Ombudsman Ombwdsmon
PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

# Response of the Public Services Ombudsman for Wales to the Welsh Government's Green Paper on 'Our Health, Our Health Service'

I welcome the opportunity to respond to the Welsh Government's Green Paper on "Our Health, Our Health Service". As Public Services Ombudsman for Wales (PSOW), I investigate complaints made by members of the public that they have suffered hardship or injustice through maladministration or service failure on the part of a body in my jurisdiction. As such, I have a unique perspective on the provision of public services in Wales, driven from the views of members of the public who have been dissatisfied with the service they have received. In particular, grievances about healthcare account for a significant number (currently 36%) of the complaints that my office receives. It is in this context, therefore, that I am responding to the consultation and my comments on various aspects of the Green Paper are set out below.

## Chapter 1: The changing shape of health care

### Promoting health and well-being

**3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people's health and wellbeing needs?**
Encouraging agencies to work together requires a cultural change which legislation cannot bring about. It is my view that legislation should state that there must be standards, but the standards themselves should not be legislated. It should impose a degree of regulation for agencies to collaborate but allow agencies to decide locally how this is done. I believe this also highlights an enforcement issue as it is unclear who oversees that agencies are working collaboratively.

## Chapter 2: Enabling Quality

### Quality and co-operation

**10. What would be the advantages and disadvantages of setting out in legislation the role of "responsible individual" for health bodies in Wales?**
From my experience of health complaints, it appears that an individual patient's care is overseen by a number of people, and there is no one person who takes overall ownership of their care. Addressing this issue would be far more beneficial for the patient than simply designating someone as the "responsible individual" for health bodies.

## Chapter 3: Quality in Practice

### Meeting common standards

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

I would welcome a common standards framework covering both the NHS and independent sector. This would provide clarity during the consideration of a complaint as to whether there had been an occasion of poor service, or indeed service failure. Furthermore, as I am also able to consider complaints about social care provided by the independent sector (included self funded care), having consistent standards extended out to cover social care too would also be beneficial to my investigations. Beyond the benefits to my office, I can only see this as being a positive development for those receiving health care and social care services. It should not be necessary for those in receipt of care to have to undertake a 'compare and contrast' exercise to understand what standard of care they are entitled to when moving from one type of service provider to another.

### Clinical supervision

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

I agree that there should be appropriate clinical peer supervision for registrants. However, there are already standards produced by the General Medical Council which state that this should be the case. Therefore, rather than developing new legislation, health professionals should adhere to current guidance and standards where they exist.

## Chapter 4: Openness and honesty in all that we do

### Being open about performance and when things go wrong

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

Yes, a statutory duty of candour should be introduced for whole organisations. I have previously put forward the argument that organisations should take responsibility of their own governance. Often, despite the findings from my investigations, senior management in organisations claim that nothing is wrong**.** Whilst I recognise that there already exists the GMC/NMC professional statutory of candour for individual practitioners, which is applicable across the UK, a statutory duty for health bodies in Wales as corporate entities would reinforce this.

**19. How could we use legislation to further improve transparency on performance in the Welsh NHS?**
I have expressed on a number of occasions my view that there needs to be a common approach to data gathering amongst health boards, so that potential differences in performance can be identified. The NHS Redress Measure 2008 and the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 already provide that health bodies must publish annual reports containing relevant data on the complaints received and the lessons to be learnt from them. My experience is that whilst health boards collect data, these are all in different formats or in differing levels of detail/analysis. Health boards also have different ways of using the same system (Datix). This means that data is not easily used, analysed or aggregated across the Welsh NHS. The National Assembly for Wales has recently issued a draft Public Services Ombudsman (Wales) Bill, which would provide the Ombudsman with a complaints standards role. If this comes to fruition, I would look to work with the Welsh Government on this problematic area.

**20. What legislative steps can we take to improve the joint investigation of complaints across the NHS and social services in Wales?**
The Model Concerns and Complaints Policy and Guidance issued by the Welsh Government in 2011 addresses this issue, Public service providers should have appropriate procedures in place for the conduct of investigations involving more than one service provider. The issue of joint investigations is also referred to in 'A guide to handling complaints and representations by local authority social services' issued by the Welsh Government in 2014. However, I would welcome any development to make joint investigation across the NHS and social services in Wales a statutory requirement.

## Chapter 6: Checks and Balances

**A seamless regime for inspection and regulation**

**25. Are there persuasive arguments against providing HIW with full statutory independence? If not, how should the law be reformed to best effect? What would be the implications of doing so for CSSIW?**
Whilst HIW is a body within my jurisdiction, I also have interaction with the Inspectorate in a different capacity. This extends to me on occasion referring to the HIW my investigation reports concerning other health bodies within the NHS, in particular those in respect of Local Health Boards. The reason I do this is to ensure ongoing monitoring of effective implementation of my recommendations.

In relation to providing HIW with full statutory independence, from the experience of my office I am of the view that the Inspectorate could operate more effectively if it had full statutory independence. I cannot see any persuasive arguments against providing HIW with full statutory independence. I will address the issue of implications for CSSIW in response to question 27 below.

**27. What are the advantages or disadvantages for citizens of a single inspectorate covering the roles and responsibilities of HIW and CSSIW?**
I would reiterate here comments previously made by this office during the review of HIW back in 2013. The nature of health care in Wales has changed enormously since HIW was founded. Large proportions of health care are now provided in the community and private nursing homes. I would suggest, therefore, that any review of the Inspectorate also needs to look at the current pattern of delivery of care where this takes place in a nursing setting or via domiciliary care. CSSIW increasingly employs health care professionals to enable it to carry out its work.

I would, therefore, suggest that in view of the increasing overlap between health and social care, an arrangement of two separate inspectorates is no longer fit for purpose. The fundamental issue facing services is how to support people, whether in relation to illness or disability. The configuration needs to be built around the rights of individuals to lead fulfilling lives in their own community where they are properly protected.

It is my view that there should be one inspectorate, covering both health and social care, provided with full statutory independence from government bodies. Such an inspectorate could also have the potential to bring about cultural change along with new processes.

**Representing patients and the public**

**28. Should CHCs' activities be refocused on representing the patient voice and on providing advocacy services? If so, how could we legislate to strengthen the CHCs role as representatives of the patient voice?**
The advocacy role of the CHCs is a valuable one and the experience of this office is that this element of the service that they provide, on the whole, works very well. CHC advocates can play an important part in helping complainants put their complaint to health boards/trusts and also, if the complainant remains dissatisfied, to this office and support them through the complaints process. In fact, I agree with the conclusions of the Williams Commission, that rather than duplicate some of the activities of other inspection and scrutiny bodies, CHCs should focus on the advocacy services and 'patient voice' aspect of their role. In fact, it is my view that there is scope to extend the role of CHCs in this regard to include a similar service in respect of social services.

## Chapter 7: Finance, functions and planning

**Borrowing powers**

**33. Should there be an equivalent statutory planning duty for NHS trusts as we have for health boards?**
I broadly support the proposal of an equivalent planning duty for NHS trusts and suggest that Trusts involve Health Boards when planning and vice versa. Trusts and

Health Boards deliver similar patient-focused services and therefore it seems logical that they would have the same responsibilities in terms of planning for the delivery of those services.

## Chapter 8: Leadership, Governance and Partnerships

**LHB size and membership**

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

From the point of view of holding the executive to account in relation to complaints and learning lessons, I believe that the current 'unified board' approach to the membership of a Health Board (that is, membership including both executive directors and non-executive directors) is problematical. I have already referred above (*see response to question 18*) to the fact that senior management on occasion refuses to acknowledge when things have gone wrong. The current level of executive presence on health boards makes independent scrutiny difficult and, I would venture, is not in keeping with good governance. This places an even greater onus on the non-executive members of the Board, who at the same time lack the dedicated support necessary to provide them with, or obtain for them, sufficient independent advice to enable them to suitably challenge the executive/management. To that end, I believe that the nature of the membership of health boards should be revised to enable proper independent scrutiny of the executive, and that they be provided with suitable independent support to conduct their governance and scrutiny duties.

**Public Services Ombudsman for Wales**
**November 2015**

**********