

Note of a public meeting to consider NHS II consultation paper: 'Delivering the New NHS in Wales', Open University in Wales, 29th January 2009.

Attendees: Gwyneth Brywnant Jones, Ron Walton, David Smith, Max Wallis, Marcus Longley, Lorraine Morgan and Kevin Pascoe

Apologies & evidence from Emrys Roberts, Hilda Smith, Susan Maddox and others.

Apologies: Rebecca Thomas

Summary

Whilst the meeting welcomed the best efforts of the Minister to renew democracy within the new Wales NHS, it is impossible to properly comment on a future effective system unless consideration is given to a number of other relevant consultations, which have or are being separately consulted upon (i). This is not intended as a response to any consultation. Rather it provides an informed contribution from a varied citizens perspective, except that we comment upon the NHS II Professional Forum questions.

Which? HQ have a big slogan on the wall that says "The aim of Which? is to make consumers (*citizens!) as powerful as the organisations they have to deal with". For 'localism and partnership working' to be meaningful, this requires a shared vision, with co-ordinated action across local authority scrutiny, CVCs, CHCs, Health and Social Care and Wellbeing Network members, the new proposed Stakeholder Reference Groups and what ever replaces the Assembly funded Regional Patient and Public Involvement Forums. After all, it is our NHS service, and it means a lot to us. *By citizen we mean carers, patients, service users, relatives, friends, neighbours, which may include NHS employees/contractors and their families.

A fresh examination of how these different aspects contribute effectively to the new NHS in Wales, including a unified public health system, is urgently required. We use the term citizen engagement (CE) to mean a step change from the past language of 'involvement'. In a time of increasing financial stringency, we can no longer continue to treat CE as an 'add on' or an after thought. What is not always understood is that an operationally effective CE strategy provides some of the evidence that scrutiny, inspection, audit and regulation needs for evidence of good quality of care provision; not just clinical outcomes and financial efficiency. It is central to the reform process.

We await responses to key questions posed to the NHS Reform Team on CE. A shared understanding will be vital if we are to optimise patient safety, public protection and public health, and avoid future overlap and duplication. The stark warning by the Finance Minister about future public finances, should include the promise of new "web 2.0" approaches building on public, service user partnerships and engagement. In particular, innovative use of the web holds much promise for widening citizen engagement. We would then have a CE system that is fit for purpose in the 21st Century.

(i) We include the CHC Review, published 30th January 2009, 'Audit, Inspection and Regulation in Wales', 'Local Authority Social Services Inspection, Evaluation and Review Process – A New Framework', the Unification of Public Health Services in Wales' consultations, but not the CHRE Health Professional Regulators Performance Review criteria. Please note the original text has been amended to illustrate the relevance of establishing a cross organisational CE strategy, including the new Public Health NHS Trust and CSSIW.

1. Introduction

WAG is holding several formal public consultation sessions, for some stakeholders, but it was thought valuable to bring together a small group of different people and experiences to consider the proposals from the perspective of the citizen and CE. The separate consultation on the role of Community Health Councils had not, as expected, been issued at the time of our discussion. It followed on the 30th – see later. Only a few individuals have had time to comment on the Unified Public Health Services consultation, available in a hard copy format on 9th February 2009. All references to the NHS include this consultation.

The NHS II consultation paper proposals are, in our view, very much along the right lines and will hopefully result in less bureaucracy and a greater desire to listen and act on the views of both service users and service providers. To be effective, fresh thinking is required across all the different facets that currently give the citizen voice, rather than each working in isolation and be independent of the NHS. How do we align all the CE interests and use existing scarce resources more effectively, with a more effective relationship between citizens and inspection functions of statutory bodies, and the public protection and patient safety roles of professional health regulatory bodies?

2. Citizen Engagement (CE)

What is absent from NHS II is a statement setting out the real added value of effective CE, which will be essential for successful reorganisation. Although statements are rightly made about the importance of CE, this is treated in a fairly mechanical way in the NHS II consultation and unrelated to other relevant developments, for example, the CHC Review and the Audit, Inspection and Regulation in Wales consultations. It is not considered worthy of consideration in the Public Health document, although this issue has been previously raised with the Public Health Framework Strategy manager.

CE does not start on an equal basis with other very well resourced professional interest groups. Without this understanding of the need for adequate resourcing and support, too much reliance can be placed upon voluntary effort, which is much less effective than it should be. This aspect will become increasingly important as we move into a new era of financial restraint and a growing emphasis on community based services, which are outside the traditional remit of CHCs. In the context of managing increasing costs of health service delivery, it is also noted that the Wanless emphasis on the significance of 'full public engagement' is an essential ingredient in managing public expenditure in a future 'age of austerity'.

Although hardly mentioned in the 'Audit, Inspection and Regulation in Wales' consultation, professional health regulatory bodies, such as the NMC, GDC, HPC and the GMC are all striving to find new ways of engaging with service users. For example, the Professional Health Regulators PPI Forum recently organised a UK consultation on how the needs of a growing diverse older population could be met by health professional regulators. How we reap the full benefits of professional regulation to achieve improved quality public service delivery can be found in detailed proposals made in relation to the proposed Professional Forums – see later.

3. LHB Board appointments and Citizen Engagement (CE)

A question was raised about the vagueness of the remit of the two (of five) LHB non-executive directors contributing community knowledge and understanding. To help drive the process of continuously renewing NHS democracy and public confidence in the new NHS Wales, the view was expressed that there should be a new focus at the LHB Board level on (a) patient safety/public protection and (b) CE strategy. The two NEDs should be specifically appointed to focus upon this agenda and to support the specific role of the LHB vice chairperson's public health remit.

It is noted that the role of championing 'patient safety' extends well beyond the 'cleaning' role indicated in the NHS II consultation paper. For example, medicine management, to prevent overdosing of very old patients, which may cause them to become unsteady and fall in hospital leading to fractures and death; adequate nutrition and hydration resulting in improved recovery and reduced possibility that frail patients will return to hospital; or those Health support workers who have little or no adequate training in infection control.

For public accountability to become meaningful, particular significance is attached to ensuring that the public appointments criteria clearly explain the essential and desirable qualities and experience required of these two specific NEDs. We can offer specimen details to the Public Appointments Unit or the NHS Reform Team, if required.

In addition, at the minimum, the Minister should review guidelines for carrying out competence linked appraisals for these two NEDs and the chair and vice chair organisational roles at (NHS) national, regional and 'local' levels so that the framework of rules which govern the way the organisation deals with key issues and objectives is reflected in the performance criteria across all competency units

We assume that the NHS reform team will be working with the National Advisory Board to prepare a higher-level guidance for Citizen Engagement guidance for all, including the new LHBs, local authorities, and the new Public Health system. This will be far more effective in ensuring a meaningful CE framework, with a new system enabling an iterative process between patients, carers, service user and other interests. Such a system, including the annual presentation by the chair of the Board of CHCs to the National Advisory Board and the Public Health Service NHS Trust, should be supported through new "web 2.0" approaches.

4. New "web 2.0" approaches

New "web 2.0" approaches building on the recent developments in public, service user partnerships and engagement, and in particular, innovative use of the web holds much promise for widening patient and citizen involvement in an efficient and egalitarian way. The potential of new "web 2.0" approaches to enabling widespread public engagement at low cost could be valuable in rural areas. Active consideration should be given to the Welsh Assembly, LHBs and others funding and supporting the pioneering work of Patient Opinion (<http://www.patientopinion.org.uk>), which would support the work of a number of partners.

Patient Opinion, a social enterprise, is currently geared up to receiving comments, views, ideas, suggestions and complaints from citizens in Wales. The way to make this bottom up approach a reality is for patients, service users, carers, relatives and friends to use this facility. Could this service be championed by CHCs in Wales; carer, children and age organisations; members of WCVAs Health, Social Care and Wellbeing Network and associated alliances and networks? Could Patient Opinion be invited to Wales to present their work and answer questions?

Should such accountability arrangements be developed to support the development of work plans for the new Public Health Wales NHS Trust? Could CSSIW support a pilot to enable service users and carers to have an opportunity to provide feedback on specific residential homes in Wales? Do we need a cross organisational approach, but one which is independent of service providers to promote and support Patient Opinion in Wales?

Overall, these suggestions could also help improve consistency between the new LHBs, inform the appraisal process for LHB Boards / Public Health Wales NHS Trust chairs and vice chairs, NEDs, executive team members, and support a process reflecting local needs and circumstances. If requested, we could assist in drafting appropriate high-level National Advisory Board CE guidance, which is currently missing.

5. Minimise overlap and duplication

Structures and guidance should help minimise overlap and duplication, avoid citizen fatigue, social exclusion and frustration, and ensure proper co-ordination with all relevant local bodies, some of whom may have their own CE strategy. It is necessary to understand that third sector organisations provide local connections with a multitude of specific interests and geographic representation, and links with national voluntary bodies. This should be properly supported by the contribution of independent local Health, Social Care and Wellbeing facilitators, who should continue to be employed by CVCs, and provide a valuable source of information direct to the two NED's, CHCs and independent appointees to the Public Health NHS Trust.

Independent local Health, Social Care and Wellbeing facilitators have the potential to support the necessary engagement with all health, social care and wellbeing groups, but this will need to be monitored. This is significant because those experiencing social exclusion are far greater in number than those covered by the Communities First programme. In this way it should be possible to optimise the potential for seeking out 'hard to reach' groups, whilst sustaining a dialogue with the LHB Board and the Public Health Wales NHS Trust, without the new bodies duplicating work already undertaken by existing partners.

6. Stakeholder Reference Group (SRG)

As presently outlined, the SRG does not provide a vehicle for citizen's views to have an impact upon services through the new LHB Board, especially since it excludes professional health stakeholder interests. For example, GPs who are able to combine an intimate understanding of relevant local services and are well placed to act as the patients champion. In what sense can the SRG be called 'Stakeholder' when the main focus of all this provision is excluded?

Two alternative models were considered, with a third very interesting model being provided by Emrys Roberts.

With the first two models, a number of elements in each are not mutually exclusive.

- Both share the perspective that the proposed SRG model would be relatively weak, with limited impact upon the LHB Board.
- Where CHCs are not performing to an optimum standard, neither would they attract people of sufficient quality to really make a difference.
- A key element in both models is the extension of citizen engagement in the public health, health and social care services, which will be crucial in a period of increasing pressures on public expenditure.
- With both models it would be necessary to reach out to a much wider group of citizens than those mentioned in the consultation.
- The economic, social and political significance of CE in a growing ageing society.
- Both models would involve two thirds of NHS users who are older people - unmentioned in the consultation, yet producer interests, such as the police and fire service are included.
- Hilda Smith's proposed that each LHB should actively consider the concept of a 'Council of Elders', supporting professional education. This as an explicit method of valuing the wisdom of our elders.
- Active use of new "web 2.0" technologies drawing upon the expertise of Patient Opinion.

Model One – Citizens Engagement Forum

The first model was to create a Citizens' Engagement Forum to focus upon monitoring the Board's patient safety /public protection, public health and citizen engagement strategy. The Forum would have direct access to the Board's Audit Committee on a quarterly basis and meet with the Professional Forum, twice a year to ensure good communication across all stakeholder interests.

The CE Forum should include specific initiatives designed to elicit the contribution of frail older people. For example, through the establishment of a 'Council of Elders' (c.f. 'A council of elders: creating a multi-voiced dialogue in a community of care' AM Katz, L Conant, TS Inui, D Baron, Social Science & Medicine, 2000, Elsevier Science Ltd). It is proposed that this development be undertaken in co-operation with the National Partnership Forum for Older People.

The CE Forum should be populated through a public appointments process to ensure a geographical spread across each Parliamentary constituency and one that includes a range of competencies to positively challenge the executive in a spirit of co-operation. Working in partnership with the CE Forum, it is proposed that two LHB Board members should focus upon patient safety/public protection, public health and citizen engagement strategy. This will require particular essential and desirable qualities and experience to support the public appointments process. It was considered that this would be a tighter focus in structuring the work of the SRG, in parallel to the work of CHCs and local CVC Health, Social Care and Wellbeing facilitators. It is suggested that the Citizens Engagement Forum would meet in public and be supported by new "web 2.0" approaches.

This could replace the existing Assembly Government regional Patient and Public Involvement Panels, currently supported by officers from the Patient Experience Team - Quality, Standards & Safety Improvement Directorate, Department of Health & Social Services.

Model Two – modified SRG

The second model retained some elements of the SRG, but would seek to strengthen its role by giving it a decisive role in the future appointment of the Board chair and vice chair. (Compare the appointment process for the Commissioners for Children and Young People and Older People). Further, that alternate meetings of the Board should be with the SRG, with an ability to shape the Boards agenda and a scrutiny role. In terms of public contact, they could have a target of 3% of the population within two years. The intention being that the LHB would commit itself to the same level and type of engagement required of English Foundation Trusts.

The concept of a CHC regulator was considered, perhaps with some lessons being learnt from the role of Monitor, in relation to English hospitals with Foundation Trust status. Some felt that setting a 3% target was mechanistic. Quality was an equally important consideration and the LHB contribution to CE strategy should be seen as part of the whole, rather than seeking to duplicate what already exists.

Model Three - District Health Planning Teams - Localism and Partnership Working

The third model focused upon the Assembly Technical Working Paper: 'Localism and Partnership Working'. It is argued that this can best be achieved by a system of District Health Planning Teams – one for each unitary authority. These teams should include a Mental Health Promotion specialist, a Public Health Leader not necessarily 'medical doctors', representatives of local GPs, Community nurses, local statutory and voluntary service providers, the Community Health Council, service user and carer representatives and general local community interests. It is essential that the medical model should not dominate. Therefore a template of planning for public health should be adopted. Local Health, Social Care and Well-Being Strategies would fit and influence here, guided by an agreed Public Health Strategy framework. This would replace the proposed SRG.

The Team should be led and co-ordinated by a District Health Co-ordinator responsible to the new LHB with a (very) small number of support staff – perhaps one admin worker, and one collator of views and information from published sources and from local partnership/consultation exercises – although it is recognised that some flexibility and variation in size according to population would be required. There would also be scope for close dialogue with the proposed CHC Area committees and local CVC health, social care and wellbeing facilitators.

The Team's remit, with local authority and perhaps Public Health NHS Trust support should be to identify the health and social care needs of the local community and propose how those needs should be met within a priority framework. Its recommendations should be submitted for approval to the relevant Local Service Board and to the new LHB for action.

The LHB might ask the District Health Planning Team to implement any agreed proposals for improving community services. The LHB itself would need to action proposals for improvements to secondary and tertiary services and consideration would need to be given to joint planning between public health, health and social care.

7. Commissioning

In the above context, in our view, it is wrong to suppose that because the internal market is being abolished there is no longer a commissioning role. Commissioning is a means of ensuring that agreed plans are put into action. The new LHB, incorporating as it will service provider functions, will be much better placed than the District Health Teams themselves to ensure plans are translated into practice in the secondary (and other more specialist) care services.

In our view, the smaller local LHBs now to be abolished were far too small and lacked the expertise to cope with planning and commissioning functions, especially when they had little influence over the major service providers. The structure now proposed will help to rectify that weakness, but the one strength of the small (old) LHBs – their ability to relate to local communities and identify their real needs – should not be lost in the restructuring process.

8. Political and social legitimacy

In our discussion it was emphasised that the particular values of the SRG or Citizen's Engagement Forum could provide a much wider basis of support from citizens in their communities and lead to increased legitimacy and influence, especially if this is supported by new web 2 technologies. Another view was that local authorities had the legitimacy, independence and resources to effectively challenge LHBs, although some local authorities could be much better placed and inclined to do so than others.

In anticipation of the CHC Review paper there was discussion of whether CHCs might take on an extended role in terms of citizen engagement. The comment was made that at present there appeared to be a lack of consistency in the performance of CHCs across Wales as well as wider public recognition. They would need to focus on engaging a much wider group of citizens, including children and young people. There are examples of this kind of development in some CHCs, but it is patchy at present and unlikely to be made easier in the present financial situation. In any event, this needs again to be considered as part of a wider CE strategy, with each organisation playing to its strengths and contributing to the whole. *The role of CHCs in relation to the Public Health Wales NHS Trust requires careful consideration in drafting appropriate CHC and Trust regulations.*

9. Accountability and resources

Whichever model is adopted in the new NHS frame work there would be a requirement for independence, and for the SRG / Citizens Engagement Forum / CHC (not WAG) to provide an annual report on its progress in engaging with citizens and its impact upon LHB priorities, policy and service provision within the national framework. One suggestion is that it should be included in the annual report of each LHB and the Public Health Wales NHS Trust.

One of the reasons for the CHCs patchy achievement in citizen engagement is the lack of resources. If the reformed NHS in Wales is to empower citizens to be involved in influencing health (and social care and public health) policies then both cultural change and additional resources will be required.

In their absence there is a high risk that none of the models will achieve effective citizen engagement, with the current imbalance of power remaining with the providers of Welsh services and the professions. The latter already receive resources from the public purse for their professional advisory committee structures and National Advisory Forum. However, it is noted that the WCVA Health and Social Care Network is proposed as a future national reference group, yet they do not receive any public financial support. This anomaly requires attention.

10. Citizen engagement, the new Wales NHS

A citizen engagement (CE) strategy, which is operationally effective, provides some of the evidence that scrutiny, inspection, audit and regulation needs for evidence of good quality care provision; not just clinical outcomes and financial efficiency. What we experience is a piecemeal consideration of CE, whilst this is stated as being central to the reform process.

This requires a simple statement on:

- The value of cross organisational CE strategy;
- How this contributes to the new Wales NHS;
- Quality services, patient safety, public health and public protection;
- Clarity on the role and responsibility of each part of the whole; and
- Decent lines of accountability to assure public confidence.

The parts include: local government, the Public Health Wales NHS Trust, CVCs and local Health, Social Care and Wellbeing facilitators, CHCs, statutory regulators and professional social care and health regulators. In respect of audit, inspection and regulation, citizen engagement means involvement in both the inspection **and** the standard setting process. For example, pre and post registration education and training, professional revalidation and 'fitness to practice' machinery.

11. The Professional Forum (PF)

Question: There are a number of important issues about the LHB Professional Forum on which this Consultation Paper seeks your views. Below are responses to two questions. It is important to note that at the National level, the WCVA Health and Social Care Network does not receive any direct financial support from WAG, apart from some officer time. In contrast, we as taxpayers actually fund Welsh civil servants to support the individual professional advisory bodies and the overall Professional Advisory Forum.

- *Will the Professional Forum provide an appropriate vehicle for the generation of professional advice to the LHB Board?*

How will the views of aspirant professional groups be heard and the voice of health care support workers – who will become an increasingly important part of the healthcare team?

- *How should it operate to ensure maximum effectiveness?*

The Welsh health professions have a range of advisory groups and a Welsh Advisory Forum. Both enjoy a publicly funded secretariat. But as Sir Ian Kennedy pointed out when considering the future of professional healthcare regulation “public participation in this process serves as a warranty that the public’s interests are being safeguarded and as a reminder that the profession exists for the public” (‘Learning from Bristol’ 2001, page 405).

The potential of professional health regulation to help drive improved public service delivery has been much neglected in relevant Assembly Government policy statements. The latest consultation ‘Inspection, Audit and Regulation in Wales’ (2009) is no exception.

As a consequence of steady work undertaken in recent years, the Board of Welsh CHCs recently recommended to the Health and Social Services Minister that a Public and Patient Professional Regulation Advisory Group be supported. This is a neglected key component in striving to improve public protection/patient safety and the quality of healthcare in Wales.

The proposed functions and future areas of work are set out below, currently operate on a voluntary basis and are worthy of public support as we deliver the new NHS for Wales.

Advisory Group Functions

- (a) Receive reports and monitor the implementation of professional health regulation in Wales;
- (b) Ensure that professional regulators work closely with employers to ensure that patient safety is paramount;
- (c) Be a focal point for Ministers, officials, and professional regulators for the patient, service user, family carer and wider public;
- (d) Provide advice and support and to complement the work of other Welsh based organisations;
- (e) Ensure the Minister and Health service providers are informed of patient and service user perspectives in making the impact of professional regulation real in improving health services in Wales.

Future areas of work

Subject to funding, over a two-year period, could include some of the following:

- (a) Championing the development and implementation of a new Nursing and Midwifery Council code specifically addressing care needs of older people;
- (b) Medicines administration (safe prescribing through to safe management);

- (c) Public engagement and the future regulation of Health Care Support Workers and nurses in Wales;
- (d) Nutrition, fluids and nutritional care needs of older people;
- (e) The revalidation of GPs in Wales;
- (f) Quality Assuring health personnel who are increasingly working in peoples homes;
- (g) Monitoring, evaluating and supporting public engagement strategies of professional regulatory bodies in Wales.

It is unclear how the Minister has responded to these issues in recent CHC Board correspondence.

12. Initial Conclusion

In conclusion, even if additional resources are made available to support their local area committees, some of us have doubts about whether the CHC review will bring about the desired consistent effect across Wales. If, as someone argued at our 29th January workshop, CHCs lack public profile, legitimacy and independence, how will the patient and service user voice be heard and acted upon?

If local authorities are to have a more central role in holding LHB's to account, how will they engage citizens and service users in their processes and how do we ensure that they allocate sufficient resources in their social care budget and in the joint planning of health and social care?

New "web 2.0" approaches building on the recent developments in public, service user partnerships and engagement, and in particular, innovative use of the web holds much promise for widening patient and citizen involvement in an efficient and egalitarian way. The potential of new "web 2.0" approaches to enabling widespread public engagement at low cost could be valuable in rural areas. The new Wales NHS Active should actively consider funding and supporting the pioneering work of Patient Opinion (<http://www.patientopinion.org.uk>), which would support the work of a number of partners.

We hope this note contributes to an important debate and we will be pleased to receive comments.

13. Following the workshop - reflections on the CHC review document

Following the workshop, we received comments from experienced and committed former CHC members:

Person A

- What is on offer is not markedly different from what we have at the moment, except that the whole CHC mechanism is more centrally driven.
- The CHC review proposed local area committees, but this will not be effective unless resources are made available to sustain extra work, especially were areas are currently underperforming.

- Ambiguity still remains within the NHS II consultation. There is much mention of localism and the importance of the third sector, but it is not at all clear how this chimes with the CHC role and the call for greater direct engagement by citizens.
- The 1974 CHC model is no longer fit for purpose in that citizen and service user expectations go beyond health, and now combine health and social care solutions.
- The remodelling of CHCs should have prompted an opportunity to integrate consideration of health and social care issues, noting the local authority and third sector role on both the CHC and SRG. Does this lack of progress, at a pivotal juncture, reflect the absence of thinking through these issues involving different political structures, with much less political control of social care experience and how this varies across Wales? This leaves unanswered the question of the beneficial impact of social care spending on the care and wellbeing of older people, as compared with an extra pound spent on the NHS.
- It is a great pity that we still have two separate planning structures for health and social care within WAG, with some liaison, but not effective co-planning.

Person B

- New CHCs will be faced with large bureaucratic, centrally managed organisations, focused upon the demands of Ministers and senior civil servants. A greater sense of strategic action will be required for CHCs to impact in this new environment.
- As a starting point, CHCs should have access to all patient/service user complaints, suitably anonymised, and automatically notified of investigations related to service user safety/public protection and the action taken by the employer/the professional regulator (if any) to prevent failures in the health system/approach to regulation.
- To avoid a tick box approach to the patient/service user experience will require a new approach to developing a system, able to use information technology with a human face to highlight issues, concerns, priorities and areas for improvement. With local authority agreement, given the large number of older people using the public library service, could they be used to key in information once people have recovered from illness.
- The effectiveness of the new arrangement, with all the extra duties envisaged, will depend upon the effectiveness of CHC staff, chairpersons and lay members – their training, mentoring and support – which should be informed by new and imaginative methods of data capture and reaching out to people. See, for example, the attached food survey questionnaire, which is also available on line. <http://www.welshfoodalliance.org.uk/survey>

Person C

A Cardiff patient brought to our attention a GP survey being undertaken on behalf of the Assembly Government. The problem is that it did not provide an opportunity to raise concerns inside the surgery. However, this could be achieved at little if any extra cost to government, through the professional health regulation branch of the Assembly who could promote and support patient involvement through promoting and supporting patient involvement in 360 degree questionnaires to be used as part of the GP revalidation process. See previous submission by David Smith, dated 31st December 2008. Why can we not use new web technology to enable citizens to comment directly on services provided in GP practices and more generally across the NHS and social care?

Person D

A former regional health authority member brought our attention to English NHS developments. She discovered that from 1 April 2009, http://www.kingsfund.org.uk/publications/articles/proms_counting_what.html the NHS will become the first health system in the world routinely to collect patient-reported outcome measures. Newly released guidance for PCTs and hospitals sets out what needs to be collected, when, and by whom and how the new data will be integrated with other routine patient statistics.

The NHS Standard Contract makes it a requirement that the monthly clinical quality performance report should include patient-reported outcome data for four areas – operations on hips, knees, hernias and varicose veins. Nationally, (England) this should mean around 250,000 patients a year will be reporting on the state of their health.

The Kings Fund says, "It's hard to overstate how profound the impact of PROMs could be for the NHS, patients and the public. For the first time there will be a quantified measure of both the generic and disease-specific quality of care patients receive from the NHS. PROMs go way beyond simply asking 'Are you satisfied?' Using detailed questionnaires they will elicit patients' assessments of aspects of their health-related quality of life – how mobile they are, their mental state, their overall health etc. Similar questionnaires have been used for years in clinical trials and more recently by BUPA to evaluate their consultants' quality of care and to feed back to patients".

Meanwhile, issues concerning more effective patient and public engagement in the Clinical Governance process have been raised, but this has elicited no response from the responsible official.

David Smith
Policy Advisor, Welsh Food Alliance and the former Welsh Lay Member of the CHRE

16th February 2009