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Green Paper

Our Health, Our Health Service

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Overview

This consultation is to promote discussion and gather views to help inform the potential for future legislation in the Fifth Assembly with regards to improving quality and governance in the NHS in Wales.

How to respond

Please respond by answering the questions at the back of this document and sending it to:

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Or by post to:

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Further information and related documents

Large print, Braille and alternative language versions of this document are available on request.

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Data protection

How the views and information you give us will be used

Any response you send us will be seen in full by Welsh Government staff dealing with the issues which this consultation is about. It may also be seen by other Welsh Government staff to help them plan future consultations.

The Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. This helps to show that the consultation was carried out properly. If you do not want your name or address published, please tell us this in writing when you send your response. We will then blank them out.

Names or addresses we blank out might still get published later, though we do not think this would happen very often. The Freedom of Information Act 2000 and the Environmental Information Regulations 2004 allow the public to ask to see information held by many public bodies, including the Welsh Government. This includes information which has not been published. However, the law also allows us to withhold information in some circumstances. If anyone asks to see information we have withheld, we will have to decide whether to release it or not. If someone has asked for their name and address not to be published, that is an important fact we would take into account. However, there might sometimes be important reasons why we would have to reveal someone's name and address, even though they have asked for them not to be published. We would get in touch with the person and ask their views before we finally decided to reveal the information.

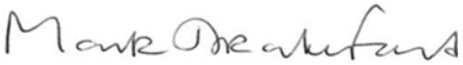
Ministerial Foreword

Our aim in Wales is to develop a model of health which promotes physical, mental and social wellbeing. This approach draws in all relevant organisations, services and people to ensure the root causes of poor health are addressed. The NHS, social services, housing, education, transport, environment and leisure services, the third sector, the independent sector, carers and people themselves must all collaborate to meet local need. A huge shift is needed towards preventative and primary care, which can keep more of us well for longer.

This starts with a desire to want to do the right thing for people and to provide services which evolve and learn in response to people's needs. The NHS in Wales is committed to putting quality at the heart of its services and there are many examples of the excellent healthcare being provided to patients. Quality services provide the right care, in the right place, at the right time and in the right way. High-quality healthcare feels right and is about caring for people, in a manner suited to their circumstances, including using the language of their choice, and in a way which recognises them as individuals. NHS staff demonstrate tremendous dedication every day. Regrettably, though, there continue to be instances when people are let down by the quality and the safety of the care they receive. Whether this is because of poor practice, poor communication and information sharing or other reasons, it is not something we should be prepared to tolerate. We want to build a culture of continuous improvement, focused on unfailing quality of all services provided by the NHS in Wales.

We must always aim to deliver consistently high standards. There is already much in place which we can build on and we now need to further support staff and organisations in order to achieve our shared aims. Strong leadership and empowerment of frontline staff is needed in order to consistently deliver the highest standards of care – all day and every day. We need to ask what else we can do to encourage, support, innovate and remove barriers to drive continuous improvements in safety and quality. Quality is also reliant on having strong, underpinning organisations, with the right sorts of powers and structures to act strategically and in the best interests of patients and the wider public good. We need to consider which existing systems and processes require improvements and whether, in some circumstances, new or extended processes would be suitable. Positive changes may be achievable through different methods, including using our powers to legislate if considered necessary.

The purpose of this Green Paper is to set out the current systems in place to support quality and governance in the NHS in Wales, to describe the current position and to seek your views on what else we can do to improve. Your thoughts on what further actions we might want to take will be instrumental in informing the way ahead and I urge you to get involved in the debate.



Mark Drakeford,
Minister for Health and Social Services

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Context

1. In a year where many have seen the future of the NHS as a pivotal political issue, we are clear that here in Wales, we have the building blocks in place to deliver a properly integrated service which will be able to support our population for many years into the future. To achieve this there will be a lot of important decisions to take about the shape of services, the people and organisations which provide them and what we are all prepared to do to manage our own health. One thing we can all agree on is, irrespective of where in Wales we might live, we are all entitled to receive the same high-quality services. This does not mean a "one size fits all" approach but a flexible and appropriate service, which provides the quality care we need when we need it and to the standards we expect.

Quality in NHS Wales

2. Quality is at the heart of every aspect of the approach to healthcare in Wales and is highlighted in the core values that underpin the NHS in Wales (Health in Wales, 2011). The values are:

- Putting quality and safety above all else: providing high value evidence based care for our patients at all times;
- Integrating improvement into everyday working and eliminating harm, variation and waste;
- Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and well-being for future generations of the people of Wales;
- Working in true partnerships with partners and organisations and with our staff;
- Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively.

3. These core values support good governance and help ensure the achievement of the highest possible standards in all the Welsh NHS does. A range of key healthcare policies, as encapsulated in policy documents and legislative measures, underpin the Wales approach to quality and quality improvement. These include:

- *Quality Care and Clinical Excellence* (Welsh Office, 1998), introduced clinical governance for all NHS organisations in Wales and provided a framework for continually improving the quality of services and safeguarding high standards of clinical care;
- *The Health Act 1999* introduced a statutory duty for NHS Trusts to establish and maintain arrangements for the monitoring and improvement of the quality of healthcare services provided to patients;
- *The Health and Social Care (Community Health and Standards) Act 2003* set out an overarching duty of quality for health bodies. It also provided for

reviews and investigations of healthcare services in Wales, which are carried out by Healthcare Inspectorate Wales (HIW);

Standards

- *The Healthcare Standards for Wales Framework 2005* (Welsh Assembly Government, 2005) helped drive improvements in the standards of services for which they were responsible;
- *Doing Well, Doing Better, Standards for Health Services in Wales* was issued in 2010 (Welsh Government, 2010), sets out the core standards for the NHS, revising the Healthcare Standards Framework with the aim of better reflecting the new integrated NHS structures in Wales and the prevention agenda;
- *The Health and Care Standards 2015* which revise the 2010 standards and aligned with the *Fundamental Standards of Care*, making them applicable to all health settings and place them in the context of prudent healthcare;

Strategies and Plans

- *The Healthcare Quality Improvement Plan (QUIP) 2006* (Welsh Assembly Government 2006) set out to strengthen the focus on quality in the Welsh NHS, to ensure that patients would be treated in the right place, at the right time and by the right people;
- *Achieving Excellence: the Quality Delivery Plan for the NHS in Wales 2012-2016* (Welsh Government, 2012) set the double goal of ensuring continuous quality improvement through inspiring all staff and managers to take responsibility for improving the quality of care they provide;
- *More than just words: the Welsh Government's framework for Welsh language services in health, social services and social care* sets out a strategic approach to ensuring patients receive services according to Welsh language need.

Listening to the patient experience

- *The NHS Redress (Wales) Measure 2008* introduced a system of compensation in low cost cases without the need to take legal action;
- *The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011* which set out arrangements for the consideration of and response to concerns raised about services provided by the NHS in Wales, adopting a much more proactive, learning approach;
- *The Framework for Assuring Service User Experience*, 2013 (Welsh Government, 2013), set out a consistent approach, and clarified expectations in relation to the need for NHS organisations to put patient and user experience at the heart of their agenda;
- *The Community Health Councils (Constitution, Membership and Procedures) (Wales) (Amendment) Regulations 2015 and the Community Health Councils (Establishment, Transfer of Functions and Abolition)*

(Wales) Order 2015 (Welsh Government) which set out revised arrangements for community health councils (CHCs) in Wales aimed at introducing consistency in the way CHCs carry out their functions.

4. The Quality Delivery Plan for the NHS in Wales outlined numerous actions already underway in Wales to support the quality agenda, including:

- A National Quality and Safety Forum to provide strategic oversight;
- Embedding the 1000 Lives Plus improvement programme with the aim of 25% of staff being trained in improvement methodology by March 2014;
- The introduction of peer review;
- The development of quality triggers and annual quality statements published by all NHS organisations in Wales.

5. These actions were built upon within *Delivering Safe Care, Compassionate Care*, the Welsh response to the Mid Staffordshire NHS Trust public inquiry.

6. These policies and legislative measures have shaped the way in which the NHS in Wales has sought to provide quality healthcare and to improve its services. We know that the vast majority of patients are happy with the quality of the services they receive. However, recent reports and reviews, such as that into events at the Princess of Wales Hospital, in Bridgend and Neath Port Talbot Hospital[1] and more recently at the Tawel Fan Ward of the Ablett Unit, Ysbyty Glan Clwyd[2], have highlighted inconsistencies which can turn into unacceptable care and behaviours. In addition, the NHS in Wales has not always reacted openly and proactively or learned lessons when faced with complaints and concerns[3]. While actions are now in place to take forward the recommendations of these reports, there is a continuing need to question whether there is more we can be doing to embed quality at the heart of the service at all levels.

7. Prior to the publication of the Mid Staffordshire inquiry report, the King's Fund published a paper[4] setting out views on how the system of quality assurance needs to evolve in order to avoid gross failings in healthcare quality in the future. The report outlined three "lines of defence" against quality failures in healthcare, which provide a useful structure for considering what actions we might need to take to take the provision of quality services into the next phase.

8. The first line of defence is the healthcare professionals who have direct contact with patients. It is important they are able to voice concerns and intervene to prevent failures in care and consideration should be given to

[1] Trusted to Care, Professor June Andrews and Mark Butler, May 2014.
[2] External investigation into concerns raised regarding care and treatment on Tawel Fan Ward, Donna Ockenden, September 2014.
[3] Using the Gift of Complaints, Keith Evans, June 2014.
[4] Preparing for the Francis Report: How to Assure Quality in the NHS, King's Fund, July 2012.

how we might do more to empower those on the frontline to deliver quality services. Some of the questions we pose in the later parts of the Green Paper touch on how we might better involve staff in improving quality and upholding standards.

9. The second line of defence is the boards and senior leaders of healthcare organisations. It is vital they are able to monitor the quality of care, take action to resolve issues and create a culture of openness which supports staff to identify and solve problems. This is also discussed further in later chapters.

10. The third line of defence is the national bodies responsible for assuring the public about the quality of care being delivered by healthcare organisations, such as the inspectorates and other organisations with statutory functions, such as Community Health Councils and the Welsh Government in its performance management role. They can take action where health organisations have failed to resolve identified issues. This concept of a third line of defence was adopted by Ruth Marks in her independent review of HIW[5] commissioned by the Welsh Government. The report reinforced the message from the King's Fund that as a third line of defence, regulation and inspection of services can contribute to the quality of those services, but will not deliver on its own. The report also recommended making HIW a stronger, more independent inspectorate with the possibility of merging it with the Care and Social Services Inspectorate for Wales (CSSIW) to form one single regulator for health and social care. This recommendation in particular requires considerable further thought and is set out in chapter six.

11. A final piece of evidence to consider will be the report by the Organisation for Economic Co-operation and Development (OECD) which is undertaking review of healthcare quality in the four UK countries.

NHS reforms

12. The NHS in Wales has seen significant positive changes in recent years in order to improve health outcomes and ensure that the NHS delivers care effectively and efficiently with its partners. The *NHS (Wales) 2006 Act* currently provides the legal framework for the powers and functions of health boards and NHS trusts. The structure in Wales had been characterised by a division of responsibilities between health boards, as commissioners of health services, and NHS trusts as providers of such services. In 2009 the NHS structure was fundamentally reformed from the separate commissioner and provider system and organisations to an integrated system and organisations, with this largely combined into health boards wholly responsible for health of their resident population and the provision of NHS services, with just three remaining NHS trusts.

[5] The way ahead: to become an inspection and improvement body, Ruth Marks, November 2014.

13. NHS reform was focused on a new simplified structure which sought to provide improved integrated and collaborative working within health economies, between primary, community and secondary healthcare, and easier access to a wider range of health professionals. The aim of the reform was to transform the NHS into an integrated healthcare system which would work closely with local government and the third sector, widening horizons through partnership working and ensuring that public health is central.

14. The legislation, which still reflects the separate commissioner and provider system and organisations, no longer matches the philosophy and needs of integrated health services and NHS bodies in Wales. For example, the NHS (Wales) Act 2006, which sets out the purpose of local health boards and NHS trusts, does not accurately reflect their combined roles, and some of the detailed schedules to the 2006 Act may not be fit for purpose to support integrated, complex NHS organisations.

15. The NHS (Wales) 2006 Act consolidated provisions from the Health Service Act 1977, as amended by subsequent legislation, and it may be the case that the powers and functions of local health boards and NHS trusts need renewed consideration in terms of equity and whether the provisions are appropriate for them to discharge their roles in an integrated health system and supporting them to deliver effectively. There are also other issues where a review may be necessary, such as the definition of a hospital and whether it meets the requirements of the modern NHS, or the definition of a university health board and who monitors its benefits and status. NHS bodies also secure professional advice and how that advice is disseminated could improve wider NHS organisational learning.

16. For the purpose of enabling a clear and constructive discussion around all the issues identified this paper is in two parts; part one focuses specifically on issues of quality and service improvement; the second looks at reforming the organisational and governance structures currently in place which are a key driver in ensuring that organisations have the skills and enablers to drive quality and improvement.

Note: throughout the document, the term “health board” is used to denote “local health board”

Part 1: Quality First and Foremost

Chapter 1: The Changing Shape of Health Services

17. Despite real efforts to make it otherwise, the historical pattern of policy and investment and delivery of healthcare services (including those contracted from outside public services) has been focused more on illness and hospitals and not as much on health and preventative primary care. Over the next few years, we want to see a change in the way all these services work together, with health boards investing in primary care, supported by hospitals and other services, where needed.

18. Many things have changed since the last reform of the health system in Wales in 2009:

- We are experiencing – and will continue to experience – a time of severe austerity in funding for public services across the UK. In Wales, investment in primary care has increased steadily since 2003 but with increasingly constrained health budgets, the focus is now on ensuring this investment is used to maximum effect;
- Local health boards and NHS trusts now have the ability and flexibility to plan over three years with the development of integrated medium-term plans;
- New law-making powers for Wales mean we can set out new legal requirements for NHS organisations to make improvements to benefit their local populations;
- Primary care services are facing increasing and more complex demands: our population in Wales is increasing and getting older;
- More people are being diagnosed with one or more preventable health conditions, such as type 2 diabetes and dementia;
- Frail and older people increasingly have more complex needs;
- There are more staff than ever working in the NHS in Wales, for example:
    - The number of nursing, midwifery and health visiting staff has increased from 28,157 in 2010 to 28,300 in 2014, accounting for 39% of all NHS Wales staff. The number of qualified school nurses has increased by nearly 34% since 2013;
    - The number of hospital consultants working in the Welsh NHS increased by nearly 50% - up by 721 (46.5%) to 2,270;
    - The number of medical and dental staff has increased by 27.5% since 2004 (up 5% since 2010), to reach 6,011 in 2014.

19. What has not changed are the difficulties which can arise when change to services are proposed. A dialogue with the public and those involved in the provision of care is now more important than ever if the health service is to continue to provide safe and sustainable services which respond to the needs of local populations in the future. This includes working in tandem with other service providers such as local authorities and the voluntary sector in partnership with communities.

20. Quality care means ensuring that people who need services provided in Welsh have access to services in Welsh. This is particularly important for vulnerable patients; for children and older people, to be able to communicate and participate in their care as equal partners through the medium of Welsh.

21. In January 2015, the Minister for Health and Social Services endorsed the four prudent healthcare principles set out by the Bevan Commission:

- Achieving health and wellbeing with the public, patients and professionals as equal partners through co-production;
- Caring for those with the greatest health need first, making the most effective use of all skills and resources;
- Doing only what is needed, no more, no less; and do no harm;
- Reducing inappropriate variation using evidence based practices consistently and transparently.

22. These principles, together with the complementary idea of only do what only you can do – the notion that no healthcare professional should routinely be providing care below their clinical competency – form the underpinning ethos for the delivery of healthcare in Wales and are therefore referred to widely in this Green Paper.

Promoting Health and Wellbeing

Current landscape

23. One of the key tenets of prudent healthcare, and therefore high-quality health services, is to achieve health and wellbeing in partnership with the public, patients and professionals through co-production. Nowhere is this aspiration set out more clearly as in the Well-being of Future Generations (Wales) Act 2015. This new law will make public bodies think more about the long term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach.

24. Working together we need to try to stop problems getting worse or even prevent them happening in the first place. This is very much the intention behind the Public Health (Wales) Bill which covers a range of issues from smoking to the provision of public toilets. The Social Services and Well-being (Wales) Act 2014 contains a wellbeing duty, which also places a duty on local authorities to provide or arrange preventative services for the purposes of reducing or delaying the development of people's needs for care and support.

25. This is a significant change in the culture of public service delivery, moving organisations away from providing services which treat problems to a position where they view the choices and behaviours of the individual as key components of their future health and wellbeing. It refocuses our combined effort on achieving outcomes, rather than simply input and output.

26. It is therefore very much the direction of travel in Wales to help people to live healthier, more productive and more satisfying lives with the assumption that the individual, in discussion with those who assist them, is the person best placed to judge and make decisions about their own health and wellbeing. We need to consider how this can be better promoted. Views are sought on whether the focus of these matters in social services legislation should also be pursued for health boards, primary and independent health service providers in Wales.

27. There is a growing awareness across many countries that preventative primary care is the essential component of an effective, efficient and equitable health system. In Wales, we want to develop a primary care service based on the principles of prudent healthcare and made up of a wide range of public and third sector organisations working side-by-side with people who use health services as a coordinated and integrated team. In this way it will become a system focused on tackling the root causes of ill health, meeting people's physical, mental and social health and wellbeing needs close to home; preventing people from being admitted to hospital unnecessarily; helping those who have been admitted to get home quickly with the right support and motivating and supporting people with chronic conditions and long-term illnesses to manage their health at home.

28. The Welsh Government's national plan for a primary care service for Wales sets out the work the Welsh Government and health boards, with partners are doing by March 2018 to develop primary care services. Primary care encompasses many health services, including, pharmacy, dentistry, optometry as well as general practice, which often provide the public with the first point of contact with the NHS in Wales. Primary care is also, importantly, about coordinating access for people to the wide range of services in the local community to help meet their health and wellbeing needs.

29. The overall principles underpinning the primary care plan are:

- Prevention, early intervention and improving health, not just treatment;
- Co-ordinated care where generalists work closely with specialists and wider support in the community to prevent ill-health, reduce dependency and effectively treat illness;
- Active involvement of the public, patients and their carers in decisions about their care and wellbeing;
- Planning care locally at community level through the 64 primary care clusters, based around collaboration between all those people, services and organisations which can help meet people's needs to improve access to and the quality of services closer to home;
- Prudent healthcare.

30. The primary care plan is based on a planning model where the needs of local communities are assessed and the resources needed to meet them

are planned by and through the 64 primary care clusters with an emphasis on prevention and early intervention. Planning on the basis of a population of between 25,000 and 100,000 focuses sources of help around the needs of families and local communities. Cluster level-assessment of need and service planning provides core information for delivering duties provided for in other settings. For example, the Social Services and Well-being (Wales) Act 2014 contains a duty for local authorities to provide or arrange preventative services for the purposes of reducing or delaying the development of people's needs for care and support. Health boards must also have regard to these purposes. In addition, section 14 of the 2014 Act requires local authorities and health boards to jointly undertake an assessment of the local population's care and support needs, including the support needs of carers. These will also be used to inform new local wellbeing plans required by the Well-being of Future Generations (Wales) Act 2015.

Summary

31. We want to explore ideas and views on the need for further actions at an organisational level, which will help promote deliver better health and wellbeing.

Questions:

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

If so, what changes should be given priority?

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

Continuously engaging with citizens

Current landscape

32. It is clear that the historical pattern of healthcare services will be unable to sustain the demands of the future. Therefore one of the fundamental roles of local health boards, working closely with the 64 primary care clusters, is to plan for how services will be provided in the future to most effectively meet the needs of their populations. Integrated Medium Term Plans (IMTPs) provide a vehicle for describing how health services will be delivered and how they might need to change but this needs to be the result of a continuous cycle of engagement with local communities, staff and stakeholders to ensure there is understanding and ownership of the way forward. A planned healthcare system, such as in Wales, means that patient choice does not revolve around individuals so opportunities for patients and the public to contribute to the way services are planned are more significant. Great skill is needed in maintaining public confidence in the service and in describing clearly and accurately the need for change and the benefits which can be delivered through a different approach. Health service change too often becomes the subject of controversy and community concern and opportunities for setting out the benefits become lost. This can be addressed through continuous engagement with local communities predicated by clear and sustained clinical leadership.

33. We need to find the most effective ways to engage people continuously in service planning so the patient and public experience fully informs decision making. Patient participation groups are one such vehicle which have the potential to help achieve this. They have been included as an element in the GP contract for 2014-15 but could be used more widely to seek views across all service areas. Strengthening the voices of service users and carers is also a feature of the Social Services and Well-being (Wales) Act 2014 which sets up national and regional citizen panels. This could also be a useful model to consider at a primary care cluster level as well as more widely.

34. In November 2014, Ann Lloyd reviewed the way in which health boards carried out their engagement and consultation role in major service reconfiguration.[6] She identified a number of strengths in the approaches taken, highlighting for example, better engagement with clinicians but she also identified a number of areas for improvement. In particular, she pointed to the need for better continuous engagement with local communities and not just when specific change options are being presented. She highlighted the role patient “expert” groups could play and said that formal set piece consultations are often not the most effective way to engage people in change decisions.

[6] Lessons learned independent review into NHS Service Change Engagement and Consultation Exercises by Health Boards in Wales, Ann Lloyd CBE, November 2014.

35. Community health councils (CHCs), in their statutory role of representing patients and the public, may refer a matter to the Minister for decision in certain circumstances if they are not satisfied with the way in which the proposed change has been consulted on or if they do not feel a particular change would be in the interests of the health service in its area. There have been a number of cases recently where local agreement with the CHC could not be reached and where some service change plans, or elements of the plans, were referred to Ministers. Referral of plans is a failure of the process – not a sign of its success. Ann Lloyd recommended that an expert panel should be introduced into the process to review such challenged service change proposals in place of the present system.

36. Health boards are already under a duty to involve and consult local people or their representatives in the planning and delivery of services, including changes. With the introduction of IMTPs, local health boards also now have the opportunity to set out how they will review local population health needs and be clear about the services that will be provided. The mechanisms are therefore already in place to ensure effective engagement on service changes and this should become the norm for the health service in Wales. However, we would like to consider the issue of referring decisions to Ministers and whether this should be replaced with an independent expert panel, as recommended by Ann Lloyd.

Summary

37. Change to the way in which health services are provided is inevitable. In light of Ann Lloyd's review of the way in which local health boards have conducted these matters so far, and the introduction of the IMTP process, it seems timely to seek views on the process so the way forward is clear.

Questions:

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

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

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

Chapter 2: Enabling Quality

38. Quality of care depends on many factors working together, including attitudes and behaviours of individuals, the culture and systems of care, as well as the overarching structure and focus of organisations. Effective leadership is a key feature which creates a system which continuously improves and is intolerant of poor care and failure. In a quality-driven system, everyone should be focused on the contribution they can provide to address arising issues and, once they have focused on their own contribution, they can consider what others can do. As is clearly described in our NHS Wales Governance Framework, everyone who works in or for the NHS is there first and foremost to serve the public. Everyone, working at every level, has a part to play in driving up standards of safe, effective, patient-centred care

39. The NHS in Wales is clearly committed to putting quality at the heart of the services it provides, however work needs to continue fully to embed the culture of continual improvement within and across whole organisations. This is evidenced in a number of recent reports, which highlight how opportunities to provide excellent care or to learn from mistakes were missed.

40. Prudent healthcare requires a change in mind-set and behaviours across Wales - from the public in taking control of their health; to staff in the NHS in meeting patients' needs, learning from mistakes and striving to improve; to Boards creating the right cultural conditions for quality healthcare. This will determine what we can achieve in striving continuously to improve health and health services.

41. The King's Fund's *Lines of Defence* model, described earlier in the Green Paper, forms a useful basis from which we can consider further actions we need to take in Wales to ensure quality of care and guard against service quality failure. Any changes we make through legislation should be aimed at strengthening each of these lines of defence and should have the prudent healthcare principles at their core. We must also seek to dovetail any actions within the NHS with the powers and duties contained in the Social Services and Well-being (Wales) Act 2014, and the proposed measures being taken forward through the Regulation and Inspection of Social Care (Wales) Bill. In taking forward proposals for NHS quality we would build on these two pieces of legislation to achieve similar provisions for the NHS in Wales. This chapter therefore looks at what other measures might be put in place to ensure continuous improvement in quality.

Quality and co-operation

Current landscape

42. The existing arrangements for promoting quality in the NHS are extensive and strong foundations have clearly been laid, however more needs to be done to keep pace with the integration of health and social care services in Wales and to improve individual and collective accountability for quality of services.

43. The existing duty of quality[7] requires NHS bodies to ensure arrangements are in place for monitoring and improving the quality of their services. This was introduced before the structure of the NHS in Wales was based on an integrated model. The focus to date has therefore largely been on developing quality systems for assurance and improvement in hospital and directly-provided services. This duty could be built upon better to reflect our planned system and one which is more explicit about quality across all aspects of the system wherever health services are provided. Organisations therefore need to ensure that quality is the driving force in all aspects of their business and that it forms a major part of their thinking around the wider needs, not just their own.

44. Recent failings in quality of care and standards, such as those at Tawel Fan raise questions about whether the system for accountability is right or whether further changes are needed. Concepts such as the "Responsible Individual", as set out in the Regulation and Inspection of Social Care (Wales) Bill and tests around the "fitness" of senior leaders and others to carry out their roles[8] have been raised and could be debated further.

Summary

45. Increasingly organisations need to work with their partners and beyond their own statutory boundaries. We therefore need to consider the existing duties on NHS bodies and how we can support them in focusing on the quality of health services they plan and provide for their citizens. We would also like to explore whether further duties around cooperation to ensure quality and safety are needed.

46. In order to provide focus, accountability and responsibility for quality matters, we would be interested in exploring views on whether specific measures such as the introduction of responsible individuals or fit and proper persons tests should be considered.

[7] Duty of Quality, Section 45 of the Health and Social Care (Community Health and Standards) Act 2003

[8] As set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for England

Questions:

Are legislative measures the most effective tool to address the issues raised in this section?

If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?

What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?

What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?

What would be the advantages and disadvantages of legislating for a "fit and proper persons" test, and to whom should it apply?

Integrated planning

Current landscape

47. The Integrated Medium Term Planning (IMTP)[9] framework is integral to ensuring that health boards and NHS trusts are planning for the types of demands and change that a modern NHS brings, with the quality of services at its heart. Comprehensive IMTPs offer a range of benefits to enable the delivery of quality of health services, such as:

- Increased emphasis on improving experience for patients and service users and health outcomes for populations, through clearly defined, evidenced-based and resource-modelled initiatives and actions;
- Promoting co-production by local health boards and NHS trusts working with staff and citizens to develop a well-rounded plan;
- Directing focus towards securing greater value through investment in services;
- Greater assurance to local health boards, Welsh Government and the Minister for Health and Social Services that high-quality health services are being provided by the NHS in Wales.

48. Part 2 of the Green Paper looks at the plans in further detail and in relation to financial duties but from a quality perspective there may be a case for looking at whether the legislation which underpins these plans should also specifically incorporate quality.

[9] The NHS Finance (Wales) Act 2014 and NHS Wales Planning Framework

Summary

49. IMTPs provide the vehicle for ensuring that quality and learning are integral to health service plans. It is now timely to reflect on whether more can be done to develop IMTPs in this direction.

Question:

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

Chapter 3: Quality in Practice

Meeting common standards

Current landscape

50. The notion that common standards should apply across all health services, including primary medical care, dentistry, optometry and pharmacy and independent healthcare settings was proposed in the Ruth Marks' review of Healthcare Inspectorate Wales (HIW). The recently-reviewed Health and Care Standards, published in April 2015, envisage their application across all NHS funded services – Welsh NHS bodies, independent contractors, and other organisations and individuals, including the independent and voluntary sectors, which provide or commission health services for individual patients, service users and the public of Wales. However, under current legislation, even though Ministers may publish standards for the NHS, and expect healthcare providers to comply with them, there is no legal obligation on providers to do so.

51. Independent healthcare services (under different legislation) are required to meet the National Minimum Standards for Independent Healthcare Services in Wales, which were published in 2011.

52. Therefore, in terms of empowering all staff to deliver standards, we would wish to consider whether all health organisations should be subject to the same consistent standards. This would place service users at the heart of all care and provide the enabling conditions to drive consistency in the standards of care provided. It would also provide the opportunity to join up these standards with those proposed through the Regulation and Inspection of Social Care (Wales) Bill for residential care, domiciliary care and other regulated social care services to present a single, common approach to standards across health and social care. This in turn would provide a consistent standards framework upon which to review and inspect services.

53. Accreditation and peer review are also useful tools in assuring and assessing service quality, identifying weaknesses and promoting improvement and we would welcome views on how these could be further developed in Wales to help improve service quality and promote the prudent healthcare principles.

Summary

54. Even though there is a standards framework in place, NHS organisations are not legally required to meet it. This differs to standards set for the independent sector, which historically are underpinned by different legislation. We would therefore like to explore views on this matter and ask whether this position should be changed, with a view to developing a common standards framework across the NHS and independent sector

which aligns, where possible, with those already developed for social care.

Questions:

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

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

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

Clinical supervision

Current landscape

55. Clinical or peer supervision is a technique which enables health professionals to address issues arising from their work with patients, clients and organisational challenges through discussion with professional colleagues. The purpose of clinical/peer supervision is primarily to enable learning through guided reflection on the individual's experience in order to help clarify best practice, identify where modification is needed and promote professionalism in the individual's practice. Clinical/peer supervision aids the individual professional in reflecting on experiences to highlight those aspects of practice that might need development and change but also shines a light on the positive areas of practice that need to be replicated and shared.

56. There are various models of clinical supervision used by health professionals in Wales, including statutory supervision of midwives, which is currently being revised by the Nursing and Midwifery Council (the UK regulator for nurses and midwives). There are currently no national standards for clinical supervision outside that set in statute for midwives. Following cessation of the statutory supervision of midwives there is a strong case to be made for some form of clinical/peer supervision to be continued for this professional group.

57. Clinical supervision is an important facet of professional revalidation, which is currently in place for doctors and is being introduced for nurses and midwives in 2016, with other professional groups to follow. Revalidation is being introduced to give confidence to the public and employers that professionals are up to date with their practice. This is crucial to the provision of a safe, quality service, compliant with standards and best practice.

Summary

58. Currently there is no consistent level of clinical/peer supervision or support from employers for health professional staff undergoing revalidation. We would therefore like views on what support may need to be provided and how this could be extended to self-employed practitioners. Various models could be considered, including group discussion which appears to be working well within the new supervisory arrangements for midwives.

Questions:

How can we ensure health professional registrants have the opportunity to have clinical peer supervision? Should we be considering the use of legislation in this regard and if so, how?

What arrangements should be put in place for self-employed health professional registrants?

Chapter 4: Openness and honesty in all we do

59. One of the main principles of prudent healthcare is co-production. This means involving the individual as an equal partner in their own health and wellbeing, creating opportunities for people to access information and support when they need it and to contribute to the changes which benefit them most. As a principle, co-production needs to be embraced across all healthcare settings and systems, to move the focus back onto the citizen rather than the system. To move towards a culture of co-production we must ensure openness, honesty and shared responsibility between professionals and citizens.

60. A culture of honesty, openness, and co-production is vital to learn from mistakes and improve the systems in place for the delivery of high-quality services and to prevent harm. This was a key message in the recent review by Keith Evans[10] of *Putting Things Right*, the complaints handling process in the NHS in Wales. *Putting Things Right* has been in place since 2011 and aims to make patients and carers aware of how they can raise concerns; who to inform of their concerns and how the NHS will respond to their concerns. It also provides guidance to the NHS on the best way to handle complaints and concerns.

61. While *Putting Things Right* has been effective and is seen as the way forward, Keith Evans' review found there are improvements to be made. He concluded that *Putting Things Right* is a valuable approach to managing complaints and concerns but highlighted variations in its implementation across Wales. The report provided more than 100 recommendations on how the system could be improved and these fell into four general themes – the responsiveness of the process; the infrastructure required; the ability to demonstrate learning and the overall culture.

62. The NHS in Wales has embraced the report and its findings and work is being carried out to implement many of the key recommendations. The National Quality and Safety Forum is leading on a number of work streams to standardise information and publication; review and simplify the *Putting Things Right* guidance and communication and learning and sharing the lessons from complaints. However, there are issues raised in the report which require further consideration and these are set out below.

Being open about performance and when things go wrong

Current landscape

63. The NHS in Wales has made progress in promoting openness and being candid about its performance. In September 2013, *My Local Health Service*, a website dedicated to communicating the performance of the

[10] See Footnote 3. Page 6.

Welsh NHS in a transparent manner, was launched. It aims to promote a more open debate between the NHS and the public about services provided. Since 2013, health boards and NHS trusts have also produced annual quality statements. This year, the Welsh Government published the first all-Wales annual quality statement, which outlined the priorities for the coming year; the achievements delivered and the actions being taken to continuously improve the services we provide. Most importantly, it lets people know in an open and honest way what and how the NHS in Wales is doing in providing those services. Despite these achievements, we want to do more to promote openness about the performance of the NHS in Wales.

64. While *Putting Things Right* promotes openness and the underpinning regulations contain a duty to be open with patients when harm has been caused, there have been calls for a stronger legal duty of candour with the aim of ensuring an open and honest culture in organisations. Keith Evans' review recommended that a legal duty of candour should be placed on the NHS in Wales, not just on individual members of staff but the organisation as a whole in order to set a clear corporate responsibility and tone for the organisation.

65. A legal duty of candour also formed part of the Mid Staffordshire NHS Foundation Trust public inquiry recommendations. The duty recommended by the Francis report promoted enabling complaints to be made without fear; sharing the truth about performance with staff, patients, the public and regulators and informing patients of any harm done to them and offering appropriate remedies, regardless of whether a complaint has been made. As a result of the recommendations a duty of candour was introduced in England through regulations[11] in 2014.

66. As *Putting Things Right* guidance is in the process of being reviewed, now is the time to give thought to further options for consolidating the arrangements for promoting openness and candour and whether there is support for a statutory duty, or another way of tackling the issue.

Summary

67. In order to move towards a culture of co-production we must explore options for further enhancing openness, transparency and candour in the Welsh NHS.

Questions:

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

[11] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Making it easier to raise concerns in an integrated system

Current landscape

68. The Evans review recommended that *Putting Things Right* guidance should be reviewed in order to reflect the closer-knit working between the NHS and social care in Wales and enhance the ability of organisations to deal effectively with cross-cutting complaints received. As we want to see greater joint working between the NHS and social care we need to ensure a complaints process which is citizen centred, not service centred. This may require changes to the regulations[12] which underpin *Putting Things Right*. Primary legislation may also be required to provide the Welsh Ministers with the powers to make such revisions to the regulations.

69. There have also been calls[13] to extend the powers of the Public Services Ombudsman for Wales (PSOW) to allow for independent investigation into situations when citizens have been provided a service through a combination of public and private services. It has been suggested that extending these powers will enable the PSOW to serve citizens more effectively.

Summary

70. *Putting Things Right* has made it easier for concerns to be raised about the NHS but it has not necessarily facilitated joint investigations between the NHS and other service providers. Complaints are one of the driving forces for improvement of the quality of services and it is essential that organisations come together in the interests of making things easier for patients and to learn lessons about the services they provide to individuals. This will contribute to a joined up and integrated approach to health and social care.

Question:

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

[12] The NHS (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2011.
[13] National Assembly for Wales Finance Committee, Consideration of Powers: Public Services Ombudsman for Wales, May 2015.

Chapter 5: Better Information, Safely Shared

71. The complex nature of the NHS in Wales means that many people will often require a combination of the services provided by primary, secondary and community care. People's information therefore needs to be shared between NHS organisations in order to provide them with the highest quality care. NHS organisations have responsibility for protecting sensitive patient information and its confidentiality through information governance processes drawing on the legal, ethical and quality standards that apply to the handling and sharing of sensitive information.

72. To ensure high-quality, safe healthcare, health professionals and citizens must be able to use evidence to make the most effective decisions and most appropriate choices. Every case is different and should be considered by both the health professional and patient together. The sharing of information applies to all four of the main principles of prudent healthcare. By effectively sharing and disseminating information, we can provide the most effective treatment, tailored to the individual needs of each patient while reducing the risk of harm.

Sharing information to provide a better service

Current landscape

73. As we move towards a new model of preventative healthcare and co-production, the effective sharing of information with patients will become an essential component of the healthcare system. In particular, ensuring the public has access to, and understands, information about their own health is increasingly important.

74. The Data Protection Act 1998 gives individuals the right to know what information is held about them and what it is used for. Other legislation specifically provides individuals with the right to access their personal health record. The NHS in Wales provides patients with advice about how they can access their records, although there is no standardised format for applying. Looking forward, the issue is whether the information we provide to patients and the format in which we provide it is the most useful and accessible for them.

75. Co-production calls for citizens and healthcare professionals to work together as equals. It builds on good working relationships founded on trust. We acknowledge that everyone is an expert in their own health with a need to contribute to decisions which affect them the most. These relationships create a culture where professionals share power and patients share responsibility which improves the quality of the services they receive.

76. Despite systems being in place, there is a perceived failure of various bodies to share patients' information even though it is in the interests of the safety and quality of their care. This has been at the heart of many

recent reports, including the UK wide 2012 Caldicott review of information governance, which found a culture of anxiety and a perceived daunting legislative landscape, which prevents sharing of information between organisations. The review recognised data sharing is vital for patient safety, quality and integrated care and concluded a re-balancing of sharing and protecting information was urgently needed in individuals'' and service users' interests. This resulted in a seventh Caldicott principle being added, namely:

"The duty to share information can be as important as the duty to protect patient confidentiality: Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies."[14]

77. Ruth Marks' review of HIW commented on the failure of bodies in Wales to share information, which could help to improve services and she suggested there should be a statutory duty on health boards, NHS trusts and community health councils to routinely share complaints information with HIW. The Commission on Public Services Governance and Delivery, chaired by Sir Paul Williams, also recognised that problems in sharing information could be cultural or technical. He suggested that organisations could be over-protective and unwilling to share information but also that they might genuinely be unable to securely share the information. It is an issue which needs to be addressed – barriers preventing information being shared can prevent healthcare services from being improved.

78. The Wales Accord on the Sharing of Personal Information is already in place to provide a framework for organisations in health, education, safety and social wellbeing to share information in order to deliver effective services. The question arises as to whether we need further statutory duties to require the sharing of information in particular circumstances.

79. There may also be other instances when the processing or sharing of patient identifiable information for non-direct patient care purposes could be in the interests of improving health and wellbeing and the effectiveness of services, for example, the way in which information is provided for research or for management purposes. We would be interested in hearing views on this issue.

Summary

80. For information to be used in the best interests of patients, we need to ensure that there are no inappropriate barriers to sharing it safely. In order to achieve this, we need to ensure that staff and organisations are

[14] This was communicated to the NHS in Wales in Welsh Health Circular (WHC) (2015) 013, April 2015.

not fearful of sharing patient information but confident in doing so and that there are no governance issues preventing them from doing so.

Questions:

What are the issues preventing healthcare bodies from sharing patient information?

How can we consider breaking down any barriers?

What are your views on the collection and sharing of patient identifiable information for non direct patient care, such as research? What are the issues to be considered?

Chapter 6: Checks and balances

81. The "third line of defence"[15] against failures in service quality is provided by those external, often national, organisations, which can provide the assurance needed that services are safe and of high quality, and where they are not, provide independent advice on continuous improvement.

82. Healthcare Inspectorate Wales (HIW) performs this function in Wales. HIW has responsibility for regulating and inspecting a wide variety of NHS and independent sector health organisations. In addition to its direct responsibilities, the development and maintenance of effective relationships with other regulators is more important than ever in an integrated health system. As such, HIW operates within a complex set of arrangements, needing to interface with other inspectorates and regulators, including the Care and Social Services Inspectorate for Wales (CSSIW) and the Health and Safety Executive (HSE).

83. In addition, and uniquely to Wales, community health councils (CHCs) are statutory bodies which provide the patient's perspective of NHS service quality. They have powers to inspect NHS premises, are entitled to be consulted by health boards on various issues and are under a duty to provide advocacy support to people wishing to complain.

84. Given the considerable changes which have taken place in the NHS over the past few years, and in light of recent reviews into HIW and CHCs, now is the time to think again about the model of assurance we have in Wales. We need to consider whether there is too much complexity, duplication of effort and potential for any gaps which prevent information being shared between different bodies.

A seamless regime for inspection and regulation

Current landscape

85. It has become evident over the past few years that the legislation underpinning HIW needs to be reviewed. In particular, certain activities, such as pop-up vaccination clinics and private midwifery services, are not covered by the existing legislative framework. These gaps need to be addressed in the interests of quality and patient safety. Secondly, and in light of Ruth Marks' review of HIW[16], it seems appropriate to consider whether more far-reaching changes should be considered not only to fill legislative gaps as mentioned above but also to address fundamental questions about independence, structure and methodology.

86. As set out in the Marks review, it would be helpful to consider whether the principles set out in the Regulation and Inspection of Social Care (Wales) Bill – registration based on services rather than establishments –

[15] See footnote 4. Page 6.
[16] See footnote 5. Page 7.

should be applicable to health services as well as social services and whether this would provide a more solid base for regulation.

87. The Marks review suggested that the independence of HIW is likely to be instrumental to it becoming an effective regulator and that this could be undermined if it is perceived that the current arrangements lack credibility in providing appropriate independence. In particular, the lack of power to implement special measures without consent of the Welsh Ministers was cited as an area of unease. Therefore, the report called for the consideration of HIW's current position and the need to strengthen its independence. Even though there is little evidence that HIW has anything less than operational independence under the current arrangements, the Welsh Government recognises the case for building full statutory independence into the system if this would give more confidence in, and status to, the role of HIW. Such a move would clearly also have implications for, and raise parallel questions about, the status of CSSIW. We are therefore particularly interested in views on these matters.

88. The Marks review also promoted the idea of closer working, or even full integration of the two inspectorates. The interface between HIW and CSSIW is certainly a matter for some deliberation since it reflects the integration of many health and social care services at a local level and it seems sensible to explore how similar methodologies could possibly be employed. However, consideration needs to be given to the way in which the inspectorates work within other settings, for example child care, and with other bodies such as Estyn or the Wales Audit Office. This Green Paper seeks to explore the advantages and disadvantages of a merger between HIW and CSSIW.

Summary

89. It is timely to consider whether we have the right arrangements in place for the effective regulation and inspection of health services both to support the integrated health system and to achieve a more seamless overview of the complexity of services across health and social care.

Questions:

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

Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?

How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?

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

Representing patients and the public

Current landscape

90. CHCs were established 40 years ago and are among the longest standing of all the NHS organisations in Wales. They have a number of functions designed to provide a strong patient voice within the health service. The fact CHCs have not substantially altered in many years may provide a certain degree of comfort and continuity, given the changes which have affected all other parts of the NHS in Wales, it is now time to reflect on whether the model we have in CHCs to represent patients' interests is the right one. Amendment regulations were introduced in April 2015, however these only address some short-term issues; it has long been acknowledged that a more radical transformation may be needed in the long term.

91. A review of the operation of CHCs[17] made a number of recommendations relating to their structure, functions and membership and the role of the CHC Board in Wales with a view to clarifying and strengthening the existing arrangements. Several subsequent reports[18] have also made recommendations about CHCs' functions and effectiveness.

92. As these reports have suggested, there may be new ways of representing the patient voice, for example through patient participation groups at GP surgery, cluster or health board level as set out in chapter one on continuous engagement. The National Social Services Citizen Panel has been set up to secure a voice for service users and carers and we would wish to explore whether a similar arrangement should be put in place for health services. The role of CHCs may need to be refocused towards some key functions, such as collectively representing the patient voice and providing advocacy for people wishing to raise concerns about care, while stepping back from activities which may be better carried out by others, such as inspections and service change proposals. In addition, the current model of one CHC for each health board area may no longer be the best fit for a service which works increasingly across boundaries and in partnership with other services. CHCs may need to change reflect a more integrated service model. Whether and how CHCs should change to fit the new integrated structure needs careful consideration.

[17] Moving Towards World Class? A Review of Community Health Councils in Wales, Professor Marcus Longley, June 2012

[18] Keith Evans (see footnote 3, page 6), Ruth Marks (see footnote 5, page 7), Ann Lloyd (see footnote 6, page 14).

Summary

93. We are interested in opening up the debate about CHCs and their role in representing the patient voice, which is so crucial in our system, as it is now time for further reform.

Questions:

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

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

Part 2: Strong Organisations, Strong Governance

Strong organisations, strong governance

94. As part of the NHS reform in 2009, a new governance and accountability structure was introduced to embed a culture, which fostered the following:

- Flexibility to work across professional and organisational boundaries;
- Innovation to meet changing service need;
- Learning to encourage training, personal growth and career development;
- Partnership working to encourage joint working of NHS staff with partnership organisations;
- Co-operation rather than competition;
- Responsiveness to ensure future service patterns and priorities are responsive to the needs of individuals within their communities;
- Accountability and leadership.

95. There were practical changes to support the new structure as part of the reform and some of these included:

- Accountability agreements;
- Standing Orders and Standing Financial Instructions;
- A values and standards of behaviours framework;
- The governance e-manual;
- A good governance guide, including various handbooks;
- Model job descriptions.

96. The governance framework continues to support health boards and NHS trusts however, much has changed in the NHS in Wales since the last major underpinning piece of legislation was put in place in 2006 and the last set of significant reforms to the Welsh NHS in 2009.

97. NHS organisations must be invested with the right powers, governance and accountabilities to enable leaders to take the right decisions in the interests of the health and wellbeing of local people. This chapter looks at the current arrangements in place for NHS governance, leadership, relationships with the workforce and other areas within functions and finance where there may be a need for review in order to reflect and support the current integrated service and structure.

Chapter 7: NHS Finance, Functions and Planning

98. The result of historical legislative and organisational structures means there are a number of differences between the powers and functions of health boards and NHS trusts in the NHS (Wales) Act 2006. This chapter considers some of the differences highlighted during the passage of the NHS Finance (Wales) Act 2014 such as borrowing powers for health boards and the removal of summarised statutory accounts requirements for NHS trusts. Achieving consistency of powers and obligations between health boards and NHS trusts may be important within an

integrated service, system and structure so these organisations can continue to grow, deliver and be accountable.

Borrowing powers for health boards, including limits, lenders, interest-free loans

Current landscape

99. The NHS (Wales) Act 2006 makes provision to allow NHS trusts to borrow from Welsh Ministers or any other person. This allows NHS trusts to take advantage of initiatives set up in other parts of government and encourages cross-sector working – for example, the opportunity to access repayable grants or interest-free loans for energy efficient investment. The borrowing powers are subject to limits placed by the NHS (Wales) Act 2006.

100. Most capital funding in NHS Wales is issued by the Welsh Government to health boards and NHS trusts. There is currently no provision for borrowing powers for health boards. The provision of borrowing powers may provide greater flexibility for health boards to fund capital expenditure from their capital and revenue funds. During the passage of the NHS Finance (Wales) Act 2014, the Minister for Health and Social Services indicated that he was minded to consider health board borrowing powers in future legislation.

101. The UK Government Wales Act 2014 gave the Welsh Government borrowing powers to invest in capital projects from 2018. In light of the broader Welsh Government borrowing powers, it is opportune to consider the present and future provision of borrowing powers for health boards in the context of the overall Welsh Government borrowing limits.

Summary

102. Borrowing powers may provide greater flexibility for health boards to fund capital expenditure from their capital and revenue funds and allow them to take advantage of other initiatives such as repayable grants, within overall Welsh Government borrowing limits.

Question:

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

Removal of summarised statutory accounts requirements for NHS trusts and health boards

Current landscape

103. The NHS trusts and health boards in Wales prepare individual annual statutory accounts. Welsh Ministers are required by the NHS (Wales) Act 2006 to prepare two separate statutory summarised accounts for NHS trusts and health boards compiled from the aggregate of the individual trusts and health board accounts.

104. The requirement to prepare summarised accounts is not reflective of the changes made to NHS Wales structures and may no longer be fit for purpose. Prior to NHS reorganisation the summarised account would have captured all hospital and community service activity across NHS Wales within the NHS Trusts Summarised Account. The 2009 reorganisation of NHS Wales transferred all of that activity (with the sole exception of Velindre specialist cancer services) to the seven new health boards. The three remaining NHS trusts in Wales have very different operating models; consolidation into a single NHS trust summarised account therefore may have limited usefulness.

105. The accounts of the NHS trusts in Wales are not presently consolidated within the Welsh Government statutory accounts; the accounts of the health boards are. Further to recommendations by the National Assembly's Finance Committee, the form of Welsh Government consolidated accounts may change in the future and could include the NHS trusts in Wales. Given the structural changes in the NHS in 2009 and potential Welsh Government reporting changes, it is beneficial to review whether two separate statutory published summarised accounts continue to be appropriate for users of this information or whether other options should be considered.

Summary

106. The NHS Trusts Summarised Account may no longer provide any added value for users due to the different activities undertaken by the Trusts. Further to recommendations by the Finance Committee of the National Assembly for Wales, the form of Welsh Government consolidated accounts may change in the future and could include the NHS trusts in Wales. Consequently there may be a need to consolidate the health boards accounts with the NHS trusts accounts for incorporation into the Welsh Government consolidated accounts. On this basis it would be beneficial to review whether two separate statutory published summarised accounts continue to be appropriate for users of this information, or whether other options should be considered.

Questions:

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

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

NHS planning

Current landscape

107. NHS Wales faces some substantial and well-recognised challenges, including:

- Inequalities in health;
- A changing demographic with increasing numbers of elderly people;
- Increasing numbers of patients with chronic conditions;
- Enduring austerity;
- Medical, nursing and other staffing pressures;
- Some specialist services, which are spread too thinly.

108. Planning provides the bedrock of integrated health services in Wales and the need for effective planning, including integrated medium-term plans (IMTPs), is clear. The new requirement is for health boards and NHS trusts to develop integrated medium term plans, setting and flexibly managing resources over a three-year period to address areas of population health need, improve health outcomes, improve the quality of care and ensure best value from resources.

109. The statutory requirements for planning, and the directions issued, through the NHS Finance (Wales) Act 2014 are only placed on health boards. While the planning duty for health boards is explicit, as per the Act, the equivalent planning duty for NHS trusts is currently an administrative duty and not a statutory requirement. The Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 are landmark pieces of legislation which impact on the statutory duties of NHS organisations to plan in partnership. There is potential overlap and duplication in the joint duties with regards to the plans for improving health and in the Well-being Plans, and there is an opportunity to improve alignment between the inter-related planning duties.

Summary

110. To ensure the emphasis on better planning arrangements is embedded in NHS Wales there could be scope to reflect this change in the NHS (Wales) Act 2006 ensuring legislative consistency between health boards and NHS trusts.

111. The NHS Planning Framework is integral to ensuring that health boards and NHS trusts are planning for the types of demands and change that a modern NHS brings. The NHS (Wales) Act 2006 may need to better align with NHS Planning Framework, which drives the development of integrated medium term planning and the legislative change made by the NHS Finance (Wales) Act 2014, in respect of the planning duties for both health boards and NHS trusts. In light of recent legislation on the statutory duties of NHS organisations to plan in partnership there is an opportunity to improve alignment between the inter-related planning duties of those Acts with the NHS (Wales) Act 2006.

Questions:

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

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

Chapter 8: Leadership, Governance and Partnerships

112. This section responds to recommendations from a variety of reports on governance arrangements in health boards, health board size and membership, including the role of the board secretary. The National Assembly's Public Accounts Committee inquiry into governance arrangements at Betsi Cadwaladr University Health Board and wider health board governance has highlighted the training of board members; effectiveness of board scrutiny regarding the quality of the care; and the openness and transparency of board performance against their core business.

113. While legislation, Directions and formal Standing Orders are important, achieving good governance is largely a matter of strong leadership, consistent culture and clear direction underpinned by having robust processes in place. The existing governance framework could be developed further to support and drive improvement. Health board governance arrangements could also be updated through secondary legislation, such as the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009. Further developing

governance and leadership is likely to involve multiple approaches, including legislation and regulation, leadership and organisational development.

Question:

What measures, including legislative, might be taken in order to strengthen leadership, governance, and partnerships?

Health board size and membership

Current landscape

114. The seven health boards have far-reaching responsibilities to ensure that care is provided according to the needs of the population. Since the creation of health boards in 2009, we have seen numerous changes across health and social care, therefore now is the time to look at the effectiveness of a number of the arrangements in delivering a more integrated service.

Independent members

115. The Commission on Public Service Governance and Delivery[19] (Williams Commission) commented that health boards must be accountable and responsive, accessible to their local populations and provide excellent leadership and direction to their senior executives (and 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.

116. However, the Commission questioned whether the current arrangements for health board membership provide the required level of challenge and, by extension, the spur to improve service quality. It recommended a review of the current number, representation and appointment process of independent members of health boards so:

- The overall size of each health boards is reduced to improve strategic decision-making and effective scrutiny;
- The appropriate cabinet members from each of the new local authorities within the health board area are appointed as independent members;
- At least one local authority director of social services should be appointed to support the integration of services with local authorities in the health board area;

[19] http://gov.wales/topics/improvingservices/public-service-governance-and-delivery/report/?lang=en

- Whether and how the election of community representation on health boards would improve transparency, public engagement and accountability in the health service.

117. Welsh Ministers appoint the health board chair, vice chair and nine non-officer (independent) members. The non-officer members must include:

- A local authority member;
- A voluntary organisation member;
- A trade union member;
- A person who holds a post in a university related to health.

118. The Commission on Public Service Governance and Delivery expressed concern that as well as creating a large board, the focus on specific professional skills from within the independent membership as is currently required, is constraining decision making and preventing strong internal challenge.

119. Welsh Ministers may also appoint no more than three associate members. The regulations[20] are silent about who the three associate members should be, but Standing Orders state they should be the chair of the health board's Healthcare Professionals Forum, the chair of the health board's Stakeholder Reference Group and a director of social services from a local authority within the health board's area.

120. If it considers it necessary or expedient for the performance by the board of any of its functions, the board may also appoint one associate member.

Senior executive members

121. Regulations set out that there can be nine senior executive members of a health board (known in the regulations as "officer members"). The roles are as follows:

- Chief executive;
- Medical director;
- Finance director;
- Nurse director;
- Director of primary, community and mental health services;
- Director of workforce and organisational development;
- Director of public health;
- Director of planning;
- Director of therapies and health science.

[20] The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009 (SI 2009/779).

122. Six years on from the advent of health boards, it is now time to examine whether the current number and configuration of officer members allows for the appropriate level of focus on effective leadership, key priorities and decision making.

123. The Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 ensure that strong joint needs assessment and integrated preventative action are essential requirements for public services. Securing strong public health input is essential across all public services. To ensure effective leadership with authority in relevant organisations it is important that directors of public health have a strong voice, in particular across NHS and local government partnerships. Joint appointments are a means of securing this and we would welcome views on this particular issue.

Summary

124. Health boards have been in existence for six years and have faced considerable financial and professional challenges. It is timely, in the light of the Commission on Public Service Governance and Delivery recommendations, to seek views on both the Commission's recommendations and a wider review of health board membership to ensure the boards are fit for the present and future challenges facing the NHS in Wales.

Questions:

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

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

What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?

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

Would you like to suggest any other changes you think are required to health board membership to ensure they are fit for the future?

NHS trust board size and membership

Current landscape

125. Welsh Ministers have powers to establish NHS trusts to provide goods and services for the purposes of the health service. There are currently three NHS trusts in Wales – the Welsh Ambulance Service, Public Health Wales and Velindre NHS Trust.

126. Each NHS trust has a board of directors made up of a chair, appointed by Ministers, and executive and non-executive (independent) directors. Ministers have powers under the NHS (Wales) Act 2006 to make regulations with, for example, provision for the numbers of executive and non-executive directors, length of office etc.

Summary

127. The need for strong and effective leadership is equally applicable to NHS trusts as it is for health boards. Therefore we are seeking views on NHS trust board membership to ensure they are fit for the present and future challenges they face.

Questions:

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

Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?

The role of board secretary

Current landscape

128. As part of the NHS reforms in 2009, health boards and NHS trusts were required to have board secretaries. The role of the board secretary is crucial to the ongoing development and maintenance of a strong governance framework within boards and is a key source of advice and support to the chair and other board members. The board secretary acts as the guardian of good governance and its role is set out in Standing Orders as:

- Providing advice to the board and to individual board members on all aspects of governance;
- Facilitating the effective conduct of health board business through its meetings, advisory groups and committees;
- Ensuring board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of Standing Orders;
- Ensuring that in all its dealings the board acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture which embodies NHS values and standards of behaviour;
- Monitors the health board's compliance with the law, Standing Orders and the governance and accountability framework set by the Welsh Ministers.

129. As advisor to the board, the board secretary's role does not affect the specific responsibilities of board members in terms of governing the organisation. They are 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. The role has been under scrutiny – it was considered by the National Assembly Public Accounts Committee's inquiry report into the governance arrangements at Betsi Cadwaladr University Health Board, in 2013[21] and the earlier joint report into governance arrangements at Betsi Cadwaladr University Health Board by Healthcare Inspectorate Wales and the Wales Audit Office.[22]

130. Recommendations in these reports included:

- The role of board secretary needs statutory protection;
- There is clarity around the separation and accountability of the board secretary role with clear and direct line of accountability from the board secretary to the chair;
- There is potential the board secretary role may be both unsustainable in terms of workload and subject to conflicts of interest, when holding a combined role. For example, secretary to the board and director of communications and governance, this includes responsibility for both clinical governance and complaints and concerns.

131. When considering whether the role of the board secretary requires greater clarity, it should be noted that there are other forms of protection which are available to NHS staff. For example, an all-Wales raising concerns (whistleblowing) policy is in place and is regularly reviewed and approved by the Welsh Partnership Forum. The board secretary role is not unique in that the head of internal audit also has a similar independence, providing advice to the accountable officer and the board, through the health board's audit committee, and provides a formal report on internal control.

[21] http://www.senedd.assembly.wales/mgIssueHistoryHome.aspx?IId=2219
[22] http://www.wales.nhs.uk/news/27842

Summary

132. Against this evidence, and given that the board secretary role is relatively new, greater clarity may be needed to prevent the role from becoming compromised. When considering whether the role of the board secretary needs greater statutory clarity, other roles need to be taken into account, such as that of the head of internal audit, or whether whistleblowing policies provide clear professional accountability lines and could offer sufficient protection. Where the role is subject to potential conflicts of interest as well as workload issues, these matters could be addressed by changing Standing Orders.

Questions:

Does the role of the board secretary need greater statutory clarity?

If so, what aspects of the role should be additionally set out in law?

How could potential conflicts of interest for the board secretary be managed?

Advisory structure

Current landscape

133. Achieving strong and effective links between healthcare professionals and the Welsh Government is essential to the development of evidence-based policy. The right mechanisms need to be in place to secure professional advice and for that advice to contribute strongly to the development of policy and service delivery. Routine interaction with NHS Wales and stakeholders provides the Welsh Government with the information needed to develop national and local priorities. The Welsh Government obtains professional advice from a large number of sources, including:

- Welsh Government employed health professionals, including the Chief Medical Officer;
- Regular meetings, briefing papers and correspondence from health board and NHS trust chief executives and executive directors;
- Expert boards, implementation groups, clinical networks and advisory bodies;
- National clinical leads and other recognised clinical leaders;
- The Wales Academy, Royal Colleges and faculties, professional societies and associations;
- Universities, the Wales Deanery and research organisations;
- Third sector organisations;
- Professional bodies, such as health professional regulators and unions;

- The UK government, NHS England and cross-border bodies such as the National Institute for Health and Care Excellence and the Joint Committee on Vaccination and Immunisation;
- International organisations, such as the World Health Organisation and European Union.

134. The Welsh Government also receives clinical advice from a number of dedicated advisory bodies[23], which meet up to four times a year and provide written or oral advice to Welsh Government officials on matters relating to their areas of expertise. These include:

- The National Joint Professional Advisory Committee;
- Seven statutory advisory committees;
- 24 national specialist advisory groups (NSAGs).

Summary

135. The Welsh Government has conducted a review of the groups listed in paragraph 134 and this has indicated that statutory advisory committees may no longer represent the most effective way for the Welsh Government to routinely access professional advice in order to develop the most effective evidence-based policy. The Welsh Government has developed more effective, routine and robust channels of professional advice as described in paragraph 133.

136. We want to consider whether or not to continue using these dedicated statutory bodies given that the Welsh Government, NHS Wales and other expert stakeholders are routinely working closely through other channels to ensure policy and service delivery is based on expert professional advice.

Questions:

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

If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?

[23] http://gov.wales/topics/health/cmo/committees/?lang=en

NHS workforce partnerships

Current landscape

137. Partnership working in the NHS includes a mixture of Wales and UK-level arrangements. It could be argued that these partnership working arrangements have not kept pace with devolution. An example of this is that changes to NHS staff terms and conditions, which are the product of discussion between Welsh trades unions, NHS Employers in Wales and the Welsh Government and have Ministerial agreement, must be signed off by UK partnership bodies.

138. A review of the current arrangements or changes in legislation could create a new framework agreement to revise this situation, however given the nature of the current arrangements it is considered likely that some form of legislative change would be necessary.

Summary

139. Given the stage we are now at in the devolution journey and the fact that NHS Wales has its own distinct identity, now is the time to seek views about the arrangements for decision making in relation to workforce matters.

Question:

Are the current partnership working arrangements fit for purpose or do they need amending in law to reflect increased devolution and the prudent healthcare approach in Wales?

Hosted and Joint services

Current landscape

140. The number of hosted services in NHS Wales has increased and there is potential for a lack of clarity in terms of accountability and governance. It is also possible that some of the host organisation's core functions are being outweighed by the size of the organisations they host. The implications of this imbalance need exploration.

141. There are a number of NHS bodies which host services, for example Velindre NHS Trust is a host to a number of external organisations, including:

- NHS Wales Shared Services (NWSSP)
- NHS Wales Informatics Service
- Health and Care Research Wales and

- The National Collaborating Centre for Cancer.

142. The Welsh Health Specialised Services Committee (WHSSC) is hosted by Cwm Taf University Health Board. WHSSC is a joint committee of all the health boards in Wales is responsible for the joint planning of specialised services on behalf of all health boards.

143. Most NHS services are directly managed with clear management, accountability and governance arrangements through the chief executive to the board of the health board or NHS trust. The board sets the strategy for its directly-managed services and holds those services to account. Hosted services sit outside of the directly-managed services and boards are not accountable for the strategy or performance of hosted services. However, the hosted service is still required to comply with the hosting body's governance arrangements set out in Standing Orders and Standing Financial Instructions.

144. The Commission on Public Service Governance and Delivery[24] (Williams Commission) included a section on shared services, which commended the NHS Wales Shared Services Partnership (NWSSP) and suggested it as a model for public sector-wide shared services. It concluded:

"We therefore recommend that, building on the achievements of NHS Wales Shared Services Partnership, a single shared services operation must be established to provide back office functions and common services across the public sector by the end of the 2016-17 financial year. The Welsh Government must co-ordinate and oversee its development and establishment. This should build on the NHS Shared Services Partnership and the National Procurement Service, and clarify the relationship between the two, without duplicating the work of either."

145. The Devolution, Democracy and Delivery White Paper said in response that it saw "a strategic case for establishing shared services across the devolved public sector in Wales…however this will require detailed work on practicalities… and the development and phasing of the introduction of shared services [must] complement rather than disrupt local authority mergers…the best approach here is likely to be one which grows over time rather than one large change on a single date."

146. For NWSSP to have the opportunity to take a wider all-Wales public sector role, the legislative framework may need to change as hosting within an NHS trust is constrained by the current legislation "to provide goods and services for the purposes of the health service".

147. The ability of health boards and NHS trusts to participate in joint ventures and similar joint arrangements, with public sector and other partners may open up more opportunities for translating research,

[24] http://gov.wales/topics/improvingservices/public-service-governance-and-delivery/report/?lang=en

innovation and best practice. We would wish to consider whether the current legislation and regulations for health boards and NHS trusts provides the appropriate framework to support these opportunities.

Summary

148. We want to explore what clarity may be needed for hosted services and joint ventures for health boards and NHS trusts, including in partnership with others, and whether services such as NWSSP could become public sector-wide shared services delivered from within the NHS.

Questions:

What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?

What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?

Summary of questions

Chapter 1: The changing shape of health care

Promoting health and well-being

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

2. If so, what changes should be given priority?

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

Continuously engaging with citizens

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

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

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

Chapter 2: Enabling Quality

Quality and co-operation

7. Are legislative measures the most effective tool to address the issues raised in this section?

8. If so, how can we use our legislative powers to build on the existing duty of quality to better fit with our integrated system?

9. What legislative measures could we introduce to ensure quality is put at the forefront of all decisions and joint decisions of health organisations?

10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?

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

Integrated planning

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

Chapter 3: Quality in Practice

Meeting common standards

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

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

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

Clinical supervision

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

17. What arrangements should be put in place for self-employed health professional registrants?

Chapter 4: Openness and honesty in all that we do

Being open about performance and when things go wrong

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

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

Making it easier to raise concerns in an integrated system

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

Chapter 5: Better Information, Safely Shared

Sharing information to provide a better service

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

22. How can we consider breaking down any barriers?

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

Chapter 6: Checks and Balances

A seamless regime for inspection and regulation

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

25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?

26. How can we improve joint working between HIW and CSSIW short of creating a single inspectorate? Do these arrangements require legislative change?

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

Representing patients and the public

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

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

Chapter 7: Finance, functions and planning

Borrowing powers

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

Summarised accounts

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

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

Planning

33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?
34. Should we review NHS (Wales) Act 2006.planning duties to avoid duplication and improve alignment with the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015?

Chapter 8: Leadership, Governance and Partnerships

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

LHB size and membership

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

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

38. What are your views about the suggestions made by the Commission on Public Service Governance and Delivery, such as the election of community representation?

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

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

NHS Trust size and membership

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

42. Would you like to suggest any other changes you think are required to NHS trust board membership to ensure they are fit for the future?

Board secretary role

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

44. If so, what aspects of the role should be additionally set out in law?

45. How could potential conflicts of interest for the board secretary be managed?

Advisory structure

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

47. If so, how might we use legislation to ensure that policy and service delivery is based on expert professional advice?

NHS Workforce partnerships

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

Hosted and Joint services

49. What legislative measures could be put in place to provide better clarity for hosted, joint and shared services?

50. What changes could be made to provide greater flexibility for NHS Wales Shared Services Partnership (NWSSP) to equip it to take a public sector-wide shared services role?