

# WLGA AND ADSS CYMRU RESPONSE TO THE CONSULTATION ON THE HEALTH AND SOCIAL CARE (QUALITY AND ENGAGEMENT) (WALES) BILL



CLILC • WLGA

**AUGUST 2019**



**ADSS Cymru**  
Leading Social Services in Wales  
Yn arwain Gwasanaethau  
Cymdeithasol yng Nghymru

## About Us

1. The Welsh Local Government Association (WLGA) represents the 22 local authorities in Wales, and the three national park authorities and the three fire and rescue authorities are associate members.
2. The WLGA is a politically led cross-party organisation, with the leaders from all local authorities determining policy through the Executive Board and the wider WLGA Council. The WLGA also appoints senior members as Spokespersons and Deputy Spokespersons to provide a national lead on policy matters on behalf of local government.
3. The WLGA works closely with and is often advised by professional advisors and professional associations from local government, however, the WLGA is the representative body for local government and provides the collective, political voice of local government in Wales.
4. As the national leadership organisation for social services in Wales, the role of the Association of Directors of Social Services (ADSS Cymru) is to represent the collective, authoritative voice of Directors of Social Services, Heads of Adult Services, Children's Services and Business Services, together with professionals who support vulnerable children and adults, their families and communities, on a range of national and regional issues of social care policy, practice and resourcing.

## Introduction

5. We welcome the opportunity to comment on the proposals contained in the Health and Social Care (Quality and Engagement) (Wales) Bill. We have welcomed the move towards a more integrated system with public services working together and the enhancement of honesty, openness and transparency throughout the NHS and agree with the rationale behind the Bill and its aim to improve and protect the health, care and well-being of the current and future population of Wales. We support the principles the Bill sets out that it seeks to achieve, building on the assets we have in Wales to strengthen and future proof our health and social care services for the future; facilitating a stronger citizen voice; improving the accountability of services to

deliver improved experience and quality of care for people in Wales and contributing to a healthy and prosperous country.

6. The Bill itself is focused on changes that in general will have a greater impact on NHS bodies, with an emphasis on improving NHS quality and performance. Some of these changes seek to place reciprocal duties on NHS bodies which would align with those duties already placed on local authorities and we welcome this approach to trying to ensure that both health and social care are based on the same footing. This should help as we move further towards a more integrated health and social care system. We are, however, mindful of current arrangements, powers and legislation that already exist to ensure that we have a coherent and consistent approach across all public services in Wales and the need to avoid duplicating work that is already underway. Our response considers the impact of the proposals from a local authority and social care lens and in particular considers the proposal to replace Community Health Councils (CHC) with a new Citizen Voice Body for health and social care in Wales.

### **Citizen Voice Body for Health and Social Care in Wales**

7. We fully support the need for meaningful engagement with the public and communities, with the voice of the citizen a crucial element in supporting the way in which health and social care is planned and delivered – it is essential that we enable the views and concerns of patients and service users to receive maximum prominence throughout the systems that we operate.
8. Given that CHCs were established over 40 years ago, the fact that they have not substantially altered in many years and the significant changes that have happened during the same period within the NHS, we agree with the need to make changes to the current model to ensure that patients' interests are adequately represented.
9. As highlighted in 'Moving Towards World Class? A Review of Community Health Councils in Wales', there were concerns about many aspects of CHCs' organisation and performance, including the size and composition of the membership, variable performance, their public profile, how they fit together with all the other health bodies, and the extent of their influence. The Commission on Public Service Governance and Delivery recognised that the work of CHCs appears to duplicate some of the work of other organisations, such as Healthcare Inspectorate Wales (HIW), in their role of inspecting health services; and the Public Services Ombudsman for Wales in his role of complaint investigations. As such we agree with the proposal that powers of inspection should principally rest with Health Inspectorate Wales (HIW) in relation to health services and Care Inspectorate Wales (CIW) in relation to social care services, rather than with any new Body. We also support the move away from CHCs being established as unincorporated associations which has required them to be "hosted" by Powys tHB. Establishing the new Body as an Executive Welsh Government Sponsored Body instead should help the Body to be seen as

more independent, with a reduction in the perceived conflicts of interests that are inherent in the current model.

10. Whilst we agree that there is a need to make changes to our current model, it is important to appreciate that changing structures will not result in good public engagement on its own. In England where CHCs were abolished in 2003, a House of Commons Select Committee Inquiry taking evidence on this issue heard that what matters is not patient and public involvement structures, but effective involvement of patients and the public. Structures and procedures will have little effect if the NHS is not prepared to listen and make changes as a result of what they learn. Effective patient and public involvement is about changing outcomes, about the NHS and social care providers putting citizens at the heart of everything they do and hence is about much more than structural change.
11. One of the most significant changes proposed for the new Body is that rather than just representing the patient voice in the health service as CHCs currently do, the new Body will exercise functions across health **and** social care. The Explanatory Memorandum (EM) highlights the findings for change evidenced from reports and reviews into CHCs in relation to how best the citizen voice may be represented more widely in relation to health. It then suggests that “these reports contain recommendations which are equally applicable to representing the citizen voice in social services” (p28), going on to say that there is, “widespread agreement as to the value and necessity of both (1) strengthening the citizen voice in modern social services and health care systems; and (2) closer integration of the two systems” (p29). However, there is no evidence provided to substantiate these claims, all of the reviews undertaken have looked solely at health and there has been no examination of social services and local authorities and their existing systems and arrangements. Page 27 references the role of Regional Partnership Boards (RPBs), their responsibility to ensure that local authorities and health boards jointly assess the needs of the people in their area as well as the requirement for citizen and carer representatives on each RPB, however across both social care and local authorities there is much more than this. We have concerns over how much consideration of these existing arrangements have been taken into account in the thinking of a new Citizen Voice Body and therefore how the new Body would align and work within existing systems without either duplicating or causing confusion to members of the public.
12. Local authorities are already under a duty to involve people in the design and provision of services under the Social Services and Well-being Act, and this is supported by the requirement for Regional Partnership Boards to have both service user and carer representatives, as well as an expectation that the boards will work with regional citizens’ panels, or other relevant groups, to ensure the citizen voice is heard to inform the development and delivery of integrated services. In addition, the then Minister for Social Services and Public Health established the National Social Care Partnership Board, which replaced the National Social Services Leadership Alliance, comprised of the Partnership Forum, Leadership Group, and the National Citizen Panel. The role of this group is to provide advice and support on the implementation of current government

social care policy, and on the development of future policies in the field of social care and importantly includes citizen representatives.

13. Significantly, there is no mention of any consideration that has been given to the role that locally accountable Elected Members play within the EM. A councillor's primary role is to represent their ward or division and the people who live in it, providing a bridge between the community and the council and being able to act as an advocate for local residents keeping them informed about the issues that affect them.
14. The Local Government (Wales) Measure sets out the governance requirements for Welsh authorities, which includes the need to have overview and scrutiny committees which call the Executive to account for their actions and to justify their future plans. The local government scrutiny role is integral to helping people feel they are able to influence what goes on in their locality. Scrutiny has an important role in stimulating connections between different individuals and groups, and channelling community intelligence into the improvement processes of the council and its partners. In this respect, the scrutiny function can be regarded as helping to both build and represent democratic capacity.
15. Whilst we fully appreciate the need to ensure the voice of citizens is at the heart of our health and social services we have some concerns over the current proposals as set out. For example, where the EM refers to the ability of the Body to be able to make, "representations to local authorities in relation to proposed change in social services" (p31). How does this fit with the existing scrutiny role played by Elected Members without adding another layer of scrutiny to the system? There is also the added confusion for members of the public over whether they should go to the new Body or their local Councillor to make any representations. If we are not clear and careful about roles and responsibilities, we risk creating a more confusing system for the citizen to try to navigate.
16. In our responses to both the Green and White Papers that led to the development of the Bill we highlighted our support for the need for changes to CHCs and suggested that this was an opportunity to ensure greater democratic oversight of the NHS, through locating some of the existing powers of CHCs within local government, something which requires further consideration. In particular, we put forward the argument that this was an opportunity to look at how and how far local authority's scrutiny role could engage in and support the scrutiny of Local Health Boards. It could help to address the "democratic deficit" in the NHS, while simultaneously giving councils an opportunity to, more powerfully, represent the views of their communities. Elected local councillors would be able to voice the views of their constituents, and hold relevant NHS bodies and relevant health service providers to account.
17. As set out at the moment there is a danger that the proposals to strengthen the voice of citizens across health and social services seek to address current weaknesses highlighted within health systems without the evidence that the same citizen engagement deficiencies exist within social

care. Further evidence is needed to justify the establishment of a body that would sit across both health and social care that takes into account the systems and processes already in place across both partners. This would help to ensure that we do not create additional structures under the banner of 'integration' that are only aimed at resolving issues identified for one partner but which could result in additional requirements and complexity.

## **Duty of Quality**

18. There is already a duty placed on local authorities under the Social Services and Well-being (Wales) Act to co-operate with their relevant partners, persons or bodies to ensure well-being and safeguarding of those who require care, and improve the quality of care and support needed. There is also a new regulatory framework with an emphasis on quality and improvement established by the Regulation and Inspection of Social Care (Wales) Act. Given these existing duties and framework it makes sense that a similar, reciprocal duty is also applied to health, aligning with those duties already placed on local authorities.
19. Legislation on its own, however, is not particularly effective in addressing quality. The main issues related to quality are cultural, training, resource and educational. Any legislation needs to be supported with the promotion and adoption of best practice, ensuring more involvement of staff, with strong leadership to improve quality.

## **Duty of Candour**

20. We support the introduction of a duty of candour which will fit with the measures already in place within social care aimed at ensuring social care staff operate openly and honestly. It will also be important to build in protection and support for those who raise concerns. There needs to be a focus on building a culture of openness, rather than purely legislating a contractual duty of openness. While you can mandate disclosure, legislation cannot deliver the attributes of high-quality and open communication such as empathy, sincerity and comprehensiveness that patients and service users expect. Staff need to be supported in fulfilling professional and ethical obligations to be open with patients and service users when things go wrong by providing ongoing support, training, mentorship and ensuring senior staff lead by example. Merely legislating a duty of candour will not accomplish the cultural changes that patient, service users and practitioners seek.
21. There is also a question over how feasible it will be for regulators to monitor behaviour under a regime of mandatory disclosure for adverse events both consistently and effectively and whether regulators are expected to and how they might enforce any sanctions for non-compliance with a disclosure.