau deddfwriaethol a pholisi a gyflwynwyd eisoes yn adnabod y Gymraeg fel rhan ganolog o'r agenda darparu gofal sy'n canolbwyntio ar yr unigolyn, ar ymyrraeth gynnar ac ar ganlyniadau personol ac ati.

Nodaf hefyd mai un canlyniad posibl cyflwyno dyletswydd ansawdd newydd o'r fath fyddai 'caniatáu newid i'r system i hyrwyddo gwasanaethau yn seiliedig ar yr unigolyn, yn hytrach nag ar y sefydliad'. Mae'r Comisiynydd wedi pwysleisio pwysigrwydd cydnabod ac anrhydeddu dewis iaith yr unigolyn yn hytrach na dewis iaith y sefydliad ar sawl achlysur, yn benodol felly o ran y maes iechyd, felly mae'r cynnig hwn i'w groesawu. Mae'n hollbwysig ystyried ansawdd yn nhermau profiad y claf yn ei gyfanrwydd yn hytrach na chanlyniad meddygol yn unig, fel y mae adran hon y Papur yn ei wneud. Yn hyn o beth, pwysleisiaf yr angen i unrhyw ddyletswydd ansawdd adeiladu ar Ddeddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014 a Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 a'r dangosyddion a'r nodau llesiant, gan gydnabod pwysigrwydd iaith a chyfathrebu – a'r gallu I wneud hynny drwy gyfrwng y Gymraeg – o fewn unrhyw ddyletswydd ansawdd i'r dyfodol.

Yn ogystal â chadarnhau'r disgwyliad/dyhead polisi, croesawaf yr awgrym y dylai'r ddyletswydd ansawdd fod yn gyfrwng i ysgogi cyrff iechyd i gynllunio gwasanaethau fel y gellid gweithredu'r ddyletswydd honno yn ymarferol. Rhagwelaf y gallai'r cynnig hwn, o'i gysylltu â'r ddyletswydd sydd eisoes wedi'i gosod ar gyrff iechyd a gofal i asesu anghenion eu poblogaethau, fod yn gyfle pellach i osod targedau o ran y sgiliau yn y Gymraeg i ymateb i'r anghenion hynny, ac annog cynllunio bwriadus er mwyn cyflawni'r
ddyletswydd ansawdd ledled Cymru maes o law.

Gosod a Bodloni Safonau Cyffredin
Pe bai Llywodraeth Cymru yn dewis parhau â'r cynnig i gyflwyno un set o safonau fyddai'n ofynnol eu bodloni mewn lleoliadau iechyd a gofal o bob math er mwyn sicrhau cysondeb, afraid yw dweud y dylai'r rheiny osod isafswm o safonau'n ymwneud â'r Gymraeg. Dylai hyn gynnwys safon(au) fyddai'n sicrhau bod y cynnig rhagweithiol yn cael ei wneud a'i anrhydeddu.

Ymchwilio ar y cyd i Gwynion Iechyd a Gofal Cymdeithasol
Sicrhau cyfiawnder i ddefnyddwyr y Gymraeg, a gosod dyletswyddau statudol a'u rheoleiddio, yw dau o amcanion strategol Comisiynydd y Gymraeg (Comisiynydd y Gymraeg (2015). Cynllun Strategol Comisiynydd y Gymraeg 2015-2017. Ar gael: http://www.comisiynyddygymraeg.cymru/Cymraeg/Rhestr%20Cyhoeddiadau/Cynllun%20Strategol%202015-17.pdf [Cyrchwyd: 26 Medi 2017]). Un ffordd y mae'r Comisiynydd yn rhoi effaith i'r amcanion hyn yn ymarferol yw drwy weithredu swyddogaethau yn ymwneud â chwynion ac ymdrin â cheisiadau i ymchwilio i ymyrraeth honedig i ddefnyddio'r Gymraeg. Adroddir yn Hawliau'n gwreiddio – Adroddiad Sicrwydd 2016-17 Comisiynydd y Gymraeg bod 97% o'r sawl oedd yn rhan o Arolwg Omnibws Siaradwyr Cymraeg Beaufort Research yn cytuno ei fod yn bwysig fod pobl
yn gallu cwyno am wasanaethau Cymraeg anfoddhaol (Comisiynydd y Gymraeg (2017). Hawliau'n gwreiddio – Adroddiad Sicrwydd 2016-17 Comisiynydd y Gymraeg).

Nodaf fod paragraffau 70 a 71 y Papur Gwyn yn amlinellu'r ddwy drefn cwynion wahanol sy'n bodoli ar hyn o bryd ar gyfer gwasanaethau iechyd a gwasanaethau gofal cymdeithasol. Yn ôl yr hyn a amlinellir, mae'r ddwy drefn bresennol, yn eu hanfod, yn mynnu: fod achwynwyr yn cwyno wrth y corff dan sylw yn y lle cyntaf i geisio datrysiad anffurfiol; y gall achwynwyr uchafu eu cwynion drwy brosesau mewnol y bwrdd iechyd neu'r awdurdod lleol fel y bo'n berthnasol, ac yn nodi y gall achwynwyr barhau i ddilyn y
llwybr unioni drwy gysylltu ag Ombwdsmon Gwasanaethau Cyhoeddus
Cymru.

Wrth amlygu ymhellach perthnasedd cynigion y Papur Gwyn hwn i'r Gymraeg ac anghenion ei siaradwyr yn adran 2, rwyf yn nodi fod Mesur y Gymraeg (Cymru) 2011 ac is-ddeddfwriaeth perthnasol yn sefydlu Comisiynydd y Gymraeg fel "rheoleiddiwr perthnasol" ac yn rhoddi imi nifer o swyddogaethau. Rwyf hefyd yn rhoi trosolwg o sefyllfa gyfredol cyrff iechyd o ran eu dyletswyddau, a chynnig cefndir a diweddariad ar y daith i ddod â'r holl gyrff hyn dan gyfundrefn safonau'r Gymraeg.

Hyd y gwelaf, nid yw hyn yn cael ei wyntyllu mewn manylder digonol yn y Papur Gwyn. Dylid rhoi sylw pellach ac ystyriaeth lawn i'r elfen hon felly wrth ddatblygu'r cynigion ymhellach. Dylid cydnabod y ffaith fod Comisiynydd y Gymraeg yn rhan o'r tirwedd cyfiawnder gweinyddol, ac y gall achwynwyr gwyno wrth y Comisiynydd yn ôl gofynion perthnasol Mesur y Gymraeg, mewn perthynas â'r maes iechyd a gofal pan fo cwynion yn ymwneud â'r Gymraeg (Nason, S. (2015). Deall cyfiawnder gweinyddol yng Nghymru: cryondeb gweithredol. Ar gael:

http://adminjustice2015.bangor.ac.uk/documents/crynodeb-gweithredol.pdf ([Cyrchwyd: 26 medi 2017]).

Mae adran 20 a 21 Mesur y Gymraeg yn caniatáu'r Comisiynydd i gydweithio a chynnal ymchwiliadau ar y cyd ag ombwdsmyn a chomisiynwyr eraill os yw ymchwiliad i orfodi safonau yn bwnc sy'n ymwneud â mater all fod yn destun ymchwiliad ganddynt. Yn ysbryd grymuso'r dinesydd, sicrhau'r gwerth mwyaf posib, ac annog datrys cwynion ar y cyd pan fyddant yn rhychwantu sawl corff, argymhellaf fod y Llywodraeth yn ystyried ymestyn y cynsail hwn i'r drefn cwynion newydd ac unrhyw ddeddfwriaeth allasai fod yn sail iddi.

Cynrychioli'r Dinesydd ym maes Iechyd a Gofal Cymdeithasoli) Credaf ei bod yn hollbwysig bod ffordd bwrpasol i ddinasyddion gael llais ynghylch y gwasanaethau iechyd a gofal cymdeithasol y maent yn eu derbyn, a bod modd iddynt ddylanwadu ar y ddarpariaeth honno. Yn naturiol, credaf bod angen lle penodol mewn unrhyw drefniadau o'r fath ar gyfer amddiffyn dewis iaith a chryfhau dewis iaith.

ii) Ceir cydnabyddiaeth benodol yn Fframwaith Mwy na Geiriau am yr angen am drefniadau o'r fath hefyd i ddarparu tystiolaeth gadarn i Lywodraeth Cymru ac eraill ynghylch traweffaith y fframwaith polisi a deddfwriaeth sy'n cefnogi defnyddio'r Gymraeg ym maes iechyd a gofal:

3.39 Byddwn hefyd yn defnyddio amrywiaeth o fesurau eraill i asesu effaith Mwy na geiriau.... ac, ymhen amser, Safonau'r Gymraeg. Bydd y rhain yn cynnwys asesiadau a gynhelir gan Gynghorau Iechyd Cymunedol o'r ddarpariaeth Gymraeg mewn gwasanaethau iechyd; manylion sut y mae'r gwasanaethau ar hyn o bryd yn ateb anghenion siaradwyr Cymraeg fel y nodir yn adroddiadau blynyddol byrddau iechyd, ymddiriedolaethau a chyfarwyddwyr gwasanaethau cymdeithasol; archwiliadau gwasanaethau yn y GIG gan gynnwys cwestiynau ynghylch yr hyn y mae pobl yn ei feddwl o'r gwasanaethau Cymraeg sy'n cael eu darparu; ac fel rhan o waith arolygu AGGCC ac AGIC. Llywodraeth Cymru. (2016). Fframwaith Strategol Olynol Mwy na Geiriau..., t.29

Disgwyliaf i unrhyw newidiadau i'r trefniadau ar gyfer cynrychioli llais y dinesydd felly gryfhau'r cyfleoedd i ddefnyddio'r Gymraeg. Dylent hefyd ganfod profiadau siaradwyr Cymraeg wrth gyrchu gwasanaethau iechyd a gofal yn ôl eu hanghenion iaith, gan gynnal a chryfhau yr ymrwymiadau presennol a wneir yn Mwy na Geiriau...

Ar yr un trywydd â'm hymateb i gwestiwn 3.2 y ddogfen ymgynghori yn yr adran uchod, hoffwn bwysleisio cyfrifoldeb cyffredinol y Comisiynydd 'I gydweithio ar y cyd â chyrff craffu eraill er mwyn ychwanegu gwerth a chreu gwasanaethau a chanlyniadau gwell i ddinasyddion Cymru... Bydd y Comisiynydd yn cyfarfod yn rheolaidd â phartneriaid craffu i drafod materion strategol a gweithredol sydd o ddiddordeb cyffredin' (Comisiynydd y Gymraeg. (2016). Fframwaith Rheoleiddio Comisiynydd y Gymraeg, t.16. Ar gael: http://www.comisiynyddygymraeg.cymru/Cymraeg/Rhestr%20Cyhoeddiadau/Fframwaith%20rheoleiddio.pdf [Cyrchwyd: 26 Medi 2017]). Gofynnaf i unrhyw ddiwygiadau i'r drefn bresennol ystyried y cyfrifoldeb hwn yn ysbryd grymuso llais y dinesydd a chaniatáu cydweithio effeithiol a phriodol rhwng cyrff sy'n

eiriol ar ran y dinesydd Cymreig.

Arolygu a Rheoleiddio
Ceir cydnabyddiaeth yn Fframwaith Mwy na Geiriau... bod angen i'r cyrff a chanddynt gyfrifoldeb statudol dros reoleiddio ac archwilio gwasanaethau iechyd a gofal ysgwyddo cyfrifoldeb priodol dros y Gymraeg er mwyn cymell llwyddiant a rhoi sicrwydd bod y fframwaith deddfwriaethol a'r polisi sydd ar waith i gefnogi defnyddio'r Gymraeg yn y maes yn cael eu gwireddu:

Mae swyddogaeth yr arolygiaethau yn hanfodol os yw angen iaith a newid diwylliannol tuag at y Cynnig Rhagweithiol yn mynd i gael eu gwireddu. Drwy eu gwaith byddant yn asesu profiad pobl ac yn canfod p'un a gawsant ofal ieithyddol addas neu beidio. Bydd hyn o gymorth i Lywodraeth Cymru fonitro'r modd y mae'r cynllun gweithredu yn cael ei gyflawni gan y sectorau iechyd a gwasanaethau cymdeithasol, a bydd yn gallu mesur y gwahaniaeth yn y ddarpariaeth uniongyrchol i ddefnyddiwr y gwasanaeth.

Mae rôl benodol gan Arolygiaeth Gofal Iechyd Cymru (AGIC) ac Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru (AGGCC) i sicrhau y darperir gwasanaethau Cymraeg fel rhan o'u trefn arolygu bresennol. Bydd yn hanfodol iddynt adrodd ar wasanaethau Cymraeg er mwyn darparu gwybodaeth sylfaenol a fydd yn sail i waith yn y dyfodol. Mae gan bawb ohonom gyfrifoldeb i wneud i hyn ddigwydd, a sicrhau bod pobl ar draws Cymru yn derbyn gwasanaethau o ansawdd sy'n cyfarfod â'u hanghenion.16

Pe bai'r cynnig hwn yn cael ei wireddu, dylai unrhyw newid i fframwaith deddfwriaethol y naill gorff neu'r llall ystyried gweithgarwch cyfredol y cyrff hyn fel gwaelodlin y dylid ei ddiogelu ac adeiladu arno ymhellach.

Yn yr un modd, pe bai'r cynnig i ystyried corff newydd unigol – er enghraifft, Corff a Noddir gan Lywodraeth Cymru – yn cael ei ddatblygu ymhellach, dylai'r Llywodraeth gadarnhau ar y cyfle cynharaf y bydd yn ddarostyngedig I ddyletswyddau iaith yn unol â Hysbysiad Cydymffurfio Gweinidogion Cymru neu fel sefydliad annibynnol. Unwaith eto, pwysleisiaf y dylai hwyluso cydweithio rhwng rheoleiddwyr ac ombwdsmyn eraill er lles y dinesydd Cymreig.

Sylwadau clo
Diolch yn fawr iawn ichi am y cyfle i gyflwyno sylwadau ar y Papur Gwyn hwn. Fel y gwelwch, rwyf wedi cynnig ymatebion i rai ond nid y cyfan o'r cwestiynau a ofynnwyd gennych – gan imi ddethol y cwestiynau mwyaf perthnasol o safbwynt nod a chylch gwaith Comisiynydd y Gymraeg. Hyderaf y bydd fy sylwadau yn ddefnyddiol ichi yn y gwaith o ddatblygu eich cynigion ymhellach. Mae pob croeso ichi gysylltu â mi pe hoffech drafod unrhyw agwedd ar yr ymateb hwn ymhellach.

WGWPMB231: Unknown
Location: Unknown

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Administers not qualified unless from Nursing Profession first – finance comes with them.

Board Secretary
Do you agree with these proposals?
Yes

Duty of Quality for the Population of Wales
Do you agree with these proposals?
See 1.1. overleaf

Duty of Candour
Do you agree with these proposals?
Yes, liaison is needed

What further issues would you want us to take into account in firming up this proposal?
Training more staff and not expecting them to pay for training.

Setting and Meeting Common Standards
Do you agree with these proposals?
Health services already overworked and understaffed.

What further issues would you want us to take into account in firming this up?
More staff training for future? Otherwise failure to maintain will ensue.

Joint Investigation of Health and Social Care Complaints
What further issues would you want us to take into account in firming up this proposal?
More staff training – more input. Otherwise great shortage will occur in the future in NHS. Also lack of facilities doesn't help.

Representing the Citizen in Health and Social Care
Can you see any practical difficulties with these suggestions?
Staff already have too many visits and not enough time to spend with each patient unless healthcare inspectorate can remedy this – no use.

Co-producing Plans and Services with Citizens

Do you agree with this proposal?

Would depend on many things.

What further issues would you want us to take into account in firming up this proposal?

Experience of persons supplying information.

Inspection and Regulation and single body

Firstly, the alth care is not sufficiently staffed. To secure this – further treaining is required to do this. Costs of training are mainly problem for young people. Surely help with financing of this would help. (With Nursting staff retiring – who will maintain these services in the future) if no input is being maintained. It's mostly hands on training required computors input can be obtained in schools etc. (Too many chiefs and not enough Indians so to speak).

WGWPMB232: R Blake
Location: Denbighshire

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up this proposal?
Your proposals hopefully will be sufficient.

Good leaders - What do you think?
I am all for progress.

Board Secretary
Do you agree with these proposals?
Yes.

What further issues would they want us to take into account in firming up these proposals?
They proposals seem adequate.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes.

What further issues would they want us to take into account in firming up these proposals?
They seem sufficient.

Good quality care – What do you think?
I totally agree.

Duty of Candour
Do you agree with these proposals?
I do.

What further issues would they want us to take into account in firming up these proposals?
Hopefully these plans will be sufficient.

Telling the truth – What do you think?
Absolutely right.

Setting and Meeting Common Standards
Do you support this proposal?
Yes

High Standards across health and social care – What do you think?
I totally agree.

Joint Investigation of Health and Social Care Complaints
Do you agree with these proposals?
Yes.

What further issues would they want us to take into account in firming up these proposals?
Cannot think of any at the moment.

High Standards across health and social care – What do you think?
Long overdue.

Representing the Citizen in Health and Social Care
Do you agree with these proposals?
Yes.

What further issues would they want us to take into account in firming up these proposals?
Hopefully none.

Make sure people have a say – What do you think?
Totally agree.

Co-producing Plans and Services with Citizens
Do you agree with these proposals?
Yes.

What further issues would they want us to take into account in firming up these proposals?
None.

Organising changes to health services – What are we going to do?
I fully support idea.

Inspection and Regulation and single body
What do you think of this proposal?

I agree

Are there any specific issues you would not want us to take into account in developing these proposals further?
Cannot think of any at the moment.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Would you support such an idea?
Certainly would.

What issues should we take into account if this idea were to be developed further?
Cannot think of any right now.

Checking how things are going – what do you think?
I think it could be a good idea: “Two heads are better than one”. I think these proposals could be very much what are needed, for the future of the ‘care system’ in Wales. Things don’t improve by ‘standing still’!

WGWPMB233: Anonymous
Location: Anonymous

General Comments

At the request of the individual, this response has not been published.

WGWPMB234: R Taylor
Location: Denbighshire

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes but if the board/ trust is not doing well then those members should be replaced not allowed to sit on it claiming their finances.

What further issues would you want us to take into account in firming up this proposal?
All Boards/ Trusts need local people on them to decide local issues not people with no idea of the area.

Board Secretary
Do you agree with these proposals?
Yes I agree especially about independent.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up this proposal?
All Health Boards/ Trusts should be brought to task to make sure they carry out what is needed. Rhyl is still waiting for the update of the Alexandra Hospital to help Glan Clwyd Hospital when will this happen?

Duty of Candour
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up this proposal?
The next time that there is any frankness in this part with this health board will be the first.

Setting and Meeting Common Standards
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up this proposal?
All Health + Social Care should be the same and a very high standard should be set whether it is private or public.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?
No

What further issues would you want us to take into account in firming up this proposal?
There should be one body to take up any complaint and be able to deal with the matter and if the complaint is found to be true then the matter should be dealt with in the best way for the complainant not the Health Board/ Trust.

Representing the Citizen in Health and Social Care
Do you support this proposal
No

Can you see any practical difficulties with these suggestions?
All you are doing is replacing one body with another costing the tax payer a lot of money.

Inspection and Regulation and single body
However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
As I have said new bodies sound good but nothing more than the old one's costing the Tax payer.

The people of Rhyl and Prestatyn and surrounding area would like the Alexandria Hospital to be upgraded.

WGWPMB235: E. A. Thomas
Location: Holyhead

Ymateb i Gwestiynau Penodol

Aelodaeth a Chyfansoddiad y Bwrdd
A ydych yn cytuno â'r cynigion hyn?
✓

Pa faterion eraill hoffech i ni eu hystyried wrth ddatblygu'r cynigion hyn?
Gallu I siarad Gymraeg.

Ysgriffenydd y Bwrdd
A ydych yn cytuno â'r cynigion hyn?
✓

Pa faterion eraill hoffech i ni eu hystyried wrth ddatblygu'r cynigion hyn?
Sylw + ymateb ir sylwadau'n brydlon.

Dyletswydd Ansawdd I Boblogaeth Cymru
A ydych yn cytuno A ydych yn cytuno â'r cynigion hyn?
C.I.C yn lluwddo yn y rol yma.

Dyletswydd Gonestrwydd
Pa faterion eraill y byddech am inni eu hystyried wrth fynd ati i ddatblygu'r cynnig hwn?
Claf au teulu

Gosod a Bodloni Safonau Cyffredin
Pa faterion eraill y byddech am inni eu hystyried wrth fynd ati i ddatblygu'r cynnig hwn?
Peidio newid cr mwyn newid glyme writh wirfoddoli – No.

Ymchwilio ar y cyd Gwynion Iechyd a Gofal Cymdeithasol
Ydych chi'n cefnogi'r cynnig hwn?
Bwrddau i wrando eu gwasanaethau.

No - cryfa lwydda! No.

Cynrychioli'r Dinesydd ym maes Iechyd a Gofal Cymdeithasol
Ydych chi'n cefnogi'r cynnig hwn?
Arselwsg No.

Llunio Cynlluniau a Gwasanaethau ar y cyd â dinasyddion
Pa faterion eraill y byddech am inni eu hystyried wrth fynd ati I ddatblygu'r cynnig hwn?
Cadw at C.I.C

Archwilio a Rheoleiddio a chorff unigol
Beth yw eich barn chi am y cynnig?
Ymweliadau C.I.C yn fuddial. Beth sy'n bwysig yw mynd i'r afael a staff asiantath.
No.

WGWPMB236: Mick Antoniw AM
Location: Pontypridd

General Comments

I am the Assembly Member for Pontypridd and wish to make a submission to the Welsh Government's white paper consultation: *Quality and Governance in health and care in Wales;* specifically (part 4) Representing the Citizen in Health and Social Care.

The Welsh Government deserves credit for retaining CHCs when they were abolished in England and I welcome the Welsh Government's commitment to an ongoing statutory role for the 'patient's voice' in the Welsh NHS.

However, in the same way that we want to see continual improvement within the Welsh health service generally, it is right that we take stock of the governance arrangements in order that any improvements can be identified.

I am supportive of the proposal to enhance the patient's voice, for example in complaint handling. Currently CHC's can act as an advocate in respect of specific patient complaints, but I would like to see this broadened so as to have a genuine oversight responsibility, for example, by interrogating data around complaint trends. Establishing the root cause of any complaint is fundamental to identifying a sustainable solution and this cannot be achieved within the involvement of service users.

CHC currently have a role in representing patient interests in respect of service changes. I have seen the importance of this recently in my own constituency, where the CHC identified issues around parking at the new Dewi Sant centre, which may have otherwise gone unresolved. I do not support any proposal to weaken this important element of consultation and oversight.

The White Paper suggests a duplication of CHC and HIW functions in respect of hospital inspections. Whilst I agree that it does not make sense to duplicate any functions, my understanding is that CHC inspections differ from those of HIW in three important ways. Firstly, CHC inspections are unannounced and can occur at any time of day. Secondly, CHC inspections also include interviews with patients and their relatives (HIW focuses on clinicians only). Thirdly, the CHC conducts follow-up visits to monitor progress, with no constraints on frequency. I believe that it is vital that we retain these elements of the inspection regime if we are to continue to accurately assess service quality.

I belive there are other areas where the patient's voice needs strengthening. For example, there is insufficient input from patients in the planning process. Currently health boards are a statutory consultee in respect of Local Development Plans, but there is no input specifically on behalf of service users. I would like to see a beefed-up CHC consulted on all major residential developments, which inevitably impact on the capacity and quality of GP and other healthcare services in that area.

In summary, there are strong synergies in respect of the CHC's current inspection and consultation roles, which are inevitably valuable and I fully support the continuing role of Community Health Councils in Wales. I am not resistant to changes in CHC's role (or name), but any changes must strengthen the voice of the patient and maintain those elements of oversight, which prioritise the intrests of service users.

WGWPMB237: Anonymous
Location: Unknown

Response to Specific Questions

All Health and Care Services
We want the group of people who lead health and care services to work to the same set of principles (code of behaviour) We want:

- them to be open and clear with everyone
- them to show how they're improving services
- them to work together with others.

Do you think this is a good idea?
Yes

Local Health Boards (LHBs) and NHS Trusts
We want:

- every LHB to have a core group of professional roles
- have others that are flexible and can change based on local need.

Do you think this is a good idea?
Yes

Who's on the LHB and Trusts
We want:

- every LHB to have a core group of professional roles
- have others that are flexible and can change based on local need.

Do you think this is a good idea?
Yes

Board Secretary
We want:

- to give the Board Secretary role protection by law. This will help them raise concerns and challenge things.

Do you think this is a good idea?
Yes

Do you have anything else to say about changes to leadership?
They should understand and be able to talk to people who use services. They need to have enough power but not too much.

Quality services

We want:

- to give them the power to work even closer with local authorities and other organisations
- to have a look at what's needed in thewir area when making plans
- work with eachother when someone needs a specialist service.

Do you think this is a good idea?
Yes

Being open and honest
We want:

- all health and care services to have the same rules about being open and honest
- all health and care services to be open and clear with people.

Do you think this is a good idea?
Yes

Is there anything else you want to say about changes to how we work and think?
There needs to be ways to do this so that people understand the reasons for things. Who wil decide the rules?

Standards of care
We want:

- One set of key standards for all services across health and social care.

Do you think this is a good idea?
No.

Making a complaint
We want:

- A clear, easy complaints system
- All services and organisations to work together to deal with problems.

Do you think this is a good idea?
Yes

Is there anything else you want to tell us about putting people first?
I'm not sure you can have one set of rules or standards as they all do different things.

Involving people
We want:

- To build a new 'citizen voice' group to help more people have a say.

Do you think this is a good idea?
Yes

Working together
We want:

- Make it possible for LHBs to make more decisions locally
- Have independent advice and support systems to help[this happen.
- To make it possible for Welsh Ministers to take decisions when LHBs cannot.

Do you think this is a good idea?
Yes

Inspection and Regulation
We want:

- HIW to have a legal framework like CSSIW so they can work together better
- To know if HIW, CSSIW, and the 'citizen voice' group should come together to form a new, single body.

Do you think this a good idea?
Yes

Is there anything else you want to tell us about getting people involved?
It sounds like a good idea but it also sounds complicated and like it will cost a lot of money?

WGWPMB238: Anonymous
Location: Unknown

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes I agree.

What further issues would you want us to take into account in firming up this proposal?
Ensure they are doing their job role to the maximum potential and monitored.

Board Secretary
Do you agree with these proposals?
Yes strongly.

What further issues would you want us to take into account in firming up this proposal?
Ensure the appointment correct and independent body to scrutinise.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up this proposal?
In some areas care is great and other areas poor, need to be good effective working.

Duty of Candour
Do you agree with these proposals?
Yes.

Setting and Meeting Common Standards
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up this proposal?
It should not be a postcode lottery, each individual deserves high care.

Joint Investigation of Health and Social Care Complaints
Do you agree with these proposals?
Yes.

Representing the Citizen in Health and Social Care
Do you support this proposal?
Yes.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes.

Inspection and Regulation and single body
What do you think of this proposal?
Yes?

However, we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.
Would you support such an idea?
Yes.

WGWPMB239: Anonymous
Location: Unknown

Response to Specific Questions

All Health and Care Services
We want the group of people who lead health and care services to work to the same set of principles (code of behaviour) We want:

- them to be open and clear with everyone
- them to show how they're improving services
- them to work together with others.

Do you think this is a good idea?
Yes

Local Health Boards (LHBs) and NHS Trusts
We want:

- every LHB to have a core group of professional roles
- have others that are flexible and can change based on local need.

Do you think this is a good idea?
Yes

Who's on the LHB and Trusts
We want:

- every LHB to have a core group of professional roles
- have others that are flexible and can change based on local need.

Do you think this is a good idea?
Yes

Board Secretary
We want:

- to give the Board Secretary role protection by law. This will help them raise concerns and challenge things.

Do you think this is a good idea?
Yes

Quality services
We want:

- to give them the power to work even closer with local authorities and other organisations
- to have a look at what's needed in thewir area when making plans

- work with eachother when someone needs a specialist service.

Do you think this is a good idea?
Yes

Being open and honest
We want:
- all health and care services to have the same rules about being open and honest
- all health and care services to be open and clear with people.

Do you think this is a good idea?
Yes

Standards of care
We want:
- One set of key standards for all services across health and social care.

Do you think this is a good idea?
No.

Making a complaint
We want:
- A clear, easy complaints system
- All services and organisations to work together to deal with problems.

Do you think this is a good idea?
Yes

Is there anything else you want to tell us about putting people first?
I believe that standards of care should always be ethical, but it makes sense that each healthcare organisation have a different set of rules in accordance with the services they provide.

Involving people
We want:
- To build a new 'citizen voice' group to help more people have a say.

Do you think this is a good idea?
Yes

Working together
We want:
- Make it possible for LHBs to make more decisions locally
- Have independent advice and support systems to help[this happen.

- To make it possible for Welsh Ministers to take decisions when LHBs cannot.

Do you think this is a good idea?
Yes

Inspection and Regulation
We want:

- HIW to have a legal framework like CSSIW so they can work together better
- To know if HIW, CSSIW, and the 'citizen voice' group should come together to form a new, single body.

Do you think this a good idea?
Yes

WGWPMB240: Police and Crime Commissioner for North Wales
Location: Colwyn

General Comments

I write in response to your White paper “Services Fit for the Future” and I write in my capacity as the Police and Crime Commissioner for North Wales, a former County Councillor and former member and Chair of the Wrexham Locality Committee of North Wales Community Health Council. I have with colleagues undertaken a number of inspections of health locations within North Wales as well as consultation events with the public of North Wales so I therefore do write with some experience as to what services look like and where the gaps are.

Whilst I agree with much of what is in the White Paper especially around the alignment of health and social care I cannot agree or support the proposals around citizen’s voice and inspection. I do not think that the proposal will strengthen the citizen voice but rather will weaken it. The current Community Health Council’s get to hear directly from service users whether they use primary services or secondary as in-patients at a DGH or Community Hospitals. The CHC’s inspection regimes have resulted in many changes for the better with BCUHB. They also advocate effectively on behalf of service users and scrutinise and delivery of health services.

The abolition of CHC’s or their functions as proposed in this paper without a clear direction for what will replace them will indeed be a backward step in your drive to a person centred approach to delivering health services and which will be regretted, as indeed was the case in England following Mid Staffs scandal.

I very much hope that decision makers will take on board my concerns and learn lessons from the disastrous decision to abolish CHC’s in England.

WGWPMB241: Unite (North West Wales retired members branch)
Location: Colwyn Bay

General Comments

I refer to your white paper consultation document titled “Services fit for the future – Quality and Government in Health and Wales”.

I list below some points that were made at the Branch meeting:

1. Nothing in this consultation is considered by our members t do anything to improve healthcare for older people. Quite the opposite!

2. Many of our members know of older people who have taken problems with obtaining a proper healthcare service to the Community Health Council (CHC) and the CHC has obtained a result for them. Yet this consultation proposes to close down CHCs; the one body that older people can rely upon to pursue problems and complaints. Our branch strongly opposes the proposal to close down the North Wales CHC and replace it by an “Citizen’s Voice Body”.

3. The North Wales CHC has 72 members in North Wales, unpaid but skilled volunteers, who are the eyes and ears of the public and have been instrumental in alerting the Health Board Management and Assembly Members to issues such as in mental health and infection control.

4. The assertions that the CHC “are not flexible enough to represent the public in the Health Services in Wales” (para 81) are attributed to former public servants Ann Lloyd CBE and Ruth Marks MBE and not to any Patient Bodies. Our members have seen the limited impact of Ann Lloyd’s actions during special measures in addressing Betsi Cadwaladr’s problems and also the work of our CHC members. They strongly support the CHC.

5. Given that older people are said to be the main users of health and social care, our members we surprised that the “Impact Assessment” covered Equality and Diversity, Children’s Rights and Welsh Language, yet made NO assessment of the impact on Older People of these proposed changes. Our own assessment is that the prposals would have a predominantly negative effect on Older People.

6. We are also surprised that there is no financial assessment of the proposals. We note that the entire CHC operation in Wales costs a similar amount annually to that which Betsi Cadwaladr has been spending on consultancy services. Our members consider that the CHC provide the public with value for money, which other elemnets of NHS in Wales Management do not appear to do.

7. We note the Minister’s acceptance of the OECD recommendation to “strengthen the voice of the citizen”. Many in Wales would agree with the importance and priority that should be given to the views of patients and their families in moulding a quality

healthcare services in Wales. Our members consider that this should be achieved by enhancing the roles and authority of the CHCs and not by closing down the most effective of the patient voice avenues that we posses.

WGWPMB242: J and M Waterhouse
Location: Brecon

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

Board Secretary
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up this proposal?
Should be able to raise relevant concerns of public with the Board without restriction.

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

Duty of Candour
Do you agree with these proposals?
Yes

Setting and Meeting Common Standards
Do you agree with these proposals?
Yes

Joint Investigation of Health and Social Care Complaints
Do you agree with these proposals?
Yes

Representing the Citizen in Health and Social Care
Do you support this proposal?
Yes

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes

Inspection and Regulation and single body
What do you think of this proposal?
Yes – this should be already in place implicit and operational surely?

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
Yes but we question 'new body', unless it is implying that it just hasn't been working in the past…

WGWPMB243: The Peoples Assembly against Austerity (Rhyl Branch)
Location: Rhyl

General Comments

The Peoples Assemble Against Austerity (Rhyl Branch) focuses on participation in all aspects of politics by people from all walks of life, therefore our main concern to the proposals is with the proposed changes to the Community Health Councils. Although in response we made some comment on the proposals as a whole.

We welcome the proposal to link up health and social care as we believe that this can benefit people in giving a more linked up approach to long term health and wellbeing.

Due to the changes in demand for health services and to the increases in people needing to access these services, we welcome this review. Although we agree that the change in demand has put pressure on the services, it is also the UK Tory Governments austerity cuts which has seen the Assembly's budget cut, which has then also had a huge negative impact onb the provision of health and social care in Wales. There is no mention of this in the consultation paper.

We do have several concerns regarding to the proposed changes to the CHCs:

- Members of our group attended a Rhyl Branch Labour Party meeting recently and were informed by AM Ann Jones that this paper was not only to consider changes but to possibly scrap the CHCs altogether. There is nothing in this consultation paper to say that totally scrapping the CHCs is being considered so we will take it that this was not correct. If this was part of the proposals we would like to be very clear that we would totally oppose this.
- Empowering citizens and holding Local Health Boards to account are essential to providing high standards of service. We believe that this is already in the CHCs remit and should not be changed.
- In the CHCs remit is inspections, we believe this is essential as the inspections the CHCs carry out are patient focussed given the patient a voice, whereas the inspections carried out by HIW and CSSIW are organisational focused. The belief therefore that the inspection role that the CHCs carry out are the same as HIW and CSSIW is incorrect and this role needs to be kept as part of the CHCs remit.
- "The membership appointments process is failing" is something that should be discussed at CHCs committee meetings on how they are, as a group, can carry out recruitment drives to ensure there is a balanced representation for health and voluntary sectors on their board. Support for this should also come from the other agencies the CHCs are in co-operation with, including the Welsh Assembly Government itself.
- The CHCs are the only body currently allowed to carry out inspections that have a quarter of the board members coming in from the voluntary sector. These individuals are essential to the process of providing a fair and just

health service as these are the individuals who will be involved in, and meet with grassroots health clubs and committees and can be their voice.

In conclusion, we, as a group, are in agreement to this review being carried out to look at improvements and a more linked up process between health and social care.

We do not agree that we should model any changes on the Schottish Health Council Model as this was designed for Scotland, who have a different process for providing health care. The SHCs have also found difficulties working alongside the health board. Reported in the following paper “A review of Scottish Health Council” April 2017 Pam Whittle CBE, Chair Scottish Health Council.

We do not agree that the cuts in finance from the health and social care sector in Wales should be omitted from any further reports as this has impacted on the pressures of the sector.

As bullet pointed above, we do not agree to parts of the review regarding the CHCs.

WGWPMB244: Anonymous
Location: Anonymous

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes

Board Secretary
Do you agree with these proposals?
Yes

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes

Duty of Candour
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up this proposal?
Candour with an apology when health care standards fall below adequate would save a lot of anguish and pain to complainants. The whole system of excessive delays for meetings and replying to letters, draws the process over a long perod of time. And can be a deliberate attempt to hold the process up until it's too late for an independent investigation.

Setting and Meeting Common Standards
Do you agree with these proposals?
Yes

Joint Investigation of Health and Social Care Complaints
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up this proposal?
However the complainant can only have full confidence in an independent investigation for serious cases. The Health Ombudsman for Wales is the only body that has that trust.

Representing the Citizen in Health and Social Care
Do you support this proposal?
Yes

Can you see any practical difficulties with these suggestions?
A replacement body for local CHC's need to be truly independent and liaise better with the Health Ombudsman for Wales. In particular when making serious complaints to the Health Ombudsman's Office.

A new body should have a good understanding of the 12 month timescale from when to make a new complaint, as laid down by law. For which the Review Ombudsman for Wales' in letter reply to me, was surprised the CHC for North Wales do not appear to have. With my complaint issue the Ombudsman could not independently investigate serious health care failing, because the CHC did not appear to understand the 12 month timescale and I was out of time.

Complainants' should also be made aware from the Health Board of the option to use the Ombudman's services at an earlier stage in clear written letters from the Health Board. Which was another concern the Ombudsman had regarding my case.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
Yes

Inspection and Regulation and single body
What do you think of this proposal?
A single body would make sense as some of their work will overlap.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
A body that is more independent will have greater confidence from the public.

WGWPMB245: Anonymous
Location: Anonymous

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
✓

Board Secretary
Do you agree with these proposals?
✓

Duty of Quality for the Population of Wales
Do you agree with these proposals?
✓

Duty of Candour
Do you agree with these proposals?
✓

Setting and Meeting Common Standards
Do you agree with these proposals?
✓

Joint Investigation of Health and Social Care Complaints
Do you agree with these proposals?
✓

Representing the Citizen in Health and Social Care
Do you support this proposal?
No

Co-producing Plans and Services with Citizens
Do you agree with this proposal?
✓

Inspection and Regulation and single body
What do you think of this proposal?
Yes

Are there any specific issues you would want us to take into account in developing these proposals further?
But a fairness of approach to patient concerns with all the difference services.

WGWPMB246: Llanelli Rural Council
Location: Llanelli

General Comments

Llanelli Rural Council has considered the above document and wishes to stress the importance of retaining community health councils.

Community health councils, as independent organisations, are well placed to support members of the public should they need advice, have complaints or concerns with the health service they have received. The public is assured by its 'watchdog' being able to comment on plans and consultations produced by organisations concerned with health, ensure that good care is provided as well as having the direct contact with patients and staff to discuss health care.

The abolition of community health councils could result in local accountability being lost and it would certainly take away an essential advice service for the public. It is the Councuil's opinion that the role of the community health councils should be strengthened and not weakened with individual community health councils being linked with hospital areas with an over-arching central community health council as in place in the early 2000s.

WGWPMB247: Maesteg Town Council
Location: Maesteg

General Comments

I confirm that Members of Maesteg Town Council have discussed and considered in detail the above document (consultation).

Having had discussions with Abertawe Bro Morgannwg Community Health Council, members were presented with a Briefing Paper outlining what functions of any People's Voice body should be going forward.

The attached document focuses on these elements and the Council believe that they should form any subsequent legislation. However, there are some further challenges common to all public voice bodies (around public awareness for example) that will better be addressed through other means.

I would advise that Maesteg Town Council fully support the elements contained in the attached Briefing Note prepared by the Community Health Councils in Wales.

WGWPMB248: Plaid Cymru Caerphilly Constituency
Location: Caerphilly

General Comments

At its meeting on 24th August 2017, members unanimously opposed the proposal in the white paper to abolish community health councils.

Members felt that CHCs have provided a valuable service to their communities over the years as the patients' voice and watchdog.
As independent statutory organisations CHCs provide the following invaluable services:

1. Advocacy for patients, their families and carers which is particularly important in disadvantaged areas such as Caerphilly County Borough
2. independent scrutiny of the NHS and the Ambulance Service, both through their reports they receive of key health statistics and through discussion with key health and ambulance officers at the CHC scrutiny, planning and executive committees
3. Involvement in consultation processes when changes to NHS and Ambulance services are planned
4. Extensive contact with local communities through the volunteer members who are drawn from many of the areas covered by each CHC and who have different skills and expertise
5. a value-for-money organisation as much of the work is carried out by unpaid volunteers (suppoted by a small paid staff)

We do not feel that the new proposed organisation will have these essential attributes. However, we agree that there should be greater integration between health and social care and would suggest that the existing CHCs could be expanded to cover social care matters.

WGWPMB249: H Roberts
Location: Caernarfon

General Comments

You've clearly spent considerable time preparing the proposals but the end objective, as I understand, is to establish one body to care for health services throughout Wales and I'm totally against this as I feel that services should be provided and run locally. You appear to be trying to establish and even more bureaucratic structure and this appears to typical of your approach,

Your name is "Quality Division" but as far as I can see you've done absolutely nothing to ensure the existence of Quality Management Systems with sound well-structured procedures in all Health Authorities. These would include regular quality management system audits which would pick up pproblems quickly in order that corrective action could be taken at the earliest opportunity. Because this has not been done is the reason for so many issues being discovered when they have been present for ages as has been the case in Betsi Cadwaladr area for example. The systems would of course include effective complaint procedures to ensure that all complaints were thoroughly investigated and dealt with effectively.

Another issue that appears to have been ignored is the desperate need to provide adequate management training to all health authority staff who have some level of management responsibility and this includes staff nurses in charge of a ward. Back in the 1970s I was responsible for the provision of management training in the then Clwyd and Gwynedd Health Authorities. I subsequently became a member of the body known as the NHS Management Training Advisory Committee for Wales. This was made up of people like me from the Glamorgan Polytechnic, Newport, Swansea and Cardiff Colleges of Technology together with managers from the health services. Our role was to ensure the consistency of management training throughout Wales and identify any areas of improvement. This was a successful venture but I can't see that there is anything similar these days. On the contrary, management training of NHS staff appears to be totally ignored.

I hope that you will take note of my comments and act on them soon.

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Yes but proposals do not provide effective governance within the bodies.

What further issues would you want us to take into account in firming up this proposal?
See attached letter.

Board Secretary
Do you agree with these proposals?
Yes

What further issues would you want us to take into account in firming up this proposal?
See attached letter

Duty of Quality for the Population of Wales
Do you agree with these proposals?
Yes but there is no integrated system

What further issues would you want us to take into account in firming up this proposal?
See letter

Duty of Candour
Do you agree with these proposals?
Yes

Setting and Meeting Common Standards
Do you agree with these proposals?
Yes at standards not spelt out

What further issues would you want us to take into account in firming up this proposal?
See letter

Joint Investigation of Health and Social Care Complaints
Do you agree with these proposals?
Yes but the organisation should work together on all issues

What further issues would you want us to take into account in firming up this proposal?
See letter.

Representing the Citizen in Health and Social Care
Do you support this proposal?
No. Don't see how an all-wales authority would be better.

Can you see any practical difficulties with these suggestions?
See letter

Co-producing Plans and Services in Citizens
Do you support this proposal?
This needs considerable thought.

What further issues would you want us to take into account in firming up this proposal?
See letter

Inspection and Regulation and single body
What do you think of this proposal?
Legislative Framework must be made to work

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice. Would you support such an idea?
??

What issues should we take account if this idea were to be development further?
See letter

WGWPMB250: Blaenau Gwent County Borough Council Social Services Directorate
Location: Abertillery

General Comments

The White Paper seeks views on proposals covering a number of health and social care issues which may require future legislation. The aim of any new legislation would be to enable organisations and empower citizens. Proposals include the strengthening of local health boards so they function as integrated, accountable, population-based organsiations; new duties of candour and quality; areas where health and social care can act more collaboratively; and more effective inspection, regulation and capture of the citizens' voices.

After reading the document our initial thoughts were that Welsh Government appear to be ploughing ahead with integration of different elements of the Health and Social Care prior to the conclusions and recommendations of the Parliamentary Review of Health and Social Care which we find alarming. Although it provides further evidence of their intention and direction of travel to move towards and intergrate Health and Social Care sytem.

The introduction talks about 'working together' to 'prevent ill health and provide the care people need, when they need it'. It states (Health and Social Care) 'cannot continue to work in isolation and we must now look beyond the boundaries when making decisions about what services and actions will deliver the best outcomes for actions. This requires mature partnership working on national, regional and local level.' Our view is we have had the Social Services and Well-being Act Part 9 and the Future Generations Act implemented within the last 15 months and before there has ample time to fully embed this legislation WG are already proposing changes which appear to be in the main to compelHealth to parcipate, if proposing changes which appear to be in the main to compel Health to participate, if this is WG's concern why did they not make it more explicit within the SS&WB Act and the WFG Act to tie Health Boards and the NHS in?

In addition we feel that the whole paper is more evidence of regionalisation and integration through the back door and avoiding the need to go through Local Government Reform.

The paper indicates that co-production is about people making joint decision about their own care and that systems across health and social care now need to make a real shift towards this way of working because this is hoiw standards and quality will be driven up. They are expecting a change of 'culture' for practitioners and quality will not happen overnight but over a few years. The Social Services and Wellbeing Act has been the catalyst for this cultural change in social services but this has only been up and running for 15 months. Are they implying that this cultural change is not working and that they need to make further changes? We also cannot agree that co-production will necessary raise standards and quality, co-production will make services more sustainable and cost effective by ensuring we work with those who need statutory services at the right time, in the right place by the right person.

They proceed to reference a green paper on seeking views to improve the quality of services provided by the NHS in Wales as well as the governance and accountability of the organisation and the people who manage them. They then appear to have pulled in Social Services to the recommendations although the consultation did not seek the views of users of social services.

The section on the 'reasoning behind our proposals section point 8 to 15 references health evidence and reports, there is no single reference to any evidence indicating the need for change within Social Services.

Chapter 1: Effective Governance
This section relates completely to the composition and membership of Health Boards and NHS Trusts. They suggest Board Executive Officer membership for local health boards should probably include some key positions which is consistent across local health boards but also allows some flexibility to appoint based on remit and priorities. This is an acceptable and agreeable recommendation as far as we are concerned and it is to obtain some consistency across Wales.

Welsh Government also feels the role of Board Secretary should be placed on a statutory basis and have statutory protection to allow the role to be independent with safeguards in place to challenge the Chief Executive of the NHS or the Board more widely. Again this is an acceptable and agreeable recommendation as far as we are concerned which allows the role to challenge if it doesn't agree with the direction of the Board or Chief Executive.

Chapter 2: Duties to Promote Cultural Change
The Welsh Government belives that the duty of quality should be updated and enhanced to better reflect our integrated system. This duty should be sufficiently wide in scope to facilitate the needs of the population of Wales to facilitate and enable collaborative, regional and all Wales solutions to service design and delivery.

This proposal appears to be about ensuring NHS bodies should also be placed under a reciprocal duty with local authorities to co-operatie and work in partnership to improve the quality of services provided to match the SS&WB Act and WFG Act.

They also believe that strengthening the existing planning duty will make sure health boards work together on the needs of the population of Wales in the planning and delivery of quality healthcare services. This appears to be seeking for Health Boards to work across boundaries.

Duty of Candour
The Welsh Government believes that the development of a statutory duty of candouracross health and social services in Wales would consolidate existing duties i.e. Health and Social Care (Community Health Standards) Act 2003 and Regulation and Inspection of Social Care (Wales) Act 2016, the first Act need to be strengthened and would be in the interest of a person centred system. Again RISCA is currently being implemented commencing April 2017 and will be phased in over the next 2 years. It appears to be down to strengthening the Health duty to candour.

Chapter 3 Person Centred Health and Care
The Welsh Government believes there should be a common set of high level standards applied to health and social care and that the standards should apply regardless of its in their own home, in their community, in a primary care setting, a residential home, a nursing home, or a hospital.

They refer to Health Inspectorate Wales who inspect NHS services against the Health and Care Standards, whilst it inspects and regulates the independent sector against the National Minimum Standards for Independent Healthcare and CSSIW who possess their own separate standards and regulations.

They indicate different standards can be confusing for services users which we can accept but also providers, which we find difficult to accept. They indicate individuals receiving care can be left perplexed as to why different standards operate in different settings when they feel that they have the right to the same standards of care regardless of where they receive it. Although it is difficult to disagree with this, our view is it is more down to who provides the care and what they are able deliver under the standards i.e. home care workers are unable to undertake health care tasks, etc. It's more about the number of people attending to deliver health and social care tasks that to different standards.

These standards will no doubt have to be high level to cover such a breadth of different environments and as such will still require more environment based standards.

In addition when implementing any new standards they can and often do have cost implications. This will mean some providers seeking additional funding to implement such standards and seeking such fnding from commissioners, at a time particularly in social care when the domiciliary and residential markets are in such a fragile state.

Joint Investigations of Health and Social Care Complaints
The Welsh Government believes that requiring different organisations to work together to investigate complaints will make it easier for people to complain when their complaint is about health and social services. They also believe it will encourage organisations to learn lessons to improve their services. They claim that people whose complaints cover health, social care or a private home have to make at least two complaints.

In reality if we receive a complaint that covers both health and social care we will jointly meet and determine who is best to investigate that complaint and will often provide a joint response to the complainant. In any complaint both organisationw will identify learning and try to ensure this learning is embedded into practice. However, if Welsh Government believes they need to legislate to ensure this is adopted legally rather than on a good practice basis then we do not see this as a problem, however it may provide the opportunity to develop a joint health and social care complaints team.

Chapter 4: Effective Citizen Voice, co-production and clear inspection

Representing the Citizen in Health and Social Care
They site a number of arrangements already in place, i.e. Citizen's Panels under the Regional Partnership Boards, the Public Service Boards and their responsibility for engaging the public, the Community Health Councils, etc. They believe they can build better, stronger ways to represent the voice of people in health and social care and work collaboratively to engage and involve the public. They question whether the CHC model is flexible enough to respond to a health and care services that work increasingly across organisational boundaries.

They propose to create a national citizen voice arrangement that would represent the interests of the public in health and social care and would sit alongside HIW and CSSIW and work closely with them. They want the bodies to be organsised so they can take a unified approach when required but operate independently of each other when necessary. They state positioning the new arrangements alongside the inspectorates, will increase the profile and visilbility, remove a number of duplicative activities and functions currently invested in CHCs and embed patient voice more systematically within the work of inspectorates.

Also the current independent advocacy service provided by the CHCs in relation to NHS complaints they want to expand to cover complaints about social services.

Although we have no objection to a new national citizen voice arrangement, I am not convinced placing it with HIW and CSSIW will have any benefit, if it is truly national and covers all of Health and Social Services then we believe they should also take a view on how the inpsectorates operate and therefore should be independent in order for them to be allowed to comment on the work of the inspectorates. Although Inspectorates are independent of Welsh Government they are also accountable to the Minister and we feel any new arrangement has to be independent of both Welsh Government and the Minister in order to be able to be candid with their views, this will not be possible if they are seen as part of the Inpsectorate.

Co-producing Plans and Services with Citizens
This relates specifically to Local Health Boards, CHC's and the public and the difficulty at the moment with disagreement between the LHB's and CHC's particularly on proposals which cross local health boards and CHC boundaries which could deliver important benefits to the wider populations i.e. substantial change and reconfiguration.

They are proposing to introduce a trigger process of further scrutiny for proposals that meet agreed criteria for substantial change and reconfiguration within Health Boards by considering the clinical evidence and an assessment of whether adequate involvement of the public has been achieved in drawing up the proposals. They expect the new citizen voice body will determine the latter.

Inspection and Regulation
They refer to the RISCA 2016 creating a clear statutory framework for CSSIW and a clearer platform for assurance that services are meeting people's needs. This has highlighted the contraints that the existing legislation underpinning HIW creates

practically; therefore they wish to at the very least overhaul HIW's underpinning legislation to ensure it is a clear, single, legislative framework similar to RISCA.

In addition they are seeking views about a new Welsh Government Sponsored Body to provide more independence in regulation and inspection and citizen voice. Such a new body could see the pooling of significant existing resources to create a more independent entity which could provide further rigor and focus on quality in a more integrated system.

We do not have any issues about the underpinning legislative framework for HIW and whether a Welsh Government Sponsored Body will provide more independence in regulation and inspection and also citizen voice would only be clear when we see the body in operation and whether if any political pressure will be put on such a body or whether it can maintain its independence.

WGWPMB251: D. & J. Hopkin
Location: Swansea

General Comments

We wish to inform you that we do not support the plans set out in the above White Paper.

We believe the Community Health Councils are a vital part of the scrutiny of the NHS.

They need to be independent and have stronger powers to help and protect patients and their families and to hold the National Health Service to account whenever and wherever it is necessary.

WGWPMB252: Socialist Health Association Cymru Wales
Location: Swansea

General Comments

The proposals in the paper are mainly about process. Good processes are always preferred to poor ones; however SHA Cymru Wales would stress that good health and care outcomes also depend on the wise inputting of relevant human, financial, technical and other resources. The UK Government appears belatedly to recognise the failure of its austerity programme but until it supports the devolved Administrations and drastically alters its own stewardship of the English NHS and English local government, our public services will remain in a precarious state until adequate investment in them occurs and their work both valued and lauded.

SHA Cyrmu Wales responded to that earlier consultation paper and highlighted many of the issues that Welsh Government now seeks to address. We therefore welcome many of the proposals in principle.

In the main, we urged caution in seeing more laws as the answer to the current challneges faced by the Welsh NHS, Welsh Local Government, and their partners. Organisational culture, strong and consistent political leadership, and an evidence – based strategic vision for the NHS and its partners are seen as important, and probably more powerful, as legal processes and powers. We understand other bodies also took a similar view.

Welsh Government led the abolition of the “internal market” in health care in Wales. A decade of experience based on the principles of co-production not competition exists and the outcome of this consultation exercise must draw upon what has been learned. With that in mind, SHA Cymru Wales would support some further legal powers as set out below. Our comments follow the headings used in the paper.

Membership of Local Halth Boards and Trusts

Currently the roles of all executive members of LHBs are specified in regulations and the paper enviseages less prescription in future. It is proposed that in future regulations will specify a core membership of Local Health Boards and Boards will be given the freedom to decide the scope of most executive posts providing that clinical and non clinical roles are recognised. SHA supports this proposal in principle.

It is also proposed that, for NHS Trusts, Executive posts will be set out in regulations and Trusts must have both a Chief Executive and Director of Finance. SHA supports this proposal.

SHA Cymru Wales also recognises that many non executive board members appear to have professional and specialist skills that may render them less typical of many users of health and care services and thus less able to relate to, and reflect, the everyday experiences of such users. While members ought to have some ability to hold the Board Executive to account, there must also be an informed capacity to reflect user experience if services are to deliver user and patient centred services.

Additonally, SHA has some sympathy with commentators who suggest that some LHBs remain dominated by the immediate interests of secondary care providers at the expense of primary care services and whole population planning. SHA retains a view that, for Local Health Boards, more needs to be done to equip the Board to a. provide proper leadership of its "provider" function b. strengthen the leadership of its longer term planning/ commissioning function for its served population and c. create Board level machinery that is robust enough to mediate its provider and commissioner roles for its defined population. This may be done in a number of ways, most of which recognises the two distinct functions of LHBs.

Role of the Board Secretary

The role of the Board Secretary is a fairly new one and it is probably too early to evaluate how it has functioned as the guardian of good processes of governance – a mainly inward looking task. Despite concerns that the post may become over-burdned with many conflicting priorities, some consideration must be given to ensuring that health boards work effectively with other partners to deliver shared agendas.

The paper proposes that the role of Board Secretary should have a statutory underpinning – for example by requiring any proposed disciplinary action against a Board Secretary to be taken independently of the Board itself. It also proposes that the Board Secretary should have a right to access to the Chair or Chief Executive if he/she has concerns.

SHA Cymru Wales supports legislation to bolster the role of Board Secretary in the ways described.

Promoting Cultural Change

The paper proposes laying a duty of care upon Boards to deliver quality of planning and providing services for whole populations in addition to their current duty to provide quality services to individuals. The paper also proposes creating a legal duty on Boards to collaborate with other Boards, local authorities, and third sector agencies, to work in harmony in order to deliver regional services and All Wales aims.

In places there is a lack of precision about the intent of proposals. It is crucial that Health Boards plan for the delivery of services to meet the needs of their defined population(s). On occasions the paper appears to be ambiguous about this when it wonders if local population planning is now outdated. The need for a new and greater priority to fashioning coherent services, especially where there are cross boundary and cross border issues, seems to be suggested.

In part this ambiguity seems to be less motivated by a desire to, as far as possible, keep the Minister out of deliberations about service reconfiguration – keeping decisions at local Board level – even when regional and national services dimensions are clearly involved. (The current debate about whether a Major Trauma Unit is needed to service South Wales, and where it should be, is one such example).

SHA Cyrmu Wales supports the first proposal – to lay a duty of care on Boards for their commissioner/ planning functions – as this follows on from above where we argue for better recognition of the Board's commissioner/ planning role.

SHA Cymru Wales is less convinced that inter Board and inter agency co-operation would be aided by introducing the proposed legal duty to co-operate. Instead, it is suggested that any contributions needed from Boards to promote the wider regional or national interest ought to be built into the performance management framework that applies to Boards and Local Government with much greater clarity about how regional and all Wales service delivery decisions are to be made.

Duty of Candour

To make progress iun delivering the 2016 Labour Manifesto promises to build on the provisions in "Putting Things Right", it is proposed to place NHS and Social Care organisations under a duty to be open and transparent – a duty of candour. England has such a duty to be open and transparent – a duty of candour. England has such a duty for NHS bodies only (excluding the contracting primary care services) while Scotland has wider powers.

The paper asks what issues are raised by this aspiration and SHA Cymru Wales responds as follows.

a) If the intention is to include services that are contracted to either the NHS (such as primary care and third sector providers) or to Local Government for providing social care, such a duty may need to operate within a framework that is informed by the interests of insurers of such service providers (for example, insurers may have a view upon perceived admissions of liability). Forms of redress that are acceptable to both service providers and service users will be necessary.

b) Likewise, similar issues may arise with bodies providing professional indemnity or other representative services for professional staff.

A duty of candour about poor political and managerial decisions ought to apply alongside aspects of direct care.

c) A duty of candour about poor political and managerial decisions ought to apply alongside aspects of direct care.

Person centred health and care

The paper proposes the application of a common set of high level standards across health and social care regardless of where that care is delivered. Thus it is intended to promote independence, autonomy, choice, and control – underpinned by an independent advocacy service for vulnerable people.

SHA Cymru Wales accepts this high level approach but is disappointed that there is no acknowledgement of some of the practical ifficulties involved in giving effect to these aspirations. For there is a fundamental fifference between the way health and social care is delivered. The former is comprehensive, free at the point of delivery and largely publicly provided. The latter is limited, means tested, and substantially delivered by the private sector. In addition, the Welsh Government drive towards

individual/ personal payments in socal care makes implementation of consistent standards even more difficult.

Abolishing the differences between these two delivery models is not, we accept, in the gift of Welsh Government (except for individual and personal payments) but their existence, and the difficulties thus caused, need to be acknowledged.

SHA Cymru Wales is not opposed to these proposals in principle; however careful crafting of such standards will be necessary if they are to proceed beyond mere exhortation to something with a clear utility. Further, were such standards to possess such a utility, regular updating of them to reflect best practice would be necessary and machinery for agreeing changes would be necessary.

Joint Investigation of Health and Social Care Complaints

The paper notes that more care relies upon joint action by services yet presently the coimplaints procedures for health and social care are clearly separated. The proposal is to change the current regulations – through legislation – to enable health and social care bodies to jointly investigate complaints where necessary.

SHA Cyrmu Wales would support the use of legislation for this purpose. We would also wish the legislation to allow for joint machinery to pursue complaints that are about both the planning/ commissioning of care as well as the delivery of care, and to give powers to commissioning bodies jointly to investigate care delivered by private or third sector providers on behalf of healthy and social care bodies.

Effective Citizen Voice: inspection and regulation

The paper sets out a good case for the better capturing of people's views, and for using this differently in the inspection and regulatory framework.

These two strands are addressed in Chapter 4 so SHA Cymru Wales comments upon these related topics below. (Proposals on co-production and the machinery for overseeing service change are considered separately in section 4.8 of this response below).

The paper describes the current Regional Partnership and Public Service Boards that are intended to offer arenas within which partnership working can flourish. Alongside these other means of involving the public in health matters are noted such s CHC's and GP patient groups – both of which currently and deliberately have a discrete population to represent. Similar machinery for local government services is not laid down in statute, presumably because the democratic oversight of such services offered by local government are judged to be sufficient.

Turning to proposals, several strands of change are explored:

- Could the CHC model be built upon to expand to cover both health and social care?
- Is the discrete population focus (of CHC's especially) a strength or a limiting constraint – and how well is the locality represented?

- Does the inspection role played by CHC's conflict with, or duplicate, the role of HIW or future similar bodies?

The proposals in the paper include new machinery for "voice" across health and social care across public service boundaries. Further, unified machinery should build upon CHCs and "sit alongside" HIW and CSSIW – retaining an independent capacity to work independently, set its own work programme, recruit volunteers, add value to the engagement work undertaken by health and local government bodies, and provide a competent advocacy service.

SHA Cymru Wales has the following views on issues raised in this part of the discussion.
1. The independent positioning of an expanded and local CHC-style "voice" covering both health and socal care within wider democratic and regulatory machinery, and its "localised" perspective, is a proper, necessary, element of "grit" in the system. It might be that such a deliberately partial perspective may, at times, be difficult for the political processes at local government and Welsh Assembly level to manage, but such a vehicle must have a place in offering a joined up and local view of how health and care services are perceived by the public.
2. The expanded CHC model, with changes to paid personnel and to its membership, must equip it to be a channel for the experiences of users of both publicly run and publicly procured NHS and Social Care services – however provided. Its remit should explicitly require it to look for "whole systems" solutions to the concerns brought to its attention.
3. The role outlined in 2 above is seen as complementary to the different inspection (and promotion / sharing of good practice) remit rather than a combined HIW/ CSSIW body should carry. It would also complement the existing democratic representational mechanisms operating within the Welsh polity.
4. Such a new style body should be able to deploy as it sees fit the resources it is given to enable it to deliver its remit. In particular, such bodies across Wales should aim to be seen as skilled at engaging different segments of their served populations using the widest range of techniques. "Hard to reach" groups should have a particular focus.
5. All new style "Voice" organisations in Wales should be required to share with their peers annually i) areas of new good practice in their care system ii) methods of engagement that were judged novel or effective.

Co-production of plans and services
SHA Cymru Wales is a strong supporter of the notion of "co-production" of health, drawing as it does upon the work of one of its most distinguished members, Dr Julian Tudor Hart. Here, a narrow definition of co-production is intended to refer to both health and wider care outcomes that individual patients/ service users help achieve for themselves by balancing the pros and cons of different interventions and their outcomes, and by their own actions.

However, the paper appears to propose that the notion of co-production be expanded to improve the management of services changes by the better use of social media to increase engagement and by mediating the challenges arising from

complex and controversial changes using “independent scrutiny” without the option of Cabinet member involvement.

SHA Cymru is not always convinced that co-productioin can always be employed in this way for the following reasons.

First, the “evidence” that has to be considered when weighing service change emanates from different sources and is of different types. Medical and other care professionals can opine on the evidence of likely benefits and dis-benefits of different interventions and care delivery options. However, the “trade offs” – for example of which communities lose from re-locating services or which social groups lose more from ceasing (or reducing) the provision of different care services – will be perceived differently by those groups affected. SHA believes it is both inevitable and right that the choices that have to made to modernise care services and keep them affordable are, in many cases, best made throough a political process employing, inevitably, apolitical rationale. Currently this often requires the Cabinet Secretary to decide between competing options – sometimes on the basis of what is politically achievable rather than what is deemed to be the best option by care professions relying on a different (often scientific) metric.

Second, service changes, especially health care changes, often involve the re-location of services to new sites many miles away. It is then that “losing” and “gaining” populations will see the change differently, with the former wanting a robust process through which its concerns can be taken. It is difficult to see changes such as these being negotiated by several new style community councils coming together to “co-produce” an acceptable outcome if, as is likely, such councils are perceived as existing to be effective advocates for the communities they serve.

In summary therefore SHA Cymru Wales is not convinced that the alternative arrangments proposed for determining contested service changes have merit. Where change has been fully explored at local level and an outcome agreed by the health and care system, any objections to that outcome ought to be capable of swift political oversight to ensure that the selected proposal has been properly considered and those objections properly weighed. This requires a more proactive role for the Cabinet Secretary than that proposed in the paper (intervening as a last resort) – and even within that limited context it is not clear what threshold would need to be crossed to trigger such an intervention.

In SHA Cyrmu’s view this debate once again highlights the need for enduring and competent All Wales Strategic Planning machinery that is able to resource and steer the Health and Care system in Wales as one inter-dependent entity with its preventative, assessment/ diagnostic, intervention/ treatment, and ongoing support/ care components continually recalibrated in the light of emerging or forecast needs. A 21st century version of the Welsh Health and Care Planning Forum that is able to weigh hard and soft evidence and apply political, managerial and professional judgement and leadership might be one approach.

WGWPMB253: County Councillor Val Smith
Location: Monmouthshire

General Comments

I consider this is the opportunity to provide an independent body to oversee common standards in both Health and Social Services/ Care.

A truly independent body, adequately funded, which also truly incorporates the voluntary sector.

Confusion exists in the public's mind, at the moment, as to who does what. This is an opportunity to provide a clearer view of where responsibility lies for services, and quality control.

Benefit of voluntary efforts should not be undervalued.

WGWPMB254: F C Hunt
Location: Powys

General Comments

Thank you for the opportunity to respond to the White Paper "Services Fit for the Future". In doing so I need to declare an interest as I am currently the Chair of Powys Community Health Council (CHC), however I also need to make it plain that I am writing this in a personal capacity.

My responses are confined to Chapter 4 of the White Paper – "Effective Citizens Voice, Co-production and Clear Inspection." I am not answering the questions directly posed at the end of each section in this Chapter but taking the opportunity to make a more detailed written response and trust that this will be both helpful to and supportive of you.

Along with the whole CHC movement – local organisations like Powys CHC and the Board of CHC's (the national body) of which I am also a member – I broadly support the Welsh Government's intention to strengthen the citizens voice. However, I am concerned that the proposals in the White Paper for replacing CHCs do not provide an effective independent voice and are in fact a step back from what is already in place.

I agree with the aspiration set out in the White Paper that health and social care bodies should get things right for themselves by continuously engaging with their communities. I also know that these bodies do not yet get this right every time – and I do not believe that new legislation alone will make this happen. It is my strong belief therefore that the people of Wales deserve an independent effective voice, one that is working hard every day to make sure people's views and experiences influence hwo thei health and care services are designed and delivered, encouraging and valuing the diverse range of voices across Wales. A voice that is capable of making sure service providers across health and social care are held to account for the services they provide.

1. The Essential Elements
I believe that any model for a new people's voice body must contain a set of essential elements. Such a body must:
Be independent
Have statutory rights
Have an independent advocacy complaints service
Be integrated – work alongside, but not be part of Health Inspectorate Wales (HiW) or Care and Social Services Inspectorate Wales (CSSiWW)
Be service wide – embracing both health and social care
Be people focussed – reflecting and representing their interests in health and social care services
Be truly representative and diverse – with volunteers as its lifeblood, reflecting the community they serve
Be transparent
Have a local focus with a national body co-ordinating and setting standards

It is extremely important that this new model should be designed and developed in Wales for Wales. Of course we should learn from experiences of others and build on what is of value within these. This is a “once in a lifetime” opportunity for Wales to “shine”, to lead not follow, be bold in developing a strong, meaningful people’s voice body, and build on what is currently working and not start from scratch.

2. The core functions of the new model.
Whilst at engagement events over the Summer, staff and members of the CHCs (the latter unpaid volunteers, including myself) took the opportunity to talk with the public, stakeholders, Assembly Members and MPs about the White Paper proposals. We meaningfully engaged with people and communities across Wales and analysed existing practice in the UK and wider afiled in order to develop through co-production, a new model that recognises the need for change. As a result it has been possible to formulate an evidence based, needs-led model of what a new people’s voice body covering both health and social care should look like. This model has been endorsed by the Board of CHCs, and also at the Full Council meeting of Powys CHC on 12th September 2017, where members unanimously supported and agreed it.

The new people’s voice body in Wales should have the following functions:
i) to encourage and support the involvement of people of all ages as individuals and communities in the design and delivery of services by:

- Engaging directly with individuals and communities on the things that matter most to them about their health and care services. Including engaging directly with people whilst accessing services.
- Supporting, encouraging and facilitating engagement and involvement through a formal alliance with others to promote co-production and co-design (building on the Scottish Health Council’s model *Our Voice*) including English NHS Trusts, Local Authorities and other service providers.
- Working collaboratively and across-boundaries and across borders to develop a creative, bilingual and accessible platform for individuals, communities, regions and the wider population to share their views and experiences and influence health and social care design and delivery on a local, regional and national level.
- Informing the development of national standards and guidance for engagement and consultation which can be adopted bycross-border service providers.
- Advising and supporting providers on involving people, including on engagement and consultation activity.
- Monitoring and evaluating the effectiveness of involvement, engagement and consultation. Checking that people have had the opportunity to be heard and that their views are properly considered and responded to.

I do not consider a new people’s voice body should be checking compliance against standards (this sits better with others) however, it could and should refer concerns to responsible bodies if it appears standards for engagement and consultation have been breached.

To represent the interests of people in health and social care by:

- Scutinising health and care policy, plans and performance locally, regionally and nationally. Challenging service providers and policy makers where improvement is needed.
- Scrutinising the work of health and care regulators and inspectors
- Sharing ideas, information and concerns about health and social care to support service improvement
- Involvement in the co-design and development of services (including service changes proposals)
- Providing independent advocacy support and assistance to individuals raising a concern about health and care services.

It should have the following rights:

- Right to visit unannounced wherever health and social care is delivered (NB. This would not extend to the homes of individuals) to report on its findings from an individual's perspective and to have those reports acted upon.
- Right to co-operation from care providers in contacting people on their behalf for the purpose of collecting independent feedback about care services
- Right to be heard in health and social care (including on service change) by:
  - Policy makers
  - Service providers
  - Scrutiny bodies
  - Regulators
- Right to a full, public and timely response from the above on concerns raised.

I do not consider a new people's voice body should take on the following existing CHC functions, duties or powers:

- Provide advice and information on health and social care services

I believe the responsibility for this should be with health and social bodies. The new people's voice body must have the right to challenge services where the advice and information is not sufficient, clear, accessible or accurate.

- Inspect premises

I belive this responsibility should sit with relevant regulators/ inspectorates.

- Responsibility to develop alternative models to service change proposals where agreement cannot be reached.

I don't believe any lay organisation would be equipped to meet this responsibility.

- Right of referral to Ministers on service change proposals

A new people's voice body should not be the decision making body for a proposed service change. All service change proposals should be open to public scrutiny. Where decisions are not considered to be in the public interest, then the appropriate challenge is through judicial review.

3. What should a new people's voice model look like?

It must be a single legal entity on a stand alone basis – so that it is and is seen to be independent.

It must enshrine the principle of decisions being taken as close as possible to the people impacted.
It must provide for local determination of priorities according to evidence of local needs.
It must have the agility to take decisions that impact locally, regionally, and nationally.
It must provide for clear lines of accountability within a strong standards and governance framework.

The new people's voice body would embrace co-production and co-design as methodologies for developing and taking its work forward. Volunteers would be its "lifeblood" truly "planted" in their local communities, and it must be free to determine how it recruits them. They would have the opportunity to contribute in different ways according to their skills and interest and their activities would be underpinned by a strong framework of competency based learning and development.

In summary, a new body is needed with a remit over health and social care. It must have the ability to listen to peopleand have the power to represent their interests and hold organisations to account on the services they deliver. It should be created with pertnersand with thoseit represents. However, the success of any future model will depend on the detailed arrangements being co-produced with partners and stakeholders and I would ask that the Welsh Government looks to facilitate this approach over the 6-12 months following this consultation period.

Service Change
Along with the Board of CHC's and Powys CHC I believe that there should be a single approach across health and social care to handle service change proposals. I am concerned that the detail in the White Paper proposals around any new service change process does not provide for this. Integrated service developments should be driven by communities whose contribution must be valued and utilised by decision makers in both health and social care. It makes no sense to develop a detailed service change process centred on NHS decision making alone.
I also have concerns that the processes described in the proposals are based upon current practice in the NHS in Scotland. This has been subject to a recent review that recommends a move away from this approach in light of expiernece. Specifically, the review recommends a shift from defining service change as significant or otherwise. The review states "decision as to whether something should be seen as 'major' or 'minor'… have become divisive, confrontational and detrimental to public confidence in the NHS". I don't believe that we would want this for Wales. In my experience where service change has been successful the level and nature of involvement, engagement and consultation has been proportionate and responsive to the needs of those affected. Futher, all service change be open to public scrutiny.
I agree with the proposals to revise existing guidance and believe that thew guidance needs to illustratewhat effective engagement based on co-production principles looks like in health and social care. In revising and extending this guidance to social care, the Welsh Government should work with NHS bodies, social care providers, the people's voice body and others with a role in helping communities to be heard. The revised guidance should explicitly recognise that decisions taken nationally and

regionally have a direct impact on how health and care services are designed and delivered locally and should provide greater clarity as to how co-production priciples will be used to ensure people are engaged at all levels.

Inspection and regulation

I am not clear how the proposals to overhaul HIWs underpinning legislation would inevitably lead to more integration and common methodologiesbetwen the two existing inspectorates (CSSIW and HIW). I recognise that removing the existing inspectorates from within the Welsh Government and housing them within a Welsh Government Sponsoered Body would bring more independence from government. However, it is difficult to see how the governance and accountability arrangments would work in a model that seeks to preserve the independence of three separate bodies within one Welsh Government Sponsored Body. The experience in Scotland with its Healthcare Improvement Scotlandmodel (which houses within it a range of distinctive groupings, including its inspectorateand the Scottish Health Council) illustrates the challneges of maintaining an individual and independent identity for each.

Cross Border Complexities

Finally, I must draw attention to those incredibly important matters the White Paper does not address. These omissions concern people across Wales in varying degrees, but they have an especially high impact on the people of Powys. For example I am awarethat Powys Teaching Health Board, with no District General Hospital of its own, commissions around £150m of secondary care services and approximately £50m of secondary services from England (£22.3m from Shrewsbury and Telford Hospital Trust alone). Because of this, patients and communities in Powys face complexities in accessing services, and I need to place emphasis on them here. In the White Paper, there is:

No reference to, nor recognition of, the cross border English services commissioned for Powys patients;
No reference, nor recognition of, the complexities of cross border/ English service changes for Powys patients;
No reference in any detail to the current scrutiny role that Powys CHC provided on behalf of Powys patients on over 60 Boards across England and Wales;
No recognition of the value that the community based membership (all unpaid volunteers) of Powys CHC and their networks – the “eyes and ears” currently provide on behalf of Powys patients;

These complexities and values must be recognised and reflected within the functions of any new people’s voice body operating anywhere in a Wales, but especially here in Powys where such a large proportion of citizens are so directly affected.

I know the Board of CHCs and the whole CHC movement is desirous to work constructively with the Welsh Government to deliver a people’s voice body that works for everyone in Wales and have some really good ideas about how the aspirations with the White Paper can be delivered. I wholeheartedly support the national response from the Board to the White Paper and the individual response

sent in by Powys Community Health Council and trust that these, together with my own responses contained in this letter, are helpful to moving matters forward.

WGWPMB255: T Conway RD* BSc DSc. CPhys. MInstP. Grad InstP. BTEC. RNR (Retired) & Mrs B Conway
Location: Anglesey

General Comments

We participated in the North Wales Consultation "EXERCISE" on Wendesday 27 September 2017. We found this to be most unsatisfactory.

We only found out about the Consultation Meeting, and its location 20 miles away, the day before. 26 September 2017.

The closing date for comments and contributions was stated to be today. 29 September 2017. The time allowed for this consultation is grossly inadequate.

It shows a total disregard for the public in Wales and the many suffering patients who are deeply troubled by the gross inadequacy of the services available.

The Consultation Documents, 4 off. Were not available at the meeting so we were obliged to print them off the web. The 4 documents compromise 88 pages of detailed print all of which needs some commentary. This is impossible in the time available.

It is quite clear that this consultation is a whitewash exercise. It is clear that the UK and the Welsh Government have made up their minds already as to what they want to do the NHS in Wales and the UK.

This is clear from the proposal to cancel the function facilities, and capabilities of the Community Health Councils (CHC). This CHC function is one of the very few things that works in the NHS in Wales. The CHC does what it says on the TIN – It holds to local Hospital Boards to account. It uses its teeth in the form of thew Advocacy Service. Since it is proven to work for the paitients who complain about the service they have receives the Government wants to replace it with some toothless talking wonder of useless proportions.

The CHC's must be retrained along with its advocacy service.

It is deduce from the contents of the presentation that the Government Health Service Politicians and Administrators have already completed and extensive consultation with Private Medical Services Companies in order to ensure the revised form of the NHS organisation as proposed in the Consultation Documents conforms with the Private Health Contractors who tender for the planned work associated with the Private Contractor takeover of the various national hospital boards who will displace the existing organisations.

The Government administration of the National Health Service and the various hospital boards only involves cuts of all types. They close hospitals, they close wards for 6 weeks to stop Orthopaedic operations, (Bangor). They arbitrarily stop elective Orthopaedic Surgery for 17 weeks and 6 weeks, (Bangor 2016 & 2017) They close wards that are capable of taking YsbytyGwynedd post operation/ treatment patients

at Holyhead Stanley Hospital to relieve pressures on beds at Bangor. 2 wards are closed with no beds at Holyhead Stanley Hospital.
Orthopaedic Patients at Bangor are having to wait 98 weeks before they can get an appointment for an operation. Hospital Appointments for Orthopaedic and Hernia Operations are cancelled at short notice up to 4 times. Hernias can strangle and reach critical life threatening conditions.

The Bangor Hospital Complaints System is incorrectly managed. They insistthat they deal with “Concerns” and do not appear to treat complaint matters as a serious issue.

There are defined treatments for various medical conditions but the NHS in Bangor Hospital which has been in “Special Measures” for some time does not seem to be able to do “what it says on the tin” and perform to the public satisfaction because of political interference in the operation of the various medical and surgical departments.

The performance of the hospital staff at all levels is seriously affected and the staff morale is also seriously adversely affected by the political interference and cuts in everything. The Hospital Management must accept responsibility for this state of affairs and do something about it.

Firstly there must be an absolute priority to provide a major increase in staffing levels and funding to ensure that the patients are correctly and promptly treated. The organisation of the NHS and Hospitals does not need changing in accordance with the White Paper. That will only cause chaos and achieve nothing.

The appointment of Private Health Service Contractors to run the Hospital Boards will cost a fortune and achieve nothing but dissatisfaction in the working level of staff. The proposed changes will involve more cuts to facilities, staff, and services.

The Community Health Councils and their advocacy service and ability to refer to the Ombudsman must be protected and reinforced.

The short notice of the consultation period indicates to me that the Political Arm of the NHS has a preconceived plan of what it wants to do and has not intention of taking any notice of any comments made on the proposals. Our comments are made in good faith but we have nor confidence in the political and administrative organisation which took such an insulting attitude to consultation. The organisation that conceived this conceived this consultation should be ashamed of itself for its disrespect of the public and patients.

WGWPMB256: HM Prison & Probation Service in Wales
Location: Cardiff

General Comments

Her Majesty's Prison and Probation Service (HMPPS) in Wales is responsible for Public Sector Prisons (PSPs), the National Probation Service (NPS) in Wales and has contract management responsibilities for the privately contracted prison HMP Parc and the Wales Community Rehabilitation Company (CRC). We supervise approximately 16,000 individuals either in custody or community (https://www.gov.uk/government/collections/prisons-and-probation-statistics. The focus of these services is to protect the public, support the rehabilitation of offenders and reduce their risk of re-offending.

The provision of and access to integrated, timely and good quality health services is essential for rehabilitating offenders. This is particularly the case for individuals whose health needs, such as mental health and substance misuse issues, can make them more vulnerable. HMPPS in Wales focus on individual needs and want make sure that an offender in custody can access the equivalent health service as any citizen in Wales. We also want to support offenders who we supervise in the community to have their health needs met. To do this we must create strong links with partners to provide appropriate wraparound support and a holistic service. We wholly endorse the person-centred approach this White Paper outlines.

We have excellent relationships with the Welsh Government, Local Health Boards, Local Authorities and voluntary sector partners and there are several examples of partnership approaches where we have worked together to implement health legislation and strategy that impacts upon the men and women in our care. This has included opening HMP Berwyn, the implementation of a smoke free prison estate and Social Services and Wellbeing (Wales) Act 2014 legislation. We fully support this White Paper's proposed duties around quality, transparency, minimum standards and collaboration and we hope to work with you on any changes that may impact on the secure estate and offender population in Wales.

Partnership working is a priority for HMPPS in Wales and we would be pleased to provide representatives and/or advice regarding the secure estate and offender population in the future arrangements for health board and trust governance. Further steps to align Local Health Boards and Local Authorities in the planning and delivery of services would undoubtedly support us in addressing some of the factors that can support rehabilitation and the successful resettlement of offenders in the community. We continue to develop and refine our health and justice governance with partners and are exploring ways to make sure social care representatives are included at a strategic and operational level. It would be helpful if any governance review as a result of this paper captured these arrangements and broader criminal justice fora such as the Public Health Wales Custodial Advisory Board, Substance Misuse Area Planning Boards and the Mental Health and Learning Disability Criminal Justice groups.

We would also endorse an integrated approach to inspection and regulation between health and social services. To provide a consistent approach within secure settings it

would be worth engaging with Her Majesty's Inspectorates for Prison and Probation and the Prison and Probation Ombudsman.
In terms of further practical issues raised in the White Paper, HMPPS in Wales would appreciate an opportunity to work with you on:

- Minimum standards of health service delivery within the secure estate
- Engaging offenders in custody and community as part of the White Papers' commitment to increase engagement with citizens
- Making the complaints process straightforward for those accessing services in custody

I hope these comments have been of use. I want to reiterate how valuable our partnership arrangements with Welsh Government and health services are. We remain committed to making sure those in our care are able to have their care and support needs met.

WGWPMB257: Anonymous
Location: Unknown

Response to Specific Questions

All Health and Care Services

We want the group of people who lead health and care services to work to the same set of principles (code of behaviour) We want:

- them to be open and clear with everyone
- them to show how they're improving services
- them to work together with others.

Do you think this is a good idea?
Yes

Local Health Boards (LHBs) and NHS Trusts

We want:

- every LHB to have a core group of professional roles
- have others that are flexible and can change based on local need.

Do you think this is a good idea?
Yes

Who's on the LHB and Trusts

We want:

- every LHB to have a core group of professional roles
- have others that are flexible and can change based on local need.

Do you think this is a good idea?
Yes

Board Secretary

We want:

- to give the Board Secretary role protection by law. This will help them raise concerns and challenge things.

Do you think this is a good idea?
Don't know? Will Welsh Ministers put in the right people – sounds good but will it help the problem?

Quality services

We want:

- to give them the power to work even closer with local authorities and other organisations
- to have a look at what's needed in thewir area when making plans

- work with eachother when someone needs a specialist service.

Do you think this is a good idea?
Yes

Being open and honest
We want:
- all health and care services to have the same rules about being open and honest
- all health and care services to be open and clear with people.

Do you think this is a good idea?
Yes

People have the right to know things – we need to trust people.

Standards of care
We want:
- One set of key standards for all services across health and social care.

Do you think this is a good idea?
Yes.

Making a complaint
We want:
- A clear, easy complaints system
- All services and organisations to work together to deal with problems.

Do you think this is a good idea?
Yes

Is there anything else you want to tell us about putting people first?
People need to get good care and be able to say when they don't.

Involving people
We want:
- To build a new 'citizen voice' group to help more people have a say.

Do you think this is a good idea?
Yes

Working together
We want:
- Make it possible for LHBs to make more decisions locally
- Have independent advice and support systems to help this happen.

- To make it possible for Welsh Ministers to take decisions when LHBs cannot.

Do you think this is a good idea?
Yes

Inspection and Regulation
We want:

- HIW to have a legal framework like CSSIW so they can work together better
- To know if HIW, CSSIW, and the 'citizen voice' group should come together to form a new, single body.

Do you think this a good idea?
Yes

There should be more ways for young people to get involved and I don't know if citizen voice would help this.

WGWPMB258: Cwm Taf Community Health Council
Location: Pontypridd

General Comments

This document forms the response of the Cwm Taf Community Health Council to the White Paper entitled 'Services fit for the future', which was launched on 28th June 2017. The contents reflect the views of local Members, stakeholders and a considerable number of patients and members of the public that have been contacted in the Cwm Taf area. However, it also takes into account the significant amount of cross boundary work that has been undertaken with the other six Community Health Councils and the Board of Community Health Councils for Wales. This is evidenced by the fact that there is extensive commonality between its content and that of the Board and other Community Health Council responses.

Cwm Taf Community Health Council has always been recognised as the independent 'watch-dog' for healthcare services within the Merthyr and Rhondda Cynon Taf areas of South East Wales. It has, and always will, continue to seek to encourage and enable patients and members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for them and their families in its local high deprivation communities.

The Community Health Council movement across Wales has continuously sought to collaborate with the NHS and other inspection and regulatory bodies to provide the crucial link between those who plan and deliver the National Health Service in Wales, those who inspect and regulate it and those who use it.

Cwm Taf Community Health Council understands that, as indicated in the White Paper, changes are needed to future-proof the 'Citizen's Voice' across the Principality. We, and a number of our stakeholders, patients and members of the public consulted, welcome a number of the changes proposed within the consultation paper. These include the desire to better align health and social care services, in order to ensure a more seamless pathway process. There also appears to be a considerable appetite for developing an organisation that will strengthen the 'Citizen's Voice' in Wales. These messages are also reflected in the further one hundred and five individual responses collected by Cwm Taf Community Health Council from local residents etc., which have been submitted to Welsh Government, along with this response.

However, Cwm Taf Community Health Council feels that there are a number of concerning proposals included in the White Paper which cannot be supported in the way presented. An example of this is the suggestion of an over reliance on legislation to deliver Welsh Government policy aspirations.
It is felt that certain changes, i.e. introduction of improved duty of candour in the service, will be achieved in a more acceptable form through a cultural change rather than imposed legislation. Concern has also been expressed where it is indicated that Welsh Government is considering introducing aspects of the process presently undertaken by the Scottish Health Council, as the way forward in developing a new 'Citizen Voice' organisation. Closer examination of the system which replaced Scottish Community Health Councils in 2004 indicates that it also requires reform

and is presently subject to a consultation white paper, having been criticised heavily by the Scottish Parliament.

Therefore Cwm Taf Community Health Council is of the opinion that any new or revised organisation MUST have responsibility to truly represent the voice of patients and the public that it represents. This can only be done if there are agreed core functions which include the following:

- It is an independent organisation with the remit of monitoring and reporting on patient pathways and concerns
- It is primarily responsive to its local population and for assisting in health and social care matters; but it also has the ability to work regionally and nationally
- It has 'teeth' and is charged with holding service providers to account where necessary
- It has the opportunity of working with other inspection and regulatory bodies on equal terms
- It has the mandate and ability to continually engage with its population.

In summary it is imperative that any 'Citizen Voice' organisation that emerges following the consultation White Paper must be provided with the appropriate key functions in order to provide the citizens of Wales with an enhanced and therefore stronger voice.

Cwm Taf Community Health Council, along with the Board of Community Health Councils in Wales and its six other Councils, therefore would welcome the opportunity to work jointly with Welsh Government and its partners in the future, to develop a new organisation which truly will improve the 'Citizen Voice.'

Executive Summary

Cwm Taf Community Health Council submits the following document as its response to the Welsh Government White Paper- 'Services fit for the future' consultation. Since the publication of the consultation document in June 2017 its Members have worked with staff, stakeholders, local public, patients and numerous groups, including Local Authorities, Assembly Members and Members of Parliament, to establish views on the role and future of Community Health Councils locally and across Wales. The views have been reflected in point form in the summary below, with supporting evidence provided in the body of this document.

- Whereas it is difficult to defend the manner in which the Community Health Councils have been managed by its Board in the past, they have always been recognised as the effective independent 'watch-dog' for healthcare services within the Merthyr and Rhondda Cynon Taf areas of South East Wales. One member commented: "I DO want to defend the local Community Health Council. I believe we have a record of work and actions to be proud of. I am proud to have been a volunteer Community Health Council Member and I KNOW we have achieved much to be proud of."
- It is recognised that there is a requirement for change from the present system to enable strengthening and future-proofing of the 'Citizen Voice' across Wales.

- Improved alignment of health and social services is not only desirable but essential to ensure that patients have ONE pathway that deals with their health and social requirement for care.
- Cwm Taf Community Health Council is of the opinion that there are a number of proposals in the White Paper that they are unable to support, i.e. there is an over-reliance on the legislation to deliver policy aspirations. This also includes an assumption that legislation will improve the duty of quality and candour, which it is felt, will be better achieved by cultural change.
- Acceptance of what has been criticised by the Scottish Parliament and described as a 'flawed process' i.e. the body which replaced Community Health Councils in Scotland, must not be introduced in Wales.
- Any new or revised organisation MUST have responsibility to truly represent the voice of local patients and the public through agreed core functions which include being:
  - an independent organisation with the remit of monitoring and reporting on patient pathways and concerns;
  - primarily responsive to, and for assisting, its local population in health and social care matters but also with the ability to work regionally and nationally;
  - a body with 'teeth' that is charged with holding service providers to account where necessary;
  - provided with the opportunity of working independently with other inspection and regulatory bodies on equal terms;
  - continuous patient engagement.
- Board membership and composition - Cwm Taf Community Health Council does not fully agree with this proposal as this does not appear to address the issues of board culture, identified in earlier governance reviews. We do accept that all Boards should have vice chairs and that executive officer membership should include some key positions which are consistent across all local Health Boards. We do not agree with the retitling of 'independent' to 'public' members as this may cause confusion and give the impression that their role is to represent the public.
- The role of the Board Secretary - we do not support the proposal to change the role and function of Board Secretaries. The White Paper is ambiguous on whether this post will be an NHS or Welsh Government appointment and it is felt that if the proposal is introduced it will be impossible to ensure the independence of the Board Secretary.
- Duty of quality for the population of Wales – the Community Health Council agrees in principal with this proposal but requires further assurance as definitions of quality vary and it can be difficult to understand and measure. It is recognised that there is a need for a change in culture, not legislation that will reflect the proposed integrated shape of health and social care services. This will ensure that patients and the public will be truly involved in the co-design and co-production of services and understand their expectations.
- Duty of candour – it is believed that further assurances and clarity are required on some aspects of this proposal. 'Putting Things Right' places a duty on the NHS to be 'open, transparent and honest.' This would have to be extended to social care providers and would require clarity on exactly who is responsible for ensuring that this duty is achieved and clearly monitored. Again, as stated above, we believe that the duty of candour can only be achieved by training and cultural change, not by legislation.

- Setting common standards – this proposal is supported on the basis that the Community Health Council believe that its population deserve/ expect clear and meaningful standards that apply wherever they receive their care and from whom it is provided.
- Joint investigation of health and social care complaints – Cwm Taf Community Health Council considers that people who have concerns about provision of their health and social care should only need to raise these concerns once, in order for them to be investigated thoroughly and in a timely manner. The focus of any new arrangements must provide for easy access in raising concerns, providing timely and co-ordinated investigation/response and shared learning. This leads to the conclusion that any new 'Citizen's Voice' body MUST take on the existing advocacy service and further support it to integrate health and social care complaints.
- Representing the citizen in health and social care - for Community Health Councils this is the most important section of the White Paper and that with which we disagree most and cannot support. We support the Welsh Government intention to create a stronger 'Citizen's Voice' provision across health and social care. However, we feel that the White Paper's proposals are lacking in sufficient detail or credible information on what any new "Citizen Voice" body, intended to replace Community Health Councils, would look like. We also have concerns that the proposals, as set out in the White Paper, have the potential to significantly weaken the "Citizen Voice" rather than strengthen it. The White Paper proposals for a stronger "Citizen Voice" in Wales appear to be predicated on a model that is not, and does not, currently describe or consider itself to be a 'Citizen Voice' organisation. Proposals laid down in the White Paper do not provide a true opportunity to co-produce the strong "Citizen Voice" that the people of Wales deserve. Again further evidence on the Cwm Taf Community Health Councils resistance to this section of the White Paper is provided below in the body of this response. Looking to the way forward we believe that any new strengthened 'Citizen Voice' must "fully reflect the views and represent the interests of people in their health and social care services." To achieve this we are keen to work with the organisation nationally and the Welsh Government to produce an organisation that is fit for the people of Wales.
- Co-producing plans and services with citizens – Cwm Taf Community Health Council does not support this proposal to create an independent mechanism to provide clinical advice on substantial service decisions. This would suggest that the public will no longer have a statutory right to be consulted with, on NHS service changes as set out in the NHS (Wales) Act 2006 section 183, which states that; the public or their representatives have the right to be involved in; the planning of provisions, the development of proposals and the decisions being made around service changes.
- The White Paper suggests that the new 'Citizen's Voice' body will ONLY be approached for advice after "substantial" service change decisions have already been made. Currently, Community Health Councils receive clinical analysis and advice on service change proposals very early in the proposal development stages.
- Inspection and regulation – the White Paper does not make clear how the proposals to overhaul Health Inspectorate Wales' underpinning legislation would lead to more integration and common methodologies between the two existing inspectorates (CSSIW and HIW). Information is provided below on the present joint working between Cwm Taf Community Health Council, HIW and other bodies.

Response to Specific Questions

Board Membership and Composition
Do you agree with these proposals?
Partly

To an extent we agree that the Boards of both health boards and NHS trusts should share certain core key principles, including delivering in partnership, to provide person-centred care and a strong governance framework to enable Boards to work effectively and meet their responsibilities. We also agree that all Boards should have vice chairs, and that executive officer membership should include some key positions which are consistent across local health boards but also allow some flexibility in appointments. However:

- the proposals in the White Paper, individually or collectively, do not appear to address the issues about Board culture identified in earlier governance reviews. The difficulties of changing Board culture are illustrated by the successive HIW/WAO annual reports setting out the shortcomings of at least one University Health Board and the unacceptably slow pace of change (despite being in Special Measures with considerable Welsh Government support). The White Paper gives the impression that legislation alone will change Board culture – this is simply not the case.
- The Community Health Council does not agree with all the core key principles identified. Specifically, we cannot understand why a re-titling of the role of 'independent' member would bring about a change in the perspective these members provide – nor why such a change is needed. There is already a clear need for the whole Board to understand and respond to the perspectives of the population in all its discussions and decisions. A system of rigorous selection against a person specification and skill set, rather than political appointment, would be an improved starting point.
- we consider that a re-titling of the current 'independent member' to 'public member' may cause confusion and give an impression that their role is to represent the public. It is our view that the public currently recognise and accept the governance and leadership role of all voting NHS Board members.

Board Secretary
Do you agree with these proposals?
Partly

To an extent we agree that the Boards of both health boards and NHS trusts should share certain core key principles, including delivering in partnership, to provide person-centred care and a strong governance framework to enable Boards to work effectively and meet their responsibilities. We also agree that all Boards should have vice chairs, and that executive officer membership should include some key positions which are consistent across local health boards but also allow some flexibility in appointments. However:

- the proposals in the White Paper, individually or collectively, do not appear to address the issues about Board culture identified in earlier governance reviews. The difficulties of changing Board culture are illustrated by the successive HIW/WAO

annual reports setting out the shortcomings of at least one University Health Board and the unacceptably slow pace of change (despite being in Special Measures with considerable Welsh Government support). The White Paper gives the impression that legislation alone will change Board culture – this is simply not the case.

- The Community Health Council does not agree with all the core key principles identified. Specifically, we cannot understand why a re-titling of the role of 'independent' member would bring about a change in the perspective these members provide – nor why such a change is needed. There is already a clear need for the whole Board to understand and respond to the perspectives of the population in all its discussions and decisions. A system of rigorous selection against a person specification and skill set, rather than political appointment, would be an improved starting point.
- we consider that a re-titling of the current 'independent member' to 'public member' may cause confusion and give an impression that their role is to represent the public. It is our view that the public currently recognise and accept the governance and leadership role of all voting NHS Board members.

1.2 The Role of the Board Secretary

In order to deliver on the key principles outlined, the Welsh Government believes that the role of Board Secretary should be placed on a statutory basis and have statutory protection to allow the role to be independent with safeguards in place to challenge the Chief Executive of an NHS organisation or the Board more widely.

<u>Do you agree with these proposals?</u>

No

Cwm Taf Community Health Council considers the role of the Cwm Taf University Health Board Secretary as being of the highest importance. It is believed that this role currently upholds the high standards of strong governance within the University Health Board and also has the ability to challenge processes of governance etc. where necessary.

- The White Paper's proposals are unclear around whether this position would, in the future, remain an NHS appointment or a Welsh Government appointment. Given that the White Paper states 'an independent process should be put into place to dismiss a Board Secretary,' it does not make clear whether their appointment would also be subject to the same independent process. The question needs to be posed that 'if it remains an NHS appointment, how will these proposals and potential statutory protection, offer adequate assurances of independent scrutiny of the Health Board or NHS Trust?' Also if it is to be a Welsh Government appointment, then this avenue suggests a Welsh Government officer will be working within an NHS remit, which may give rise to accusations that the NHS will not be sufficiently independent from the operational scrutiny of Welsh Government.

- We agree that a representative voice should be heard at NHS Board level. Associate membership of Boards could contribute to achieving this. However, care would be needed to ensure that any such Associate Member has a clear mandate from the wider population, e.g. a representative from a new, stronger, 'Citizen Voice' body.

• Therefore in order that the Board Secretary is able to carry out their role as principal advisors to their constituent NHS Boards on governance matters, and so that they can properly protect the organisation they serve, it is important that the role has sufficient status and protection. We believe that, on a practical day-to-day basis, it will be impossible to ensure the independence of the Board Secretary. Whistle-blowers in the NHS rarely fare well, even when protected by the Public Interest Disclosure Act, and we foresee that the role of Board Secretary could become untenable in certain situations.

Duty of Quality for the Population of Wales
Do you agree with these proposals?

In principal - but with the following assurances

Cwm Taf Community Health Council considers that as the current duties and definitions of quality are set out differently in a variety of places, it is complex for both bodies and individuals to understand and measure.

There is a desire that any new legislation will genuinely simplify and clarify what is expected of service providers and what quality means from a service user's perspective. The actions needed to deliver services that meet public expectations on quality must therefore extend beyond introducing primary legislation. This in itself will not bring about a shift in culture and behaviours. There will be a requirement for a change in culture to reflect the proposed integrated shape of health and social care services and population expectations. There should be a reciprocal duty placed on health and social care services to co-operate and work in partnership to improve quality. If agreed, following the outcome of this White Paper, assurance is required that a measure to meet public expectation, consultation and engagement will be provided to ensure that their perspective on quality and planning is fed directly into the updated duties placed on health and social care organisations. This would ensure that the public are truly involved in the co-design and co-production of services and the providers of these services truly understand the realistic expectations. Also, the updated duties should clearly set out processes that can be initiated, in the unlikely event that the health and social care organisations fail to work collaboratively and fail to agree on reasonable project goals.

Furthermore, avenues for the public to challenge health and care services during the decision making processes need to be clear and accessible. As the White Paper stands, it is unclear how Health Boards and Local Authorities will balance national or regional priorities and needs against conflicting local views and wishes. Cwm Taf Community Health Council recognises that, during times of national or regional service reconfiguration or development, difficult decisions will need to be made and those decisions will be unpopular with different areas in some way or another. At present, Community Health Councils are involved in local, regional and national processes to ensure that the public's voice and view on the quality and planning of health services are taken into consideration, for example the Community Health Council's involvement in the South Wales Programme. Community Health Councils also ensure that communication with the public on service change and provision is clear so that the public are adequately informed on the reasons for local, regional

and national foci. Cwm Taf Community Health Council believes the proposed new 'Citizen's Voice' body should hold statutory rights to be involved with health and social care services; to represent the public on matters around the quality and planning of those services.

Duty of Candour
Do you support this proposal?

Yes - but assurances and clarity are required on some aspects

The White Paper rightly refers to the NHS's 'Putting Things Right' procedure which places a duty on the NHS in Wales to be 'open, transparent and honest' when health incidents occur, whether they are identified through the submission of complaints or identified by members of staff when undertaking their duties. Extending this duty to social services is a clear necessity. Lessons can be drawn from the implementation of the Duties of Candour in England and Scotland to learn from good and bad experiences when attempting to encourage a culture change in multiple public service organisations.

It should be clear who the responsible body will be to ensure that a culture of openness, transparency and honesty is being achieved and how it will be monitored; will it be Healthcare Inspectorate Wales, Care and Social Services Inspectorate Wales, both or neither?

We recognise that cultural changes are not achieved immediately and eventually there should be one monitoring body in place to be responsible for assessing health and social care organisation's commitments to the Duty of Candour.

It's imperative that any duty of candour being developed (or being built upon) in Wales should itself be clear and accessible for public and staff understanding and the requirements should be 'jargon free' and written in plain language. Training days for all relevant staff should be developed to encourage open and honest reporting of incidents. It should also be clear that a duty of candour not only covers the reporting of incidents but also encourages openness and transparency on all levels, including Executive/Board decision making.

The ethos of the duty of candour should encourage learning and improvement to improve staff and service user experiences, rather than harbour any negative connotations that are perceived to be attached to whistle-blowing.

Setting and Meeting Common Standards
Do you support this proposal?

Yes

Cwm Taf Community Health Council and the population that it serves have the right to expect clear and meaningful standards that apply wherever they receive their care

and from whom it is provided. All such standards should be informed by and reflect what is important to people on the receiving end.

Community Health Councils all recognise that there may be a need to address the limitations within current regulations that specify what standards must be followed. In doing so, it is important that any new legislation is framed in a way that allows flexibility and adaptability to meet future expectations.

Joint Investigation of Health and Social Care Complaints
Do you support this proposal?

Yes

Cwm Taf Community Health Council and the population that it serves have the right to expect clear and meaningful standards that apply wherever they receive their care and from whom it is provided. All such standards should be informed by and reflect what is important to people on the receiving end.

Community Health Councils all recognise that there may be a need to address the limitations within current regulations that specify what standards must be followed. In doing so, it is important that any new legislation is framed in a way that allows flexibility and adaptability to meet future expectations.

3.2 Joint investigation of Health and Social Care Complaints

The Welsh Government believes that requiring different organisations to work together to investigate complaints will make it easier for people to complain when their complaint is about both health and social services. We also believe it will encourage organisations to learn lessons to improve their services.

Do you support this proposal?

Yes - but with assurances required

Cwm Taf Community Health Council considers that people who have concerns about their health and social care should only need to raise these concerns once in order for them to be investigated thoroughly and in a timely manner. We agree that there should be a common complaints process across health and social care, accessed through a single point. We consider that a single advocacy service should form part of a new 'Citizen Voice' body.

The focus of any new arrangements must ensure:

- easy access for people to raise concerns
- a timely and co-ordinated investigation and response
- shared learning.

Any new arrangements must recognise the need to ensure co-ordination within health and social care organisations/sectors and not just between them.

The valuable role of the Independent Complaints Advocacy Service, provided by Community Health Councils must not be diminished. In England the service has become one of providing leaflets and call-centre advice, rather than the hands on, personalised, service which is currently provided in Wales.

Advocacy is a key element of the work undertaken by Community Health Councils and should not be considered in isolation. The proposals for a future 'Citizen Voice' organisation need to consider every aspect of work currently undertaken by Community Health Councils, as integral to the whole. The loss of any one core function would weaken the effectiveness of the whole organisation.

It is vital that a new representative body should offer a truly independent Complaints Advocacy Service. This must be completely independent of the health care provider with whom the patient has an issue. It is undeniable that health care providers have not been adequately responsive to concerns raised by families and patients about the quality of care provided.

Cwm Taf Community Health Council believes that the public expects clear and meaningful standards that apply wherever and whoever provides their care. Any such standards should be informed by and reflect what is important to the public. The White Paper proposal is in line with the Social Services & Wellbeing (Wales) Act 2014 – part 10 – Complaints, representations about Social Services. However, it can be questioned whether the social care aspects of any complaint submitted would be subject to the same principles of the NHS's 'Putting Things Right Procedure' (2011) and whether proven social care failings or breach of duties in care, where harm has been caused, will be subject to the same investigation/panel review for assessing whether a qualifying liability in tort exists. This level of investigation and legal responsibility should be transferred to the Local Authority complaints' procedures so that complainant outcomes are not negatively impacted upon when the organisation at fault (whether NHS or Local Authority) has been identified.

Currently, Community Health Councils in Wales offer a free and professional Independent Complaints Advocacy Service for all NHS complainants. The Cwm Taf University Health Board has publically stated that concerns/ complaints where a Community Health Council advocate is involved 'can be a smoother and less stressful process for patient, their family and staff, as advocates assist and guide patients/relatives through the correct processes. It goes on to say 'CHCs ensure the complaint is addressed fairly and through the correct channels.' If in future, joint investigations between health and social care are realised, it is believed that the new 'Citizen Voice' body should take on the existing complaints Advocacy Service and support it to integrate health and social care complaints. This will ensure the public feel a greater reassurance that the advice and support they receive will be through a truly independent, citizen-focused body.

Representing the Citizen in Health and Social Care
Do you support this proposal?

No

Cwm Taf Community Health Council welcomes the Welsh Government's intention to create a stronger 'Citizen's Voice' across health and social care services. The White Paper provides a 'once in a generation' opportunity to do this in a way that best serves the people of Wales. However, the Cwm Taf Community Health Council would strongly voice the opinion that the White Paper's proposals are lacking in sufficient detail or credible information on what any new 'Citizen Voice' body, intended to replace Community Health Councils, will look like. It also has concerns that the White Paper proposals have the potential to significantly weaken the 'Citizen Voice' rather than strengthen it. In fact it would go as far as to state that the White Paper lacks assurances around the ability of a new 'Citizen Voice' body to truly represent the public and it would be unable to hold heath service providers to account. Further, it does not provide any statutory assurance that service standards would be monitored and reviewed; with feedback provided to the public who they affect.

Over the summer Community Health Councils asked patients, stakeholders and members of the public what was important to them. Further, representatives of the Board of Community Health Council in Wales thoroughly researched 'Citizen Voice' arrangements across the UK and beyond. The organisation also considered, in great detail, what has been written or said about the strengths and weaknesses of the different models.

As indicated earlier, given that the Welsh Government's proposals reflect in large part, the arrangements in place in Scotland, particular attention to the role and remit of the Scottish Health Council was paid. Representatives from the Board of Community Health Councils visited the Scottish Health Council to hear from them directly about their current arrangements, the recent review which identified a clear case for change in their role/remit and the on-going consultation on their future direction.

Cwm Taf Community Health Council is concerned that the White Paper proposals for a stronger 'Citizen Voice' in Wales are predicated on a model that is not, and does not, currently describe or consider itself to be a 'Citizen Voice' organisation. It is also recognises that proposals, as laid down in the White Paper, do not provide a true opportunity to co-produce the strong 'Citizen Voice' body that the people of Wales deserve. Such a body must "reflect the views and represent the interests of people in their health and social care services."

As indicated earlier, Cwm Taf Community Health Council is concerned with the lack of information provided in the White Paper, on what the new organisation would look like and what its powers would be. This concern is compounded by what powers will be lost if Community Health Councils are abolished.

The following elaborate on a number of concerns that Cwm Taf Members and others have voiced on the contents of the White Paper:

• It states that currently Community Health Councils are limited in cross-boundary working, due to “their attachment to a particular geographical area and population” and this presents “challenges”. It concludes that its proposals will “strengthen the voice of people in the way that health and social care is planned and delivered by setting up a new arrangement which will have national and local focus”. There appears to be no evidence provided to substantiate such a claim and the converse can be demonstrated through a number of cross-boundary working initiatives recently undertaken:

 The consultation undertaken on the South Wales Programme in 2013 considered all options for the future of consultant-led maternity services, neonatal care, inpatient children's service and emergency medicine (A&E) at hospitals across South Wales. As well as Cwm Taf, the consultation spanned the Health Board areas of Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff and Vale of Glamorgan and South Powys, to create safe and sustainable hospital services for people living in South Wales. The process also included the Welsh Ambulance Service. All Community Health Councils across the area were involved in consultation events between May – July 2013 and worked with the Health Boards to gather the public’s view and wishes for the future of those services. Each event involved representatives, or was chaired by Community Health Council officers or volunteer Members to assist in the public engagement.

 The Board of Community Health Councils, as part of their 2016/2017 annual plan, identified 5 national projects. Each of the 7 CHCs participated in these events to provide a pan-Wales perspective. These projects included: Ophthalmology Patient Experience Review, Care of the Elderly, Dementia, Child and Adolescent Mental Health Services and Adult Mental Health Services. The Cwm Taf and Cardiff and Vale of Glamorgan Community Health Councils led on the national review of Child and Adolescent Mental Health Services. The Wales-wide project included considerable desk-top research, supplemented by collating information gathered from all the Community Health Councils in Wales. The report was published and complemented similar work undertaken by the National Society for the Protection of Children in Wales. Members also participated fully in a national project to identify the level of boredom in community hospitals. Results from all Community Health Councils across Wales were correlated and a report was produced by North Wales Community Health Council. For Cwm Taf the results were exceptionally positive, particularly in one hospital, Ysbyty George Thomas. Following publication of the report managers from hospitals across Wales have visited the Hospital to examine why the results indicated that it could be considered the ‘gold standard’ of patient satisfaction. The Aneurin Bevan CHC led on the national Ophthalmology Patient Experience Review. The Wales-wide survey was conducted by all CHCs in Wales, and gathered national feedback. The report then fed directly into HIW’s National Ophthalmology Thematic Review, whilst HIW looked at clinical experiences and standards. The CHC’s patient experience review informed their review at ‘Stage 1’, to offer patient-led guidance for their ‘Stage 2’ review. This also demonstrated national scope and collaborative working with HIW.

 Also, where true cross border schemes have been identified by Health Boards in a specific region, i.e. South East Wales, the constituent Community Health Councils have responded by working together and mirroring the South Wales

Collaborative. This ensures duplication is avoided. Examples of this are seen in the Ear, Nose and Throat, Major Trauma and Thoracic Surgery projects.

The White Paper proposes to make the new ‘Citizen’s Voice’ an "advisory body" with regards to service changes and base this in some respects around the Scottish Health Council (SHC) model. During its research the Community Health Council found that the SHC does not have any statutory powers to protect the Citizen Voice, with regards to NHS service changes and it is currently under review by the Scottish Government as it is deemed "unfit for purpose". During the Consultation Institute’s conference in Cardiff, which focused on the proposals set out within this White Paper, the Chief Executive of the Scottish Health Council presented on their role and remit, to provide a better understanding of what their structure and purpose could mean for the public in Wales. The Chief Executive explained that they do not currently speak for or protect the patients or public in Scotland, with regards to healthcare service change proposals; their purpose is to “quality assure the [consultation] process as it develops”. They do not voice or consider the feedback received from the public on any proposed changes. The SHC does not hold a view or opinion on the proposed changes or the decisions made but simply ensures the NHS follow a specific service change consultation pathway. Community Health Councils in Wales also do this, but also focus very heavily on the patient/public voice and the potential impact on this group and their wishes. The Scottish Health Council monitor processes for adherence only and do not follow-up on agreed service changes. This cannot ensure that what was proposed and agreed, is eventually delivered for the benefit of patients, which Community Health Councils in Wales do via their Scrutiny Committees and annual visiting schedules. The Chief Executive of the SHC stated that he believes their inability to represent the patients’ voice is a “gap in their process” and they want more of a role in expressing what the public think. The SHC therefore hold more of a governance role in service change proposals and do not speak for patients. In conclusion, we are deeply concerned by Welsh Government intentions to “strengthen the voice of the people” by shaping some aspects of the ‘Citizen Voice’ body for Wales on the model currently in place in Scotland, who themselves have stated, they do not currently represent the interests of the public in health or social care.

The White Paper is proposing that the NHS itself will determine whether a service change is "substantial" or not and therefore will be able to set its own course of action to implement a service change. Whilst approaching the newly developed ‘Citizen Voice’ body afterwards and deciding, without any obligation, whether or not to take its advice into consideration. Again this will only weaken the ‘Citizen Voice’ body’s position and ability to protect the public voice and ensure it is heard and listened to.

Currently, Cwm Taf Community Health Council has the ability to analyse daily NHS performance data i.e. from Health Boards and from Wales Ambulance NHS Trust. The latter includes response times, A&E handover times, A&E waits and delayed transfers of care and referral to treatment times. The NHS is also obligated, under the CHCs statutory powers, to answer and address any concerns brought to their attention about patient waiting times. The concern is that the White Paper does not cover or explain this aspect of the Community Health Council’s current work but describes it as a new function of the Board Secretary, who is based within the health

board itself. This proposal therefore takes independent analysis of patient pathway away from the citizen and intends to place it within the remit of an NHS employee. We believe that when developing the new model for the 'Citizen Voice' body, this analysis and statutory remit must be undertaken by an independent citizen focused body. If this is removed, it will again weaken the 'Citizen Voice' body's ability to challenge the NHS and social care services on the citizen's behalf.

Co-producing Plans and Services with Citizens
Do you agree with this proposal?

No

The White Paper's proposals to create an independent mechanism to provide clinical advice on substantial service changes, with advice from the proposed new 'Citizen Voice' body, suggests that the public will no longer have a statutory right to be consulted with on NHS service changes, as set out in the NHS (Wales) Act 2006 section 183 which states that; 'the public or their representatives have the right to be involved in; the planning of, the development of proposals and decisions being made around service changes.'

The White Paper suggests that the new 'Citizen Voice' body will be approached for advice after "substantial" service change decisions have already been made. It does not explicitly state whether an amendment to the NHS (Wales) Act 2006 will be made in order to remove these rights from the public. Currently, Community Health Councils receive clinical analysis and advice on service change proposals very early on in the proposal development stages. We believe that these statutory rights should continue as part of the new 'Citizen Voice' body.

Inspection and Regulation and single body
What do you think of this proposal?

Whilst the proposal of creating a clearer underpinning legislative framework for HIW is acceptable, there is no clear indication within the proposals of how this will lead to more integration and closer working between HIW and CSSIW.

Are there any specific issues you would want us to take into account in developing these proposals further?

- The White Paper states that Community Health Councils currently "duplicate" the work of Healthcare Inspectorate Wales (HIW) and therefore their statutory right to enter and inspect should be removed, when developing the new 'Citizen's Voice'. Responses received indicate that the public and the NHS in Cwm Taf feel very reassured that the Community Health Council can enter NHS areas to 'visit', not 'inspect', services, to ensure that the patient voice is heard and acted upon. HIW, as the regulators, inspect NHS services from a clinical perspective, when they inspect a ward they look at patient notes, ensure that risk assessments, fluid charts and medication charts are all in order and completed to their fullest. They look at clinical

adherence to national and local policies and also look at staffing resources and pressures etc. However, when the Members of Community Health Councils conduct GP visits, they send the surveys out two weeks prior to the visit (50 per GP partner) and 'test' patient experience on the day. In Cwm Taf all secondary care visits are unannounced. During 2016/2017 Cwm Taf Community Health Council undertook ninety six secondary care visits and seventeen visits to primary care establishments. Each visit generated a report which was submitted and responded to by the UHB with an in-depth reply or action plan to improve patient experience. These reports and action plans are all shared with HIW, for intelligence sharing purposes and for the specific purpose of not duplicating work on areas or specific topics. The advantage Community Health Councils have is that they often carry out a high volume of visits. These are undertaken at various times of the day, evening and on weekends. Revisits to wards are standard practice and also there is a high level of 'follow up' visits conducted to confirm that action plans etc. have been implemented.

- Cwm Taf Community Health Council works in conjunction with the Cwm Taf UHB and HIW in undertaking joint hospital visits. These 'Partnership Dignity Visits' aim to provide assurance and support the delivery of the Health Board's vision and objectives, to deliver safe and effective care and achieve excellent patient and staff experience. This supports the local quality strategy, quality delivery plan and patient experience plan:

- To provide the highest possible service quality and excellent patient experience
- To improve health outcomes and help reduce inequalities
- To get high value from all services.

The visits are undertaken by Independent Members of CTUHB; Community Health Council; Health Inspectorate Wales; representatives of the office of the Chief Nursing Officer for Wales; Patient Experience Manager; CTUHB Senior Nurse Professional Standards & Quality with CTUHB Staff Side representative and RCN Wales. These are very successful and are seen as duplicitous.

- HIW and CHCs may visit the same wards/GP sites, but they focus on completely different aspects of care. The White Paper says it wishes to strengthen the citizen's voice by removing the 'Citizen Voice' body's statutory power to visit patient and public services. This will only weaken their position and ability to represent the citizens of Wales. Therefore, there is no duplication of work, simply a different focus, which both bodies conduct well, one as the Welsh Government's regulator and the other as the independent patients' voice. This separation instils the much required credibility that patients seek from a body set up to represent their needs. It is paramount that the new organisation retains this statutory function as statutory powers and rights will give the future model the strong "Citizen's Voice" authority that is required to hold NHS and social care services to account.

- The White Paper also appears to suggest that simply working to a similar framework will promote more integration between HIW and CSSIW. This ideal is simplistic and the way in which the two inspectorates are required to work jointly requires greater exploration before the proposals can be developed further.

However we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.

Would you support such an idea?

No

What issues should we take into account if this idea were to be developed further?

It is accepted that housing the existing inspectorates within a new 'Welsh Government Sponsored Body' has the potential of bringing more independence from the Welsh Government. The pooling of resources and creation of an integrated system are notions which the Cwm Taf Community Health Council would certainly agree with.

However, the proposals in the White Paper provide no clear explanation of how the new system would work. The difficulties of incorporating the existing inspectorates into a single new body whilst retaining the independence of each inspectorate are complex. Ensuring governance and accountability arrangements are adequate and robust, while allowing for each individual body to retain its independence, is essential and there is no guarantee within the proposals that this is achievable.

This model of incorporating the inspectorate within an overarching and independent body is currently found in Scotland with the 'Healthcare Improvement Scotland' model, where it has been found that it is difficult to maintain the independent identity of each inspectorate.

Therefore, we are concerned that by pursuing independence from the Welsh Government, the proposals will in fact decrease the independence of each inspectorate contained within the new body.

Conclusion

Cwm Taf Community Health Council hopes that any proposals on providing a 'Citizen Voice' body takes note of its response, as set out above and protects the strength of the 'Citizen Voice' in Wales, It would also ask Welsh Government to ensure that the new 'Citizen Voice' body has the necessary statutory powers and rights it will require. If statutory functions are not provided for the new 'Citizen Voice' body, there will be no obligation on any health or social care body to engage with the new organisation in any meaningful way and will only weaken their position in the community that they serve. The public will also feel that the 'Citizen Voice' body lacks the 'authority' to enable it to represent them and hold the service providers to account.

WGWPMB259: Powys Community Health Council
Location: Brecon/ Newtown

General Comments

Powys Community Health Council welcomes the opportunity to respond to the Welsh Government's White Paper: Services fit for the future.
CHCs are the independent watchdog of NHS services within Wales and seek to encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities.

CHCs seek to work with the NHS and inspection and regulatory bodies to provide the crucial link between those who plan and deliver the National Health Service in Wales, the English Trusts, those who inspect and regulate them, and those who use them.
CHCs maintain a continuous dialogue with the public through a wide range of community networks, direct contact with patients, families and carers through our enquiries service, independent complaints advocacy service, visiting activities and through public and patient surveys.

Through a series of summer engagement events Powys CHC asked people what was important to them about the proposals contained within the White Paper and looked at the different arrangements across the UK and beyond. Powys CHC considered in detail what others had said about the strengths and weaknesses of related arrangements in other UK countries.

Powys CHC was keen to engage with the wider communities and stakeholders of Powys in preparation for the submission of its response. Over the summer months Powys CHC members and staff met with key stakeholders and attended a number of events (including the Royal Welsh Agriculture Show and a number of other local agricultural shows) to seek the views of: individuals, community groups and organisations from Powys – over the 8 week period, Powys CHC members have been in touch with over 400 individuals across Powys.

We used a wide variety of methods to engage; face to face discussion, email, social media, telephone and land mail.

In addition to submitting its own response, Powys CHC has been closely involved in the preparation of the national response prepared by the Board of CHCs in Wales and fully supports the content of that document; it is a response that has been co-produced with extensive input from, and engagement with, all seven CHCs.

At the Full Council meeting of Powys CHC on 12th September 2017, members unanimously supported and agreed the proposed alternative/ new model that has been prepared by the Board of CHCs to support the response to the White Paper.

Additional quantitative and qualitative information is attached in the form of the Powys CHC Annual Report 2016-2017.

This response represents our opportunity to be heard on these proposals and to highlight local concerns and place emphasis on issues unique to Powys.

OVERVIEW
Powys CHC strongly supports, and welcomes, the Welsh Government's aspirations for a health and social care system that enshrines good governance, telling the truth, delivering high quality services which are independently checked by an effective inspection and regulation regime.

We particularly welcome the aspiration to strengthen the people's voice across health and social care, and embed the key principles of co-design and co-production. Powys CHC both notes and welcomes PtHB and Powys County Council's continued commitment to aligning and integrating both health and social care across Powys. Developing, co-producing and publishing the first Health and Care Strategy for Powys which builds on thousands of conversations between the people of Powys, Powys Teaching Health Board, Powys County Council and key partners over the last year.
Powys CHC has been an active participant in these developments and has attended workshops, working groups and engagement events. Powys CHC is represented on both the monthly Health and Care Standards meetings and on the Health and Care Strategy Board.

We recognise that primary legislation can play an important role in achieving Welsh Government aspirations for a stronger citizen voice.

However, there is little evidence to suggest that primary legislation alone would provide the catalyst to deliver real and long lasting change.

Powys CHC has concerns that in some areas the White Paper places an over reliance on legislation to deliver its policy aspirations rather than looking at other ways of doing so. There is a real risk in over using legislation in terms of the ability and flexibility of health and care services to deliver real cultural change and respond flexibly to future needs.

Powys CHC notes, if primary legislation is to be introduced, consideration must be given to the implication on services commissioned and provided by Health Trusts, Local Authorities and other service providers based in England.

Powys CHC notes that, generally, at a time of change, there is often focus on structure and not on organisational and individual cultures/ working practises/ behaviours.

Powys CHC believes that the Welsh Government should also consider the issue of organisational cultural changes (and challenges) in addition to structural changes (and challenges).

Powys CHC is disappointed that the White Paper does not acknowledge the complexities faced by Powys residents and communities, in particular, Powys CHC notes, with concern, that:

i) The White Paper does not contain any reference, or recognition of the complexities of cross-border/ English services commissioned for Powys patients
ii) The White Paper does not contain any reference, nor recognition of the complexities of cross-border/ English service changes for Powys patients
iii) The White Paper does not refer in any detail to the current scrutiny role that the Powys CHC provides on behalf of Powys patients on over 60 Boards across Wales and England
iv) The White Paper does not recognise the value that the community based membership (and networks) provide on behalf of Powys patients – the "eyes and ears"

Specific illustrative examples will be given to support these concerns in the substantive sections of the response.

Powys CHC would welcome the opportunity to work with the Welsh Government, key stakeholders and communities of Powys to ensure that any future model recognises and reflects these complexities.

We set out below our detailed response to each of the proposals.

Response to Specific Questions

Board Membership and Composition
We agree that the composition boards of both health boards and NHS trusts should share some core key principles including, delivering in partnership to deliver person centred care and a strong governance framework to enable boards to work effectively and meet their responsibilities. We also agree that all boards should have Vice Chairs, and that Executive Officer membership should include some key positions which are consistent across local health boards but also allow some flexibility in appointments.
Powys CHC notes, as observers at the PtHB meetings, the gravitas and experience that PtHB independent members bring and, whilst welcoming consistency in approach across Wales, Powys CHC feels strongly that there is a risk that the White Paper seeks to introduce change rather than recognise, and build upon good practise.

Our own experience in Powys demonstrates the positive difference that more open and inclusive leadership can bring without legislative change. The relationship between the CHC and the Health Board continues to develop and strengthen to a position where we can, and do, disagree (often passionately, yet constructively) on some matters without it damaging our relationship overall.

This has required a strong investment in the relationship from the Health Board and the CHC, based on a common goal of improving services to individuals and our communities - ensuring that the needs of the patients and communities of Powys are at the forefront of all we do.

However,

 the proposals in the White Paper individually, or collectively, do not appear to address the issues about some board cultures identified in earlier governance reviews. The White paper gives the impression that legislation alone will change Board culture – this is simply not the case.
 we do not agree with all the core key principles identified. Specifically, we cannot see that a re-titling of the role of 'independent' members would bring about a change in the perspective these members will bring – nor why such a change is needed. There is already a clear need for the whole board (and not just a re-titled public member) to understand and respond to the perspectives of the population in all board discussions and decisions.
 we consider that a re-titling of the current 'independent members' to 'public members' may cause confusion and give an impression that their role is to represent the public.
Powys CHC agrees that a representative voice should be heard at NHS board level. Associate membership of boards could contribute to achieving this. However, care would be needed to ensure that any such associate member has a clear mandate from the wider population, for example, a representative from a new, stronger, people's voice body.

Powys CHC believes that any recruitment process should involve stakeholders.

Board Secretary
We recognise the important role that Board Secretaries have within NHS organisations and welcome proposals to ensure this role is carried out consistently and not compromised through conflicting duties and responsibilities.

In order that Board Secretaries are able to carry out their role as principal advisors to their NHS boards on governance matters, and so that they can properly protect the organisation they serve it is important that the role has sufficient status and protection.

Powys CHC members raised concerns as to whether:
 an employee can independently challenge the Board (their employer) effectively?
 the Director General of Health and Social Services will continue to be responsible for holding the Chief Executives of Health Boards to account?

Powys CHC welcomes the proposal that the post holder should be the guardian of good governance (to challenge the decisions of the Chief Executive and Board) but notes that the Board Secretary role does not challenge on behalf of the citizen – the post holder is not the voice of the patient.

Duty of Quality for the Population of Wales
We consider that as the current duties and definitions of quality are set out differently in a variety of places, it is complex for both bodies and individuals to understand and measure.

We would want any new legislation to genuinely simplify and clarify what is expected of service providers and what quality means from a service users perspective.

We believe that the actions needed to deliver services that meet public expectations on quality must extend beyond introducing primary legislation. Legislation in itself will not bring about a shift in culture and behaviours.

A key concern for Powys CHC is that this proposal does not provide the reassurance to the citizens and communities of Powys that the same Duty of Quality (and standards) will be applied to providers of health and social care services that are based in England.

Duty of Candour

In general terms, the public should and do expect that those responsible for providing their health and social care (both individuals and organisations) do so in a manner that is open, honest and frank.

We recognise that the current duty for NHS bodies to promote rather than require candour means that there is currently no sanction on bodies who fail to do so. On this basis, we support in principle the introduction of a duty of candour for health and social care providers.

However, primary legislation in itself cannot bring about the cultural change necessary to embed this at every level in every organisation. We are concerned that the introduction of new legislation – if not done properly – could focus on the wrong things and distract from, rather than bring about the change needed.

To date, we are unaware of any real evidence that the introduction of a duty of candour in England is benefitting patients by having a meaningful impact on organisational behaviour.

A key concern for Powys CHC is that this proposal does not provide the reassurance to the citizens and communities of Powys that the same Duty of Candour (and standards) will be applied to providers of health and social care services that are based in England.

Setting and Meeting Common Standards

The public expects clear and meaningful standards that apply wherever and whoever provides their care. Any such standards should be informed by and reflect what is important to people.

We recognise that there may be a need to address the limitations within current regulations that specify what standards must be followed. In doing so, it is important that any new legislation is framed in a way that allows flexibility and adaptability to meet future expectations.

Powys CHC welcomes further clarity on:

- who will inspect the inspectors/ regulators?

 how will these common standards be reflected in cross-border provision of services?

Joint Investigation of Health and Social Care Complaints

We consider that people who have concerns about their health and social care should only need to raise these concerns once in order for them to be investigated thoroughly and on a timely basis.

We agree that there should be a common complaints process across health and social care accessed through a single point.

The focus of any new arrangements must be to ensure:

 easy access for people to raise concerns
 timely and co-ordinated investigation and response
 shared learning

Any new arrangements must recognise the need to ensure co-ordination within health and care organisations/sectors and not just between them.

Powys CHC believes that a single independent complaints advocacy service should be an integral part of a new people's voice body.

The valuable role of the independent complaints advocacy service, as provided by CHCs, must not be diminished. In England, the service has become one of leaflets and call centre advice rather than the hands on, personalised service currently available in Wales.

Advocacy is a key element of the work undertaken by CHCs and should not be looked at in isolation. The proposals need to consider each aspect of work done by CHCs as the loss of any aspect of work would weaken the others.

It is vital that a new representative body should offer a truly independent Complaints Advocacy Service. This must be completely independent of health and social care providers with whom the individual and/ or family has an issue. It is undeniable that some health care providers have not always been adequately responsive to concerns raised by families and patients about the quality of care provided.

Powys CHC believes a localised service is critical, given the complex pathways that individuals living in Powys follow; the current independent complaints advocacy service regularly deals with extremely complex cases that more often than not, relate to (and cut across) a number of service providers in England and Wales.

Representing the Citizen in Health and Social Care

Powys CHC welcomes the Welsh Government's intention to create a stronger people's voice across health and social care. The White Paper provides a once in a generation opportunity to do this in a way that best serves the people of Wales in health and social care.

We are not convinced however that the proposals as outlined will achieve this and are concerned they will dilute rather than strengthen this voice in the NHS.

Furthermore, we are concerned that the evidence presented in support of the proposals is flawed in some key aspects.

Powys CHC is extremely concerned that the proposals contained within the White Paper do not reference or reflect the complex health and social care pathways which patients, individuals and families in Powys follow. These pathways are both cross-boundary and cross-border and are often a combination of both for primary care, secondary care and social care.

Illustrative example from a recent engagement event:
“I have to travel 2½ hours to Stoke for cancer treatment. When I needed my operations I had to be there for 7am! My husband who takes me is 80+. The people in Cardiff have wonderful healthcare and don’t understand how difficult it is for most of us living in Powys”.

Over the summer, CHCs asked people and bodies who represent them what is important to them and looked at the different arrangements across the UK and beyond. We considered in detail what others have said about the strengths and weaknesses of the different models. We have reflected on what works well in our current arrangements.
Given that the Welsh Government’s proposals are drawn, in a large part, from the arrangements in place in Scotland, Powys CHC paid particular attention to the role and remit of the Scottish Health Council.

The Chief Executives of the Board of CHCs visited the Scottish Health Council to hear from them directly about the current arrangements; the recent review which identified a clear case for change in their role and remit and the on-going consultation about their future direction.

Powys CHC is concerned that the White Paper proposals for a stronger citizens’ voice body in Wales are predicated on a [Scottish] model that is not, and does not currently describe, or consider, itself to be a citizen’s voice body.

The CHC movement has jointly agreed what we consider to be the key functions and principles underpinning the detailed design of a new people’s voice body for health and social care in Wales. At the Full Council meeting of Powys CHC on 12th September 2017, members unanimously supported and agreed the proposed alternative/ new model that has been prepared by the CHC movement to support the Board of CHCs response to the White Paper.

What should a people’s voice body do?
We believe a new people’s voice body in Wales should have the following functions:
i) To encourage and support the involvement of people of all ages as individuals and communities in the design and delivery of services by:
 Engaging directly with individuals and communities on the things that matter most to them about their health and care services. Including engaging directly with people whilst accessing services.
 Supporting, encouraging and facilitating engagement and involvement through a formal alliance with others to promote co-production and co-design (building on the

Scottish Health Council's model Our Voice) including English NHS Trusts, Local Authorities and other service providers.
 Working collaboratively and across-boundaries and across borders to develop a creative, bilingual and accessible platform for individuals, communities, regions and the wider population to share their views and experiences and influence health and social care design and delivery on a local, regional and national level.
 Informing the development of national standards and guidance for engagement and consultation which can be adopted by cross-border service providers
 Advising and supporting providers on involving people, including on engagement and consultation activity.
 Monitoring and evaluating the effectiveness of involvement, engagement and consultation. Checking that people have had the opportunity to be heard and that their views are properly considered and responded to.

Whilst we do not consider a new people's voice body should be checking compliance against standards (this sits better with others) it could and should refer concerns to responsible bodies if it appears standards for engagement and consultation have been breached.

Illustrative Example:
The Fan Gorau Inpatient Assessment Unit in Newtown closed in June 2016 due to safety concerns arising from the inability to maintain safe 24-hour staffing.
In response to this, a Dementia Home Treatment Team was established in North Powys to provide home-based support for people with dementia and their families and carers, along with a "crisis bed" to provide access to overnight care alongside the other services provided and commissioned by PTHB. Between February 2017 and July 2017, PTHB undertook an extensive engagement and consultation exercise (in close collaboration and regular communication with Powys CHC, and in line with both CHC regulations and Guidance for engagement and consultation) which resulted in a service change from a single location based model to a community/ home based model.
Summary - following 5 months of comprehensive, meaningful, inclusive engagement and consultation with the CHC, individuals and communities of North Powys (in line with CHC Regulations and Guidance), an enhanced, needs-led community based provision is now being delivered.

This significant service change should be recognised as an exemplar of good practise, for the inclusive approach that was adopted, in close partnership with Powys CHC.
To represent the interests of people in health and social care by:
 Scrutinising health and care policy, plans and performance locally, regionally and nationally. Challenging service providers and policy makers where improvement is needed
 Scrutinising the work of health and care regulators and inspectors
 Sharing ideas, information and concerns about health and social care to support service improvement
 Involvement in the co-design and development of services (including service change proposals)
 Providing independent advocacy support and assistance to individuals raising a concern about health and care services

Illustrative Example:
Powys CHC has, over the past 5 years, ensured that the views and voices of Powys patients have been considered and heard in the discussions, developments and decisions relating NHS England's Future Fit Programme (in this particular instance a strategic approach between Shropshire Clinical Commissioning Group, Telford and Wrekin Clinical Commissioning Group and PtHB).

Powys CHC is/has been observers of the Programme Board, Joint Committee, the Engagement and Communication Work stream, the Integrated Impact Assessment Work stream and has attended numerous workshops and engagement events over the five years.

Powys CHC, its members and officers, has consistently (and regularly) reminded partners of the need to ensure compliance with both CHC Regulations and the Welsh Government Guidance on Engagement and Consultation.

The Future Fit consultation will be launched in October 2017. This represents the next stage of the process.

Powys CHC members will continue to ensure that the voices of Powys patients are sought, listened to and incorporated in any future service changes.

A new body should have the following rights:
 Right to visit unannounced wherever health and social care is delivered (NB. This would not extend to the homes of individuals) to report on its findings from an individual's perspective and to have those reports acted upon
 Right to co-operation from care providers in contacting people on their behalf for the purpose of collecting independent feedback about care services
 Right to be heard in health and social care (including on service change) by, policy makers, service providers, scrutiny bodies and regulators
 Right to a full, public and timely response from the above on concerns raised.
Powys CHC notes that the White Paper provides no reference to the scrutiny role undertaken by CHCs. Powys CHC members sit on over 60 Boards, committees and sub-groups across England and Wales.
Powys CHC does not consider a new people's voice body should take on the following existing CHC functions, duties or powers:
 Provide advice and information on health and social care services
We believe the responsibility for this should be with health and social care bodies. The new people's voice body must have the right to challenge services where the advice and information is not sufficient, clear, accessible or accurate.
 Inspect premises

We believe this responsibility should sit with relevant regulators/inspectorates.

Responsibility to develop alternative models to service change proposals where agreement cannot be reached
We believe any lay organisation would not be equipped to meet this responsibility.
 Right of referral to Ministers on service change proposals

We believe a new people's voice body should not be the decision making body for a proposed service change. All service change proposals should be open to public scrutiny.
Where decisions are not considered to be in the public interest, the appropriate challenge is through judicial review.

What should a new people's voice body look like?
So that a new people's voice body is, and is seen to be, independent, it should be established as a single legal entity on a stand-alone basis.

So that it is accessible and can respond quickly to what matters most to people and communities about their local services it should have a strong local presence and focus.
The organisational design of a new people's voice body must:
 enshrine the principle of decisions being taken as close as possible to the people impacted
 provide for local determination of priorities according to evidence of local needs
 provide for the agility to take decisions that impact locally, regionally and nationally
 provide for clear lines of accountability within a strong standards & governance framework

Volunteers should be representative of the communities they serve and:
 be the lifeblood of a new people's voice body
 have the opportunity to contribute in different ways according to their skills and interests underpinned by a strong framework of modular and competency based learning and development.

In order to ensure equality, diversity and inclusivity, a new people's voice body must be free to determine how it recruits its volunteers. In summary, we believe our outline proposals for a new people's voice body provides a strong framework on which to base future arrangements in Wales. However, the success of any future model will depend on the detailed arrangements being co-produced with partners and stakeholders. Powys CHC asks that the Welsh Government looks to facilitate this approach over the 6-12 months following the consultation period.

Co-producing Plans and Services with Citizens
Powys CHC considers that there should be a single approach across health and social care to handle service change proposals and is concerned that the detail in the white paper proposals around a new service change process does not provide for this.
Integrated service developments should be driven by communities whose contribution must be valued and utilised by decision makers in both health and social care. It makes no sense to develop a detailed service change process centred on NHS decision making alone.

Powys CHC also has concerns that the detailed process described in the proposals are based upon current practice in the NHS in Scotland, which has been subject to a

recent review that recommends a move away from this approach in light of experience.

Specifically, the review recommends a shift from defining service change as significant or otherwise. The review states “decisions as to whether something should be seen as ‘major’ or ‘minor’……. have become divisive, confrontational and detrimental to public confidence in the NHS”.

Our experience is that where service change has been successful the level and nature of involvement, engagement and consultation was proportionate and responsive to the needs of those affected.

Powys CHC considers that all service change should be open to public scrutiny. We agree with the proposals to revise existing guidance. We believe that the guidance needs to illustrate what effective engagement based on co-production principles looks like in health and social care. In revising and extending this guidance to social care, the Welsh Government should work with NHS bodies, social care providers, the people’s voice body and others with a role in helping communities to be heard.

The revised guidance should explicitly recognise that decisions taken nationally and regionally have a direct impact on how health and care services are designed and delivered locally and should provide greater clarity as to how co-production principles will be used to ensure people are engaged at all levels.

Inspection and Regulation and single body

We are not clear how the proposals to overhaul Healthcare Inspectorate Wales’ underpinning legislation would inevitably lead to more integration and common methodologies between the two existing inspectorates (CSSIW and HIW).

We recognise that removing the existing inspectorates from within Welsh Government and housing them within a Welsh Government Sponsored Body would bring more independence from government.

However, it is difficult to see how the governance and accountability arrangements would work in a model that seeks to preserve the independence of three separate bodies within one Welsh Government Sponsored Body. The experience in Scotland with its Healthcare Improvement Scotland model (which houses within it a range of distinctive groupings, including its inspectorate and the Scottish Health Council) illustrates the challenges of maintaining an individual and independent identity for each.

WGWPMB260: G John
Location: Unknown

General Comments

1. Changes on how to have better leadership

* Employing someone who has best highest qualifications and experience for the job (rather than jobs for friends/family network who haven't got relevant qualifications or experience- often resulting in them giving a second rate performance with the heavy reliance on their network to get them out of difficulties and cover their shortcomings).

2. Changing how they work and think

* Employing best most qualified person with background & experience in multi-disciplinary research of best international outcomes and implementing these changes through engaging effectively with all stakeholders on ground, through introducing more fit- for-purpose fluid top down/bottom up joined-up policy.

3. Changes to help put people first

* Empowering all service-users to use their voice and listen to staff ideas. Creating fresh space for new vision for change. This in itself will come in line with best practice, producing value for money strategies.

4. Changes on how to get more people involved

* Meet people where they are. Listen to people where they are at. Instead of judging people according to their text book diagnosis or circumstance, listen to what people's needs are. For example, someone with mental health, learning difficulties or an older person might struggle with remembering appointments so a text or phone-call on that morning might be a strategy which would keep them in the system rather than excluding them for missing appointments which might be a symptom of difficulties which they need help with.

Instead of telling people what an out of date text book says they need, engage with them by showing respect, value, care and concern for individual, listening and being kind. Developing effective relationship based on mutual respect.

Kindness opens doors and people are more likely to get involved, if they trust that they will not be harmed or have their information used against them or their children. Unfortunately too much harm has happened in past towards innocent service-users in Swansea so a culture shift is required.

WGWPMB261: Mirus-Wales
Location: Brecon

Response to Specific Questions

Good Leaders
We might change the law to make it easier to get the best group of people to make the right decisions on how health services in Wales are run. What do you think?

Chris – I am very aware of the problems from the news. We need the best people in charge, people who will listen. Health is usually the most important thing for most people. I have seen on the news that there are not enough GPs in Wales. And everyone thinks that the nurses should have more pay.

Tina – This is a good idea – team working means that people get their voices heard. Community nurses would be good people to be part of this – they are out there working day to day and are the best people to say what is happening.

Hannah – One person trying to do a million things all at once is too much for one person. They are juggling too much. If more people were involved they would be part of a team which is good.

Good Quality Care
We might make a new law to make everyone work together to plan and give good quality care. This means organisations will have to decide and work together on what is best for all the people, not just the ones in their own areas. What do you think?

Chris – If people share ideas and if they all work together, then may be people could easily travel to different hospitals for operations.

Tina – If places worked together, say Cardiff and Brecon, then we could pick the good ideas from each area.

Hannah – If everyone worked together they would get more done. There would be more staff to choose from. There would be more communication and more variety. There might also be more recruitment because people might be more enthusiastic to travel to different areas.

Telling the Truth
We might make a new law to make sure workers and organisations will always tell the truth and speak to people. If workers and organisations are not honest then the new law will mean they could get into trouble. What do you think?

Chris – Why would you not tell the truth? I can't think of a time when you would not. It is especially important for people who work with other people to tell the truth. People like social workers, care workers, and doctors.

Tina – For me this is the most important thing of all. I have been trying to show social services that I want to be a better person but sometimes feels like people are taking over my life. I have often felt that people are trying to persuade me to do something, and I ended up in a situation I did not like. I wanted to understand more. I wanted to be involved from the start. If people were more clear with me from the start then my situation in the past might have been better.

Hannah – People should always be told if things are going wrong. If not then the patient would suffer more and feel confused. People should be honest from the beginning, not cram all the information in at the end which makes it difficult for people to understand.

High standards across health and social care

We might make a new law to ensure the same standards apply wherever you get your care. What do you think?

Chris – It should be the same level everywhere. Otherwise it's confusing.

Tina – I think this might be a bit tricky to do. It might make the standards too broad. There are lots of different areas of work. If we made just one set of standards for all it might get too broad.

Hannah – It would make sense especially for people who have difficulty understanding. It's very confusing otherwise.

Making a Complaint

We might make a new law to make health and social care organisations work together to look into a complaint. This should make things easier for the person making the complaint. What do you think?

Chris – I know how to complain about mirus. But I don't know where to go to complain about a hospital.

Tina – I have had problems in the past, a lot of different things, not just one thing. I went straight to the big boss. That worked and good things happened for me. The big boss had the authority to make things happen. A new department would need the same authority. They would have to understand and take the time to find out that it is probably not just one thing causing a problem for someone but lots of things.

Hannah – On the one hand, having to deal with just one person might be really good for some people. They might find it difficult to complain to a lot of people. But on the other hand, there is just one department looking into a complaint, what if they were really pushed and busy. They would not have time to do a proper job.

Making sure people have a say

We might make a new law to set up an organisation in Wales which makes sure people are having a say about health and social care. What do you think?

Chris – Health is wider than just doctors – we should one thing to cover all. One organisation would mean less meetings, and they could all share information from the start.

Tina – Talking about social care is more difficult for people. People get embarrassed giving feedback on social care. Things with social care are less cut and dried than for health. Things get more emotional.

Hannah – It's a really good idea to get an organisation that lets people have their say on health and social care. At the moment, the chance to give feedback is patchy (like I am giving feedback now).

Organising changes to health services

We might make a new law to make it clear about what will happen if people can't agree about a change to health services. This will mean that Ministers will be able to decide but they will have to take advice first. What do you think?

Chris – This does have to be sure to listen though.

Tina – It's a good idea that they go away and talk to each other and take advice from people who know.

Hannah – Taking advice is important. They have to make sure that they listen! And that they get the time to listen to every argument.

Checking how things are going

We might make a new law to set out what HIW can check. We will put all the new law in one place so it is easier for people to find and read it. We might also make a new law to ensure HIW and CSSIW work together better. Another idea is to have a new organisation to bring together HIW and CSSIW. What do you think?

Chris – I think this is a good idea that would save a lot of paperwork and repeating the same things.

Tina – Joining together might be quite good. A lot of social care and health care is mixed up – like mirus people giving medicine.

Hannah – I think it might be better to keep two departments rather than merge them into one. It might be too overwhelming for one department.