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Welsh Government

Consultation – summary of responses

Services Fit for the Future

February 2018

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
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Ministerial foreword

In June 2017, Rebecca Evans, the then Minister for Social Services and Public Health, and I published for consultation a White Paper – *Services Fit for the Future* – setting out a range of proposals for potential legislation in quality and governance in health and care services. The White Paper built on an earlier Green Paper consultation held towards the end of the last Assembly.

I was encouraged by the response to the consultation, which ran until 29 September. There were a large number of submissions from individuals and organisations as well as numerous proforma responses related to our proposals for citizen voice and representation. There was particular interest in the future of the current Community Health Council (CHC) model in Wales and our proposals to replace CHCs with a different arrangement working across health and social care.

It is clear that people feel strongly that we need to act now to preserve our services for generations to come and also that the public voice must be heard loud and clear in taking any change forward.

Of course, the outcome of the consultation is also of great interest in light of the recently published final report of the Parliamentary Review of Health and Social Care. How we link the outcome of the White Paper consultation to the recommendations of Parliamentary Review will be crucial.

I would like to thank everyone who took the time to respond to the consultation and for their contribution to the debate at this pivotal time in the history of our health and social care system.

Vaughan Gething
Cabinet Secretary for Health and Social Services

Introduction

1. On 28 June 2017 the Welsh Government published the White Paper 'Services Fit for the Future'. The purpose of the White Paper was to seek views on proposals covering a number of health and social care issues which may require future legislation to take them forward.

2. Proposals in the White Paper included the strengthening of local health boards so they function as integrated, accountable, population-based organisations; new duties of candour and quality; areas where health and social care can act more collaboratively; and more effective inspection, regulation and involvement of citizens' voices.

3. This report summarises the key themes arising from the White Paper consultation, including those identified from the written responses, from various meetings attended by Welsh Government officials and from eight focus group meetings held towards the end of the consultation. It also outlines the next steps to be taken by the Welsh Government.

4. 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.

5. A detailed breakdown of the themes identified in response to the questions posed in the White Paper is shown under each Chapter heading.

Consultation period and responses received

Individual written responses

6. The consultation was held over a three month period and ended on 29 September 2017. A total of 336 individual written responses were received either online or via the Healthcare Quality Division mailbox. Potential respondents to the consultation were advised that their response may be published, together with their name, unless they contacted the Welsh Government requesting anonymity. A full list of the individual respondents is at **Annex A** and can be broken down as follows.

Type of respondent	**No**
Individuals	180
Local Government	19
Universities and academic bodies	1
Political parties/union groups	17
Health professional groups and associations	21
NHS organisation/staff	22
Government departments/agencies	10
Citizen voice/third sector/Commissioners	56
Social enterprise/business	9
Religious Groups	1
Total	**336**

7. The full text of all individual written responses is published on the Welsh Government website with this report.

Proforma responses relating to Citizen Voice proposals

8. During the consultation the Community Health Councils (CHCs) issued their own proforma seeking views on the proposals in the White Paper relating to the citizen voice. We received 1328 of these completed proforma responses, signed by members of the public. The questions contained in the proforma are reproduced at **Annex B** and we have taken these into account as part of our consideration of the consultation responses.

Stakeholder engagement

9. In addition to the written responses, Welsh Government officials gave presentations, on request, to several stakeholder meetings before and during the consultation period. The list of meetings attended is at **Annex C**.

Focus groups

10. In terms of consultation events, the Welsh Government wished to take a different approach to the usual large consultation events, instead holding a number of informal, focus group meetings aimed at attracting members of the public who do not normally get involved and/or respond to Welsh Government consultations. Communities Connected were engaged to facilitate these events on behalf of the Welsh Government.

11. The events were held between 18 and 28 September at various venues across Wales and attracted just under 100 people in total. On the positive side, a number of groups attended who are traditionally under-represented in consultations, including people with learning disabilities and their carers, young people, older people and BAME participants. It was very useful to hear from people who had experience of the whole health and social care pathway and it was apparent that people were very happy to engage with and give their ideas to the consultation process. However, some challenges were encountered with this approach, particularly in relation the delivery of a lot of detailed information to an audience largely unfamiliar with the issues. Welsh Government officials will seek to learn from these events for future consultations.

12. Many of the comments made by participants at these events were similar to those made in written responses and are reflected throughout this report. A list of the focus group meetings arranged is at **Annex D**.

Conclusions drawn from the consultation exercise

13. We conclude that in many instances, people generally supported the intent behind the White Paper proposals. The White Paper looked at the whole system of person centred health and care and suggested a package of measures to support closer integration. These measures encompass leadership, citizen voice, decision-making

and planning, better alignment of standards, the handling of concerns and effective regulation and inspection.

14. There was a clear understanding in many of the responses that action is needed to secure sustainable services for the future and that this can only be achieved by working with the population. Responses reflected the view that joint working between organisations is essential in order to promote well-being, to identify people's needs and to plan and provide quality services to a robust and consistent standard. However, many responses focussed on the implementation of the proposals and wanted more detail on how they might work in practice.

15. There was support for more effective leadership, for having the right skills and experience at Board level, and for robust action to be taken if organisations were seen to be failing. In terms of service change decisions, people were keen to ensure clinical evidence was considered and that the views of citizens were given equal weight to those of experts. We will therefore look to develop these areas further.

16. As in the previous Green Paper consultation, some respondents remained unconvinced about the use of legislation to promote behavioural change, and wanted to see the more effective use of provisions set out in existing Assembly legislation. However, many respondents saw the value of the proposed new Duties of Quality and Candour and felt these could provide further impetus to collaborative working and better outcomes for people in Wales. We will therefore pursue these areas further.

17. There was clearly a very large groundswell of opinion in favour of an independent voice for the public in the health and social care system. The proposal to replace Community Health Councils with a new national body to represent citizens across health and social care was described at a high level in the White Paper. As a result there was an assumption that certain functions or aspects of the current arrangements would be lost, which was not the intention. However, despite the concerns raised, there was a broad consensus that reform in this area is needed, if we are to strengthen the voice of citizens in health and social care, and many constructive suggestions were made, which we will now build upon.

18. There were mixed views in relation to a merger of the health and social care inspectorates and making them independent of the Welsh Government. We will therefore not be looking to make these changes at this time but will instead take a more proportionate approach to addressing the regulatory gaps which exist and future-proofing the underpinning legislation for Healthcare Inspectorate Wales. This will also allow for closer working with Care Inspectorate Wales. Linked to this, there was support for a common standards framework across health, social care and the independent and third sectors, which we will seek to develop further.

Next steps

19. The detailed analysis of the consultation responses are shown from page 7 onwards. In summary, and taking into account the issues raised during the consultation, we propose to undertake further policy development, in collaboration with stakeholders, in relation to the following areas:

- Health Board membership and composition*
- Welsh Ministers' ability to appoint additional Board members to deal with performance concerns
- Role of the Board Secretary
- Duty of Quality
- Duty of Candour
- Common Standards
- Joint Complaints handling*
- Citizen Voice
- Service Change
- Healthcare Regulation and Inspection

*these areas may not require primary legislation

Detailed breakdown of consultation response themes

Chapter 1: Health board membership and composition

20. This part of Chapter 1 of the White Paper set out our proposals and suggestions for how NHS boards can be strengthened to deal with the challenges ahead. It covered the size and composition of NHS boards and how they work with others.

The Questions we asked:
The Welsh Government believes that the Boards of both health boards and NHS trusts should share some core key principles which are outlined including delivering in partnership to deliver person centred care and a strong governance framework to enable the Board to work effectively and meet its responsibilities.

All Boards should have Vice Chairs in order to support focussed and skilled leadership.

The Welsh Government also believes that Ministers should have the authority to appoint additional Board members on time limited appointments if an NHS Health Board/Trust is under performing or under escalation procedures in accordance with the NHS Wales Escalation and Intervention arrangements.

The Welsh Government believes that Board Executive Officer membership for local health boards should probably include some key positions which are consistent across local health boards but also allow some flexibility to appoint based on remit and priorities.

Do you agree with these proposals?

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

Response themes

General

21. Many respondents either did not answer the questions relating to board membership and composition, or if they did, agreed to the proposals with no further comment. Very few respondents disagreed with the proposals. Of those who did respond to the questions in this section, the following key narratives were noted.
22. Generally those responding agreed there **should be a set of core principles**, as outlined in White Paper. They felt ensuring Boards of both NHS Trusts and Health Boards share common principles relating to partnership working (including service users, third sector, and social care partners), person-centred care, and a strong governance framework should help Boards work effectively and remove barriers to integrated working.

Leadership, Board Culture, and Behaviour

23. Respondents were clear legislation alone could not provide for strong management and leadership skills and highlighted the importance of ensuring board members

have the **necessary skills and training** to understand their role and their population's needs. Ideas for robust board development programmes included incorporating equality and diversity training, the NHS core principles, and internationally recognised quality management training. There was also recognition that **leadership was required across the NHS**, not just at board level, while others outlined performance evaluation for board members was required to ensure boards perform to the highest standards and that every board member is able to add value to the work.

24. There was a clear sentiment that board membership should **properly reflect the diversity of its population**, and effective recruitment processes should be utilised to attract individuals from different backgrounds, age groups and ethnicities with a greater wealth of diverse experience and calibre of skills (including Welsh Language) required in taking on the role. This was also the view expressed at some of the focus group meetings.

25. Some identified the importance of ensuring representation of the staff voice at Board level, with others highlighting the need to explore opportunities to increase and improve involvement of wider NHS staff within Board processes. Having the employee voice within the formal governance structure was seen to provide a different perspective and information set that is shown to improve the quality of Board decisions.

26. Some were of the view Board members should have opportunities to experience "the frontline" and recognise how decisions impact on the delivery of care. Similarly, others called for the Boards' **primary focus to be on the overall health and well-being outcomes of the population**, delivering a sustainable service that maintains wellbeing and independence.

Majority of Independent Members

27. Generally, there was agreement **a strong majority of Independent Members was required** to provide sufficient challenge at board level, although one respondent highlighted that this would only be the case within a culture of learning and improvement.
28. There were also wider comments on the role, including some who viewed the current time allocations for Independent Member roles as unrealistic and called for increasing the **notional commitment expected from 4 days to a minimum 6 days per month**. Some also called for Independent Members appointments to be staggered to prevent experience leaving the board in mass. Others queried whether Independent Members roles should be so prescriptive and suggested it would be useful to review and appoint on the basis of the skills required for the Board although others preferred clearly defined roles.

Independent Members referred to as 'Public Member'

29. The term 'Public Member' was **widely rejected** as a new title for Independent Members. Those unsupportive of the measure provided it would have little practical benefit and could be misleading or misunderstood as someone representing the public by election. Similarly, others highlighted potential confusion between the roles of the Independent Member and the Associate Member (with the stated role of citizen representation). Some provided existing terms such as Non-Officer Member and

Non-Executive Member are already widely understood. Others determined that it could detract from all members of the board considering and understanding of the public's perspective.

30. A few suggested to mediate this issue, the term 'Independent' should be retained but shared with the term 'Public'.

Vice Chairs

31. Although a few respondents felt the White Paper document had not clarified the benefit of appointing Vice Chairs to all NHS boards, **the proposals received significant widespread support as a principle**. Respondents provided that having Vice Chairs on all boards would ensure continuity of service and consistency across all NHS Wales organisations. It would also be seen to strengthen leadership and governance arrangements.

32. A few highlighted specific areas for consideration, such as, whether the Vice Chair should form an Executive or Non-Executive post and how fixed or flexible the role should be in terms of holding additional responsibilities.

Ministerial Appointments

33. There was also **significant support for the principle of introducing time-limited Ministerial appointments** where health boards or NHS trusts are found to be underperforming. Many respondents were clear that any such process would need to be transparent and ensure continued independence of the Board. This was also the view of some of the participants at the Brecon focus group who felt that Ministerial appointees would need a clear remit.
34. One respondent highlighted the need to determine whether such appointments should be full or associate members.

35. Some called for an evaluation of whether the process could be used effectively as a preventative measure rather than in reaction to underperformance; this included whether Boards should be able to request or make such appointments at times where a Board's work or organisational priorities required a specific skill set.

Associate Membership

36. There was **general consensus that the public and their representatives should be able to make meaningful contribution to Board meetings** and Board members should understand local peoples' needs and local issues. Some suggested the make-up and accountability of board membership needed to change to allow this; be it elected members from Local Authorities, members of the public or third sector/community group representation.

37. Some were in agreement that associate membership of boards could address representative voice, but suggested the person in the post would require a clear mandate from the public. This included multiple suggestions that a member of the Community Health Council, or reviewed public voice representative body, could hold such a role.

Specified Executive Members vs. Flexible model

38. On the balance of the comments received, the favoured position was to **implement a model featuring a collective of core board positions with flexibility built into other roles**.

39. Those respondents who preferred this approach reasoned that a clear governance framework with a **core composition is vital for a consistent approach across the Welsh NHS** and for delivering key functions, whilst allowing boards some flexibility would enable organisations to be responsive to local need and demographics. **Complete flexibility** on executive membership **held potential for Boards being managed and led very differently**.

40. There were **differing suggestions of what the core executive members should be**. The roles of Chief Executive, Director of Finance, Medical Director, Nursing Director, Director of Primary, Community and Mental Health, Director of Workforce and Organisational Development, Director of Public Health, and Director of Therapies and Health Science were all cited to varying degrees as roles which required a core role on all boards.

41. Some suggested **reducing the overall board size** to a range of ten to twelve members may enable improved effectiveness. It was noted a smaller Board should demonstrate the knowledge, understanding and awareness of issues to properly consider all relevant interests, such as those of different groups of health professionals, whilst not necessarily attempting to represent them. It was noted by one respondent that such a move would require a review of time commitments from Board Members.

42. Some other respondents, however, suggested **allowing variation of 'non-core' executive roles could inadvertently lead to the exclusion of important areas of expertise, perspective and skill** from key decision making and ultimately reduce the effectiveness the board.

43. Some, in support of complete flexibility **suggested providing the Boards' with full control over the executive structure,** in terms of numbers and roles, would enable the board to better take forward the objectives and priorities of the organisation. Others called for a minimum or maximum number of Executive posts to be set out, with Boards taking decision on roles and skills required. One respondent set out that the size and membership of the Board should be determined by the resource needed to meet the range of roles and responsibilities required to deliver the business of the organisation.

Chapter 1: Board Secretary role

44. This part of Chapter 1 of the White Paper set out our proposals for strengthening the important role of the Board Secretary, to give it the appropriate protections needed to operate properly. We also outlined a number of key principles for the role.

The Questions we asked:

In order to deliver on the key principles outlined the Welsh Government believes that the role of Board Secretary should be placed on a statutory basis and have statutory protection to allow the role to be independent with safeguards in place to challenge the Chief Executive of an NHS organisation or the Board more widely.

Do you agree with these proposals?

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

Response themes

General

45. In common with many other topics being raised within this consultation, there were a significant number of respondents who did not directly refer to the role of the Board Secretary. Others provided a 'yes' or 'no' answer with no additional comments or explanations for their views.

46. Of those who did respond directly to the question, the vast majority were in favour of statutory protection being in place, enabling the Board Secretary to challenge the Board, without fear of recrimination. This was also the view of some who attended the focus groups. Some highlighted the **potential for the role** of the Board Secretary **to be modelled on the Local Authority Monitoring Officer**, albeit in such a form that it would meet the needs of NHS Boards. The Local Authority Monitoring Officer role was viewed as a suitable example of a role which provides a legal duty to report on legal issues and maladministration, to manage the code of conduct and complaints associated with the conduct of Principal Officers and elected members. They also have the specific duty to ensure that the Council, its officers and elected Councillors maintain the highest standards.

Job Title, Description, and Skills

47. Some respondents called for a **change to the job title** from Board Secretary to Director of Corporate Governance. Several of these responses highlighted that the role is not well understood in some organisations, even though they are expected to challenge the Board and be at Director level themselves, within their organisation. Others highlighted their view that the terminology was outdated. As such **a clearer designation of the role appears popular** with respondents.

48. Support existed in some areas for the role of the Board Secretary **to not be allowed to deviate from the model job description contained in Model Standing Orders**. This includes the role having no scope to include operational management issues or

any scope for local interpretations of key principles to take place. It was felt that removing scope for local interpretation of the role would reduce the possibility for conflicts of interest. One respondent queried whether consideration should be given to an **appropriate qualification** or accreditation forming part of the requirements for the Board Secretary role. They gave the example of the Chartered Secretaries Qualifying Scheme from the Institute of Chartered Secretaries and Administrators (ICSA).

Lines of Reporting

49. Responses highlighted the issue of the **most appropriate line of reporting** for Board Secretaries. Some queried whether it would actually be possible for the Board Secretary to be independent of the Board, as they report directly to the Chair/Chief Executive and are employed by the organisation. Several respondents **suggested that the Board Secretary should be employed by Welsh Government directly**. Some attendees at the Pontypridd focus group suggested that the Board Secretary role should report to the Wales Audit Office. One respondent suggested that the Board Secretary should also be responsible for informing Welsh Government if any changes were made to the roles of Chief Executive, the wider Board or the NHS organisation as a whole which would affect Board governance arrangements.

50. Some respondents outlined the need to further consider issues such as **whether the Board Secretary would also be subject to the Duty of Candour**.

Chapter 2: Duty of Quality for the Population of Wales

51. This part of Chapter 2 of the White Paper set out our proposals for a new Duty of Quality to be placed on NHS organisations in Wales which would help shift the focus on service planning away from organisations and towards the citizen. We also proposed to strengthen the existing planning duty.

The Questions we asked:

The Welsh Government believes that the duty of quality should be updated and enhanced to better reflect our integrated system. This duty should be sufficiently wide in scope to facilitate the needs of the population of Wales to facilitate and enable collaborative, regional and all-Wales solutions to service design and delivery

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.

Welsh Government also believes that strengthening the existing planning duty will make sure health boards work together on the needs of the population of Wales in the planning and delivery of quality healthcare services.

Do you agree with these proposals?

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

Response themes

General

52. Many respondents did not answer the questions relating to a Duty of Quality, or if they did, just gave a “yes” or “no” answer with no further comment. A notable number of the online responses appeared to be generally in favour of a Duty of Quality but did not really make any comment about the proposal. Of those who did respond to the questions in this section, the following key themes were noted. It was discussed at most of the focus groups, where people felt it could be a helpful duty if properly implemented.

Whether an updated Duty of Quality for the Population of Wales/revised planning duty is a good idea

53. There was a fair amount of support for a new or updated Duty of Quality, with some respondents feeling that it would **improve collaboration** and encourage services to be **planned across a person’s life course**. Other people felt that a Duty of Quality **could be helpful in ending unfairness** in the way services are provided in different parts of Wales and/or even cross-border. A number of people commented that a **reciprocal duty** on NHS bodies to work in partnership with local authorities **is well overdue**.

54. On the other hand, a number of respondents felt that there **was little need for new duties of this nature,** because in their view, health boards should already be striving

to provide quality services and should be working with others in order to do so. Some people commented that insufficient explanation had been given as to why the existing Duty of Quality was no longer fit for purpose. Others felt that that there were **already enough collaborative duties** on public bodies and if these were used properly, there would be no need for further legislation. Some people commented that if a Duty of Quality were to be put in place then it **would need to be aligned with existing** Social Services and Future Generations legislation, with **similar language and concepts**. The aim should be to **simplify** the planning and collaboration landscape, **not complicate** it further.

55. One respondent felt that local health boards can only ever act locally, as is implicit in their name and functions, and that **Public Service Boards and Regional Partnership Boards** should therefore take a **central role in driving collaboration and cultural change**. A number of people felt that all-Wales or centralised solutions should be looked for wherever possible and that **shared aims, single plans and pooled budgets** would bring about collective responsibility for outcomes.

56. Some respondents were concerned that a revised Duty of Quality for the Population of Wales could **cause accountability problems** and that the various organisations would need to be clear who was responsible for the decisions and the delivery of the services. This was of particular interest to people who attended the Welshpool focus group, because of the complexity of cross border planning for Powys residents.

57. Other people expressed concern that a Duty of Quality which required health boards to look beyond their own populations might have some **unintended consequences**, including a detrimental effect on **local people.** This was a particular issue for people in **rural areas** who thought they might see services moved away towards bigger population centres. Other people felt that **financial issues and the need to save money** would get in the way of quality.

58. There was a view from some respondents that legislation should incorporate **what quality means from a service-user and carer** perspective.

Enforcement of a Duty of Quality

59. A fair number of responses raised concerns about how such a new duty would work in practice, and whether local health boards would be able to demonstrate they were compliant. There were a few concerns that **such a duty might be seen as "gesture" legislation,** rather than something that could be rigorously enforced, and certain respondents **felt unclear about how the duty would work in practice**. Some people said they did not understand fully what was being proposed.

60. Some respondents offered practical suggestions, including that there should be **formal scrutiny by Welsh Government** of how well local health boards take forward **collaborative working**; that health boards should be able to **show evidence of the effectiveness of partnership working**, including with the third sector; and whether the introduction of **quality impact assessments** would provide the right level of focus.

61. There was some suggestion that **sanctions** could be considered for organisations which persisted in working in silos, for example, **escalation measures, interventions, or a direction to collaborate**.

Culture and behaviour

62. More generally, some respondents to the consultation felt that **legislation alone would not deliver** ways of working that will transform health and social care. They felt **the involvement of staff and the public** in devising plans would support a change in behaviour and that **co-production** should become part of professional training.

Chapter 2: Duty of Candour

63. This part of Chapter 2 of the White Paper set out our proposals for a new Duty of Candour to be put in place across health and social care bodies to encourage a culture of openness and transparency. We proposed that this would build on work already being done on candour under the Regulation and Inspection of Social Care (Wales) Act 2016.

The Questions we asked:

The Welsh Government believes that the development of a statutory duty of candour across health and social services in Wales would consolidate existing duties and be in the interests of a person centred system.

Do you support this proposal?

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

Response themes

General

64. Many respondents did not answer the questions relating to a statutory Duty of Candour, or if they did, just gave a "yes" or "no" answer with no further comment. A notable number of the online responses appeared to be generally in favour of a Duty of Candour but did not really make any comment about the proposal. Of those who did respond to the questions in this section, the following key themes were noted. This topic was also widely discussed at the focus groups.

Whether a Duty of Candour is a good idea

65. There was a considerable amount of support for a statutory Duty of Candour and in addition, for it to apply to **all settings** across health and social care, including the independent sector. Some people felt this would increase trust between health and social care organisations if properly implemented.

66. Certain responses felt that there would be a need to **align** any statutory Duty of Candour **with regulations made under the Regulation and Inspection of Social Care (Wales) Act 2016**, which require openness in all dealings with people. There were also calls to learn from the experiences of Scotland and England in bringing forward a Duty of Candour.

67. A significant number of people felt that a statutory Duty of Candour should apply to **organisations and not individuals**. This is because many staff are already under professional duties to be open and honest and a statutory Duty of Candour should complement, not duplicate existing duties. Some people were concerned about how a Duty of Candour could apply to independent contractors, such as GPs, dentists, etc. A small number of respondents felt that a Duty of Candour **should extend to organisational decision-making**, including service change decisions.

Enforcement of a Duty of Candour

68. Some respondents, including those who attended the Carmarthen focus group, voiced concerns about how a Duty of Candour would be enforced. There was some suggestion that there should be an **incentive** for being truthful. Other responses felt that **fines and penalties would not work well** in a Welsh context. There was some suggestion that **inspections** carried out by Healthcare Inspectorate Wales could include an assessment of how well a Duty of Candour was being implemented.

69. A number of respondents felt that there would need to be **a publicity campaign** to ensure the public was aware of the Duty of Candour as it was felt this would empower people to ask questions of health and social care services in the knowledge that they could expect openness and transparency.

Culture and behaviour

70. A number of respondents felt that **openness and honesty should not require legislation** and should be an integral part of the way organisations are run. Others felt there was already enough legislation or process in place to ensure candour and that if these were properly implemented, there would be no need for further measures.

71. A large number of responses talked about a **learning, no-blame culture** which prioritises the safety of patients and supports staff. These respondents were keen to see a Duty of Candour implemented alongside work to improve culture and behaviour, including appropriate “whistle-blowing” policies.

72. There were some concerns about how a Duty of Candour could be successfully implemented across health and social care, including independent and third sector providers, where cultures are very different and where there may be a variety of arrangements in place for insurance. There was a view that considerable **staff training** would be needed if a Duty of Candour was to be introduced.

Chapter 3: Common standards

73. This part of Chapter 3 of the White Paper set out our proposals for a common set of high level standards to apply across health and social care, regardless of the setting or location.

The Questions we asked:

The Welsh Government believes there should be a common set of high level standards applied to health and social care and that the standards should apply regardless of the location of care.

Do you support this proposal?

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

Response themes

General

74. Many respondents did not provide comments on the proposal and just gave a 'yes' or 'no' answer. The majority of those who commented agreed with the proposal and provided comments on the reasons for their support. The main theme throughout responses was that individuals **should be entitled to a high standard of care regardless of the location of care or the provider**. Some suggested that common standards may address inconsistencies in care. This was generally the view of the people who attended the focus groups, although some were concerned about how this would work in practice.

75. A smaller number disagreed with the proposal suggesting that there are already a plethora of "standards" many of which are ignored due to cost pressures. They further commented that creating yet more standards will do nothing to improve matters stating that it will simply **create yet another layer of management to "monitor" said standards**. There was a belief that professionals work to already very high standards required by their own regulatory bodies. The following key themes were noted from responses.

Practicality of implementation and measurability of standards

76. Many respondents commented that they agreed that **that this provides a good opportunity for co-production, not just with service users but between organisations.** Many felt that the use of common standards, applicable across all areas, is a logical and sensible move which should facilitate the continuity of quality care being delivered. Some attendees of the Wrexham and Neath focus groups felt it would be a good opportunity to look at **training and learning** across health and social care.

77. Some responses commented that it should be recognised that there are **circumstances in which variation is acceptable** and may reflect a particular demographic, financial or clinical situation.

78. Some respondents expressed concern that there would be a danger that such a **high level set of proposals would be anodyne and unusable by frontline staff** unless the language and aims were carefully fashioned to be clear, appropriate and brief. Some respondents were unsure what this meant in practice.

Integration between health, social care and the third sector

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

Chapter 3: Joint complaints

80. This part of Chapter 3 of the White Paper set out our proposals for health, social care and independent organisations to come together to follow a joint process for complaints which cover both health and social care.

The Questions we asked:

The Welsh Government believes that requiring different organisations to work together to investigate complaints will make it easier for people to complain when their complaint is about both health and social services. We also believe it will encourage organisations to learn lessons to improve their services.

Do you support this proposal?

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

Response themes

General

81. Many respondents did not provide comments on the proposal and just gave a 'yes' or 'no' answer. Many respondents' answers were influenced by the views on the proposals in the paper relating to the citizen voice and the future of the Community Health Councils (CHCs). Their role in the provision of independent advocacy services was particularly highlighted in both the written responses and by people who attended the focus groups. The following key themes were noted from responses.

Different organisations should work together to investigate complaints

82. There was a high level of support for a seamless complaints process between health and social services where both are involved.

83. Many people, including some who attended the Newport focus group, felt that there should be a **single point of contact** for complaints, whether health, social care or joint complaints. Some people went further, suggesting **one body for all complaints**, whilst others suggested the body should also **investigate complaints** independent of health or social care bodies. Others suggested that complaints should be **handled locally** and **link** with **inspections**. Some respondents felt complaints should be i**nvestigated** by **CHCs** and some felt independent **members of the public** should be included on **investigating teams**. People felt it important that **clear, accessible information** on the joint process will be **essential** to make it easier for people to **understand** how to make a complaint. Other comments and suggestions included a **fining system** that is **not detrimental** to service users, the need to ensure a system is simple for those in **custody** and the need to address a lack of clarity about how **safeguarding processes** and complaints interact.

84. There were a number of concerns raised around **joint investigations** such as the need to be **clear over** who will **lead the investigation** and who will have **final sign off.** A number of people were concerned **joint investigations** would lead to **an**

increase in the time taken to investigate complaints. Several people pointed out that **cross border issues** would need to be taken into account. There were also concerns that the proposal could **cost more** than the present system and lead to a **drain on resources**.

85. Several people noted that the **Putting Things Right** and **Social Services Complaints** procedures **regulations** will need to be **amended**. Others highlighted that consideration will need to be given to how **redress** will work in social care.

86. It was felt that **links** will need to be made with **independent, third sector or social enterprises** when complaints are investigated. Several people highlighted the importance of **sharing information** between **professional regulators** and investigators, whilst ensuring the role of professional regulators is **not undermined.** The issue of **patient confidentiality** was raised with regard to the **sharing** of information.

Joint investigations will be more person-centred and make it easier to learn lessons across service areas

87. A small number of people felt a joint process would not work as people need **to understand** that **different organisations** are responsible for **different parts** of their care. They felt that this could lead to a **loss of co-production** and **patient centredness**. One person was concerned a joint process would be too **bureaucratic**.

88. There were concerns that people **are afraid** to raise complaints for **fear of** reprisal, especially for **mental health** and **learning disability** complaints.

89. A large number of people were supportive of the need for organisations to **learn lessons** from complaints. It was stressed that any **learning** should be **published** as well as details of **improvements to services** as a result of learning.

90. A number of people suggested that an **experience feedback system** should be introduced in order to **resolve issues** before they become complaints. Some people felt that there should be **greater emphasis** to **prevent complaints** happening in the first place. Several people highlighted the **link** between concerns **raised by staff** and those by members of the public, suggesting processes for the investigation **of staff complaints** need to be **strengthened**.

91. One person noted that it is important to take **positive feedback** into account as well as complaints. Another person highlighted the need for a **development programme** for a new system and **feedback from complainants** and their **advocates.** There was **strong support** for an **independent advocacy service** to provide appropriate **support** for those wishing to complain whether health, social care or joint complaints.

Chapter 4: Citizen Voice

92. This part of Chapter 4 of the White Paper set out our proposals for further strengthening the voice of citizens in health and social care, including potentially replacing the current Community Health Council model with a new national body which could also operate regionally and locally.

The Questions we asked:

The Welsh Government believes that local health and social care organisations should be working with the public to co-design and co-create services and that the way they do this needs to be independently monitored. We propose replacing the current statutory CHCs and their functions with a new national arrangement to represent the citizen voice in health and social care, to advise and provide independent assurance. The new body will work alongside Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales and have autonomy to decide how it will operate at local level.

Do you support this proposal?

Can you see any practical difficulties with these suggestions?

Response themes

General

93. The vast majority of respondents to the consultation answered the questions related to citizen voice. The majority of those who responded provided a narrative response to the questions rather than just "yes" or "no" answers. Many of the responses were multi-thematic, even within the single topic of citizen voice, and did not always deliver a consistent message. This part of the White Paper was also the area discussed most at the focus group events.

94. It was clear that responses to the citizen voice questions influenced respondents' answers to questions related to regulation and inspection, service change and joint complaints. The following key themes were noted.

A new, national body to replace Community Health Councils ("CHCs") that would also operate regionally and locally.

95. There was **some criticism** of the perceived **lack of detail** around the proposals, but this did not prevent the vast majority of respondents from expressing their view. There was a general consensus amongst respondents that **there is a need for a strong citizen voice body in Wales**. However, there were mixed views on whether or not the adoption of the citizens' voice proposals in the White Paper would result in achieving what is needed. .

96. A large number of respondents opposed the proposals on the basis that their adoption would result in a **diminution in the strength of the citizen voice in Wales.** This was also the view of some of the people who attended the focus group events. Feeling was particularly strong in the Llangefni event about the future of

CHCs in Wales. Opposition stemmed in the main from the belief that the current CHC model is working well and/or adoption of the proposals would result in certain key functions of CHCs (such as their independence, the ability to hold the health service to account and the ability to engage with people on a local level) being lost. Some opposition to the proposals stemmed from a lack of information and/or understanding of the functions that would be performed by any new body and the way it would operate. **Some concerns** were expressed about the **cost** of any new arrangement.

97. A large number of respondents expressed the view that rather than create a new body, **the opportunity should be taken to strengthen CHCs and extend their existing functions**. Thus many of these respondents acknowledged the need for some reform of the existing system. Some respondents commented that strengthening the role of CHCs would build on the good work that they were already undertaking.

98. Many of the respondents who expressed opposition to the proposals and/or expressed the view that CHCs should be retained and their functions extended, also expressed views which demonstrated that they agreed with certain propositions in the White Paper such as the extension of the citizen voice arrangement to social care, the retention of advocacy support in any new arrangement and the general need for a strong citizen voice body in Wales.

99. There were also a considerable number of respondents who **expressed their support for the proposals,** on the basis that they agreed that their adoption would result in the desired strengthening of the citizen voice arrangements in Wales.

100. Other respondents were more neutral in their comments, expressing the view that if CHCs were to be replaced, **it was important to ensure that the new citizen voice body was an improvement on the current arrangements.**

101. It is notable that certain comments recurred in fairly large numbers across the whole spectrum of responses (i.e. from those who supported the proposals through to those who opposed them) these included the view that the new arrangement should have teeth, be **independent**, be able to **hear directly from citizens** and have a **strong local presence**.

102. Certain respondents also suggested **alternative models** that could be adopted for the citizen voice arrangement in Wales. Suggestions ranged from detailed proposals relating to the potential functions to be exercised by any new body, to recommendations that other arrangements, such as those employed to give mental health patients a voice, could be considered.

103. A significant amount of concern was expressed by respondents in relation to the **proposal to base the new citizen voice body "in some respects" on the Scottish Health Council ("SHC"). Many respondents** drew attention to recent **criticism** of that body. Other respondents indicated that if the SHC was to be used as a model, more detailed thought would need to be given to how that model could be adapted effectively for use in Wales.

Citizen voice arrangement to cover health and social care.

104. There was a high level of support for the proposal to enable **one organisation to have the function of representing the citizen voice across health and social care**. Respondents who opposed the proposal to replace CHCs, generally thought CHCs' functions should be extended to social care. Respondents who supported the proposal to create a new citizen voice body generally agreed the new body's functions should extend across health and social care.

105. However, a number of respondents cautioned that, in order to avoid confusion and potential duplication, thought would need to be given to **how the new arrangements would fit in with existing citizen voice arrangements in social care.** Other respondents commented that in developing any new arrangements, account should be taken of existing fora for citizen engagement in the third sector.

Key attributes/functions to be exercised by a citizen voice body

106. The responses revealed a number of key attributes and functions respondents considered would be desirable for a citizen voice body to exercise (whether that be the existing CHCs or a new citizen voice body).

107. There was broad support for the continuation of the **advocacy and complaints advisory service** currently run by CHCs. Some respondents commented on the need to improve advocacy services for children.

108. A large number of respondents indicated that the citizen voice arrangement needed to be **independent** and to be able to **hear directly** from citizens about their experience and have a **strong local presence**.

109. A number of respondents expressed the view that the citizens' voice body should **make use of formal and informal engagement** to help reach those persons whose voices are not usually heard (including children and young people, older people and persons with disabilities) and **look at new and innovative ways of engaging with people,** including those with medical or social conditions that make it difficult for them to engage in the usual way.

110. A number of respondents expressed the view that any new arrangement needed to have the **power to hold services providers to account**.

111. In terms of **"inspection**", a **range of views** were expressed. Some respondents were of the view that CHC visits had a different focus to inspections performed by HIW/CIW and, whatever the new arrangement, these types of citizen focussed visits should continue. Other respondents expressed the view that the CHC inspections/visits were a duplication of the inspections carried out by HIW/CIW and should not continue under the new arrangements. Others thought that representatives of the citizen voice body should make up the lay element in HIW/CIW inspections. Certain respondents took the view that if new arrangements were put in place, it would be an opportune time to clarify the difference between the "inspection" roles of HIW/CIW and the citizen voice body.

112. Some respondents **criticised the CHCs' cumbersome membership process** which acted as a disincentive to recruitment. Others criticised the CHCs'

lack of diversity and commented that **any new arrangement would need to ensure that mechanisms were in place to secure more representative and diverse membership.**

113. A small number of respondents expressed the view that the citizen voice body should have **paid members,** rather than volunteers. **Other respondents** praised the current CHC model (where members are unpaid) for delivering value for money. Therefore, there was no consensus on this issue.

The new body will work alongside Healthcare Inspectorate Wales and Care Inspectorate Wales and have autonomy to decide how it will operate at local level.

114. A large number of respondents who responded to the citizen voice questions did not directly comment on this aspect of the question or combined their response with the related questions on regulation and inspection. Amongst those who did respond, **responses were mixed**.

115. Some respondents thought that a single body housing the citizen voice, HIW and CIW would be a **positive step** as it would encourage joint working, reduce duplication and help to raise the profile and influence of the citizen voice. A number of respondents who were in favour of such an arrangement, indicated that the citizen voice body would need to be an **equal partner** in the arrangement if it were to be a success.

116. Other respondents were **totally opposed** to the idea on the basis that a citizen voice body needed to be wholly independent of the inspectorates and have the ability to hold the inspectorates to account.

117. Other respondents indicated that they were keen to see joint working between the citizen voice body and the inspectorates, but had concerns about the independence of the citizen voice arrangement and the potential for conflicts of interest to arise if all of the separate functions were housed in one body.

Chapter 4: Service change

118. This part of Chapter 4 of the White Paper set out our proposals for how services should be co-created with citizens, and how the decision-making process relating to service changes can be strengthened to include input from clinical experts and citizens.

The Questions we asked:

The Welsh Government believes that introducing an independent mechanism to provide clinical advice on substantial service change decisions, with advice from the proposed new citizen voice body, will encourage continuous engagement and increase the pace of strategic change through enabling a more evidence-based, transparent process and a more directive and guiding role on the part of Welsh Government.

Do you agree with this proposal?

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

Response themes

General

119. A substantial number of respondents did not comment directly on the service change proposals and of these, opinions were evenly split between those supporting and those not supporting the broad proposal. Of those who did provide comments in response to the questions asked, the following key themes were noted.

Establishment of independent clinical advice panels to advise local health boards

120. Some respondents felt that the lay citizen voice body was likely to be overshadowed by the independent clinical advice panels and would never be taken to be as authoritative as the clinical perspective. For this reason, it was felt there was **a need for some lay representation on the clinical panels to create greater balance** in terms of how the evidence in relation to a service change was interpreted.

121. There was stronger support for the principle of **clinical leadership in service change decision making and that the clinical evidence base was critical to decision making** and best understood and interpreted by clinicians themselves. This was the also the view of some of the people who attended the Brecon focus group. A significant number commented further that while they supported decision making informed by public and patient input, this input should not be allowed to deter Ministers from making difficult decisions or to slow down strategic change.

122. In terms of the membership of independent panels, there was considerable support for **greater detail as to how such panels would be set up and panel members recruited to ensure relevant expertise and independence**. Some felt there was too much emphasis on “clinical” and wanted other important factors and impacts such as **cost and accessibility** of services to be reflected.

123. Some respondents felt the service change proposals should support the strategic move towards integrated health and social care and be **applicable across both health and social care settings**, with a number of respondents seeing little point in a detailed process centred on NHS decision making alone.

124. There was significant support for **the meaning of "substantial change" to be clarified and better defined**, to ensure a common understanding. However, many respondents felt that it wasn't appropriate for organisations themselves to determine their own thresholds and criteria and that this should be subject to wider consensus. This was the view of some of the people who attended the Pontypridd and Newport focus groups. However, views were split on this point and some other respondents saw **little value in the definition of 'substantial change', feeling that all service change should be considered on the same footing and subject to the same levels of scrutiny**. This was, in particular, the view of Community Health Councils.

125. A small number of respondents felt the proposal would add another unnecessary level of bureaucracy.

Role for new citizen voice body in quality assuring the public engagement process

126. There was strong support across the consultation responses for **an independent body to fully represent public views in service change discussions**. There was also strong support for the principle of co-production and a multi-disciplinary approach to service change decision making, in which the public voice was an equally vital component alongside clinical and other considerations.

127. Many respondents cautioned **against adopting a citizen voice body in Wales based on the Scottish model**, given that following review, this model had been subject to criticism in terms of its ability to be fully representative. There was also strong feeling that Welsh Government had provided **far too little information in relation to the proposed form and function of the citizen voice body** and how it would be resourced, such that it wasn't possible to comment intelligently on its relative ability to quality assure the public engagement process on service change. It was felt that this ambiguity undermined the credibility of the proposal.

128. There were strong concerns about **the ability of such a body to be fully representative**, with respondents highlighting in particular the local context and the potential for loss of effective local community representation. A significant number of respondents felt that for the body to effectively quality assure the engagement process (and have a clear basis for doing so), there would need to be **an agreed set of participation standards** based upon the Principles of Citizen Engagement and the National Standards of Participation for Children and Young People in Wales. There was also a consensus amongst those who commented that this should be supported by **clear guidance** in relation to co-production.

129. To provide wider assurance on engagement, a significant number of respondents highlighted the importance of ensuring the inclusion and representation of **harder to reach and underrepresented groups**, the digitally excluded, children and young people, protected characteristics groups and sub-groups and the wider third sector. This scope of inclusion was considered critical to effective co-production. This was also the view of people attending the Wrexham focus group.

130. Many of the consultation responses suggested a misunderstanding regarding the proposals in relation to co-production and several respondents highlighted their concern that the proposals seemed to infer that **formal public consultation was likely to be replaced**, effectively by a generic co-production approach to engagement.

Ministerial referral only if local decision making fails

131. There was some support for a formal power of referral and **for that power to be retained in any new arrangement**, but there was wider support for the more general principle of the ability for the public to have a **right to challenge** service change decisions. A small number of respondents gave specific support for the proposal that decision-making by Ministers should only happen as a final resort, if local decision making fails.

132. There was significant support for the view that, where decisions were not considered to be in the public interest, **the appropriate challenge should be through judicial review** and that consideration should be given to providing funding to a new citizen voice body to initiate judicial review in appropriate cases. This was, in particular, the view of Community Health Councils.

Chapter 4: Regulation and inspection

133. This part of Chapter 4 of the White Paper set out our proposals for bringing further clarity and future-proofing to the work of Healthcare Inspectorate Wales (HIW), including how it might work with Care Inspectorate Wales (CIW) to support an increasingly integrated health and social care system. We also proposed the setting up of a new independent body to include inspection, regulation and citizen voice.

The Questions we asked:

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

What do you think of this proposal?

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

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

Would you support such an idea?

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

Response themes

General

134. Many respondents did not answer the questions relating to inspection and regulation, or if they did, just gave a "yes" or "no" answer with no further comment. It was clear that many respondents' answers to the questions in this section were influenced by their views on the proposals in the paper relating to the citizen voice and the future of Community Health Councils (CHCs). Of those who did respond to the questions in this section, the following key themes were noted.

A clearer underpinning framework for HIW

135. There was a high level of support for a review of HIW's legislative framework. People commented that doing so would be a **rational move towards integration** and in support of the way people actually receive and experience care; that it would **close important gaps** in the regulatory framework and address areas of **duplication** where a service might be regulated by both HIW and CIW. Some people felt that if this work were to go ahead, it would be important to **build on existing legislation** already in place in social care, i.e. the Social Services and Well-being (Wales) Act 2014 and the Regulation and Inspection of Social Care (Wales) Act 2016.

136. Some respondents **could not immediately see why** a review of HIW's legislative framework would help with closer working with CIW or integration more generally.

Merger of the inspectorates

137. There were mixed views on whether HIW and CIW should be merged. Some respondents felt that this should **definitely happen as soon as possible**, whereas others agreed it should happen but possibly on a **phased basis**. One respondent felt that a more radical approach should be taken to merge **all Welsh inspectorates** into one body. Some others thought that having a single health and social care inspectorate would **only be effective if the health and social care system was itself already fully integrated**. Many respondents felt that much more could be done to encourage closer working between the inspectorates without resorting to primary legislation or formal mergers.

138. Other respondents warned about the dangers of attempting to merge two inspectorates with **distinct identities and responsibilities**. There was a fear that **expertise could become diluted** and affect the focus of the inspectorates. Other were worried that health issues could **swamp social care** in such an arrangement.

139. Certain responses dealt with the **process** of regulation and inspection, reminding of the importance of **lay involvement**, and the need for the process to recognise the needs of **Welsh language** speakers much more robustly. A small number of respondents felt there was a need for inspection and regulation to be carried out in accordance with **internationally recognised standards** such as ISO.

Independence of the inspectorates and creation of a new independent body to cover inspection, regulation and citizen voice

140. There was some support for the idea of an Assembly Sponsored Public Body or other suitable arrangement to improve independence, although a number of people felt that if a new body was to be set up then it would need to be **truly independent of government**, not just at arms length. Again, some respondents felt that **more independence could be built into the current arrangements**, for example through remit letters.

141. However, a fairly large number of respondents felt they **needed more information** on the proposed new body before they could comment fully and others felt they could not see the benefit of setting up another body. Others cautioned that the **process** of merging or setting up a new body **could divert resources** away from inspections at a time when there is already a great deal of change and financial pressure.

142. As noted previously under the citizen voice response, there were a number of concerns about the proposal to locate regulation, inspection and citizen voice into the same body. Whilst some felt that there could be **benefits to having fewer organisations**, which would be easier for people to understand, others had concerns about how the component parts of such a body would **preserve their independence** and have **clarity of functions and their own identities**. People felt this would need to be very carefully considered if the proposal was to be taken forward. Some respondents, including some of the people who attended the Neath, Llangefni and

Newport focus groups, felt that the **citizen voice should always have its own distinct identity** and be independent of the inspectorates or anyone else. Others thought a body housing all these functions would be **too large and unwieldy**.

143. Other respondents made comments about the operation of such a new body, including how it would **interface with other entities** in the same "space" such as Estyn, Social Care Wales, the Auditor General for Wales and Public Services Ombudsman for Wales. This issue was also raised at the Wrexham focus group. There were some concerns about how **such a large national body would connect with local people** and reflect the needs of distinct groups such as children and young people.

Annex A

Services Fit for the Future White Paper Consultation – Full list of respondents

Key to identify groups		No.
1	Individuals	180
2	Local Government	19
3	Universities and academic bodies	1
4	Political parties/union groups	17
5	Health professional representative and advisory groups and associations	21
6	NHS organisation/staff	22
7	Government departments/agencies	10
8	Citizen voice/third sector/Commissioners	56
9	Social enterprise/business	9
10	Religious groups	1
Total		**336**

Those marked with a * requested to remain anonymous. Others shown as anonymous did not give their name

Ref No.	Name	Organisation	No.
WGWPMB1	D Kenny		1
WGWPMB2	Dame C Black		2
WGWPMB3	H Randall		3
WGWPMB4	C Ringer		4
WGWPMB5	G James		5
WGWPMB6	D Hart		6
WGWPMB7	M P Boyle		7
WGWPMB8	R Lewis	Age Cymru	1
WGWPMB9	N Taylor	Vale of Clwyd Trades Union Council	1
WGWPMB10	L Bidmead/G McCullagh	Community Recovery Education and Skills Training Group (CREST)	2
WGWPMB11	H Shaddick	Your Voice Advocacy	3
WGWPMB12	B Stapley		8
WGWPMB13	J Finch Saunders	Assembly Member	2
WGWPMB14	S M Sandham		9
WGWPMB15	R Goodway	Community Pharmacy Wales	1
WGWPMB16	K Kras	Medical Protection Society	4
WGWPMB17	L George	Gwent Association of Voluntary Organisations and Torfaen Voluntary Alliance	5
WGWPMB18	P Edwards		10
WGWPMB19	D Price	Blaenau Gwent People First	6
WGWPMB20	Professor R Moore		11
WGWPMB21	S Milsom	Caephilly 50 plus forum	7
WGWPMB22	L Saville Roberts	Member of Parliament	3
WGWPMB23	J Morgan	Newport 50 plus forum	8
WGWPMB24	C Woodhall	Royal College of Anaesthetists	2

WGWPMB25	J Mills	Newport Carer's Forum	9
WGWPMB26	M Watts		12
WGWPMB27	J Browne		13
WGWPMB28	Dr N McKenzie		14
WGWPMB29	K White		15
WGWPMB30	N Ramsay AM	Assembly Member	4
WGWPMB31	L Whalley	Abergele Town Council	1
WGWPMB32	P Rendle		16
WGWPMB33	N Bennett	Public Services Ombudsman for Wales	1
WGWPMB34	Dr R Walton	Wales Progressive Co-operators	1
WGWPMB35	D Smith	Co-Ops and Mutuals Wales	2
WGWPMB36	Dr I G Higginbotham		17
WGWPMB37	Dr C Walters	Royal College of Speech and Language	3
WGWPMB38	P Pinto de Sa	Nursing and Midwifery Council	4
WGWPMB39	C Mortimer	Gelligaer Community Council	2
WGWPMB40	T Brooks		18
WGWPMB41	L Pritchard	Glamorgan Voluntary Services	10
WGWPMB42	C Owen	British Dental Association	5
WGWPMB43	S Blythe	Welsh Local Government Association	3
WGWPMB44	N Blanluet		19
WGWPMB45	B Parker		20
WGWPMB46	R Lanchbury	Cilybebyll Community Council	4
WGWPMB47	P Allen		21
WGWPMB48	Committee Administrator	Bro Taf Local Medical Committee	1
WGWPMB49	L Carver	Vale of Glamorgan Council	5
WGWPMB50	W Thomas		22
WGWPMB51	M Jones		23
WGWPMB52	C Fidler	Wales Co-operative Centre	6
WGWPMB53	A Shakeshaft	Directors of Therapies and Health Science Peer Group	2
WGWPMB54	*Anonymous		24
WGWPMB55	C Costello	Ballynahinch Support Group	11
WGWPMB56	M Jones	Wrexham County Borough Council	7
WGWPMB57	H Williams		25
WGWPMB58	L Harper		26
WGWPMB59	Dr S Francis		27
WGWPMB60	DCC M Jukes	South Wales Police and health lead for all 4 Welsh Police Forces	2
WGWPMB61	H Rogers	Royal College of Midwives	6
WGWPMB62	*Anonymous		28
WGWPMB63	E Petitti	Royal College of General Practitioners	7
WGWPMB64	*Anonymous		29
WGWPMB65	J Pearce		30
WGWPMB66	P Ford MBE MCSP	Chartered Society of Physiotherapy	8
WGWPMB67	K Houston	Plaid Cymru Caerphilly Constituency	5
WGWPMB68	M Joyce		31
WGWPMB69	R Walton	Vale of Glamorgan 50+ forum	12
WGWPMB70	Dr S Aitken	Public Health Directors Leadership Group	3
WGWPMB71	*Anonymous		32
WGWPMB72	H Vaughan Thomas	Auditor General for Wales	3

WGWPMB73	E Murphy	Social Services, Flintshire County Council	8
WGWPMB74	D Vincent	Motor Neurone Disease Association	13
WGWPMB75	E Hicks	Diverse Cymru	14
WGWPMB76	J Shaughnessy	St John Cymru-Wales	15
WGWPMB77	M Tippett	The Royal College of Psychiatrists in Wales	9
WGWPMB78	S Howe	Future Generations Commissioner for Wales	16
WGWPMB79	B Evans	Carers Wales	17
WGWPMB80	R Raison	Royal College of Nursing Wales	10
WGWPMB81	G Ryall-Harvey	North Wales Community Health Council	18
WGWPMB82	*Anonymous		33
WGWPMB83	*Anonymous		34
WGWPMB84	H David AM	Assembly Member	6
WGWPMB85	H Thomas	Information Commissioner's Office	19
WGWPMB86	A Roper	Cartrefi Cymru Co-operative	3
WGWPMB87	S Allen	Cardiff and Vale of Glamorgan CHC	20
WGWPMB88	A Mutlow	Aneurin Bevan CHC	21
WGWPMB89	G Owens		35
WGWPMB90	F McDonald	Multiple Sclerosis Society Cymru	22
WGWPMB91	M Ashe	The Royal College of Paediatrics and Child Health	11
WGWPMB92	J Robertson	Aneurin Bevan Community Health Council	23
WGWPMB93	Lieutenant Colonel (Retd) J Skipper		36
WGWPMB94	J Pritchard		37
WGWPMB95	Revd G Rhys	Cytûn (Churches Together in Wales)	1
WGWPMB96	*Anonymous	Individual	38
WGWPMB97	G Halfpenny	Neath Port Talbot Older Person's Council	24
WGWPMB98	B Campbell		39
WGWPMB99	C Harris		40
WGWPMB100	J Burgen	Ynys Mon Citizens Advice	25
WGWPMB101	B Woodward		41
WGWPMB102	C Edwards	Hospice UK and Hospices Cymru	26
WGWPMB103	M Lewis	Hawliau	4
WGWPMB104	M Davies		42
WGWPMB105	F Webster		43
WGWPMB106	M John-Williams	The Co-production Network for Wales	5
WGWPMB107	Dr E Youd	Royal College of Pathologists	12
WGWPMB108	*Anonymous	Individual	44
WGWPMB109	K Laugharne	General Medical Council	13
WGWPMB110	R Jones	All Wales Directors of Nursing Peer Group and Assistant Directors of Nursing	4
WGWPMB111	G Baranski	Care and Social Services Inspectorate Wales	4
WGWPMB112	O Smith MP		45
WGWPMB113	J Field	Welsh Health Specialised Services Committee	5
WGWPMB114	G Galletly	Velindre NHS Trust	6
WGWPMB115	Dr R Hall and Mr J Evershed	Mid Wales Healthcare Collaborative	7

WGWPMB117	R Crowder	Royal College of Occupational Therapists	14
WGWPMB118	M Goodfellow	Torfaen County Borough Council	9
WGWPMB158	G Evans	Social Care Wales	5
WGWPMB159	R Davies	Hywel Dda University Health Board	8
WGWPMB160	T Gilling	Centre for Public Scrutiny	27
WGWPMB161	M Williams	Betsi Cadwaladr University Health Board	9
WGWPMB162	Kevin Brennan MP	Member of Parliament	7
WGWPMB163	P Welsh	Cardiff and Vale University Health Board	10
WGWPMB174	Llyr Gruffydd AM	Assembly Member	8
WGWPMB175	Cindy Chen	Pro-Mo Cymru	6
WGWPMB176	Claire L Marchant	Monmouthshire County Council	10
WGWPMB177	Michelle Lewis	Citizens Advice Cymru	28
WGWPMB178	Alyson Thomas	The Board of Community Health Councils	29
WGWPMB181	C Jenkins	Abertawe Bro Morgannwg Community Health Council	30
WGWPMB182	R Bevan	NHS Board Secretaries Group	11
WGWPMB183	A Thomas	Hywel Dda Community Health Council	31
WGWPMB184		Older People's Commissioner for Wales	32
WGWPMB185	S Beach	Chief Pharmacists Wales	12
WGWPMB186	M Crossley	Health and Safety Executive	6
WGWPMB187	H Williams	Action against Medical Accidents (AvMA)	33
WGWPMB188	N Roberts	Healthcare Inspectorate Wales	7
WGWPMB189	H Avoth	Public Health Wales	13
WGWPMB190	S Combe	Abertawe Bro Morgannwg University Health Board	14
WGWPMB191	R Williams	Parkinson's UK	34
WGWPMB192	G Pycroft	MacMillan Cancer Support	35
WGWPMB193	P Martin	Hafal	36
WGWPMB194	Dr. E Williams and Mr. M Thornton		46
WGWPMB195	N Evans	Children's Commissioner for Wales	37
WGWPMB196	R Wright		47
WGWPMB197	D Young	Welsh Independent Healthcare Association	15
WGWPMB198	A Hughes	NHS Listening and Learning from Feedback Group	15
WGWPMB199	D Hughes	The General Pharmaceutical Council	16
WGWPMB200	P Lathbury	Powys Association of Voluntary Organisations	38
WGWPMB201	N Lloyd-Jones	The Welsh NHS Confederation	16
WGWPMB202	D Blench	Professional Standards Authority	8
WGWPMB203	O John	Academy of Royal Medical Colleges Wales	17
WGWPMB204	A Evans	Cystic Fibrosis Trust	39
WGWPMB205	C Kissick	British Heart Foundation	40
WGWPMB206	H Howson	The Bevan Commission	1
WGWPMB207	E Hitchon	Welsh Ambulance Services NHS Trust	17
WGWPMB208	G Lang	Directors of Planning, Welsh NHS	18
WGWPMB209	R Williams	Cwm Taf University Health Board	19
WGWPMB210	S Capstick	Cardiff Third Sector Council (C3SC)	41
WGWPMB211	C Shillabeer	Powys teaching Health Board	20
WGWPMB212	P Pavia	The Association of Directors of Social Services	11

WGWPMB213	L Merredy	The British Medical Association Cymru Wales	18
WGWPMB214	David T C Davies MP	Member of Parliament	9
WGWPMB215	R Ebley		48
WGWPMB216	P Gripper		49
WGWPMB218	A Jones	The Royal College of Surgeons	19
WGWPMB220	D Hutton	Unison Cymru/ Wales	10
WGWPMB221	L Barry	Powys County Council Adult Social Care	12
WGWPMB222	P Murphy	TLC Nursing & Homecare Plus Ltd, Domiciliary Care Association Wales	
WGWPMB223	R Nowell-Phillips	Royal National Institute for the Blind	42
WGWPMB224	R Hedge	Royal College of Physicians	20
WGWPMB225	Cllr. Mabon ap Gwynfor		50
WGWPMB226	C Phillips	Cyngor Gwynedd Council	13
WGWPMB227	L Edwards		51
WGWPMB230	S Bryn	Comisiynydd y Gymraeg	43
WGWPMB231	Unknown		52
WGWPMB232	Mr R Blake		53
WGWPMB233	Anonymous*		54
WGWPMB234	R Taylor		55
WGWPMB235	E Ann Thomas		56
WGWPMB236	M Antoniw AM	Assembly Member	11
WGWPMB237	Anonymous		57
WGWPMB238	Anonymous		58
WGWPMB239	Anonymous		59
WGWPMB240	Arfon Jones	Police and Crime Commissioner for North Wales	12
WGWPMB241	Mr J E Jenks	Unite (North West Wales retired members branch)	13
WGWPMB242	J and M Waterhouse		60
WGWPMB243	P Cutress, D McGregor	The Peoples Assembly against Austerity (Rhyl Branch)	14
WGWPMB244	Anonymous		61
WGWPMB245	Anonymous		62
WGWPMB246	W Evans	Llanelli Rural Council	14
WGWPMB247	M Buckley	Maesteg Town Council	15
WGWPMB248	K Houston	Plaid Cymru Caerphilly Constituency	15
WGWPMB249	H Roberts		63
WGWPMB250	D McCann	Blaenau Gwent County Borough Council Social Services Directorate	16
WGWPMB251	D M and J L Hopkin		64
WGWPMB252	A J Beddow	Socialist Health Association Cymru Wales	16
WGWPMB253	Cllr V Smith		65
WGWPMB254	F C Hunt		66
WGWPMB255	T Conway and B Conway		67
WGWPMB256	A Rees	HM Prison & Probation Service in Wales	9
WGWPMB257	Anonymous		68
WGWPMB258		Cwm Taf Community Health Council	44
WGWPMB259		Powys Community Health Council	45
WGWPMB260	G John		69

WGWPMB261	R S	Mirus-Wales	46

WGWPOL1	*Anonymous		70
WGWPOL2	Anonymous		71
WGWPOL3	Anonymous		72
WGWPOL4	*Anonymous		73
WGWPOL5	*Anonymous		74
WGWPOL6 Response 6	Cancelled – form not completed		
WGWPOL7	S Mitchell		75
WGWPOL8	*Anonymous		76
WGWPOL9	*Anonymous		77
WGWPOL10	*Anonymous		78
WGWPOL11	D Esteve	SIS Cymru	7
WGWPOL12	*Anonymous		79
WGWPOL13	N Taylor		80
WGWPOL14	*Anonymous		81
WGWPOL15	*Anonymous		82
WGWPOL16	*Anonymous		83
WGWPOL17	*Anonymous		84
WGWPOL18	*Anonymous	*Anonymous	47
WGWPOL19	*Anonymous		85
WGWPOL20	*Anonymous		86
WGWPOL21	*Anonymous		87
WGWPOL22	A Griffin		88
WGWPOL23	*Anonymous	*Anonymous	48
WGWPOL24	*Anonymous		89
WGWPOL25	C Warlow	Builth Wells Community Support	49
WGWPOL26	J B Jones	Unite Retired Members Bangor	17
WGWPOL27	*Anonymous		90
WGWPOL28	*Anonymous		91
WGWPOL29	T Jones		92
WGWPOL30	G Bell		93
WGWPOL31	*Anonymous		94
WGWPOL32	D Cooper		95
WGWPOL33	Dr DG Salter OBE		96
WGWPOL34	*Anonymous	*Anonymous	8
WGWPOL35	*Anonymous		97
WGWPOL36	*Anonymous		98
WGWPOL37	*Anonymous		99
WGWPOL38	J Evans		100
WGWPOL39	M Poole		101
WGWPOL40	*Anonymous		102
WGWPOL41	S Moore		103
WGWPOL42	Anonymous		104
WGWPOL43	Dr A Jones	School of Healthcare Sciences Cardiff University	105
WGWPOL44	*Anonymous		106

WGWPOL45	*Anonymous		107
WGWPOL46	P Fenner		108
WGWPOL47	*Anonymous		109
WGWPOL48	*Anonymous		110
WGWPOL49	*Anonymous		111
WGWPOL50	P Egan	Llandough Community Council	17
WGWPOL51	*Anonymous		112
WGWPOL52	P Bolton		113
WGWPOL53	H Randall	North Wales Community Health Council	114
WGWPOL54	*Anonymous		115
WGWPOL55	L Jones		116
WGWPOL56	C Davies		117
WGWPOL57	*Anonymous	*Anonymous	18
WGWPOL58	C Laphap		118
WGWPOL59	*Anonymous		119
WGWPOL60	Cancelled – form not completed		
WGWPOL61	*Anonymous		120
WGWPOL62	Nicki		121
WGWPOL63	*Anonymous		122
WGWPOL64	*Anonymous		123
WGWPOL65	John		124
WGWPOL66	*Anonymous		125
WGWPOL67	L Coller		126
WGWPOL68	W R Williams		127
WGWPOL69	R Overington		128
WGWPOL70	*Anonymous		129
WGWPOL71	L Hayward		130
WGWPOL72	D R Harries		131
WGWPOL73	*Anonymous		132
WGWPOL74	*Anonymous		133
WGWPOL75	*Anonymous		134
WGWPOL76	*Anonymous		135
WGWPOL77	*Anonymous		136
WGWPOL78	Mrs J Thomas		137
WGWPOL79	M Imms		138
WGWPOL80	T Matthews		139
WGWPOL81	*Anonymous		140
WGWPOL82	D P Thomas		141
WGWPOL83	*Anonymous		142
WGWPOL84	*Anonymous		143
WGWPOL85	*Anonymous		144
WGWPOL86	*Anonymous		145
WGWPOL87	*Anonymous		146
WGWPOL88	*Anonymous		147
WGWPO89	A Easson		148
WGWPOL90	R Norris		149
WGWPOL91	A Wilson		150
WGWPOL92	T Masters		151
WGWPOL93	J Kell	The Patients Association	50

WGWPOL94	*Anonymous		152
WGWPOL95	*Anonymous		153
WGWPOL96	Dr A Rayani	Morgannwg Local Medical Committee	20
WGWPOL97	*Anonymous		154
WGWPOL98	*Anonymous		155
WGWPOL99	*Anonymous	*Anonymous	51
WGWPOL100	*Anonymous		156
WGWPOL101	*Anonymous		157
WGWPOL101	*Anonymous	*Anonymous	19
WGWPOL102	*Anonymous		158
WGWPOL103	Cancelled – form not completed		
WGWPOL104	*Anonymous		159
WGWPOL105	*Anonymous		160
WGWPOL106	*Anonymous		161
WGWPOL107	D Schaffer	Fair Treatment for the Women of Wales	52
WGWPOL108	*Anonymous		162
WGWPOL109	*Anonymous		163
WGWPOL110	*Anonymous	*Anonymous	53
WGWPOL111	*Anonymous		164
WGWPOL112	C Connell	NICE and Wales NICE Liaison Group	10
WGWPOL113	*Anonymous		165
WGWPOL114	*Anonymous		166
WGWPOL115	*Anonymous		167
WGWPOL116	E Bacon		168
WGWPOL117	C Sanderson	Royal College of Surgeons of Edinburgh	21
WGWPOL118	*Anonymous		169
WGWPOL119	Cancelled – form not completed		
WGWPOL120	K Holmes	Opinion Research Services	9
WGWPOL121	T Windle	Prostate Cancer UK	54
WGWPOL122	*Anonymous		170
WGWPOL123	J Morris	Care and Repair Cymru	55
WGWPOL124	S Howard		171
WGWPOL125	*Anonymous		172
WGWPOL126	*Anonymous		173
WGWPOL127	J Allen		174
WGWPOL128	*Anonymous		175
WGWPOL129	S Jenkins		176
WGWPOL130	J Lewis		177
WGWPOL131	R B Harrison	Flintshire 50+ Action Group	56
WGWPOL132	A Wales		178
WGWPOL133	Dr K Saunders	Butetown Medical Practice	21
WGWPOL134	Mr R Ebley		179
WGWPOL135	*Anonymous		180

Annex B

In Response to the Welsh Government White Paper, Chapter 4:

Please indicate if you support the following proposals…

The Welsh Government believes that local health and social care organisations should be working with the public to co-design and co-create services and that the way they do this needs to be independently monitored. **We propose replacing the current statutory CHCs and their functions with a new national arrangement to represent the citizen voice in health and social care, to advise and provide independent assurance**. The new body will work alongside Healthcare Inspectorate Wales and Care and Social Services Inspectorate Wales and have autonomy to decide how it will operate at local level.	Yes	No
The Welsh Government believes that introducing an independent mechanism to provide clinical advice on substantial service change decisions, **with advice from the proposed new citizen voice body**, will encourage continuous engagement and increase the pace of strategic change through enabling a more evidence-based, transparent process and a more directive and guiding role on the part of the Welsh Government.	Yes	No
The Welsh Government believes that ensuring a clearer underpinning legislative framework for HIW will help to foster closer integration and joint working with CSSIW and at the very least this should be taken forward.	Yes	No
However, we also believe there could be merit in considering a new body – for example, a Welsh Government Sponsored Body – to provide more independence in regulation and inspection and citizen voice.	Yes	No

Please include any comments:

Your name: _____

E-mail: (if applicable): _____

Your address: _____

_____

Please return to: Healthcare Quality Division Welsh Government Cathays Park, Cardiff CF10 3NQ	Or e-mail to: HQDMailbox@wales.gsi.gov.uk

☐ Welsh Government advises that: responses to consultations are likely to be made public, on the internet or in a report. If you would prefer your response to remain anonymous, please tick here.

Annex C

Services Fit for the Future White Paper - presentations to stakeholder groups (including pre-White Paper engagement meetings)

Date of meeting	Stakeholder Group
May 2017	
24/5/17	Community Health Council (CHC) Board meeting
June 2017	
29/6/17	Welsh Independent Healthcare Association
July 2017	
12/7/17	Heads of Inspection Group
21/7/17	NHS Wales Board Secretaries Group
21/7/17	Public Health Directors Leadership Group
27/7/17	National Quality and Safety Forum
August 2017	
02/8/17	Betsi Cadwaladr University Health Board
23/8/17	Aneurin Bevan University Health Board Development Day
September 2017	
7/9/17	Listening and Learning from Feedback Group
8/9/17	Welsh Clinical Audit and Effectiveness Association meeting
14/9/17	Monmouthshire County Council
18/9/17	CHC Board Joint Chief Executives
27/9/17	Mental Health Service User and Carer Forum

Annex D

Focus group events

Communities Connected were contracted by the Welsh Government in mid August to facilitate eight focus groups across Wales with participants drawn from existing networks and community groups with additional support from the Co-production Network for Wales. The location, dates, and number of attendees are outlined below:

Where	Date	Number of attendees
Neath	18th September	10 public/stakeholders
Wrexham	19th September	7 public
Pontypridd	20th September	16 public/stakeholders
Brecon	22nd September	8 public/stakeholders
Newport	23rd September	29 public/stakeholders
Carmarthen	26th September	9 public/stakeholders
Llangefni	27th September	15 public/stakeholders
Welshpool	28th September	3 public/stakeholders