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Patient and Public Involvement in Healthcare Governance

Summary and Institutional Recommendations

Wales

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1. Summary and conclusions

1.1. English and Welsh health policy began to diverge significantly after England turned back to markets and competition in 2002. Wales was unwilling to replicate English policies on Foundation Trust hospitals and Independent Sector Treatment Centres (ISTCs) and did not introduce standard tariffs for contracted treatments. As an alternative to the arms-length regulator the Healthcare Commission, whose predecessor had operated in both countries, Welsh policy makers created a new body, Health Inspectorate Wales (HIW), which remained within the Assembly Government. The English patient choice policy was widely perceived in WAG circles as a building block in a consumerist healthcare market. Welsh policy makers preferred to emphasize improved service integration and PPI policies centering on representative local bodies and opportunities for collective 'voice'. PPI activity continues to be steered directly from the central departments, though with the fresh twists associated with the policies of localism and small-country governance.

1.2. After 2002 when England began introducing new patient choice policies, Wales adopted a more incremental approach to reform, building on existing structures. The WAG's first major policy document, the NHS Plan for Wales, articulated a vision of partnership encompassing patients and communities (NHS Wales 2001a). Patient choice was not ruled out, but it was patient 'voice' – the right to be informed, to express views and be understood – that received explicit endorsement. The Plan laid the foundations for what was to be called the 'new localism' of the NHS in Wales. The creation in 2003 of 22 Local Health Boards (LHBs) operating alongside local government authorities, with 'co-terminosity' of purchasers in the two sectors, was something that did not apply to English PCTs. Together with the retention of Community Health Councils (abolished in England in 2003), this was the central plank of the Assembly's strategy to bring a greater local voice to NHS decision making. The institutional infrastructure to support PPI policies was developed through initiatives at various levels. As far as NHS bodies are concerned, NHS Trusts and LHBs were required to undertake a baseline assessment and annual reports on progress regarding PPI, which are an element in the performance assessment framework monitored by WAG. Practical suggestions for the elaboration of Welsh PPI policies were set out in the guidance paper, *Signposts* (NHS Wales 2001b) and *Signposts 2* (NHS Wales 2003). At the community level, a number of umbrella social development programmes such as *CommunitiesFirst*, provided project-based funding for schemes initiated by local people and organizations.

1.3. WAG made no attempt to link policy on PPI to patient choice as in the English Choose and Book reforms, but introduced a Second Offer scheme in April 2004, offering an alternative treatment option for patients experiencing excessive delays on surgical waiting lists. Initially this scheme offered treatment at a second hospital for patients waiting more than 18 months, but the threshold was reduced to 12 months in March 2005. Currently the WAG Health Department is in the final stages of implementing its strategy to reduce maximum waiting times to 26 weeks within 3 years

('Access 2009'), and it is anticipated that this will lead to a winding down of the Second Offer scheme. Welsh policy makers were clear that Second Offer is not a patient choice mechanism designed to shape referral pathways and patterns of service purchasing, and the initiative is primarily about reducing waiting times. HIW currently assesses the performance of NHS bodies against the Welsh Health Standards, last revised in 2007. Patient Experience is one of four domains to which the Welsh Healthcare standards apply, with at least four standards relating directly to PPI. While at first sight HIW's remit overlaps with that of the Healthcare Commission in England, it has been created as a traditional inspectorate and lacks the Commission's wide-ranging enforcement. powers.

1.4. As time passed and Welsh policy makers began to articulate a clearer alternative to the English policies, the big idea that emerged was small-country governance: the notion that limited scale made it possible to make better connections between local service delivery organisations and achieve greater responsiveness to citizen needs and wishes. The policy document *Making the Connections* (WAG 2004) set out the case for an integrated, collaborative model of public sector services, better suited to Welsh conditions than the English model of autonomous provider units in a quasi-market. Options for the operational implementation of this vision were discussed in the 2006 Beecham Report (WAG 2006), which proposed a revamping of government and service delivery organizations to achieve better integration at both central and local levels. Beecham suggested the creation of multi-agency, 'local service boards' (LSBs) in each local government /LHB area, which would further strengthen engagement with communities. Six pilot LSBs were created in 2007–2008, with a plan to establish boards in all the 22 local government areas in 2009. At the present time the small-country governance model remains largely aspirational, with much depending on how the policies are implemented. In the PPI arena, there are question marks about whether connections across the central departments can overcome what might otherwise appear as complexity and fragmentation of responsibility, and how far local representative bodies engage in a meaningful sense with communities and citizens.

1.5. Just as in England, both centralizing and decentralizing tendencies persist. The Welsh system places considerable power with the executive, which appears likely to carry forward in such areas as direct Ministerial oversight of delivery plans at the local level. At the same time, public bodies make routine use of many of the new public management-style tools and instruments developed since the 1980s. Thus in the PPI field in Wales, as across the border, there is a mix of organizations bound by statutory duty, hierarchical command, contract or voluntary participation. Within the NHS system, new public management tools such as performance management against standards and the 'balanced scorecard' (a tool for weighting policy priorities) are much in evidence. The major difference from England is that there is little attempt to use competition, contestability or external regulation to create appropriate incentives. Rather regulation of the system is achieved mainly via continuing central steering, linked to the democratic accountability of the WAG to the Assembly.

1.6. The future direction of PPI policies was thrown into doubt by proposals to end the NHS internal market in Wales published in 2008. The latest restructuring, which is still ongoing, appears to foreshadow a return to centralism and seems to threaten the 'localism' associated with LHBs, LSBs and the associated PPI policies. The proposed

unified bodies (legally constituted as LHBs but known as 'health boards), will mostly absorb two to three old LHBs and one NHS Trust. Except for Powys health board (where a one-to-one relationship with local government will remain, the health boards will align with two or three local government authorities, and the co-terminosity of the old LHBs and local authorities will thus be lost. The principle of securing democratic accountability via inclusion of local government representatives on NHS bodies will be weakened. The 2008 Consultation Paper acknowledged that: 'With fewer organizations, patient and public engagement will have to be secured in new ways' (WAG 2008, p.6) At the time of writing it appears likely that CHCs will play an important role in the new system. Larger merged CHCs covering the same areas as the health boards will operate from April 2010, but these will include local committees which retain co-terminosity with local authorities.

2. Implications and recommendations

2.1. The Welsh case: can social learning occur in periods of rapid change? The NHS in Wales is presently undergoing a period of rapid change with the ending of the internal market and the restructuring of the Trusts and LHBs. This raises the questions of whether organisational memory is lost, past lessons are remembered, and existing lines of PPI policy are maintained. In crude terms the levels of social learning delineated by REFGOV include: (a) the progressive move towards governance forms that promote efficient operation (as predicted by transaction cost economics) (b) the development of relational networks and deliberative capacities; and (c) institutional mechanisms to promote democratic experimentalism and reflexive learning (conscious attempts to build learning into policy making), and (d) cognitive reframing and identity transformation on the part of key actors in healthcare networks (so as to transform these networks in a more fundamental way). At face value these processes rest on a kind of evolutionary process, where successive adaptations occur as social learning occurs. It might be assumed that social learning and adaptation occur best in periods of relative system stability where solutions for emergent problems can be developed over time.

There is, of course, the possibility that organizational reform can result from other factors such as a change of government (and political values) or an external crisis such as the economic slumps that affected Europe in the 1960s and Asia after 1997. Certainly there has long been a strand of policy analysis that recognises that periods of progressive policy adaptation may be interrupted by changes that *do not* build incrementally on what went before. 'Punctuated equilibrium theory' (Baumgartner and Jones, 1993) is perhaps the best known contemporary exemplification of this approach. A variant is the distinction drawn between crisis-ridden policy reform and politics-as-usual reform, 'where change is incremental, with considerable scope for trial and error or scaling up if initial efforts provide positive results; and more time is available to decision-makers for studying the implications of change, and policy elites are able to determine the extent to which it will be actively pursued' (Grindle and Thomas, 1991: 86-89).

It is by no means clear, however, that the existence of key turning points or external contingencies negate the long-term significance of social learning processes, even if these processes are understood largely in evolutionary terms. Gradualist conceptions of

policy evolution do indeed requires a period of stability when incremental development can occur, but it may be true that rapid organizational transformations can yield lessons for future policy. There is a parallel here between the policy studies field and debates in evolutionary biology between the advocates of phyletic gradualism and punctuated equilibria (cladogenesis) in evolutionary biology (see: Eldredge and Gould, 1972). Indeed the punctuated equilibrium theory mentioned above illustrates how these ideas have passed across into policy studies. The point for our purposes are that both types of evolutionary change carry possibilities for social learning, and in the present Welsh context we must be alive both to the possibility that initiatives and ideas developed over some years will have a continuing impact and that new elements may be introduced into PPI policies as a result of change driven mainly by political factors. Certainly among the enthusiasts for biological cladogensis it is the short periods of accelerated change (produced as new mutations emerge) rather than the long periods of 'statis' that are critical, and possible parallels with social learning in the policy field need to be considered. At present it is too early to suggest definite conclusions on the relative impact of these factors in the Welsh context.

2.2. Social learning as a policy objective. In the present turbulent conditions Welsh policy makers face the challenge of keeping service restructuring plans on track at a time when sharp reductions in service budgets are being demanded by central government. The focus is on immediate problems and arguably officials and senior managers are more preoccupied with 'fire-fighting' than with cumulative policy development. Yet it is important to keep sight of a social learning dimension to policy making, and in particular not to forget lessons that has emerged from the period of steady incremental development of PPI policies. The risk is that PPI will be put on the backburner as financial and efficiency pressures dominate managerial agendas, and that the new structures will fail to incorporate the collaborative and relational aspects of the previous arrangements. In particular it is important to keep hold of the distinctive perspective on citizen engagement that Wales was beginning to articulate.

2.3. Social learning and small-country governance. While England pushed ahead with ideas about the regulation of a pluralistic system, Wales developed an alternative vision based on the virtues of localism and small scale. This promised to strengthen engagement with communities and make connections between local organizations and groups that had previously lacked capacity and institutional support. If, as the current policy discourse states, public engagement continues to be a feature of the new NHS Wales as much as the old one, it is important to align the new institutional arrangements with the system of local service boards (LSBs) that were in the process of being set up and to protect local networks that were beginning to emerge. Early Welsh PPI policy gained considerable momentum as a result of the *Signposts* and *Signposts 2* guidance papers. Arguably that momentum has been lost recently, and given the uncertainty generated by the present reorganization, we recommend the preparation of a further major policy paper in the PPI area. This needs to chart a clear path for the future development of PPI in the context of 'localism', and set limits on any return to centralism implicit in the move to larger Health Boards. Such a document needs to offer clear prescriptions for the development of locality-based divisions within the new Health Boards and clear guidance about how these will mesh with the work of Community Health Councils. A strengthening of the local committees within the new

CHCs would be one means of preserving 'localism' in the face of the demise of the former 22 Local Health Boards. It is important to safeguard the relational networks and deliberative forums were evolving under the old system, often in particular community settings, and also the diversity of smaller voluntary agency projects (often funded from *Communities First* and other regeneration schemes), which involved experimentation with new approaches to public engagement. Although the latest reforms are certain to involve some institutional re-building, efforts should be made to build on (rather than erase) what already exists.

2.4. The regulatory framework. The Welsh inspection framework contrasts markedly with the English arms-length regulation approach, and here the challenge is to achieve greater responsiveness via more incremental development of the traditional inspectorate model. The Beecham Review Report articulated the vision of a more streamlined and better co-ordinated inspection regime whereby closer connections between local service delivery organizations would be accompanied by shared inspection approaches and similar methodologies. It held out the prospect that improved citizen engagement on the part of service delivery bodies might go hand in hand with a bigger role for the public in shaping inspection regimes. We believe that this approach had considerable promise and recommend that steps are taken to safeguard the continuation of these policies after the present NHS reorganization. One big potential gain of improved inter-sectoral communication at local level is that grassroots voices may feed through more clearly into the Welsh Healthcare Standards. We believe that there is considerable scope in future to widen the involvement process so that there is a more systematic effort to develop standards by 'bottom-up' engagement with the public. This would benefit Health Inspectorate Wales' by improving responsiveness and increasing legitimacy. The bottom-up development of standards combined with a more joined up inspection regime, close to local service delivery organizations, would provide an alternative to England's arms-length regulation of a consumer market that avoids a simple return to command and control.

2.5. Building institutions and capacity in a changing NHS. Just as was the case under the old system, achieving meaningful public engagement in the NHS Wales of the future depends on improving representative structures to build up deliberative capacities and involve an appropriate range of actors. As mentioned already the upheaval associated with major NHS reform is likely to damage some of the fledgling networks that have been emerging, and currently there is a lack of clarity about which NHS or other statutory bodies might act as focal points providing institutional support for PPI. The seven new Health Boards appear to be less well placed than their predecessors to build local engagement and widen community representation. Even if strong locality-based divisions emerge, these will be in a weaker position than old-style LHBs to make connections with local authorities and Local Service Boards (LSBs). The (non-NHS) Local Service Boards are only just taking shape. They are not yet sufficiently developed and lack the legal standing to take the lead in taking public engagement forward. The Community Health Councils, even if given enhanced powers, are handicapped by a history of relative powerlessness and limited effectiveness, and may also struggle to set a lead in this area. More policy development is required here and arguably this is one of the main areas of weakness in the consultation exercise on the restructuring of the NHS in Wales just completed. We do not have an easy answer

to this problem but believe that closer working between the NHS and local government and the gradual development of LSBs as lead organizations may be the best way forward.

2.6. Better horizontal connections at the centre. The thrust of the *Making Connections* policy has been on building links between organizations at the service delivery level, and also achieving better connections between service delivery and the centre. While these are indeed important areas, one weakness in existing PPI arrangements found in our study was poor co-ordination between key central departments, particularly at the middle-level where officials oversee the day-to-day running of specific initiatives connected with citizen engagement. We recommend that the central departments develop better communication and co-ordination mechanisms for engagement policies at these lower levels concerned with roll out and implementation.

2.7. Transforming organizational identities. Health policy in NHS Wales since the millennium has stayed closer to the vision of the traditional NHS model than policy across the border. However, an increased role for the mutuality principle might accord fully with the spirit of Bevan and the Tredegar Workman's Medical Aid Society (often claimed as the model for the NHS). In our view the best prospects for real innovation in service delivery and avoiding the classic command and control problems of unresponsiveness and bureaucracy lies in joint working between the NHS and the voluntary agencies. The vision of integrated local service delivery laid out in the Beecham Review Report opens the way for productive exchanges and shared social learning by the NHS and the third sector. Third sector bodies working alongside or under contact to the NHS have the potential to have a transformative impact of the health and social care sector, and may turn out to be the pathfinders in promoting the frame reflection and identity transformation that reflexive governance entails. In the PPI field real progress may be made if approaches to engagement pioneered by NGOs can be carried across into the statutory sector. This again underlines the need to persevere with the line of policy emerging from Making Connections and Beecham, and to resist any return to centralism triggered by the ending of the internal market in Wales.

2.8. The conditions for social learning. As argued earlier a change of direction arising from a different political analysis of the health and social care system may very well bring positive benefits and contribute to a longer term spiral of improvement linked to ongoing social learning. It is too early at this stage of the Welsh NHS reforms to know whether this is the case. At the time of writing there are worrying signs such as recent delays in clarifying future policy on CHCs that suggest that the reforms may have negative as well as positive consequences in the PPI field. Whatever the longer term impact of this restructuring, what seems clear is that there is a limit to how much organizational turbulence and how much continuing reform is compatible with social learning. In the early days of the Welsh Assembly there was a feeling in many quarters that the NHS needed a period of consolidation for policies to settle, which it has never really had. In the PPI field progress has been quite slow and it is important not to jettison those cumulative gains that have been achieved. It is important to ensure that the primary policy goal of building an integrated Welsh NHS as an alternative to the internal market does not throw the baby out with the bath water. If the policy

prescriptions of *Making the Connections* and *Beecham* are abandoned, Wales will find its policy options limited to the choice between a watered-down PPI in the context of old-style command and control or a belated conversion to the English consumerist policies. Welsh policy makers should therefore strive to maintain a large degree of continuity with existing engagement policies and look towards a period of stability after the NHS reorganisation when further incremental development could occur.

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