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Consultation – summary of responses

Our Health, Our Health Services Green Paper

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Ministerial foreword

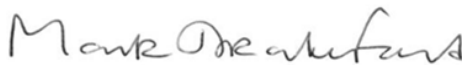
In July 2015 I published a Green Paper for consultation setting out a range of proposals and questions asking how and if we should build on the arrangements currently in place to ensure continuous improvement in the quality of services from our NHS in Wales. I was also keen to explore what steps we could look to take to further strengthen NHS governance. The focus of the Green Paper was primarily to seek views on what legislative steps could be taken, but not surprisingly, during the course of the consultation many other ideas and suggestions came forward. Many of these pointed to the essential ingredients of good leadership and having the right culture in place to ensure good quality and well governed organisations.

The consultation ran over four months and generated significant interest. I am heartened by the level of engagement in these important areas and would like to thank the many individuals and organisations who participated and gave us their views and suggestions. I am therefore pleased to present this report which provides a summary of the main themes and views that emerged during this extensive consultation.

I said at the outset that this exercise would helpfully inform the incoming Government following the National Assembly of Wales elections in May this year. Whilst this report sets out the main findings, it is underpinned by a rich source of information to inform and enable the next Government to bring forward any detailed proposals requiring changes to legislation in the new term. Moreover the feedback we have received over the past months will be shared more widely to inform and strengthen existing policies and guidance where this may be needed.

We will of course continue to gather more feedback and evidence to inform any future changes. The recent governance review of the Welsh Health Specialised Services Committee is but one example, as will be the report following the UK wide review of quality systems recently undertaken by the OECD.

It is important that we do not stand still and continue to evolve our arrangements to ensure good quality care and governance in our ever changing NHS.



Mark Drakeford,
Minister for Health and Social Services

Introduction

1. On 6 July 2015 the Welsh Government published the Green Paper 'Our Health, Our Health Service'. The purpose of the Green Paper was to seek views on what else we might do to improve the quality of services provided by the NHS in Wales, as well the governance and accountability of the organisations and the people who manage them. It asked how we might encourage closer working with other public services, what the barriers are to more joined up working and ultimately whether the Welsh Government should use legislative powers to help achieve continuous improvement and stronger accountability.
2. This report summarises the key themes arising from the consultation, including the written responses, various meetings attended by Welsh Government officials and two hosted events held in November 2015. As with any summary document, it is not possible to convey every individual comment received but we have tried to present a balanced view and hope the majority of respondents will see at least some of their comments reflected in the themes set out in the document. There has been no attempt to weight the responses received in favour of any organisation or individual. The Welsh Government will revisit the responses in taking forward proposals, whether they are legislative or otherwise, in the coming months.
3. A detailed breakdown of the themes identified in response to the questions posed in the Green Paper is shown under each Chapter heading.

Consultation period

4. The consultation was held over a four month period and ended on 20 November 2015. A total of 170 written responses were received; 15 of these arrived after the closing date but the comments have been taken into account. A full list of respondents is at Annex A.
5. All responses received an acknowledgement confirming that the response would be published, together with the identity of the respondent, unless they contacted the Welsh Government requesting anonymity. The full text of all responses is published on the Welsh Government website with this report. The breakdown of responses is set out in the following table:

Type of respondent	No
Individuals	47
Local Government	8
Universities and academic bodies	4
Political parties/union groups	4
Health professional groups and associations	30
NHS	31
Government departments/agencies	6
Citizen voice/third sector/Commissioners	34
Social enterprise/business	4
Legal and other professionals	2
Total	170

6. In addition to the written responses, Welsh Government officials gave presentations to over 40 stakeholder meetings during the consultation period. The list of meetings attended is at Annex B. Officials also hosted two large events for the public and professionals, in Wrexham on 10 November and Carmarthen on 12 November. Around 200 people in total registered for the events, with approximately 50-60 actually attending each event. These meetings and events helped many individuals and organisations to formulate their written responses. The comments made by participants in the Carmarthen and Wrexham events were captured and themed and many are reflected throughout this report. These are also published on the Welsh Government website with this report.

Wider messages

7. As well as addressing the questions posed in the Green Paper, many of those who responded to the consultation and who attended the events also identified a number of wider themes, which are worthy of mention. These include:
- How legislation can have a role in changing and modifying behaviour if used carefully but how **culture, values and behaviour** are equally, if not more, important.
 - Not necessarily supporting the introduction of new legislation in a number of areas where **existing provisions** that **could be more effectively used**. Strengthening systems and mechanisms rather than placing further statutory duties.
 - The need for a **shared vision** in health and social care and closer **involvement of the third sector** in the planning and provision of services.
 - A system of planning and service provision which is **preventative** and which **maintains wellbeing and independence**.

- Information and services **tailored to people's needs** including language and sensory requirements, placing the **needs of the person at its centre** rather than those of the organisations.
- The need for any future health legislation to **complement other legal frameworks** in social services and the wider public sector.

Areas of broad agreement identified in the responses

8. A detailed breakdown of all the issues identified, by Chapter, appears in the next section. Of these, the following key areas have emerged as those where there is most support for further work:

- Development of **joint working** arrangements, including pooling of budgets and resources, training and performance management.
- Clarification of expectations around **continuous, flexible and inclusive public engagement** and more detailed consideration to be given **to an expert panel and the role of CHCs** in service change proposals.
- Exploration of the potential for a **revised duty of quality** to give a strong message on how care will be delivered across health and social care as well as support for **improving accountability at Board level**.
- Consideration of a **duty to comply with a common set of standards** across health and the independent sector with potential links to social care.
- Development of **more robust arrangements for clinical supervision**, but not necessarily via legislation.
- Consideration of a **statutory duty of candour** to drive a culture of openness and honesty.
- The potential alignment of **health and social care complaints processes** to provide a seamless service to people wishing to raise concerns.
- Clarification of **responsibilities on data sharing** so people are aware of when and what to share and more detailed consideration to be given the subject of **using patient data for non-patient care purposes**
- Looking at **the remit and independence of the inspectorates**, leading to exploring the potential for a **full merger**.

- Consideration of whether the **current model, focus and functions of CHCs** requires further change.
 - The potential alignment of **the powers and duties of health boards and NHS trusts** for financial and planning arrangements
 - An exploration of the size and composition of health board membership including **flexibility for individual health boards**, along with the use of **community and joint appointments** and remodelling NHS trust board membership.
 - Further reflection on **how to achieve greater independence and integrity** for the Board Secretary, including looking at other public sector models.
 - Improving **the development and use of health professional advice** whilst taking into account reviews already undertaken and recognising that Welsh Ministers already routinely consult on policy matters.
 - The development of **consistent models of joint, hosting and shared services**, based on a clear governance framework and considering further the **idea of shared services for the whole of the public sector**, based on the NHS model.
9. Future work in these areas could take the shape of further **guidance, policy development, or legislative proposals**, but decisions will be taken on the direction of travel in accordance with the next Welsh Government's requirements and priorities.

Detailed breakdown of consultation response themes

Part 1 – Quality First and Foremost

Chapter 1 – The changing shape of healthcare

10. This chapter explored ideas and views on the need for further actions at an organisational level, which will help promote and deliver better health and wellbeing. It also set out the potential ways forward in delivering service change.

The Questions we asked:

Promoting health and well-being

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

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?

Response themes

Promoting health and well-being

The need for legislation

11. There was general consensus that **further legislation is not required** and that the Well-being of Future Generations Act 2015, and the Social Services and Well-being Act 2015, should be properly embedded and their impact evaluated before any further legislation is considered.

Actions to enable local collaboration

1. Although appetite for further legislation was low, responses provided a wide range of **ideas for enabling local collaboration** in planning and meeting people's health and wellbeing needs, including:
 - **Supporting the work of primary care clusters** and the preventative primary care model, including joint-working with social care, independent and third sector providers. It was felt, this required clear lines of leadership, responsibility, finance, and accountability with primary care providers becoming more involved in service plans;
 - Promoting **joint-working culture** through training, vision, plans, meetings, performance management, co-location (where possible), and accountability across Health and Social Services (including third sector providers);
 - **Joint budgets and pooled resources** for Health and Social Services (if not public services-wide), to ensure real integration and joint-working;
 - **Service plans should prioritise independent** living and bringing services closer to home, wherever possible, including better joint-planning for hospital discharges.
 - Consideration of changes required for **regulators to deal with services shift towards primary care** and home care.

Continuously engaging with citizens

The need for legislation

2. Opinion varied about how effective legislation would be in shaping service change but **many felt more work was needed**. Some suggested explicit guidance, setting out the level of engagement

required against the levels of service change planned, would be sufficient. Those who supported the use of legislation called for it to ensure consistent service change engagement processes across Wales. It was acknowledged that any statutory requirements would require appropriate instruments and frameworks to ensure the public are involved at every level, governing how change is managed and how services are improved. It was generally agreed, however, that **regardless of whether legislation was introduced, the level of engagement expected should be unambiguous.**

Permanent engagement mechanisms

3. Similarly, **opinions were split over legislating for permanent engagement mechanisms.** Supporters referred to the potential benefits of consistently including service users, such as; patient-centred services and real co-production. However, others stressed that there is already an existing duty for health boards to engage with citizens and suggested that guidance, identification of good practice, and engagement plans would be more suitable than legislation. The Community Health Councils' role was highlighted with support for strengthening it in terms of engagement.
4. Generally, there was considerable concern about whether legislating for specific models of engagement, might restrict the level and approach of engagement. There were wide calls for **engagement mechanisms to be inclusive and accessible** (tailored to individuals needs) with input from the third sector to encourage as wide involvement as possible.

National Expert Panel

5. **Division in opinion continued over the idea of a national expert panel.** Supporters suggested it would bring a consistent process and focus to reviewing service change on behalf of the public and would depoliticise the decisions. Those in opposition suggested that such a group would add an unnecessary layer of bureaucracy, would not reflect the principles of prudent healthcare, and that ultimately the Minister should remain responsible for such decisions.
6. Generally, responses identified that **further detailed consideration was required** to determine how a group would be set up, how independence would be secured, how members would be recruited to ensure relevant expertise and a lack of bias, and what the impact would be on Community Health Councils.

Chapter 2 – Enabling quality

7. This chapter considered 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.

The Questions we asked:

Quality and Co-operation

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

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

Response themes

Quality and Co-operation

The need for legislation

8. There was a **strong feeling that legislation was not effective in addressing quality**, with the main issues viewed as cultural, training, resource and educational. It was suggested that adopting best practice and ensuring more involvement of clinical staff would be more effective for driving up quality, than legislation.

9. There was **some support for using legislation to supporting cultural change**, ensuring consistency through clear expectations on quality, but acknowledged that strong leadership was required to ensure effectiveness in following legislation.
10. In terms of building on the **existing duty of quality**, there were calls for; the **to apply across Health and Social Services**, for it to align with the Well-being of Future Generations Act/Social Services and Well-being Act, and to create **a shift in focus from finance to the quality of services**.

Actions to enable quality

11. In order to enable this shift in focus and put quality at the heart of all decisions, numerous opportunities were identified, including:
 - Introducing **a clearer outcomes framework and measures** with the need for better outcomes data to be published;
 - Introducing **Quality Impact Assessments/analyses**;
 - Defining **'quality' as 'providing the best possible care'**;
 - Providing a **specific duty for leaders and senior staff**;
 - Introducing **incentives for providing quality** and disincentives for failing quality.

Responsible individual

12. The **concept of "responsible individual" received a mixed response**. Those in support suggested benefits would include clear accountability for leaders, provided that safeguards were in place and that the equivalent measure was seen to be effective in social services. Those opposed, highlighted that there were too many complex factors to hold one person responsible and that it would dilute the importance of the responsibility of the Chief Executive, the Board, and Accountable Officer.

Fit and proper persons test

13. **Support was also varied for 'fit and proper persons tests'**, with those in support outlining that the mechanism could improve accountability and responsibility of leaders. Others suggested that robust recruitment processes should already assess such qualities and there may be practical issues which have a negative impact on the effectiveness of such a mechanism.

Integrated planning

The need for legislation

14. **Opinion was divided over whether to strengthen legislation** to provide for quality as part of Integrated Medium Term Plans. Those in favour proposed that **quality needed to be a key feature in plans**, with a total quality approach, equal to finance, which reflected public views. Others expressed that it was **already possible to achieve within the existing legislative framework**, but that the NHS Planning Framework needed to reflect the Social Services and Well-being Act, in order to promote collaboration.

Chapter 3 – Quality in practice

15. This chapter considered whether we could improve quality by developing a common standards framework across the NHS and independent sector which aligns, where possible, with those already developed for social care. It also sought views on support that may need to be provided for health professional staff.

The Questions we asked:

Meeting common standards

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

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?

Response themes

Meeting common standards

Changing the basis under which the healthcare standards are set

16. There was largely **agreement that the setting of healthcare standards needed to change**. Here it was highlighted that any changes should ensure the NHS have a duty to comply to standards, the standards should be patient and outcome focussed, and **should ensure consistency across health and social services**.

17. It was highlighted that **any change to the standards framework would have implications for regulators**, and there was a need for consistent standards which could easily be monitored and enforced.

18. Some felt that the Health and Care Standards, which have recently been refreshed, needed to be embedded and further reviewed before introducing changes.

Common Standards Framework

19. There was large support for **introducing common care quality standards across both NHS and independent providers in Wales** in order to improve quality of services consistently across providers, and to ensure public confidence of the expectation of quality in every health setting. Some called for **a common standards framework to also provide for third sector providers and others called for common standards across Health and Social Services.**

20. Some highlighted the need to further consider how common standards would work in practice, giving thought to whether common standards would provide high level objectives with specific or professional standards providing detail for individual settings.

Accreditation and Peer Review

21. There was wide support for the use of peer review as a tool for improving the quality of services. However, while there was some support for a consistent approach, **there was no consistent support for legislation as an enabler.** The responsibility was seen to be that of employer to support peer review and ensure it is seen as integral part of the system. Making investment and resources available in order to properly support peer review was flagged as an issue which may help as opposed to legislation.

22. It was also acknowledged by some that accreditation could provide benefits for organisations, but that it needed to be subjected to quality assurance and must be viewed as more than a tick-box exercise. However, others highlighted the negative potential that legislating for accreditation might hold, such as being unfavourable in attracting employees if an organisation is struggling, the costs and requirements becoming burdensome and adding an additional layer of assessment.

Clinical Supervision

Clinical Peer Supervision

23. **Support was varied for legislation to support Clinical Peer Supervision, with those in support calling for legislation to ensure a robust and consistent method of providing clinical supervision** across all professions, right throughout staffs' careers. It was seen that it could form part of a common standards framework. Statutory requirements could also provide reporting mechanisms for training issues to be raised in healthcare organisations.
24. Those not supportive of legislation suggested existing examples of clinical supervision routines and revalidation processes should be considered and could be adopted. Organisations needed to support clinical supervision through setting up specific areas for it to take place, providing effective training for supervisors, ensure 1:1 supervision is available. It was also suggested that **legislation was not necessarily the way to enable clinical supervision. Culture change needs to occur** if clinical supervision is to become a regular part of clinical practice.

Self Employed

25. **There was little support for legislation to provide for clinical peer supervision for arrangements to be put in place for self-employed health professional registrants.** There was some agreement that arrangements for self-employed should not differ from set up for employed health professionals. It was suggested that the NHS could offer mutual supervision cover with private practitioners (i.e. cross sector supervision or peer review arrangements). Health professional bodies, university expertise, or regulators were also suggested to have a role to play in providing these opportunities for the self-employed. Employment should be subject to a contract which stipulates you adhere to the health boards policies and procedures (including clinical supervision).
26. Others suggested that self-employed health professional should take responsibility and make arrangements for themselves. It was suggested that registrants would need to adhere to the professional body requirements, with some professions already have systems in place.

Chapter 4 – Openness and honesty in all we do

27. This chapter outlined a vision for moving towards a culture of co-production, one where organisations learn from mistakes and improve the quality of services as result. In order to achieve this, we must explore options for further enhancing openness, transparency and candour in the Welsh NHS.

The Questions we asked:

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

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

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

Response themes

Duty of Candour

The need for legislation

28. The large majority of those who responded regarded a **statutory duty of candour as the appropriate mechanism** for driving a culture of openness, honesty, transparency, and learning across healthcare providers in Wales.

29. There was large support for such a duty to require staff to be open and report when things go wrong, with **built-in protection and support provided for those who raise concerns**. There were also calls for the duty to be explicit in terms of what behaviour is expected and of who, and what should happen when there is a failure to comply with the duty.

30. There was mixed opinion as to **whether a duty should apply purely to organisations** (as professional bodies already set duties for individuals), **or to individuals as well**, with particular responsibilities for board members. But, it was highlighted that, if we were to take a

duty of candour forward, we would need **to take account of existing duties of candour and guidance set out by professional bodies** for health professionals and the impact of the existing legislation in England.

31. There were also a few calls for a **duty of candour to apply to independent providers and across both health and social services** for the purpose of consistency and to drive the integration of services.
32. There was **some objection** to a duty of candour. Some called for the Putting Things Right **guidance** and The NHS (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) **Regulations 2011 to be further amended before introducing new legislation**. Others set out a statutory duty was not required given professional bodies' existing duties.

Improving transparency on performance

The need for legislation

33. In terms of improving transparency on performance, there were **no clear ideas for utilising legislation**, while some suggested legislation was not required for this purpose.
34. The focus was largely on providing the type of information which would be useful to the public and to improving services, such as **real time outcome performance** data rather than process performance data. It was acknowledged that information should be published in an accessible format and a consistent approach should be adopted across Wales. The **national performance framework** was cited as a potential vehicle for this work.

Improving the joint investigation of complaints

The need for legislation

35. There was **some support for taking legislative steps to create a standard complaints process** to ensure and clarify the responsibility of staff and departments to hold joint investigations across health and social services. This included calls for a single, clear, patient-focussed process to enable staff and patients to raise concerns and duty for organisations to provide evidence of outcome to incidents and lessons learned.

36. Equally, **there were some who felt new legislation was not required** and that better joint investigation could be achieved through clear and consistent guidance, or for the Putting Things Right guidance and The NHS (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2011 to be further amended to balance the investigation of complaints between health and social services.
37. In terms of considering and examining complaints, there were **some calls for an independent body or regulator** to take responsibility and others for the Public Services Ombudsman for Wales' remit to be extended in this area.

Chapter 5 – Better information, safely shared

38. This chapter highlighted the need for information to be used in the best interests of patients and ensure that there are no inappropriate barriers to sharing it safely.

The Questions we asked:

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?

Response themes

Issues preventing healthcare bodies from sharing patient information

39. There were two central themes in the responses to this question.

- There is a **lack of understanding** or a misunderstanding by staff and a **fear of breaching sharing protocols, frameworks** (Wales Accord on the Sharing of Personal Information), principles (Caldicott) and **legislation** (Data Protection Act).
- **IT systems across the NHS are insufficient** and there were incompatibilities between departments, bodies, providers, primary and secondary care, and across different sectors.

40. A smaller number of responses, both from individuals and organisations, suggested that **professional boundaries** and **codes of confidentiality** and a **lack of trust** between healthcare professionals, health bodies, and sectors **contributed to a reluctance to share information**.

Breaking down barriers

The need for legislation

41. It was **not felt that legislation was required** in order to tackle these barriers. Instead, there were calls for **improved IT systems** or an all-Wales national IT system (such as Community Care Information System) with one patient record which could be accessed wherever the patient presents. There were also calls for staff to be **educated and provided with clear guidance** with regards to sharing information, with a consistent approach to be adopted right across public services in Wales.
42. There was acknowledgment that sharing information for the benefit of the patient should be allowed, although some suggested only between those involved in direct care. It was also acknowledged that **a change in culture was required** to ensure trust and sharing between organisations.
43. There was also a **strong level of support for patients ‘owning’ their own information** and holding responsibility for deciding who it is shared with. It was advised that such a policy would require informed consent, with accessible advice for people and a consistent process for recording decisions. Some also highlighted the need to determine to what extent patients already expect information to be shared and available when they require services in order to improve confidence.

Considerations for sharing of patient identifiable information for non direct patient care

44. The **large majority of those who responded were extremely supportive** and stressed the benefits of sharing of information for non direct patient care, while some highlighted current opportunities being missed with existing information already being routinely collected but not used effectively. Only **a slim minority were completely opposed** to the sharing of information for these purposes.
45. Of those that responded positively, a large proportion outlined the **importance of acquiring patient consent**. Patients would need to be well informed of what was being shared and the purpose of sharing it, including the positive benefits it holds before making a decision. Transparency and open engagement was seen as vital to the process. Some suggested that there may be scope for a presumed consent or “opt out” system.

46. It was also felt there would need to be a common process based on ethical approval and procedures with assurance of UK wide principles and legislation (including Caldicott Principles and Data Protection Act etc.) The **purpose should solely be focussed on improving quality of health and services with no potential for commercial gain**. Clear controls and guidance would also be needed along with strict security measures for holding information and ensuring confidentiality. Transparency and governance would be required to ensure the correct purpose of research, but would need to be proportionate so not to become a barrier. A consistent approach would be required across Wales.
47. A sizeable group, while supporting the sharing of information for non direct patient care, called for **anonymity to be preserved** (wherever possible, the preferred method) or pseudonyms used. Although acknowledging benefit in using data, they were not convinced of the need for patient identifiable information to be used. Individual cases should have to justify the reason/ need for using patient identifiable information before it is allowed and it should be the exception. Existing systems such as SAIL were cited as using anonymised information successfully.
48. It was acknowledged by a few that this was an area which would require **much more detailed consideration and consultation** before being taken forward in any direction.

Chapter 6 – Checks and balances

49. This chapter examined whether we have the right arrangements in place for the effective regulation and inspection of health services by Healthcare Inspectorate Wales (HIW) and for Community Health Council to effectively represent the patient voice

The Questions we asked:

A seamless regime for inspection and regulation

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

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?

Response themes

A seamless regime for inspection and regulation

50. No-one felt that the current legislative framework for HIW was without gaps. The gaps identified by those responding included:

- HIW's **inability to take regulatory action** and place organisations into special measures or accredit NHS premises in the same way as it can for the independent sector;
- The current **legislation has not kept pace** with innovative services and the requirement for more collaboration across services;

- Significant **differences in the underpinning regulatory principles** of health, social care and independent healthcare; and
- Consolidate HIW responsibilities and functions into **one single statute**.

Independence

51. There was **support for** providing HIW (and CSSIW) with **more independence**. In order to build public trust and appropriate levers, there was a view that HIW needed to be independent with enforcement powers, for example, in line with the CQC model in England. Others highlighted the need for careful consideration around the accountability of HIW if it was given more independence.

Enabling joint working

52. In order to improve **joint-working between the inspectorates**, suggestions included:

- Developing **shared objectives and outcomes**, through a memorandum of understanding, a concordat, or single framework and staff secondments;
- Better sharing of information with **joint training and common back office functions**;
- Developing a better understanding amongst the public of their roles;
- Where **dual regulation** is required, then **a lead regulator should be appointed**. Learn from best practice in other areas of joint inspection, such as community pharmacy.

Merger of the inspectorates

53. There was **considerable support for exploring a single inspectorate, working to common framework and standards** which would be in line with a more integrated approach in health and social care. It was seen as more proportionate for Wales and would be easier for service providers and users to understand.

54. There were some **potential disadvantages** highlighted, including:

- The process of merger **diverting resources and attention** away from inspections;
- Integration could lead to an organisation which is **too large and unwieldy** with a loss or imbalance of specialist expertise.
- CSSIW was seen to be struggling with last round of changes, so a merger would likely be too difficult.

Representing patients and the public

55. There was **some support for CHCs to retain their existing functions and possibly extend them further**, to social care and primary care settings. Within these, there were also calls to provide them with further resources.

56. Similarly, there was **support for changing the focus and functions of the CHCs** with some suggesting that the current functions (particularly inspection) were **a duplication of the work of HIW and the CHCs should operate under the umbrella of HIW**. Others suggested that there should be more of a **focus on patient voice**, with clarity over what sort of representation was required and a **properly resourced advocacy service** which focusses on the whole care pathway, including social care.

Strengthening patient voice

57. In order to strengthen patient voice, there were calls to **create a single CHC, with focus on an all-Wales remit, with CHC clusters deployed at a local level**. Others identified the need to move to a more participatory model and review membership selection with options for increasing the proportion of appointments from the third sector or allowing CHCs to recruit for themselves.

Patient voice within an integrated system

58. There were numerous suggestions of how CHCs could fit within a more integrated system, including:

- Redeveloping CHCs into a model which is **fully aligned to local government or passing some functions to local authorities** in the scrutiny of health services as they are perceived to possess the democratic mandate which CHCs lack;
- Develop **relationships between CHCs and the Social Services National Citizen Panel**; and;
- Consider **a single organisation for regulation and inspection and patient/service user voice**.

Part 2 – Strong Organisations, Strong Governance

Chapter 7 – NHS Finance, Functions and Planning

59. This chapter set out some of the differences between the powers and functions of health boards and NHS trusts highlighted during the passage of the NHS Finance (Wales) Act 2014 such as borrowing powers for health boards, consistency and alignment of statutory planning duties and the removal of summarised statutory accounts requirements for NHS trusts.

The Questions we asked:

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

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?

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?

Response themes

Borrowing Powers for Local Health Boards

60. Overall **NHS bodies were in favour of borrowing powers**, highlighting some of the benefits that it could bring such as greater local flexibility, the ability to accelerate capital investments and more effective planning and business case development.

61. However, to support borrowing powers **governance arrangements would need to be strengthened**: borrowing would need to be **aligned to the planning process** and would require **performance management** by Welsh Government so that health boards do not become exposed to over borrowing. It was suggested that **prudential borrowing framework** under which borrowing is allowed needs to be established and a set of core principles underpinning the governance and decision making for entering borrowing arrangements.
62. Where respondents were undecided about borrowing powers for health boards some felt that there could be more innovative and alternative ways of funding NHS Wales's capital programme. They felt **borrowing powers would carry significant risks** and need appropriate safeguards. It was suggested that health boards needed to have some way of generating income and that their management systems would need to be externally accredited.
63. Respondents who were **not in favour of borrowing powers** felt that health boards **had not shown the planning delivery or financial maturity to support such a provision** and that borrowing would only be appropriate for high performing organisations. Some respondents assumed that borrowing might be used to fund revenue deficits, leading to further serious debt, rather than borrowing only being available to support additional capital investment based on robust business case with clear payback plans.

Summarised Accounts

64. The majority of responses **felt the preparation of the summarised account was no longer relevant** and did not represent the current landscape of the NHS. Most of the responses from NHS bodies proposed that a summarised NHS Wales account as a whole will provide a far clearer understanding to the public of the activities of the NHS. Overall respondents **were supportive of legislative change**, citing that the summarised accounts should reflect the current structure of the NHS in Wales, and be coterminous with government and financial reporting regimes.
65. There was a view from some respondents that summarised accounts are **important in terms of transparency and accountability**, which is essential to public confidence. However, it appeared this was based on some confusion between All Wales summarised accounts and individual health board and NHS trust annual accounts. Some of the

comments about language, clarity and accessibility may be relevant for future annual report guidance for individual health organisations.

NHS Planning

66. Nearly all of the respondents to this question **were in support of an equivalent statutory planning duty for NHS trusts** as this would result in better collaboration and consistency of planning for NHS Wales and therefore ensure more seamless planning to meet patients' needs across pathways of care.
67. The small number of respondents that did not consider change necessary did suggest that **health boards should include the planning requirements of NHS trusts within their plans.**
68. A large majority of the respondents were **in support of a review of the NHS (Wales) Act 2006 to better align planning duties**, both within the Act and with other legislation. There was also a suggestion to include the Housing (Wales) Act 2015 as part of the review. Whilst most respondents supported the principle, some did not because they felt that **time was required to fully understand the implication of other legislation**, namely the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015. Some considered that Public Service Boards would provide leadership and alignment of planning duties to meet shared aims.

Chapter 8 – Leadership, Governance and Partnerships

69. Chapter 8 focused on the current arrangements in place for NHS governance, leadership and a number of NHS partnerships arrangements where there may be a need for review in order to support and drive improvement.

The Question we asked:

Measures to strengthen leadership, governance, and partnerships

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

70. Overall, many of the respondents suggested using **training programmes, with a focus on cultural change**, as a way to achieve strengthened leadership, governance and partnerships, with a route of escalation if concerns arise built on sound principles with clear expectations and outcomes. It was suggested that an increase in national training and network events for Board members would assist development – particularly a programme of engagement with professional and public perspectives and communication with other public third sector providers.

71. **Guidance, possibly statutory, could strengthen** the ability of Board members to request information and cover the roles and duties of the Board in greater depth including how they should engage with the public and representative groups such as professional forums.

72. Many respondents indicated that **legislation should be regarded as last resort**, emphasising the need to allow Social Services and Well Being Act and the Well-being of Future Generations Act to be implemented and consolidated prior to any further legislation, including involving, promoting and developing the values, behaviours and mind set required to do business differently across the public service.

73. Other suggestions put forward included:

- **External scrutiny** to ensure governance is robust, timely and meaningful.

- Creation of an **all-Wales body to plan and manage organisational service matters.**
- A stronger emphasis on holding health boards to account for improving their public's health through **population health improvement.**
- **Welsh Government's role** in dealing with governance issues across the system must be better defined and implemented.
- Need to **separate the dual role of Director General and NHS Wales Chief Executive.**
- The role of **commissioning** and how this will operate going forward in the NHS Wales planned healthcare system.
- Social Service and Wellbeing (Wales) Act and the Wellbeing of Future Generations (Wales) Act should be used as springboards for further thinking regarding the overarching architecture of the NHS and the potential for improvements to strategic service planning and commissioning on an all-Wales basis.

The Questions we asked:

Local Health Board Membership

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?

Board composition and size

74. The majority of respondents felt that **the current size and configuration of health board membership did not best promote effective decision making, priorities and scrutiny**. Changes proposed were varied, covering number of board members; clinical membership; executive membership; independent membership; associate membership; social services representation; carer representation; and patient representation.
75. Those respondents who considered the current size and configuration of boards to be appropriate, made comments in relation to **board development and the challenges of collaborative decision-making**.
76. Whilst some respondents supported smaller boards, concerns were also expressed that a **smaller board is in danger of becoming too cohesive** and lacking in challenge and effective scrutiny.

Board membership - discretion

77. In response to the question of discretion for boards in relation to executive members, there were **mixed comments** ranging from full flexibility; some flexibility to align portfolios to best suit skills and experience and deliver on the required agenda; through to concerns that if such an arrangement were put in place there is a risk that each health board could end up with a completely different structure than a neighbouring board. This would make it difficult to enact or discuss all-Wales issues across health boards and could introduce variation across Wales.

Board membership – community representation and joint appointments

78. **Views on the election of a community representative were also diverse**, ranging from support for the proposal; to support for community representation but not elected; to use of existing community representation mechanisms such as CHCs. **Support for joint appointments was strong in principle**, but some respondents were unsure if legislation was necessary. Generally, it was considered that joint appointments could strengthen the roles where integrated working is the core activity and promote partnership working.
79. Where respondents were undecided or not in favour of joint appointments, **concerns expressed included how these would work if there are several local authorities to one health board footprint**.

80. Respondents made numerous other suggestions about changes that could ensure health boards are fit for the future covering topics including **training, independent membership, clinical membership, the role of the stakeholder reference group, roles of members, innovation and development.**

NHS Trust Board Membership

The Questions we asked:

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?

Board size

81. Most of the respondents felt that **the current size and configuration of NHS trust board membership did not best promote effective decision making, priorities and scrutiny.** Suggestions about how it might be reformed included remodelling based on the health board membership; the number of executive members; the number of independent members and primary care representatives.

82. Other changes that respondents put forward to ensure NHS trust boards are fit for the future covered topics including **mandatory committees; the role of independent members; co-production and co-creation of services; the digital age and people with such skills being on the board; through to the appointment of vice chairs.**

The role of the Board Secretary

The Questions we asked:

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?

The need for legislation

83. The respondents who were in favour of greater statutory protection for the board secretary role considered that **defining it in statute would firmly establish and protect its integrity**. Others agreed in principle, but felt that it could be achieved through Standing Orders without new additional legislation. Some of the respondents described similar roles within the public sector, for example, **the statutory role of the Monitoring Officer within Local Authorities, as a possible model** to achieve greater independence and integrity.
84. Some suggested that there should be **no deviation from the model Job Description** to ensure the protection of the independence of the Board Secretary role and eliminate opportunity for conflicts of interest. There were also calls for the role to be perceived at a more senior level, to enable it to provide effective challenge and advise the Board, Chair, Chief Executive and executive directors. It was also proposed that the **role could be set out in regulations supplemented by a model Job Description**, but the role should remain described in Standing Orders and not defined in new legislation but could include aspects of the Local Government Monitoring Officer role.
85. Some **suggestions for new legislation included** specifying in law board secretary **appointment on a term basis by Welsh Government**; a **re-numerated, full time, public appointment**, not a Local Health Board employee. In relation to managing conflicts of interest, respondents' comments were varied covering the content of the role, including a single role without other director, managerial or operational responsibilities; external support for board secretaries; accreditation for the role; concern reporting.

Advisory Structure

The Questions we asked:

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?

86. Those in favour of the change to the statutory status of the advisory committees were **concerned by the duplication, inefficiency and lack of effectiveness considered to be inherent in the current system**; as well as the uni-professional nature of the statutory committees. There was also concern about a **'disconnect' between the national groups and actual service delivery**; as well as the exclusion of third sector representatives and patients from the current statutory committees.
87. Some of the responses were undecided on a need for change but acknowledged that **advisory committees are useful sources of professional advice and made suggestions about how to improve the development and use** of health professional advice.
88. Where respondents were not in favour of change, there were clear views about keeping the statutory advisory committees because it is considered they provide clear, independent and impartial advice to Welsh Government. There was **concern about the potential for abolishing the statutory advisory committees and a blanket approach being taken regardless of the individual performance of each committee concerned**. There were also concerns any abolition of statutory advisory committees would undermine transparency of policy development, public confidence in the evidence-based approach to policy and the voice of less influential professions or subspecialties. It was also suggested committees **should be made better use of in order to make their roles more effective** rather than disbanding them.

Need for legislation to ensure policy development is based on expert advice

89. Some suggestions for legislation were put forward including a **duty for the NHS and the Welsh Ministers to consult with the relevant professional bodies and relevant Welsh Government professional officer** and making NICE guidance statutory. Other suggestions

included reforming the clinical network system, obtaining advice from front line workers, patients, carers, citizens and the third sector, an information hub for clinically approved guidance to inform policy development.

90. Other stakeholders **questioned whether legislation was either necessary or the best way of improving further the advice** used to inform policy developments.

NHS Workforce Partnerships

The Question we asked:

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?

91. A large number of respondents thought the question was concerned with working in partnership with other organisations at an operational or service delivery level rather than workforce partnership arrangements (i.e. the mechanisms in place to agree workforce terms and conditions). These respondents commented on the legislation already in place which will encourage partnership working and collaboration.
92. Of those who responded in relation to the workforce partnership questions, there was a **fairly even split across those who felt the current arrangements were fit for purpose, those who did not and those who were undecided** or did not give a clear view.
93. Amongst those who did feel the current arrangements were fit for purpose were organisations who are involved in the Welsh Partnership Forum and UK Staff Council arrangements as they currently stand. They commented that they **would like to see improvements that have already been discussed bearing fruit.**
94. A number of other respondents who consider the current partnership working arrangements to be fit for purpose or who were undecided, put forward the view that the **current arrangements should be kept under review, especially given the potential for workforce partnerships to become more complex** and the need for changes to reflect the policy framework set by Welsh Government, including the

possibility of a Welsh Public Service contract for the NHS, local government, Assembly Sponsored Bodies and the Welsh civil service being pursued.

95. Respondents who felt the current arrangements should be amended were of the view that change must not disadvantage Wales within the employment market, that the prudent healthcare approach needs to include social service, that **partnership working needs to become an enabler for work across health and social care, as well as potentially including housing and the third sector.**

Hosted and Joint Services

The Questions we asked:

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?

96. Overall, respondents considered that better clarity could be achieved through a **consistent and well understood governance framework for hosted, joint and shared services**, including clear lines of accountability. Most responses covered hosting arrangements and shared services, not joint ventures.

97. Many respondents noted that there were a range of different models for hosted services, joint committees and shared services built up over time. That this had led to a complex system that was often difficult to navigate, leaving individual accountabilities unclear. Accordingly respondents **supported review and rationalisation of arrangements with an aim for consistent models of hosting and shared services.**

The need for legislation

98. Many noted that change **may not necessarily require legislation** and that changes could be accommodated through the use of or amendments to statutory instruments or directions.

99. The potential to establish **a single all-Wales body to manage or host these arrangements** was mentioned. Such a body could also provide strategic direction for the NHS in Wales.

100. There were numerous comments about improving the existing disparate arrangements, including:

- Separating out in directions or regulations the functions of hosted organisations from their hosts,
- The use of service level agreements
- All NHS Wales organisations to be given the power to host
- Health boards to have the same powers as NHS Trusts, to establish joint ventures to form companies with a University partner for example.

Extending the remit of NHS Shared Services Partnership to other parts of the Welsh public sector

101. There was a mix of suggestions to this question, with **a number of respondents supporting a public sector wide remit**, however others suggested **evaluation of current arrangements** prior to any proposal to change. Respondents noted that the scale and complexity of a public sector role would be much greater than NHS only and that further maturity and resilience of current shared services may be required before being able to extend reach to the wider public sector.

102. A more prudent option may be to **look at opportunities to extend some of the services gradually**, particularly those which are already consistent across all 10 NHS organisations. There was a view that any future public sector-wide shared service needed to **be flexible enough to enable further collaborative working should the opportunities arise**.