White Paper Consultation Services fit for the future - Quality and Governance in Health and Care in Wales

Caerphilly 50 plus Forum comments

Measures to promote effective governance

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

Duty of Quality for the Population of Wales

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

Common Standards for Person-Centred Care

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

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

Joint Health and Social Services Complaints System

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

Representing the Citizen in Health and Social Care

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

The White Paper does not contain adequate arrangements for independent scrutiny of the Health Service, which is a role currently carried out by CHCs. Staff members scrutinise statistics provided by the Health Board daily and raise relevant issues very quickly. The CHC's advocacy work feeds in to the choice of locations to visit and the committed volunteer membership base provide considerable flexibility in this respect.

Health Board professionals address regular meetings of Scrutiny, Planning and Executive Committees and answer the many questions asked by members on behalf of the public. It would not be difficult to extend the scope of these committees to include Social Care.

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

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

Inspection and Regulation and a Single Body

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

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