Agenda - Health, Social Care and Sport Committee

Meeting Venue:	For further information contact:
Committee Room 2 - Senedd	**Sarah Beasley**
Meeting date: 19 September 2019	Committee Clerk
Meeting time: 09.15	0300 200 6565
	SeneddHealth@assembly.wales

Informal pre-meeting (09.15-09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Health and Social Care (Quality and Engagement) (Wales) Bill: Evidence session with Public Services Ombudsman for Wales

(09.30-10.30) (Pages 1 - 351)

Nick Bennett, Public Services Ombudsman for Wales

Chris Vinestock, Chief Operating Officer and Director of Improvement, Public Services Ombudsman for Wales

Research Brief

Paper 1 - Consultation Pack

Paper 2 - Public Services Ombudsman for Wales

Break (10.30-10.40)

3 Health and Social Care (Quality and Engagement) (Wales) Bill: Evidence session with Royal Colleges and British Medical Association Wales

(10.40-12.00) (Pages 352 - 366)

Dr Robert Morgan, Vice Chair of Policy and Public Affairs, Royal College of General Practitioners Wales
Lisa Turnbull, Policy, Parliamentary and Public Affairs Manager, Royal College of Nursing Wales
Dr Rob Bleehan, Deputy Chair, Welsh Consultants Committee, British Medical Association and Consultant Radiologist, University Hospital of Wales

Paper 3 – Royal College of General Practitioners
Paper 4 – Royal College of Nursing
Paper 5 – British Medical Association Cymru

Break (12.00–12.45)

4 Health and Social Care (Quality and Engagement) (Wales) Bill: Evidence session with Local Health Boards

(12.45–13.45) (Pages 367 – 396)

Ann Lloyd, Chair, Aneurin Bevan University Health Board
Jan Williams, Chair, Public Health Wales NHS Trust
Richard Bevan, Board Secretary, Aneurin Bevan University Health Board

Paper 6 – Welsh NHS Confederation
Paper 7 – Professor Vivienne Harpwood
Paper 8 – Public Health Wales

Break (13.45–13.50)

5 Health and Social Care (Quality and Engagement) (Wales) Bill: Evidence session with Local Health Boards (2)

(13.50–14.50) (Pages 397 – 401)

Carol Shillabeer, Chief Executive, Powys Teaching Health Board
Mandy Rayani, Director of Nursing, Quality and Patient Experience, Hywel Dda University Health Board

Alex Howells, Chief Executive, Health Education and Improvement Wales

Paper 9 – Hywel Dda University Health Board
Paper 10 – Health Education and Improvement Wales

6 Paper(s) to note

(14.50)

6.1 Letter from the Minister for Health and Social Services regarding the work of the Inter-Ministerial Group (IMG) on Paying for Social Care

(Pages 402 – 403)

6.2 Letter from the Chair to the Minister for Education regarding draft curriculum for Wales 2022

(Pages 404 – 405)

6.3 Reply from the Minister for Education regarding draft curriculum for Wales 2022

(Pages 406 – 408)

6.4 Letter from Aneurin Bevan University Health Board with additional information following the meeting of 17 July

(Pages 409 – 413)

6.5 Letter from Minister for Health and Social Services regarding antipsychotic medication in care homes

(Pages 414 – 415)

6.6 Welsh Government response to Hepatitis C Report

(Pages 416 – 420)

6.7 Letter from Future Generations Commissioner regarding Future Generations Report May 2020

(Pages 421 – 422)

6.8 Letter from Independent Maternity Services Oversight Panel with additional information following the meeting of 17 July

(Pages 423 – 424)

6.9 Letter from Minister for Health and Social Services regarding Cwm Taf Morgannwg University Health Board Maternity Services

(Pages 425 – 426)

6.10 Letter from Hywel Dda University Health Board with additional information following the meeting of 13 June

(Pages 427 - 432)

6.11 Letter from Minister for Health and Social Services regarding UK Common Policy frameworks

(Pages 433 - 435)

6.12 Letter from the Minister for Health and Social Care on the Health and Social Care (Quality and Engagement) (Wales) Bill

(Pages 436 - 469)

7 Motion under Standing Order 17.42 (vi) to resolve to exclude the public from the remainder of this meeting

(14.50)

8 Health and Social Care (Quality and Engagement) (Wales) Bill: Consideration of evidence

(14.50-15.00)

By virtue of paragraph(s) vi of Standing Order 17.42

Agenda Item 2

Document is Restricted

By virtue of paragraph(s) vi of Standing Order 17.42

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Ombudsman
Ombwdsmon
PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

Response by the Public Services Ombudsman for Wales in response to the Consultation on the Health and Social Care (Quality and Engagement) (Wales) Bill

I am pleased to have the opportunity to respond to the Welsh Government's consultation on the Health and Social Care (Quality and Engagement) (Wales) Bill.

As Public Services Ombudsman for Wales (PSOW), I investigate complaints made by members of the public who believe they have suffered hardship or injustice through maladministration or service failure on the part of a body in my jurisdiction, which essentially includes all organisations that deliver public services devolved to Wales. These include:

- local government (both county and community councils);
- the National Health Service (including GPs and dentists);
- registered social landlords (housing associations); and
- the Welsh Government, together with its sponsored bodies.

I am also able to consider complaints about privately arranged or funded social care and palliative care services.

Health services account for nearly half the complaints made to my office (46% in 2018/19) but I currently receive only a small number of complaints about social care, despite the introduction of the Social Services and Well-being (Wales) Act 2014. The own initiative powers I have been granted under the Public Services Ombudsman (Wales) Act 2019 will allow me to investigate systemic failings in the social care sector, even if service users themselves are not raising complaints.

My response to this consultation reflects evidence from my office's casework, and it is in this context that I am responding to the consultation. My comments on various aspects of the Bill are set out below.

Opening remarks

I welcome the Bill and its aspirations to drive improvements in the quality of the care the NHS delivers to patients. I am also pleased at the evident desire to improve transparency and accountability of the NHS and to strengthen the voice of Welsh citizens who receive health and social care services. The proposal for an advocacy body that can support citizens through, often closely entwined, health and social care issues is one I very much support.

I am disappointed, however, that the Welsh Government has decided not to proceed with the proposals in its white paper for an alignment of the NHS and Social Services complaints procedures in Wales which would require joint investigation of complaints which involve the provision of both of these elements of public service provision. It is regrettable, in my view that "Putting Things Right" does not contain the same requirement in this respect as does the social services complaints procedure. As I have outlined previously, I consider that it is vital that the complaints process for the citizen is as seamless as possible, particularly when services are jointly delivered by different public bodies.

One final general point, it appears that the Bill as drafted at Section 16 (5) identifies that the Citizen Voice Body may provide assistance (by way of representation or otherwise) to any individual making, or intending to make a complaint to me in relation to the functions of a local authority's social services department and in relation to actions taken by care home or domiciliary care providers. However, I see no reference in the Bill as drafted, to the Citizen Voice Body providing assistance to individuals wishing to complain to me in relation to the functions of the NHS in Wales. I consider this to be a critical omission.

Part 2: Duties to Promote Cultural Change

2.1. Duty of Quality for the Population of Wales

Health boards working together or working collaboratively with local authorities could create additional complexity for the citizen/complainant in terms of who has ownership of a complaint when it is received by my office. It is my view that a public service must be accountable for all of the services it offers, whether it delivers that service itself or contracts it to another public body or external party, and the process for complaining about that service should be clear for the service user.

The new Public Services Ombudsman (Wales) Act 2019 gives me the power to establish a Complaints Standards Authority which would facilitate standardisation of public bodies' complaints procedures and put the service user at the heart of the complaints process.

I welcome any initiatives to promote a sustainable improvement in the delivery of healthcare in Wales. I would also ensure that the clinical standards I apply in my work are reflective of such improvements in quality.

Part 3: Duty of Candour

In my thematic report 'Ending Groundhog Day: Lessons from Poor Complaint Handling' I highlighted effective governance as key to transforming the fear and blame culture that is innate in public bodies, which will consequently end the cycle of poor complaint handling and poor service delivery. A statutory duty of candour, introduced for whole organisations, would make a substantial contribution to addressing the issues I identified. Whilst I recognise that there already exists the GMC/NMC/CQC professional statutory duty of candour for individual practitioners, which is applicable across the UK, a statutory duty for health and social care bodies in Wales as corporate entities would reinforce this.

I note the Explanatory Memorandum accompanying this Bill refers to a well-publicised case which involved failures to address injustice and which demonstrated a need for candour and transparency. I see the introduction of a duty of candour on public bodies in Wales to be a positive step towards addressing some of the shortcomings highlighted by that case.

Part 4: Citizen Voice Body (CVB)

4.1. Representing the Citizen in Health and Social Care

Advocacy is extremely important from my office's perspective, as our impartiality prevents us playing an advocacy role in assisting complainants when making a complaint. Currently there is no consistent provision of advocacy services for social care or joint social care/health and I would welcome the introduction of a body that offers advocacy for social care.

I note the white paper published in 2017 made specific reference to the new body having an independence to represent the citizen. It proposed "… the creation of a new, independent, arrangement to replace CHCs". The consultation also stated the new Citizen Voice Body:

"… would have considerable operational autonomy and be free to decide its own work programme and recruit volunteers locally in line with a number of refreshed functions."

Furthermore, the white paper consultation proposed a "new independent body picking up on Ruth Mark's review".

However, the Bill indicates that members of the Citizen Voice Body would be directly appointed by the Welsh Government, with Welsh Ministers having an effective veto on the appointment of the Chief Executive and controlling remuneration and terms and conditions of staff. This, coupled with control of funding of the new body, calls into question not only the independent status of the Citizen Voice Body but also, as importantly, the perception of its independence. It would appear to be more appropriate for a wholly independent body, such as the National Assembly for Wales, to make or oversee appointments and decisions.

Turning to other aspects of the proposal for the new Citizen Voice Body I would suggest that, in order for the proposed Body to be effective in voicing the concerns of Welsh citizens, it must retain a local presence which can articulate the concerns of local citizens. There will be different issues arising in different areas reflecting, for example, the local service model, rurality, GP provision, demographics and healthcare capacity. I consider that freedom to operate locally, whilst retaining the benefits of a clear strategic direction, national standards and consistent approaches across Wales, is important.

It is noted that the Bill proposes to grant the Citizen Voice Body the power to make representations. However, I would suggest that any power to make representations is compromised if such representations fall on deaf ears. I would therefore suggest that those persons identified in paragraph 15 (2) should be required to have due regard to formal representations from the Citizen Voice Body and that failure to do so may be referred to an independent body for consideration.

Nick Bennett
Public Services Ombudsman for Wales
July 2019

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Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Health, Social Care and Sport Committee

HSCS(5)-24-19 Papur 3 / Paper 3

13 September 2019

Dr Dai Lloyd AM
Chair
Health, Social Care and Sport Committee
National Assembly for Wales

Dear Dr Lloyd,

Health and Social Care (Quality and Engagement) (Wales) Bill

Thank you for inviting the views of the Royal College of General Practitioners (RCGP) Wales with regard to the Committee's scrutiny of the Health and Social Care (Quality and Engagement) (Wales) Bill. RCGP Wales represents a network of around 2,000 GPs, aiming to improve care for patients. We work to encourage and maintain the highest standards of general medical practice and act as the voice of GPs on resources, education, training, research and clinical standards.

The College believes the principles set out in the Bill to be reasonable. Where there is a concern it relates to the definitions of 'quality' and 'effectiveness' and how these would be monitored in general practice. Aspects of the work of general practitioners would not necessarily be easily assessed in terms of effectiveness because in primary care many conditions are extremely uncommon. Large numbers of patients would require treatment for a small number of them to benefit from preventative treatments. For example, the majority of patients taking statins to reduce the risk of cardiovascular events or anticoagulation treatment to prevent stroke will not benefit as they would not have had the event anyway. We cannot predict who will benefit but we can estimate those who are at greatest risk. This is not to dismiss the principle of an assessment on quality or effectiveness being made but noting that there must be strong emphasis on informed choice so that we share that estimate of risk and the potential benefit (and harms) of any treatment.

There has been a great deal of work on shared decision making and the College believes that informed choice by patients must be a consideration rather than simply measuring the uptake of 'effective' treatments as the desired outcome. This is particularly important for older patients and those with multiple conditions where combinations of many medications can increase risk of adverse events. The bill should clearly incorporate the principle of patient choice.

The monitoring of health outcomes requires resource to carry out the work efficiently and effectively. At present GPs are short of resources to see all their patients within a reasonable timeframe without further potentially onerous data collection requirements made of them. The principle is welcome, but the resources must be provided to help maintain sustainable primary care.

There is increasing debate about some screening programmes and it must be ensured that the focus is on clear and impartial information rather than uptake levels.

The duty of candour is welcome, but it is important to ensure that appropriate training is provided along with support for all clinicians to ensure that this is done well for all involved. It will be essential that the definition of candour also allows for proportionality for it to be effective.

The College understands both the purposes of the proposed change to a Citizen Voice Body and acknowledges the concerns which have been raised regarding how this body would operate. At this stage our only comment on this aspect would be to ensure that the new body is suitably independent and able to carry out its work with due rigor.

Should you or the Committee wish to discuss any points raised in this response further, please do not hesitate to let us know.

Best wishes,

Peter Saul

Dr Mair Hopkin
Joint Chair
RCGP Wales

Dr Peter Saul
Joint Chair
RCGP Wales

Coleg Nyrsio Brenhinol
Cymru
Royal College of Nursing
Wales

Health and Social Care (Quality and Engagement) (Wales) Bill

Royal College of Nursing Wales Position Statement and Suggested Amendments

Summary

The Royal College of Nursing is supportive of the aims of this Bill. However, we believe the Bill should be strengthened by including as part of the definition of 'quality' the need for a skilled and valued workforce.

The powers of the proposed citizen's voice body need to be strengthened to include the promotion of equality, right of access to healthcare premises and the duty of health and social care bodies to respond to representations.

Part 2 - Duty of Quality – A Proposed Amendment

To amend the duty of securing improvement in the quality of services for Health Boards, Trusts and Welsh Ministers by broadening the definition of quality as follows:

"quality" includes, but is not limited to, quality in terms of—

(a) the effectiveness of health services,

(b) the safety of health services, and

(c) the experience of individuals to whom health services are provided

(d) the employment of a workforce of suitably qualified and competent individuals, from such a range of professional disciplines as necessary, are working in such numbers as are appropriate for—

(i) the nature of the particular kind of health care provision,

(ii) the local context in which it is being provided,

iii) the number of patients being provided it,

iv) the needs of patients being provided it, and

(v) appropriate clinical advice.

The Royal College of Nursing believes this fits with the ambition and policy intent of the Bill as laid out in the Explanatory Memorandum and it will significantly strengthen the duty of quality in a way that will increase the benefits and positive impact of the Bill.

The amendment fits with the expressed Policy Intent

The explanatory memorandum describes (para.21) how the duty of making arrangements for improving the quality of healthcare has hitherto been interpreted narrowly by NHS Bodies and focused on the establishment of quality assurance or control mechanisms and also in monitoring the implementation of service standards. The policy objective of the Bill is for health bodies to consider how they can improve the quality of services and outcomes for patients on an ongoing basis.

Services provided to the public by health bodies are provided by the workforce. No health service can be provided without healthcare staff, whether health care support worker, doctor, nurse, pharmacist, biomedical scientist, occupational therapist or any other health care team member.

The workforce is explicitly part of the Quadruple Aim outlined by the Parliamentary Review against which health and social care should deliver. This is referenced on the first page of the explanatory memorandum: **"enrich the wellbeing, capability and engagement of the health and social care workforce".**

The explanatory memorandum sets the Bill in the context of the core values outlined by Together for Health in 2011. One of the quoted values (para 6.) reads:

"Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively."

Health Education Improvement Wales (HEIW) has been established by the Welsh Government to have a leading role in the education, training, development, and shaping of the healthcare workforce in Wales. In partnership with Social Care Wales they are producing the first national workforce strategy for health and social care this year (2019).

The consultation document states the ambitions of this strategy:

> "By 2030 we will have the right number of engaged, motivated and valued people including volunteers and carers, able to deliver flexible and agile health and social care that meets the needs of the people of Wales. Our workforce will be reflective of the population's diversity, Welsh language and cultural identity, with the right values, behaviours, skill and confidence to deliver care and support people's wellbeing as close to home a possible.
>
> By 2025 we will make working in health and social care the sector of choice, through excellent people and employment offer and practices, to attract the right people into our workforce.
>
> By 2022 we will have aligned recruitment, education, training and development of staff to our future ambition, and will have accelerated cross sector workforce intelligence, to inform scenario planning and workforce modelling to deliver our medium and long term plans"

Including workforce planning as an additional factor in the legislative definition of quality will provide an excellent foundation for the work of HEIW.

In 2016, the Assembly passed the Nurse Staffing Levels (Wales) Act. This places a general duty on health organisations to ensure sufficient nurses to provide sensitive patient care. There is also a duty to calculate the level of nursing according to a specified methodology in adult acute medical and surgical wards. Wales was the first country in the UK to adopt this statutory based approach to the provision of safe and effective patient care, which has now been followed in Scotland.

This Bill provides an ideal opportunity for the Welsh Government to progress with the principles of the Nurse Staffing Levels (Wales) Act 2016 and broaden their applicability. It is particularly relevant to Section 25D of the Act which states that the Welsh Government may **"make provision about workforce planning that Local Health Boards and NHS Trusts may undertake in order to enable them to comply with their duties under sections 25B and 25C.".**

The suggested text of this amendment is drawn from the Health and Care (Staffing) (Scotland) Act 2019. This Act in Scotland was passed by a cross party consensus in the Scottish parliament. The policy objective of the Bill was to provide a statutory basis for the provision of appropriate staffing in health and care service settings "thereby enabling safe and high quality care and improved outcomes for service users." (Policy Memorandum)

The case for change

Health bodies in Wales have not historically undertaken workforce planning as a duty. The Integrated Medium Term Plans (IMTPS) now used as an approach are still relatively new and vary considerably in quality. In March 2019 3 Health Boards were unable to submit plans at all. Although the expectations of the Welsh Government are clear in terms of content for the IMTPs (e.g. asking for the Welsh language needs of the population or the needs of the care home sector to be taken into account), Health Boards appear struggle to achieve this. Demographic data and analysis do not seem to be deployed in the planning process. This means that the national education commissioning process of HEIW has limited evidence on which to base its decision-making on. What skills are required? What courses and how many places should be commissioned? The work of HEIW would clearly benefit from an increased emphasis on workforce planning at a Health Board level.

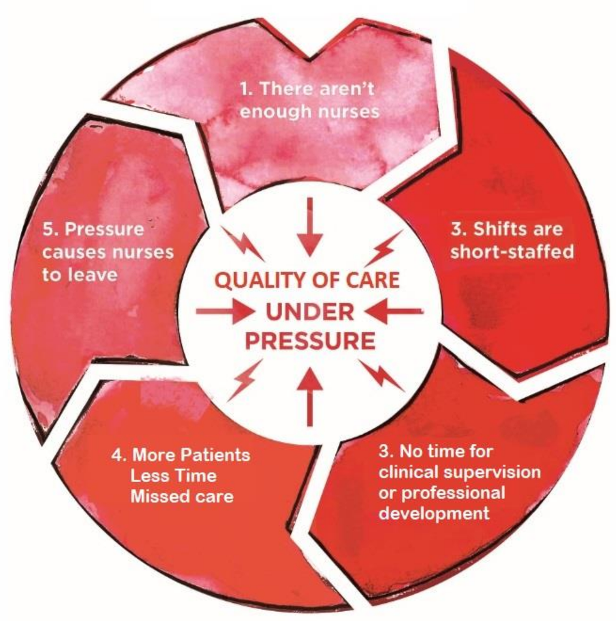
Betsi Cadwaladr Health Board is not unusual in that the Board received their first workforce strategy in November 2018. Examination of all Health Board agendas for 2018 and 2019 reveals no discussion at Board level of workforce recruitment or retention strategies. As a result of the Nurse Staffing (Levels) Wales Act 2016 papers on compliance with this legislation are regularly presented to Boards but it is notable that these papers rarely reference any wider recruitment or retention plans. High vacancy levels are instead presented as an unalterable fact.

NHS Wales is clearly facing a workforce crisis. The examination of any restructure consultation from any Health Board in the last year will show that services are being redesigned *because of this crisis.*

The Royal College of Nursing estimates that some 1600 registered nurse posts are currently vacant in NHS Wales. This is not the number of nursing posts needed clinically – it is simply the number currently vacant.

With some Boards having nursing vacancies of over 500 nursing posts the potential impact on patient care is concerning. Reports into poor care from Tawel Fan to Cwm Taf cite poor staffing as a factor.

The Royal College of Nursing believes that many actions could be taken to ameliorate this crisis and eventually move beyond this situation. These actions include developing retention strategies, prioritising the development of flexible working arrangements, professional development and clinical supervision for professional staff.



Train Work Live Wales provides a clear national brand for NHS recruitment in Wales but examination of health Board papers reveals that Health Boards still tend to think of recruitment as a series of self-contained activities such as attending a recruitment fair or putting an advert on Facebook, rather than a strategic driver for the organisation.

Reporting

It would be helpful to clarify the relationship between the proposed quality report and the existing annual quality statement process. The reporting is proposed as annual in the legislation but the reporting on the Nurse Staffing Levels (Wales) Act 2016 was set at 3 years. There was considerable discussion during the passage of that Act that re reporting requirements should fit with the already existing reporting 3 year framework for the NHS. Perhaps all statutory reports should be annual?

Commissioning/Providing

Many health care services are commissioned by Boards/Trusts. It is not always clear whether the duty of quality applies to commissioned services in this Bill. The language of the explanatory memorandum could be made more consistent on this point.

Safe and effective patient care at the heart of quality

Having a workforce, recruitment and retaining a workforce and professionally developing the skills and capabilities of the workforce is critical to providing high quality patient care.

In order to achieve this ambition every opportunity must be taken to strengthen the capability of focus of health bodies on developing a workforce that can provide high quality care and outcomes for the public.

Assembly Members have raised many important areas of patient care that need improvement such as responding to the needs of people with dementia, providing services in Welsh language, providing diagnostic tests or processes such as endoscopies, timely services for children with mental health concerns or needing speech and language therapy. Healthcare professionals support all of these aims but struggle to improve services without a strategic focus on development the workforce. HEIW now provides a national level focus and this is an opportunity to align the core values and strategic aims of NHS Wales to the national ambition.

By embedding the workforce as an essential part of the performance and duty of quality the bill will then achieve its ambition improve care and outcomes of care for the public.

Part 3 – Duty of Candour

The Royal College of Nursing supports this proposed duty and welcomes the commitment expressed in the explanatory memorandum to involve clinicians in the development of the guidance.

It needs to be clear how this legislative duty differs from, or relates to, the already existing duty of candour on the complaints process. We would suggest the regulations proposed for this duty should also make clear the relationship with the professional duty of candour on individuals.

The provisions on reporting year and financial year are unclear and we would welcome some clarity here as to the intent and specifically the expectation as to which financial year should be reported on.

There do not appear to be any proposals for how breaches of this duty or failure to comply with this duty shall be dealt with in the Bill. We suggest two options for consideration:

Could the legislation states there would be an automatic escalation in the health organisation status in monitoring/intervention form the Welsh Government? A breach of the duty of candour would seem serious enough to promote a governance review.

Alternatively could regulations be explicitly made that in the appointment of Chairs and Vice Charis of organisations any breaches of the duty of candour that had occurred during candidate’s previous appointments would be taken into account?

Finally many health care services are commissioned by Boards/Trusts. It is not always clear whether the duty of candour applies to commissioned services in this Bill. The language of the explanatory memorandum could be made more consistent on this point.

Part 4 – Citizens Voice Body (CVB)

The Royal College of Nursing believes that a strong independent body with knowledge of local community issues and the confidence of local communities should represent the public in Wales. The RCN believes that the proposals in this section need to be significantly strengthened to achieve this.

15 representations to Public Bodies – Suggested Amendments

(2) The persons are—

(a) a local authority;

(b) an NHS body

(c) Welsh Ministers (insofar as the exercise of their functions relates to the provision of health and social services)

This follows the example of Part 2 of the Bill where an equal duty of quality is laid on Welsh Ministers, as on health bodies, because of the impact of their functions on health and social care. The decisions of the Welsh Government and other bodes influence the provision of health services e.g., the commission of education for medical students therefore it is logical for CVB to be able to comment on this.

In addition, it needs to be clarified whether bodies such as Social Care Wales and HEIW fall under the definition of 'an NHS body' for the purposes of this Bill. If they do not then they need to be added to this section. Indeed there is a rationale for adding regulatory bodies more generally.

(3) A person to whom representations under subsection (1) are made must have regard to the representations in exercising any function to which the representations relate and is required to respond in writing and publish the response setting out how they have had regard to the representations.

In order to build public confidence and trust in the CVB and in health bodies it is important the health bodies are required to respond to the CVB and this response is made public. This transparency will assist expectations and ensure that the CVB is taken seriously as a public key stakeholder in decision-making around health and social care policy.

Proposed Additional Rights and Duties for the new body

A right of access to NHS premises: The RCN believes the CVB should be able to visit health promises to observe and understand the physical locations and their impact on health care. This right could be worded to restrict its applicability to NHS premises to avoid the objection that health and social care is delivered in people's homes. NHS hospitals are a distinct location for the provision of care and *because* people are "living in them", (however transitory the planned stay) they require effective scrutiny.

Promotion of Equality: The RCN believes the new body should have a specific purpose to promote equality of access and equity of outcomes for marginalized groups in health and social care. There are communities and demographic groups that continue to struggle to access health and social care services and there is clear evidence that certain groups do not receive the same level of care or outcomes as others. Examples of these include but are not limited to: Veterans, Welsh speakers, the deaf and hard of hearing community, people who are homeless, refugees and asylum-seekers, the LGBT+ community, people with dementia, people with learning disabilities etc.

13 General objective

(1) The Citizen Voice Body's general objective, in exercising its functions, is to represent the

interests of the public in respect of health services and social services.

(2) For the purposes of achieving that objective, the Citizen Voice Body must seek the views

of the public, in whatever way it thinks appropriate, in respect of health services and

social services.

(3) In achieving that objective the Citizen Voice Body must have regard to the promotion of equality of access to health services and social services for individuals and communities and parity of outcomes

CVB – Schedule 1 – Suggested Amendments

2 – Specifies the appointment of members and Chair by the Welsh Ministers. Given the important of the body being seen to be able to represent the communities of Wales the RCN suggests an amendment is considered to this Schedule that the Welsh Ministers have in appointing members, due regard to the geographical residence of the applicants and other diversity criteria.

9 – Allows the creation of Committees. The RCN suggests that specifying the need to create regional or locally based committees is considered. The great strength of the current CHC system is this local approach and local knowledge. There is a very real danger that the new body will lack local knowledge, be unable to form local connections or inspire trust in all localities without a specific effort to build such connections. The health Boards in Wales are large organisations covering huge geographical areas. It is vital that the knowledge of services in the community is not lost.

19 – Provides for an annual plan. There should be a specific requirement to consult the public as well "those persons it considers appropriate". There should be a requirement to publish this plan on a publically available website. The consultation and plan should be available in the Welsh language.

20 – Annual report. There should be a requirement to publish this report on a publically available website. The report should be available in the Welsh language.

HEALTH AND SOCIAL CARE (QUALITY AND ENGAGEMENT) (WALES) BILL – GENERAL PRINCIPLES

Consultation by the National Assembly for Wales Health, Social Care and Sport Committee

Response from BMA Cymru Wales

1 August 2019

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the inquiry by the National Assembly's Health, Social Care and Sport Committee into the general principles of the Health and Social Care (Quality and Engagement) (Wales) Bill.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

RESPONSE

Executive Summary

- Whilst BMA Cymru Wales welcomes the Bill as published in broad terms, we feel that many of its provisions could benefit from amendment to strengthen them and add clarity to the Bill's intent.
- Amendments should be made to better define how quality in service provision will be assessed and judged, and how a failure to deliver insufficient improvements in service quality will be addressed.
- The Bill should recognise a clear link between service quality and the provision of appropriate staffing levels, including for medical staff. This could be achieved by incorporating similar duties to many of those contained in the Health and Care (Staffing) (Scotland) Act 2019. A duty of staff governance should also be added, similar to that contained in the National Health Service Reform (Scotland) Act 2004.
- Amendments should be made to ensure the impact of the duty of candour is not overly burdensome, particularly on individual GP practices. This should include providing greater clarity around when it would apply, defining a mechanism for arbitration and considering proposed changes to the reporting timeframe. More detail should also be included in the Bill about how the duty of candour will be enforced.
- Amendments should be made so that the remit of the proposed new Citizen Voice body is more clearly defined. This should include better establishing how it will enable citizens to have a stronger voice contributing to the planning and development of health and social care services and how the proposals in the Bill can deliver an independent mechanism to provide clinical advice and assurance on substantial change proposals.

- The proposed power for Welsh Ministers to appoint vice-chairs to the boards of NHS trusts should be supported.
- Additional proposals should be added to the Bill to introduce a system of regulation for non-clinical health service managers.

General response

BMA Cymru Wales is grateful for the opportunity to comment on the proposals put forward in the Health and Social Care (Quality and Engagement) (Wales) Bill, having previously responded to the Welsh Government's Green Paper, *Our health, our health service*,[1] and White Paper, *Services fit for the future*,[2] which preceded it.

We have considered the provisions put forward in the Bill as introduced and provide the following observations on the following sections:

Part 2 – Improvement in health services

We support the principle of a duty being placed on Welsh Ministers, local health boards, NHS trusts and special health authorities to secure quality in health services. However, we believe that the proposals could be strengthened in a number of ways.

As the Bill is currently written, it is not sufficiently clear on what basis the provision of quality will be judged other than in the broadest of terms.

The bodies which will be subject to this duty will be required to produce annual reports of the extent to which they have secured improvements in the quality of health services and these reports must contain assessments of the extent to which any improvement in outcomes has been achieved as a result. However, there is nothing within this process which requires any level of expected improvement to be set, so that performance can be judged against it. Nor are there any provisions which detail how this performance will be evaluated other than through self-assessment.

We do not therefore feel that the provisions as currently drafted provide the sufficiently robust mechanism to monitor and evaluate effectiveness which we previously called for in our response to the White Paper.[2] We would therefore suggest that this aspect needs to be addressed through amendments to the proposed provisions.

This might be achieved, for instance, by agreeing amendments that would introduce requirements for regulations and/or guidance to be produced by Welsh Ministers which could address these aspects in more substantial detail. Unless this is done, we are unconvinced that the duty as currently proposed will be sufficient in itself to drive the improvement in quality of health service provision and quality of experience for patients we believe Welsh Government will want to see.

We also note the omission of any mechanisms within what is proposed to suggest that anything would happen should it be judged that the bodies subject to this duty have not delivered sufficient improvement in the quality of health services. This also needs to be addressed in our view. Unless some form of sanction or corrective action is triggered, we believe that the proposed duty would run the risk of lacking effectiveness, and at worst would become a mere box-ticking exercise.

A further significant concern we have is the lack of any linkage in these provisions between the quality of health service provision and the level of staffing resource provided to deliver it. We feel it should be implicit within the Bill that quality cannot be delivered unless an appropriate level of staffing is in place, and we therefore believe this represents a major lost opportunity for this to be both recognised and addressed. We would therefore urge the committee and Welsh Government to acknowledge within the legislation that there is a clear link between these two factors.

Indeed, this lack of reference to the link between service quality and appropriate staffing levels contrasts starkly with the recently passed provisions in Scotland of the Health and Care (Staffing) (Scotland) Act 2019. This Scottish Act explicitly recognises such a link by stating that the one of the main purposes of staffing for health care and care services is to provide safe and high quality services.

Such a principle has already been recognised in legislation in Wales in relation to nurse staffing levels in certain settings, and BMA Cymru Wales applauds the Welsh Government and the National Assembly for Wales for previously passing the Nurse Staffing Levels (Wales) Act 2016. This legislation has helped address a key issue that was central to a number of different independent reports into concerns and failings within the NHS in both England and Wales in recent years. These include the report of the Francis inquiry into the failings at the Mid Staffordshire Foundation Trust;[3] the subsequent Keogh review on hospital deaths;[4] the Berwick review into patient safety; [5] the Andrews report into failings in the standard of care within the former Abertawe Bro Morgannwg University Health Board, *Trusted to Care*;[6] and the Evans report, *Using the Gift of Complaints*.[7]

We would suggest that this new Bill now be used as a vehicle to extend the principles of the Nurse Staffing Levels (Wales) Act 2016 to other health care staff, including medical staff. In order to achieve this, we therefore suggest the committee calls for the incorporation into this Bill of similar provisions to many of those contained in the Health and Care (Staffing) (Scotland) Act 2019 including in relation to medical staff.

This could include providing guiding principles for health and care staffing and planning; a duty on NHS bodies to ensure appropriate staffing; a duty to have real-time staffing assessments in place; a duty to have a risk escalation process in place; a duty to ensure adequate time is given to clinical leaders; a duty to ensure appropriate training of staff; a duty to have arrangements to address severe and recurrent risks; and a duty to seek clinical advice on staffing.

A further duty taken from legislation in Scotland that could also contribute to the delivery of improved quality of health service provision, and which we also therefore suggest should be included, is a duty of staff governance along the lines of the one contained within the National Health Service Reform (Scotland) Act 2004. A similar duty incorporated in to this Bill could place a duty on NHS bodies to put and keep in place arrangements for the purpose of improving the management of staff employed by them; monitoring such management; and workforce planning.

In Scotland, this duty is underpinned by the publication of the NHS Scotland Staff Governance Standard,[8] currently in its fourth edition as published in 2012. This standard very much draws out the clear link between good and effective staff governance and the provision of quality services. We would therefore advocate a similar approach be undertaken here in Wales by incorporating similar provisions into this Bill.

Part 3 – Duty of Candour

BMA Cymru Wales welcomes the aspirations of the Bill to embed a culture of openness, transparency and candour in the Welsh health and care sectors. The Bill aims to realise this through the introduction of an organisational duty of candour upon providers of NHS services, in addition to the long-established existing professional duties determined by regulators.

We have previously articulated our support for such a complementary organisational duty of candour [2] as a means to change the culture of the NHS where many of our members feel discouraged from speaking up. Doctors are accustomed to being open and honest, as per the principles of the GMC's *Good medical practice*, but many NHS organisations operate a defensive culture in our experience with little means for them to be held to account.

However, we do have concerns with the potentially burdensome impact of the Bill as presented, particularly as regards to the impact it could have on primary care providers. As has been much publicised, there are long-term difficulties with recruitment and retention into Welsh general practice and we should therefore be wary of introducing policies, procedures and regulations that would increase the pressure on already hard-pressed GPs and have negative impact on the fragility of the service. Notwithstanding such concerns, we do support the principle that the duty of candour should apply within primary care.

To address these concerns, we would firstly suggest that robust guidance is needed around the point at which the duty applies. Until an investigation takes place, every minor adverse outcome that occurs during a period of care could potentially incur the duty. The impact could therefore be significant.

Exactly what will be construed as “more than minimal” unintended or unexpected harm must therefore be carefully considered and appropriately defined. There also needs to be a means of arbitration when providers and the person in receipt of an adverse outcome do not agree. We would suggest that these points are therefore addressed by agreeing appropriate amendments to the Bill.

Secondly, we feel that the reporting mechanisms, which apply to small-scale independent practitioners in the same manner as large health boards, will be overly burdensome for such independent practitioners.

Requiring an annual report detailing each incident where the duty of candour was applied, and the lessons learnt, near the end of the financial year will be an additional burden at the time of year when many practice staff will be occupied with contractual and financial concerns. This could particularly impact on smaller, or single-handed, GP practices. A change to the timescale to align with calendar year might be one way that this burden could be eased. It could also provide health boards with an opportunity to review all primary care provider reports in time for the end of the financial year.

Finally, we feel that the Bill as drafted lacks detail regarding how the duty will be enforced, as well as about any possible sanctions for breaching the duty.

Whilst this may follow in accompanying guidance, stipulating this within the Bill itself – or referencing within it that Regulations will be brought forward by Ministers to provide such level of detail – could help to eliminate variation through interpretation at a local level.

Despite these concerns, we would reiterate our support for the general approach of introducing an organisational-level duty of candour which we feel could support the need to engender a culture in which the raising of concerns is encouraged. Implemented appropriately, we feel it could play an important role in helping to create an NHS with an operational culture that is not rooted in blame but supports and encourages learning and improvement.

BMA Cymru Wales also notes that such an approach could be further complemented in Wales through the adoption here of Freedom to Speak up Guardians overseen by a National Guardian, as was introduced within the NHS in England in 2016. This is an initiative we have been discussing with Welsh Government, Welsh NHS employers and other key stakeholders a something we would be keen to see taken forward in Wales. We see it as something which could effectively sit alongside an organisational-level duty of candour, as it could further assist the creation of the open and learning culture we wish to see fostered.

Part 4 – The Citizen Voice body for health and social care

In response to the White Paper which preceded this Bill, we said that we broadly supported the proposals contained within it in relation to how the voice of citizens would be represented in health and social care.[2]

The principle of having a new body which can provide a voice for citizens across health and social care is certainly one which we support, but we do have concerns about aspects of the proposals as they are currently presented in the Bill.

One concern we have is that the White Paper provided significantly more detail as to what the remit of the new body could be and how it would operate in practice, but this has been left much less defined in the Bill.

For instance, the White Paper listed a proposed new set of functions that the new body could take on which included a role in the co-design and co-creation of services, thereby providing a vehicle to feed in a voice from communities as proposals are developed. This was described as enabling citizens to have a stronger, continuous voice contributing to the planning and development of health and social care services.

The White Paper also noted that by abolishing Community Health Councils (CHCs), there would no longer me a mechanism for referring disputed substantial change proposals to Welsh Ministers and it suggested that a new mechanism could be developed that would involve the new Citizen Voice Body.

We are concerned that none of this is made clear in the Bill which lacks detail at this level. We feel this needs to be rectified to provide far more clarity as to what role the proposed new Citizen Voice body will have, and what powers it will be given to undertake such a role whilst also ensuring that we maintain local, visible and accessible structures.

As the Bill is currently written, it seems that the Citizen Voice Body will be left to define for itself what it will do to fulfil its role of representing the interest of the public in respect of health and social services. This is worryingly vague in our view, and fails to address the need to ensure appropriate checks and balances are placed on the new body.

We are therefore concerned that important safeguards could be lost in how substantial service change proposals are made, and how health boards and trusts will be held to account in future in relation to the way they are determined. Indeed, we note that the White Paper referred to a proposal for establishing an independent mechanism to provide clinical advice and assurance on substantial change proposals, but we are very concerned this does not appear to have been taken forward in the Bill.

We would be much less concerned if the Bill was talking forward proposals that more close matched those outlined in the White Paper and would suggest this is addressed through amendments as the Bill continues its passage.

A further concern we have relates to the proposal to move away from the current system for CHCs where the membership is nominated from different sources (some by Welsh Government, some by local authorities and some by third sector organisations) to a new body which is fully appointed by Welsh Government. It is not entirely clear to us how this can ensure we will have a body that can truly provide a voice for citizens, as well as being able to take up local concerns on behalf of communities. This is also something we feel needs to be addressed.

Part 5 – Miscellaneous and general

We support the proposal to give the power to Welsh Ministers to appoint vice-chairs to the board of NHS trusts, which we note is in line with the power that Welsh Ministers already have to appoint vice-chairs to the boards of local health boards. In that context, the addition of this new power would seem to be entirely reasonable.

Additional proposal – regulation of non-clinical health service managers

Another issue which we suggest could be taken forward by this Bill would be to introduce a process whereby non-clinical managers can subject to a system of regulation in the same way that clinical staff are regulated by professional bodies. This is something we previously advocated in response to the Green Paper that preceded this Bill,[1] noting that a doctor who fails badly in their conduct runs the risk of being struck off, and thereby prevented from working again as a doctor, whilst a manager who presides over significant failure may go on to secure a new management position in a different part of the NHS.

We note that the National Assembly has recently agreed to give Helen Mary Jones AM leave to proceed to introduce a Bill which, amongst other proposals, would "establish a professional body for NHS managers in Wales to set core professional competencies for managers at all levels, ensure the development of appropriate initial training programmes and continuous professional development, and with the power to take sanctions against managers for poor or unsafe performance." Whilst the progress of this Member's Bill proposal remains to be determined, we note that the Bill which is the subject of this consultation could also provide a vehicle to take such proposals forward. We therefore suggest that this is explored.

As such, we advocate that additional provisions be added to this Bill to address the regulatory imbalance between clinical staff and non-clinical managers. Such provisions could ensure that where a manager has presided over failure of sufficient magnitude, and which can be directly attributed to their performance in their role, they could then be prevented them from taking up a new management position elsewhere within the NHS. This could be a useful safeguard that could lead to more effective management of the NHS in Wales. It could also create a system where non-clinical managers share in the risks that clinicians must accept, and therefore become more accountable for the role that they play in health care delivery.

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[1] BMA Cymru Wales (2015). Response to Welsh Government Green Paper, *Our health, our health service.* Available at: https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-ourhealthourhealthservice-27-11-2015.pdf?la=en

[2] BMA Cymru Wales (2017). Response to Welsh Government White Paper, *Services Fit for the future.* Available at: https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/influence/uk%20governments/wales/services-fit-for-the-future.pdf?la=en

[3] Robert Francis QC (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Available at: https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

[4] NHS England (2013). Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. Available at: https://www.nhs.uk/nhsengland/bruce-keogh-review/documents/outcomes/keogh-review-final-report.pdf

[5] National Advisory Group on the Safety of Patients in England (2013). A promise to learn – a commitment to act: Improving the Safety of Patients in England. Available at: https://www.gov.uk/government/publications/berwick-review-into-patient-safety

[6] June Andrews and Mark Butler (2014). Trusted to Care: An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board. Available at: http://www.wales.nhs.uk/sitesplus/863/page/73970

[7] Keith Evans (2014). A review of concerns (complaints) handling in NHS wales: "Using the Gift of Complaints". Available at: http://www.wales.nhs.uk/usingthegiftofcomplaints

[8] NHS Scotland (2012). Staff Governance Standard, fourth edition. Available at: https://www.staffgovernance.scot.nhs.uk/what-is-staff-governance/staff-governance-standard/

Introduction

	The Welsh NHS Confederation response to the Health, Social Care and Sport Committee's inquiry into the Health and Social Care (Quality and Engagement) (Wales) Bill.
Contact:	**Nesta Lloyd-Jones**, Assistant Director **Xxxx** Policy and Research Officer
Date created:	2 September 2019

1. The Welsh NHS Confederation welcomes the opportunity to respond to the Health, Social Care and Sport Committee's inquiry into the Health and Social Care (Quality and Engagement) (Wales) Bill ('the Quality Bill').

2. The Welsh NHS Confederation represents the seven Local Health Boards, three NHS Trusts and Health Education and Improvement Wales (HEIW). Our response to the Bill has been developed through engaging with our members and receiving detailed information from the Chairs and Chief Executives.

Summary

3. The Welsh Government's long-term plan for health and social care, *A Healthier Wales*, sets out a whole-system approach to the provision of services that is based on health and wellbeing and preventing illness. The proposed Quality Bill is a lever to achieve this vision, particularly in relation to developing a shared understanding of how the health and social care system will operate in future.

4. In our written responses to the '*Our Health: Our Health Service*' Green Paper ('the Green Paper) in November 2015 and the '*Services Fit for the Future*' White Paper ('the White Paper') in September 2017, we emphasised that any legislation in this area would need to support the planning and delivery of a truly integrated health and social care system that supports the long-term aims of the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015. Our position is that the proposed Quality Bill achieves this vision and we therefore broadly support the general principles of the Bill.

5. However, there are a number of areas where further information and guidance is required and without these points of clarification we would stop short of fully supporting the proposed legislation in its current form. Specifically, the Bill does not clarify how the duties of quality and candour will be applied to social care services in an increasingly integrated health and social care system. In addition, it is not clear what the definition of quality within the Bill is and within the current proposals what it will mean for patients and service users (particularly those receiving integrated services).

A summary of the Welsh NHS Confederation's position on the four areas of the proposed Quality Bill is outlined below:

- **Duty of quality:** We support the introduction of the proposed duty of quality. Embedding the duty into legislation supports the drive to put patient safety at the heart of everything the NHS in Wales does. However, there are areas where it is unclear how the duty will operate in practice, particularly in relation to what we mean by quality and how quality will be measured.
- **Duty of candour:** We support the introduction of the proposed duty of candour, which builds on the work that has already taken place across the health system to achieve a culture of openness, honesty and transparency. However, greater clarity is needed on a number of areas, particularly how the duty will support integration and what the duty on social care organisations will be.
- **The Citizen's Voice body:** We support the proposed introduction of a single, independent Citizen's Voice body that will replace the existing functions of Community Health Councils (CHCs). However, we would recommend that the new Citizen's Voice body is independent from Welsh Government to ensure public confidence that the body provides a representative voice on their behalf.
- **The proposed appointment of Vice Chairs to NHS Trusts:** We support the Bill's proposition to appoint Vice Chairs to NHS Trusts and would recommend that the Vice Chair be considered an additional appointment of an Independent Member, rather than taken from the existing composition of a Trust's Executive Board. This will ensure greater consistency across the NHS and strengthen existing governance arrangements. We recommend that this proposal should be extended to Special Health Authorities e.g. Health Education and Improvement Wales.

General principles of the Bill

a. Placing quality considerations at the heart of everything the NHS in Wales does

6. We are broadly supportive of the proposed duty of quality. However, there are a number of areas where further clarity is required, for example: what do we mean by 'quality'; how will quality be measured; and how the proposed duty will interlink with other reporting frameworks and requirements placed on an increasingly integrated health and social care system.

7. If we are to ensure that we put the needs of people at the centre of our plans and services, then a duty of quality is fundamental and integral to the ways in which we work with organisations that deliver health and care services. In our response to the White Paper in 2017, we questioned whether such a duty was needed given that NHS Wales has adequate legislation that clearly sets out how organisations need to work in partnership to deliver high quality, person-centred services. However, we support the Bill in as far as it demonstrates a clear commitment to focus on quality and safety in all areas of service delivery.

8. NHS bodies in Wales have been under a duty to make arrangements for the purpose of improving the quality of health and care services since 2003 under section 45(1) of the Health and Social Care (Community Health and Standards) Act. Although the 2003 Act requires NHS bodies to make arrangements to monitor and improve the quality of service, it has largely been interpreted as requiring NHS bodies to have quality assurance (control) arrangements in place across their organisations to monitor and improve the quality of service. This is a

different approach to delivering continuous improvement to what is set out under recommendation six of the Parliamentary Review of Health and Social Care in Wales e.g. the need for "*constant and serious attention to quality control, improvement and planning*".

9. The duty of quality set out in the 2003 Act has succeeded in providing some focus on improvement in quality and safety in NHS Wales. The clearest example of progress has been the development of an infrastructure that provides assurance that improvement is taking place, namely through the establishment of Quality and Safety Committees at every Health Board and Trust. These Committees report directly to their respective Health Board/Trust Board and provide robust arrangements for the reporting, investigation and learning from patient safety incidents and concerns. Reporting mechanisms of this kind are beneficial because they allow bodies that are subject to the duty of quality to demonstrate how their functions have been exercised to secure improvement in the quality of services provided. Moreover, such mechanisms are a transparent way of demonstrating how the organisation has taken steps to comply with the duty.

10. It is positive to see within the Bill that there is a focus on patient experiences as well as outcomes and the application of consistent quality, safety and experience standards across Wales. This will support the implementation of the Quality Improvement Framework. It is positive also to see that the patient experience aspect of the proposed duty of quality supports the drive for transformational change through values that underpin the NHS in Wales.

11. The duty of quality is also welcomed from a Health Education and Improvement Wales (HEIW) perspective. HEIW recognise that they have a lead role to play in the delivery and commissioning of education and training in respect of this duty for undergraduates, postgraduates and the professional workforce in the NHS.

Areas where clarification is required

12. Despite our broad support for the proposed duty, there are a number of areas where further clarification is needed.

What do we mean by 'quality'?

13. Firstly, we need to be clear what we mean by 'quality', not just from an NHS perspective, but from a social care perspective too. Delivering continuous quality improvements should not be a priority that is exclusive to the NHS but should be considered a health and social care priority as well. Health and social care should work towards the same quality standards and targets, and these standards and targets should be agreed by the Welsh public. The drive towards treating patients as active participants in their care, rather than passive recipients (as per the Prudent Healthcare agenda) is a positive step in this direction. The challenge now is to go a step further and open up a debate with the wider Welsh public about what the health and social care sector should be prioritising.

14. The Social Services and Well-being (Wales) Act 2014 is a useful lever to accelerate progress through its emphasis on a citizen-centred approach to the design and delivery of services, partnership working and integration. Having a precise definition of quality is also important

for the purposes of developing a benchmarking matrix that can bear scrutiny within NHS Wales as well as external (international) benchmarks.

15. While the Bill does attempt to define quality, using deceptively simple phrases like "*duty to secure quality*" and "*improvements in quality*" conceals the need to consider the underlying issues such as prioritisation and justifiable innovation. The inclusion of a very broad concept of quality in legislation is likely to generate more questions than could ever be answered. NHS Wales organisations recognise that defining these terms is a difficult task to ensure implementation, so the danger is that the Bill creates a wish-list in being drawn too broadly to impose specific obligations.

How will quality be measured?

16. There is a need for greater clarity around how compliance against the proposed duty of quality would be measured. NHS Wales already has a set of Health and Care Standards which were developed through engagement with patients, clinicians and a range of external stakeholders. The Standards are structured along seven themes, which collectively describe how a service provides high quality, safe and reliable care that is centred around the person. It is currently unclear how the proposed duty of quality supports these existing Standards. In addition, measuring compliance against a duty of quality is likely to be based on the presentation of qualitative evidence – for example, through patient feedback forms – which could be open to interpretation. Consideration should be given to intertwining the existing NHS Wales Health and Care Standards (as well as existing competencies and codes of conduct for management) with the duty of quality so that health and social care organisations are clear on the processes and measurements that will be required to conform to the requirements of the Bill. The new standards framework needs to be clear and supported by a robust evidence base in terms of their definition and meaning, not only from a professional point of view, but also from the patients' perspective.

What are the aims of the duty of quality?

17. Greater clarity is required on whether the duty of quality is intended as a procedural issue on behalf of Welsh Ministers, or whether the duty is aimed at providing the public with an expectation that a particular level of quality (however defined) will be provided whenever they come into contact with health or social care services. In other words, it is unclear whether the duty of quality is intended to apply primarily to NHS staff (by creating an environment where quality and safety are considered the overwhelming priorities, thereby modifying general working practices to reflect this), or whether the duty seeks to provide the Welsh public with an expectation on quality. The distinction is a subtle but significant one because managing patient expectations of what the NHS can and cannot provide, and generating good public understanding of those expectations, is part of a much broader conversation. If it is intended that the duty of quality is primarily about patient expectations of health and social care services, then there needs to be greater emphasis on the need for an open and honest dialogue with the public about what the future of health and social care looks like.

18. Ensuring quality will rely on organisational structures, their accountabilities and performance regimes. While we are broadly supportive of the duty, it needs to be implemented in a way that does not act as a barrier to NHS professionals getting on with their day-to-day

responsibilities of caring and providing high quality services to the population. Significantly, it is not just frontline staff who will need to take account of this – senior managers and service leaders will need to work together to create an environment that supports frontline staff to work in this way. Improving and ensuring quality, and supporting a process of continuous improvement, is an organic process that will not be achieved by the introduction of legislation alone. These ideas need to be woven into the values and cultures of individual organisations and measured against a robust performance and audit regime. This supports the key point that there needs to be consistency across the integrated health and social care system around how quality is measured, with the same principles and standards applied to directly-provided services, commissioned services (e.g. from primary care or the third and independent sectors), and all professional groups that may not have a regulatory framework in place (e.g. healthcare support workers). The Bill does not clarify whether the duties of quality and candour would apply to those organisations from whom NHS organisations commission services, and if so, whether they would be enforced in the same way. Greater clarity is needed here.

19. Finally, partnership responsibilities in respect of the aims of the duty of quality, particularly where NHS Wales organisations are already developing integrated services, are not clear. We would welcome further clarity in the Bill on this point.

Enabling services

20. The introduction of this duty should only outline the process to achieving an improved health and social care system for the people of Wales. Consideration needs to be given to key enabling services and the ways that these services would be framed, achieved and reported under the Bill. Clearly, the proposed duty of quality will not achieve the system-wide improvement without these enabling services. For example, a shared performance management framework would need to be introduced across health and social care to monitor performance across geographical and organisational boundaries, and this would need to encompass specific measures to enable monitoring and evaluation of 'real-time' performance indicators through a dashboard. This would rely on designing and implementing sophisticated IT structures, interoperable across NHS Wales and social care services. Further guidance and assurances would need to be provided around how these enabling services will be supported to deliver a framework of this kind. We would emphasise however that the resulting framework is a positively-framed system – in other words, it should be enabling and facilitative rather than punitive. Similarly, it is unclear how the proposed duty of quality will apply to clinical and independent contractors, and whether the duty will be extended to apply to non-clinical contractors.

b. Placing a duty of candour on NHS organisations

21. We are supportive of the proposed duty of candour under the Bill. This approach is predicated on openness, honesty and a positive culture within organisations and across the broader health and social care sector. Honest communication and candid apologies when things go wrong indicate a willingness on the part of healthcare professionals to support patients in providing respectful treatment and care.

22. We recognise also that the introduction of this duty would bring Wales into line with jurisdictions in England and Scotland and there will be opportunities for NHS Wales to learn from those systems when Regulations are drafted. The duty of candour is also an excellent opportunity to achieve uniformity across health and social care in Wales.

23. The Francis Report of 2013, which reported on the series of failures in patient care at Mid Staffordshire NHS Foundation Trust, made nearly 300 recommendations around organisational culture and values that should be upheld to maintain high quality performance, quality and safety standards. Specifically, the Francis Report recommended that "*the NHS, and all those who work for it, must adopt and demonstrate a shared culture in which the patient is the priority in everything done*". This is a significant statement as it implies that the duty to act in an open, honest and transparent manner should be imposed not only to individuals who work within a health and social care system, but also to the system as whole (in other words, it should be applied both individually and systematically). The report argued for "*fundamental change*" in the culture of the NHS to make sure that patients are put first.

24. Set against the conclusions of the Francis report, the proposed duty of candour is to be welcomed. The duty will improve service user experience, communication and engagement between NHS Wales and service users. It will build on the work that has already been undertaken to ensure NHS bodies in Wales are open and honest when things go wrong through the 'Putting Things Right' process and has the confidence and trust of service users. Our members also welcome the proposed duty of candour insofar as it supports recommendation six of the Parliamentary Review of Health and Social Care in Wales, namely to develop a system that's always learning and enhancing the infrastructure and leadership required to support it.

25. It is important to recognise however that steps have already been taken towards developing a culture of openness in the NHS. These include the introduction of new arrangements for handling complaints in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011; improved reporting and investigation of serious incidents; reviews of all deaths in hospitals; and the publication of Annual Quality Statements by Health Boards, NHS Trusts and the Welsh Government.

26. We support the proposition that the principles of openness and candour be extended beyond the current requirements set out in the 'Putting Things Right' regulations to include the design of care plans as well as the delivery of health and social care services. Like the proposed duty of quality, emphasis needs to be on embedding the associated values and behaviours of the duty of candour into the fabric of NHS Wales organisations without exception (that is, from the board to frontline staff). This needs to be done from the design and agreement of plans and care plans, not exclusively as part of investigations or redress. If NHS Wales and the social care sector apply these principles in the earliest stages of service design, the expectations of patients, their families and their carers should be more clearly understood.

Areas where clarification is required

27. There are a number of questions posed by the implication of the duty of candour that require further discussion.

How will the duty of candour support integration?

28. Firstly, it must be remembered that health and social care services in Wales are operating under an increasingly integrated system, and so greater clarity is needed in terms of how this duty will apply in practice to social care. While it is relatively clear how the proposed duty will apply to NHS Wales organisations, the fact that the duty seems to apply only on an organisational level, rather than on an individual level, means it is unclear how this will work in practice when a patient receives an integrated service. It is similarly unclear how the duty will apply to partnership arrangements.

29. Further clarity is also required around accountabilities and responsibilities and how the inspection regime might work in practice. This means providing further information around how the duty will take into account the current social care regulatory landscape and the arrangements for assurance work that extend across health and social care partners.

The duty of candour could cause complications with policies on whistle-blowing

30. The implementation of the proposed duty of candour needs to dovetail with existing policies that require NHS staff to be honest when errors are made and to speak out, if necessary, to protect patients. This may require NHS Wales organisations to re-examine existing policies on whistle-blowing to ensure that there are no adverse situations that could discourage staff from reporting their concerns.

Primary care

31. From a primary care perspective, further clarity is needed around how the duty will apply where providers of services operate on a contractual basis and not directly as part of NHS Wales-provided services e.g. GP practices, pharmacy and dentistry. Further information is needed around the level of support and assistance that would be provided to primary care to explain the systems to them and implement the proposals. It will be important to establish the position of primary care provision and who holds the governance ring on systems provided by independent contractors e.g. General Medical Services (GMS) and General Dental Services (GDS) contracts. It is unclear where the final arbitration about the level of candour would be made under the proposed Bill, particularly against a backdrop of medical litigation.

Defining 'candour'

32. Clearly, the precise definition of candour as it applies under the Quality Bill will need to be carefully considered. Candour is defined in the Francis Report as: "*the volunteering of all relevant information to persons who have, or may have been, harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made. Prompt apologies and explanations, with a reassurance they will not reoccur, may prevent a claim being brought at all*".

33. Some of the wording under this section of the Quality Bill is imprecise, which could lead to differences in interpretation. For example, paragraph 4(2)(a) under Part three of the Bill requires NHS bodies to give notification to the service user that the duty of candour has come into effect when the NHS body "first becomes aware" of this. It would be difficult to pinpoint the exact moment that a member of staff becomes aware that the duty has come into effect, and subsequently, the exact moment that this should be communicated to the service user.

34. Another related challenge here is that use of the word “apology” could lead to defensive behaviour on the part of NHS Wales bodies. Section 2 of the Compensation Act 2006 makes it clear that an apology is not intended to amount to an admission of liability for the purposes of negligence claims. This should be reflected in the Bill because the current wording may bring about situations where NHS staff are deterred from apologising for fear of litigation.

35. Definitions, thresholds and triggers need to be very carefully defined, and the process of defining them needs to be done while considering the potential impact on the service user. Moreover, section 11(5) of the Bill does not consider the commissioning responsibilities of Health Boards within or outside of Wales, which we feel ought to be reflected.

36. Recommendation 181 of the Francis Report provides that there should be a statutory obligation of candour on healthcare providers, registered medical practitioners, nurses and other registered health professionals where there is a belief or suspicion that any treatment or care provided to a patient by or on behalf of their employing healthcare provider has caused death or serious injury. These definitions are accepted. Indeed, candour is a two-way process as it requires that any patient who is harmed by the provision of less than safe care is informed of the that fact and is offered appropriate remedy, regardless of whether they have made a complaint or questioned the care the care they have received.

37. It is acknowledged that social care professionals are already subject to the standards and codes of conduct set out in “Openness and honesty when things go wrong: the professional duty of candour”. This guidance is intended as a practical tool to aid social care professionals (social workers, social care managers and residential child care workers registered with Social Care Wales) in their practice. Implicit in this guidance is an expectation that employers will actively promote an open, supportive and fair culture in the workplace, with an emphasis on continuous improvement and learning from mistakes. Consideration should be given to developing similar guidance that embeds the duty of candour across NHS Wales and social care organisations.

An independent authority for NHS and social care staff to turn to

38. We recommend that there needs to be an independent authority for NHS and social care staff to turn to if they feel their concerns are not being listened to or acted upon. It is not enough to simply provide staff with the ability to respond to systemic problems or instances of poor care through a formal mechanism.

39. Consideration should be given to introducing a similar service to that of the National Guardian’s Office (NGO) in NHS England, which was introduced following the publication of the Francis Report. The NGO was established as an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes ‘business as usual’. The NGO is not a regulator, but is sponsored by the Care Quality Commission, NHS England and NHS Improvement, and is supplemented by a network of local Freedom to Speak Up Guardians across all NHS Trusts. The NGO also has a key role in reviewing Trusts’ ‘speaking up culture’ and the handling of concerns in instances where the Trust has not followed good practice. If Wales is to consider a similar body, greater clarity will need to be provided around how such a system would work in an increasingly integrated system. A key priority in

developing this type of body would be establishing clear lines of sight for NHS and social care staff so that they are left in no doubt where to turn to when they feel that their concerns have not been effectively managed through conventional lines of accountability.

A recent case of the duty of candour in England

40. We should also consider the recent case of duty of candour in NHS England. The case related to a baby who died after being admitted to Bradford Royal Infirmary in July 2016. Although the Trust had recorded the baby's care as a Notifiable Safety Incident – which triggered the operation of the duty of candour - the family were not informed of this and did not receive an apology or explanation until October of that year. The Trust was fined for breaching the duty of candour by the Care Quality Commission.

41. The Care Quality Commission guidance document '*Regulation 20: Duty of Candour March 2015*' states clearly that the duty of candour applies to all "*unintended or unexpected incidents*" if they result in the requisite level of harm, even if they are recognised (and consented) as complications of the treatment. Significantly, there doesn't have to be a failing in the care provided for the duty to come into effect.

42. This prosecution is a sign that the Care Quality Commission exercises its authority to ensure compliance with certain minimum standards – standards below which care must never fall – and serves as a reminder that healthcare providers must be open and transparent with patients and their families not only in cases where something goes wrong, but also in cases where there is no suggestion that a failure in patient care has occurred.

43. The Care Quality Commission's chief inspector of hospitals, Professor Ted Baker, said: "*The action that we have taken against Bradford Teaching Hospitals does not relate to the care provided to this baby, but to the fact that the Trust was slow to inform the family that there had been delays and missed opportunities in the treatment of their child. Patients or their families are entitled to the truth and to an apology as soon as practical after the incident, which didn't happen in this case*."

44. The case is a timely reminder that the duty of candour is not just about the receipt of clinical services – it is equally about the way that NHS staff communicate with patients and manage the patient-NHS relationship, even in cases where there has been no failing in the care provided. The case is also a reminder that the duties will likely be invoked in cases where there is a delay in care or incorrect advice being provided, not just the receipt of services.

Sanctions for dealing with non-compliance with the duty of candour

45. It is difficult to find in the Explanatory Memorandum any mention of sanctions for dealing with non-compliance with the duty of candour. That said, we recognise that the Justice Impact Assessment (JIA) does consider the potential impact on the judicial system of the proposed duty (at paragraph 163). The JIA states: *"Based on similar schemes that operate in England, we believe that the likelihood of civil claims arising from the new duties to be low. The likely impact on the justice system of the proposals of the Health and Social Care (Quality and Engagement) (Wales) Bill is therefore minimal or nil".* This suggests that the 'new' duty of candour is, to some extent at least, optative (as in, it indicates a wish or a hope) and may

achieve little over and above the duties that NHS Wales organisations and healthcare professionals are already subject to.

c. Strengthening the voice of citizens across health and social services

46. As a health and social care sector, we recognise and value the patient voice to support, plan and deliver high quality health and social care services. The Welsh NHS Confederation values the role of citizens' (the public and patients) voice and the contribution that CHCs have made to the improvement of healthcare services. However, in our response to the Welsh Government's Green Paper in 2015 and the White Paper in 2017, we emphasised that we believe the citizen's voice could be strengthened due to the more integrated way health and social care are working, either by reforming CHCs or establishing an altogether new body that builds on the strengths of the current system. The proposed Citizen's Voice body under the Quality Bill is closely associated with this suggestion, and we therefore support this proposal.

47. While we support the Citizen's Voice body however, it should be emphasised that Health Boards continue to have positive and constructive relationships with CHCs in their respective areas. Despite some challenges, the relationships Health Boards have maintained with CHCs have ensured that both organisations work collaboratively in the interests of patients and service users. Our members also welcome that the proposed body will not be dependent on NHS Wales hosting arrangements for its pay and rations, which has caused unnecessary complications in the past.

The Citizen's Voice body is an opportunity to build on the existing framework

48. Currently the way the seven CHCs are configured enables them to represent the public's interest in the NHS. This is not reflective of an increasingly integrated approach to service delivery because there is no specific statutory body for citizen engagement in social care. Local authorities are under a duty to promote user-led services and to involve people in the design and provision of services, but the fact remains that no CHC-equivalent body exists for social care. Effective citizen engagement is an expectation within the Social Services and Well-being (Wales) Act 2014 and the new proposed national arrangement will ensure this without duplication between health and social care issues.

49. Health Boards already have strong mechanisms in place for involving the citizen's voice in the design and delivery of health and care services, including patients' fora, community engagement and public consultations on service change (e.g. the Transforming Clinical Services programme at Hywel Dda UHB). Regional Partnership Boards (RPBs) are another example of this. Under the Social Services and Well-being (Wales) Act 2014, RPBs must include as core membership:
    - **At least two** persons who represent the interests of third sector organisations in the area covered by the RPB; and
    - **At least one** person who represents the interests of *national* third sector organisations in the area covered by the RPB.

50. The Social Services and Well-being (Wales) Act 2014 also requires Health Boards to work with Local Authorities to jointly carry out an assessment of the needs for care and support

(population needs assessments). The assessment must identify the range and level of preventative services necessary to meet that need.

51. The first population assessment reports were published in May 2017. A supporting Code of Practice makes clear that these assessments must include a combination of quantitative and qualitative information that clearly sets out the care and support needs in relation to various core themes. Population needs assessments underpin the integration of health and social services by producing a clear and specific evidence base to which RPBs are expected to respond. They also inform a range of other operational and planning decisions in relation to care and support services e.g. they inform, and are informed by, Integrated Medium Term Plans (IMTPs).

52. In undertaking these assessments, there is a requirement for partners to engage with citizens, as well as the third and private sectors, to ensure that their voice is heard in the planning of services. This is an example of how NHS Wales is already using the existing framework to involve the people of Wales in the design and delivery of services.

53. In addition to the integration agenda, Health Boards are working in a more integrated way across organisational boundaries and services are increasingly being provided regionally, particularly specialist health services. This has the potential to cause problems when there are structural changes to Health Boards that impact organisational boundaries. CHC's attachment to a defined geographical area means that challenges can arise when cross-boundary working or changes to service delivery are proposed because rather than considering the wider health and wellbeing benefits put forward by the proposed service change, CHCs will exclusively consider the potential impact on their local populations. This could lead to scenarios where innovative proposals for transformation of services are rejected even in cases where alternative proposals to deliver improvements are lacking. An all-Wales body, like the one proposed in the Quality Bill, avoids these potential challenges.

Areas where clarification is required

Advocacy services for complaints

54. Our members are supportive of the approach suggested under section 16 of the Quality Bill to provide assistance/advocacy services in respect of complaints made. However, our members emphasise that complaints should be made in accordance with the 'Putting Things Right' scheme under the NHS (Concerns, Complaints and Redress) (Wales) Regulations 2011.

Raising awareness of the Citizen's Voice body

55. In 2014, Ruth Marks MBE carried out an independent review of Healthcare Inspectorate Wales (HIW). While the review focused primarily on HIW, it also considered the role and function of CHCs. It acknowledged their importance in promoting and protecting the interests of patients and in providing advocacy services to patients who wished to make a complaint about NHS services. However, the review also emphasised that CHCs needed to have a higher public profile among the Welsh population as "*too many people do not know of their existence*" and offer "*much more advice and support to people who have concerns and wish to make complaints about their health care*".

56. Steps need to be taken to ensure that public awareness of the Citizen's Voice body is greater than was the case for CHCs. This should be done by a Welsh Government-led engagement approach that involves Health Boards, Trusts and social care organisations as equal partners. The mechanisms for raising public awareness of the Citizen's Voice body should also consider how the national body is going to operate on a regional and local level so that it is transparent and accessible to all.

Welsh language

57. We recommend that the Citizen's Voice body is able to deliver a fully bilingual service in accordance with the Welsh Language Standards (No. 7) Regulations.

58. It is likely that patients, their families or their carers will interact with the Citizen's Voice body when in a state of disappointment, distress, sadness and perhaps anger and it is important therefore that vulnerable people and their families can access services in their first language.

Clear governance framework to support public trust

59. The Citizen's Voice body needs to be representative of the Welsh population as a whole. A key part of achieving representativeness is to have a clear governance framework in place for Board composition and membership, terms of office, role descriptions, and a programme for member training and development. Moreover, efforts should be made to ensure meetings take place across the geographical landscape of Wales. Positive measures should be taken by Welsh Government during the appointments process to ensure members of the Citizen Voice body represent the diverse communities they serve.

60. Governance arrangements are not just about accountability – they are also about achieving public trust. As a new body, public trust will need to be established right from the outset. Consideration needs to be given to how the public will respond to a Welsh Government-appointed body, and questions about the true independence of the body, given that the Board will be appointed by Welsh Government, are inevitable. Similarly, given the importance of achieving such a level of public trust in the new body, we feel that the Welsh Government should clarify why the appointment of the Chief Executive Officer has to be endorsed by Welsh Ministers.

61. We would emphasise also that the Bill does not clarify where the final arbitrator will be placed in dealing with potential conflicts. Without addressing this with more precision, the Bill would not deal with the 'elephant in the room' around supra-regional service changes.

Children and young people

62. It is unclear whether the proposed Citizen's Voice body will represent children and young people. Children and young people are currently not within the remit of CHCs, so clarity on this point would be welcomed.

d. Strengthening the governance arrangements for NHS Trusts

63. NHS organisations in Wales are supportive of the Bill’s proposal to introduce Vice Chair roles for NHS Trusts. Overall, it is felt that this approach will ensure consistency across Health Boards and Trusts and strengthen leadership and governance arrangements. However, further clarity is needed around whether the proposed Vice Chair for a Trust will be considered an additional Independent Member of the organisation or taken from the existing composition of the Board, and also whether the Vice Chair will be remunerated for time required above and beyond that of an Independent Member. It is currently unclear whether a Vice Chair at an NHS Trust will need to go through the same appointment process that applies to Vice Chairs at Health Boards. We recommend that the Vice Chair be considered an additional Independent Member.

64. HEIW would also request that the Quality Bill enable Welsh Ministers to appoint the Vice Chairs at Special Health Authorities. This would bring HEIW’s governance structure in line with the current position of Health Boards and the proposed position of NHS Trusts.

Conclusion

65. We broadly welcome the proposed introduction of the Health and Social Care (Quality and Engagement) (Wales) Bill. While there are a number of areas around the duties of quality and candour where further clarification is required, our position is that embedding these duties into legislation is a significant step towards achieving a system-wide approach to quality and candour in health and social care for future generations. We are also broadly supportive of the Bill’s proposition to establish a Citizen’s Voice body, which consolidates the commitment of the health and social care sector in Wales to put people’s voices at the heart of the design, delivery and improvement of services which supports the long-term vision in *A Healthier Wales.*

66. These developments build on the work that has already been done in Wales but provides a more streamlined approach to achieving an integrated health and care system that places patients at the heart of everything it does, is continuously learning and improving, and is working towards being fit for the future. Our members look forward to providing further detail to the Committee at the oral evidence sessions on 19th September 2019.

The Health and Social Care (Quality and Engagement) (Wales) Bill

The main focus in this paper is on the general principles of the Bill, and the barriers to implementation and potential unintended consequences of the parts 2 and 3 of the Bill.

Comments on the General Principles underpinning the Bill

- Attempts to improve and protect the health, care and well-being of the population of Wales are to be welcomed. However, it is important that to take account of the many and various ways in which quality and continuous quality improvement is already a central factor in the provision of health services in Wales.
- The introduction of a statutory duty of candour has been recommended in recent years in order to bring the law in Wales in line with that in other UK jurisdictions, and this is an important consideration, although there is already a high level of support for the concept of candour in *Putting Things Right*, and in guidance issued by professional bodies, defence organisations and numerous policy documents. It is important to recognise that a range of measures have already been introduced in Wales with the aim of developing a "culture of openness" in the NHS. These include arrangements for handing concerns in the *National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 201126*; measures for reporting and investigating serious incidents, and the publication of annual Quality Statements by LHBs, NHS Trusts and the Welsh Government.
- The introduction of a process by which NHS Trusts will be able to appoint Vice Chairs will put Trusts on the same footing as Health Boards and strengthen their governance arrangements. It gives formal recognition to the work of Independent Members of Trusts who give up additional time and take on extra responsibilities, for example when attending meetings as deputies for their Chairs
- The creation of the proposed new Citizens' Voice Body which is independent , will create an important opportunity for strengthening the voice of service-users and patients and gathering views about existing services and proposals for planning and delivery of services.

Part 2: Quality

Much of what is contained in the Bill concerning quality is aspirational and is already at the heart of what those responsible for the NHS at every level are working to achieve. Quality considerations are central to the present healthcare system in Wales, which is subject to many forms of continuous formal and informal monitoring and inspection, and failure to meet high standards can already have serious consequences under existing common law and statutory provisions. Numerous policy documents contain statements which are evidence of this strategic direction, and there is a strong argument to the effect that a duty to bring about improvements in the quality of health and care services already exists and that additional statutory duties of the kind stated in the Bill are unnecessary.

Barriers to implementation of Part 2 and potential unintended consequences

Problems defining "quality" could hinder progress.
While the Bill does attempt to define quality, using deceptively simple words such as *"duty to secure quality"* and "*improvements in quality"* conceals the need to consider underlying issues such as prioritisation and justifiable innovation, and the inclusion of a very broad concept of quality in a statute is likely to generate more questions than can ever be answered. It is inevitably difficult for those drafting legislation to define vague concepts and produce suitable language to ensure implementation, so the danger is that the Bill creates a wish-list in being drawn too broadly to impose specific obligations.
Unlike *"candour",* at a philosophical level *"quality"* is too nebulous to define in appropriate detail even in the context of healthcare, as any attempt at a precise definition would inevitably be encyclopaedic. The more one attempts to define it, the more elusive it becomes. Obviously high quality, affordable healthcare is desirable, but is this an aspiration that will prove too difficult to monitor in the modern world when new and more expensive treatments are regularly coming on-stream?

The King's Fund attempted a definition of "*quality improvement"* in its comprehensive research report in 2015, arguing that the NHS would be unable to meet the health care needs of the population without *"a coherent, comprehensive, unifying and sustained commitment to quality improvement as its principal strategy".*

Their definition covers some of the ground but it also contains a number of omissions.

"By quality improvement we mean designing and redesigning work processes and systems that deliver health care with better outcomes and lower cost, wherever this can be achieved. This ranges from redesigning how teams deliver care in the clinical microsystems that make up health care organisations to large-scale reconfigurations of specialist services such as stroke care and cancer care. It includes redesign of training, budgeting processes and information systems and requires leadership and cultures that both understand and value quality improvement".

Other jurisdictions have attempted to define quality in this context. For example NHS England refers to the Health and Social Care Act 2012 which states that it has a duty to continually *drive improvements in the quality of care* across a comprehensive health service, and quality is defined in the statute without the inclusion of specific details as having three dimensions: safety, clinical effectiveness and patient experience.

It follows that the only sensible approach to such a broad and multi-faceted concept as quality is for those who draft the legislation to list some examples of its scope such as those contained in the Bill, recognising that the list provided is not exhaustive.

The proposed quality duties do not apply across the whole health and care system

Wales is in the process of encouraging organisations providing health and social care to become more closely aligned in order to meet the needs of patients, carers and vulnerable groups. An opportunity to extend uniform basic principles across systems may be missed if a whole-system approach does not form the basis of every attempt to achieve long term plans for integrating health and social care.

Part 2 is a classic example of "aspirational" legislation and is difficult to enforce
A number of sociologists of law and legal commentators (among them Weber, Renner, Feldman), have taken the view that any attempt to enshrine political and moral aspirations into legislation will inevitably produce amorphous and vague concepts which are ultimately difficult to enforce, amounting to the creation of wish-lists rather than serious attempts to change the law.
David Feldman, Professor Law at Cambridge University, gives examples of this type of legislation and its consequences in a seminal paper in 2015. In Feldman's words:

"[Such statutory provisions] do nothing to shape or dictate policy, except by making it necessary to consider whether, at a high level of abstraction, what is being proposed is consistent with these high-level standards. They do not preclude anything, because views of what is safe, integrated, efficient and economic can differ widely". [i]

The Explanatory Memorandum states that the existing legislative framework results in too narrow an approach to driving up quality, and that a legislative change is necessary to achieve a system-wide approach, hence the inclusion of a duty on Welsh Ministers and Special Health Authorities. However, the aspirational tone of the legislation means that in effect it adds little more than the reporting obligation it imposes on all the relevant bodies and persons.

In summary, there are as many ways of bringing about improvements in the quality of health and care as there are patients receiving or hoping to receive it. While some aspects of quality improvement, such as effectiveness and safety, are clearly measurable, many others cannot be measured as easily – for example subjective issues such as the experience of patients.

Potential loss of public confidence
There is a danger of "initiativitis" arising from the introduction of yet another aspirational duty in a statute, leading people in general and staff in particular, to lose confidence in the Bill through lack of full understanding of what is intended, and an inability to envisage how the duties stated in part 2 could be enforced.

The duty on organisations to report annually their assessments of improvements in outcomes is to be welcomed. However, there is a danger that a tick-box exercise could emerge.
Another unintended consequence of part 2 is that reference to quality and the need to achieve improvements in quality could produce a tick-box exercise which distracts from the important task of creating a culture in which excellent healthcare can flourish, with the result that measuring quality improvement becomes a daunting task. It is a relatively simple matter to

produce an annual report, but care will need to be taken to ensure that the issuing of a meaningful report with numerous examples of measures taken to achieve improvements in quality is more than a routine box-ticking procedure.

The existing framework could become over-complicated by rhetoric

As there are already satisfactory arrangements in place for enhancing the quality of care, further statutory provisions could complicate a system that appears to be effective. One could take issue with the statement in the explanatory memorandum accompanying the Bill that without the proposed legislative change aimed at reforming the 2003 Act, a system-wide approach to quality based on outcomes is unlikely to be achieved and is unsupported by evidence. The present framework relies on policy documents that provide achievable goals and the prevention agenda and the sharing of good practice are already operational. Other systems, such as IT services are subject to monitoring, and appropriate governance structures dealing with quality which are already in place. Reporting systems and scrutiny of patients' experiences are well-established and are unlikely to be strengthened by the proposed new reporting obligations.

Part 3: The Duty of Candour

The proposal to introduce a statutory duty of candour into healthcare in Wales is to be welcomed. Importantly, it will bring Wales into line with the England and Scotland and there will be an opportunity for Wales to learn from the systems implemented in those jurisdictions when regulations are being drafted. It is also an excellent opportunity for ensuring uniformity across health and social care in Wales.

Ironically, Wales has lagged behind other UK nations in creating statutory recognition of the need to openness and transparency in healthcare, although the concept is firmly embedded in processes which have already been in place for some years. Among recommendations which have led to the inclusion of the duty in the Bill, a review of the concerns process in 2018 concluded that an explicit new legal duty of candour should be introduced.

In 1969, a report into failings at Ely Hospital in Cardiff revealed many examples of poor care and attempts to conceal evidence, even to the extent of intimidation of people who reported problems.[ii] Originating in Wales, the case of Robert Powell which reached the European Court of Human Rights in 1998 led to a campaign that highlighted the need to introduce a duty of candour throughout the United Kingdom[iii]. That was well before the publication of the Bristol Inquiry Report in 2001 and the Report of the Francis Inquiry in 2013 which identified many problems that can arise when individuals and organisations become defensive, and create a culture of secrecy in order to conceal errors, avoid costly litigation, professional disciplinary processes and even prosecutions.

Throughout the UK and elsewhere in the world there has been a clear shift of emphasis in the doctor-patient relationship towards greater respect for patients' autonomy, which is evidenced by changes in professional guidance, popular culture and social policy over the past thirty years. Honest communication and candid apologies indicate willingness on the part of healthcare professionals to support patients in providing respectful treatment and care" [iv]. This has also been reflected in the regulatory processes for health professionals and in the case law on consent to treatment which highlights the importance of being open and honest to patients.

For many decades the doctors' defence organisations have advised their members that being open and honest when errors are made is likely to deflect claims and complaints and produce fairer outcomes for patients. That view is evidenced in the medico-legal literature.[v] Evidence to support this position was presented to the NHS Complaints Review Committee (The Wilson Committee) whose recommendations[vi] formed basis of modern complaints systems in the UK. Patients frequently say that they are more interested in receiving an explanation and apology than compensation.

The Bill clarifies situations in which the duty of candour is triggered and will become operational, including some of the more complex issues that can arise when services are provided by one body on behalf of another or when bodies outside Wales are commissioned to provide treatment for Welsh patients or from independent providers. Arrangements for monitoring compliance with the duty are also outlined in the Explanatory Memorandum.

Barriers to implementation of Part 3 and potential unintended consequences

The Bill could be criticised for making no provision for sanctions
It is difficult to find in the Explanatory Memorandum any mention of sanctions for dealing with non-compliance with the duty of candour stated in the Bill. However, the Justice Impact Assessment (JIA) (para 163) does consider the potential impact on the justice system of the proposals, and states as follows:

"The Bill does not create any new, or modify any existing offences, sanctions or penalties and the duties that it introduces are placed on public bodies or bodies carrying out functions on their behalf, meaning that enforcement will be a matter of public record, through publicly available annual reports on quality and candour, rather than through specific sanctions"

The statement continues:

"Based on similar schemes that operate in England, we believe that the likelihood of civil claims arising from the new duties to be low. The likely impact on the justice system of the proposals in the Health and Social Care (Quality and Engagement) (Wales) Bill is therefore minimal or nil".

This view suggests that like the proposed duty of quality, the "new" duty of candour is to some extent optative and may achieve little over and above the existing duties[vii] placed on healthcare organisations[viii], and on healthcare professionals by their regulatory bodies – the GMC, NMC etc. It is worth referring to attempts to impose a duty of candour in other spheres – as follows.

Social Care in Wales

The Explanatory Memorandum to the Quality Bill refers (paras 47-49) to the parallel duty of candour in social care placed on providers and certain responsible individuals in Wales:

"In social care, a duty of candour already exists for providers and responsible individuals of regulated services. The 2017 Regulations10 deal with the duty of candour in regulations 13 and 83 and require service providers and responsible individuals to act in an open and transparent way".

The statutory guidance issued under section 29 of the 2016 Act sets out how the requirements may be complied with, namely by promoting a culture of candour,

"By having policies and procedures in place to support a culture of openness and transparency, ensuring that staff are aware of them and follow them".

The 2017 Regulations made under the Act include measures which support the duty, for example by requiring providers of regulated services to ensure that there are systems for recording and keeping records of incidents, complaints and concerns. In addition, Regulation10 requires the individual designated as responsible for the service to make provision for the quality of care, and support to be reviewed as often as required but at least every six months, and to report to the service provider on the basis that:

"This requirement supports a culture of continuous improvement and includes an analysis of the aggregated data on incidents, notifiable incidents, safeguarding matters, whistleblowing, concerns and complaints".

The Duty of Candour in NHS England

A duty of candour enforceable by the CQC came into force in 2014 in NHS England by Regulation 20 introduced under the Health and Social care Act 2008 (Regulated Activities) to complement pre-existing professional and contractual requirements. A review of the research literature indicates that this has not been hailed as an unqualified success[ix], and although failure to comply with the legislation is a criminal offence, it was not until January 2019 that the CQC announced that Bradford Teaching Hospitals NHS Foundation Trust had become the first NHS Trust to be prosecuted for failing to comply with the statutory duty of candour. A fixed penalty notice of £1250 was imposed, equivalent to 50% of the maximum fine that can be imposed by a Court.

By introducing Regulations by means of which criminal sanctions can be imposed for non-compliance with the duty of candour, NHS England has taken more emphatic steps than Wales is proposing in the Bill.

Problems of implementation in mental health settings

Implementation of the duty of candour could prove difficult in the context of treating vulnerable patients such as those suffering some forms of mental illness. For example, it is not always possible for relatives of patients with certain psychiatric conditions to be given details about adverse outcomes experienced by their loved-ones because patients can refuse staff permission to share information about their care and treatment. This problem arises regularly in psychiatric units, but families need to be able to understand and support patients when harm occurs and they should be supported by candid explanations when mistakes are made.

A related practical problem can arise when no power of attorney is in place and a patient lacks capacity to consent to treatment and is unable to understand information about an adverse outcome.

These matters could be dealt with in the Regulations, but will require careful consideration, since an unintended consequence could be that certain groups of patients do not receive the full benefit of the proposed duty. Some instances of harm may never be disclosed. This would also mean that organisations would not be compliant with the legislation.

The use of the word "apology" could cause defensive behaviour - clause 4 (3)
It is possible that staff will be deterred from apologising for fear of litigation, and it has been noted in many academic and professional publications that anxiety about possible litigation has long been recognised as a barrier to disclosure of errors[x].

As an apology is not intended to amount to an admission of liability for the purposes of negligence claims, (see Compensation Act 2006 s 2), this should be emphasised in Regulations and during the passage of the Bill.

The duty to report annually could prove onerous for small organisations (clauses 5 and 6)
While larger organisations with good administrative support should be able to provide all the detailed information required annually on the duty of candour, smaller bodies and individuals such as community pharmacists and optometrists might experience serious practical problems in connection with candour reports, especially in meeting deadlines for reporting to LHBs. The knock-on effect could well result in difficulties for LHBs in publishing their reports in a timely fashion, so risking non-compliance.

Confidentiality in reports should extend to staff – Clause 9
The clause dealing with confidentiality in duty of candour reports prohibits the naming or identification of those to whom care has been provided. Extending that protection to prohibit identification of staff members should encourage openness. Allowing people to be named or identified in generalised reports might deter staff from being candid. However, focusing blame on systems rather than individuals can dilute individual responsibility, so it is necessary to balance these risks.

Training will be essential but will drain resources

It is important for relevant staff to receive training in all aspects of the duty of candour, but this will involve setting aside time for training and refresher courses at a time when staff shortages are already causing practical problems in the NHS.

The new duty could cause complications with policies on whistle-blowing

The implementation of the duty of candour needs to dovetail with existing policies requiring staff to be honest when errors are made and to speak out, if necessary, to protect patients. This might require organisations to re-examine existing policies on whistle-blowing to ensure that there are no adverse situations that could discourage staff from reporting their concerns.

Part 5: Vice Chairs of NHS trust boards

Some details require clarification

Clarity is required on whether trusts, on appointing Vice Chairs, should use the same appointments process as that which is currently in place for Vice Chairs' appointments in Health Boards.

There is also a need to clarify whether the Vice Chair's post in trusts will mean an extra member of the board over and above the present number allocated to trusts. If that were to be the case, there would be further strengthening of governance, which is to be welcomed.

Professor Vivienne Harpwood, Chair of Powys Teaching Health Board and Chair of the Welsh NHS Confederation Management Board.

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[i] Legislation as Aspiration: Statutory Expression of Policy Goals. A Lecture for the Statute Law Society delivered at the Institute of Advanced Legal Studies, London, 16th March 2015

[ii] Ely Hospital Cardiff: Inquiry Findings HL Deb 27 March 1969 vol 300 cc1384-93

[iii] Powell v United Kingdom [1998] ECHR 45305/99
Powell v Boladz [1998] Lloyd's Rep Med 116, 39 BMLR 35

[iv] Smith M and Forster H, "Morally Managing Medical Mistakes" (2000) 9 Cambridge Quarterly of Healthcare Ethics 30 – 53 in which following famous statement was made: *"Mistakes can be viewed as gems or treasures because much can be learned from them for the betterment of future patients".*

[v] C. Vincent: Why do people sure doctors? (1994) The Lancet 1609 -13, 1613; O Quick "Outing Medical Errors: Questions of Trust and Responsibility" 2006 Medical Law Review 22, 41-42

[vi] "Being Open" DOH Publications 1994

[vii] See Wijesuriya J.D. and Walker, D "Duty of Candour: a statutory obligation or just the right thing to do? British Journal of Anaethesia, Volume 119, Issue 2, August 2017, pages 175-178

[viii] Including arrangements for handing complaints in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 201126; reporting and investigation of serious incidents, reviews of deaths in hospitals; Annual Quality Statements by LHBs, NHS Trusts and the Welsh Government.

[ix] Vick, L CQC Bares its teeth: Duty of Candour Four Years On", Medico Legal Magazine Issue 11, page 2

[x] For example, NHS Litigation Authority "Apologies and Explanations" NHSLA London 2007.

Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-24-19 Papur 8 / Paper 8

C

Public Health Wales Response to the Health and Social Care (Quality and Engagement) (Wales) Bill

The Public Health Wales Board welcomes the opportunity to provide comments and observations on the important legislation being put before the Assembly Health, Social Care and Sport Committee (Quality and Engagement) (Wales) Bill. We understand that the legislation will further complement other legislative levers for change. I.e. Social Services and Wellbeing (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015.

Public Health Wales have considered the four areas that the Bill is proposed to cover:

1. Duty of Quality;
2. Duty of Candour;
3. Establishment of a new Citizens' Voice Body; and
4. Requirement for NHS Trusts to have vice chairs.

1 General Observations and Comments

The Bill is focused more on the NHS rather than social care combined. Which elements of the Act are to be applied specifically to NHS services or social care and which are to be applied equally to both could be made more explicit.

It is not clear from the Bill what the overall vision and ambition for quality in health and care is in Wales. It would be logical for the Bill to define and create the legislative levers and drivers that will enable the vision in *A Healthier Wales*, although the connection to this could be stronger. Similarly, there is an opportunity to articulate in the Bill what the tolerance and threshold for quality and safety will be in NHS Wales (and social care) in a way that is not currently articulated in other documents. This should be an articulated and deliberate intent with the associated actions resulting in light or heavy touch approaches to standards, scrutiny and regulation clearly provided for in the Bill. This is currently absent and it is therefore unclear as to how these levers are expected to change to achieve what the ambition for quality and safety is.

In relation to this, has learning from other jurisdictions been taken into account in the drafting of the Bill? For smaller countries, health and social care regulation has been/is being, brought together into one regulatory body in order to establish more 'smart (or prudent) regulation' that brings with it economies of scale and integrated business intelligence to more enable risk-based and proportionate regulation. Similarly, this approach enables a more holistic approach to the experience of users of services who traverse health and social care. The opportunity to integrate Health Inspectorate Wales and Care Inspectorate Wales to benefit improvements in the care and experience of people regularly accessing health and social care is a missed opportunity.

Given that health and social care operate and work within wider partnerships, it could be considered appropriate for quality outcomes to be developed and agreed at RPB or PSB level. The mismatch between different systems has arguably caused barriers to date and the increasing emphasis on a partnership approach indicates that this is an opportunity to grasp.

2 Response to the specific areas of the Bill

2.1 Part 2: Duty of Quality

The Existing Duty of Quality

NHS bodies have been under a duty to make arrangements for the purpose of improving the quality of health care since 2003, under section 45(1) of the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act"). Although the 2003 Act requires NHS bodies to make arrangements to monitor and improve the quality of health care, it has largely been interpreted as requiring NHS bodies to have quality assurance (control) arrangements in place to monitor and improve the quality of healthcare provided rather than a comprehensive focus on the three aspects of a quality system as described by the parliamentary review: quality planning, improvement and control to ensure a focus on quality services at a wider population level.

The new proposal under the Bill to establish a Duty of Quality applies to all NHS bodies. The Bill provides an interpretation of "health care" described in the following way:-

(1) A reference in this part to health care is to services provided in Wales under or by virtue of the 2006 Act for or in connection with-
    (a) the prevention, diagnosis or treatment of illness;

(b) the promotion and protection of public health

There is no explicit definition of quality, which suggests that there is an expectation that everyone who is expected to comply with the legislation would have the same interpretation. Experience would suggest that this is not necessarily the case. A definition would therefore be helpful such as the US Institute of Medicine's definition.

Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Together with the 6 domains which the institute has identified:

- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable

In Section (1) of the Bill, it is clear that the legislation is intended to and does apply to Public Health Wales, however it will be important that the guidance provides sufficient guidance as to how the duty of quality would be applied in the context of population health.

The Bill and provision of subsequent guidance would need to provide clarification in order to reduce the risk of different interpretation and variation, if the health and social care system is expected to apply the approach to quality consistently.

This would require a more robust and supporting regulatory framework that enables the health and social care system focus on the right things.

To date, the focus of quality in the health service has largely been on developing systems for quality assurance within local services. Quality, however, is more than just meeting service standards; it is a system-wide way of working to provide safe, effective, person centred, and timely, efficient and equitable care.

- The new overarching duty will require Welsh Ministers and NHS bodies to exercise their functions with a view to securing improvements in the quality of services they provide to their service users. This duty will apply to all of their functions, not just clinical functions.

- NHS bodies will be placed under a duty to produce an annual report setting out how they have complied with the new duty. It is clear that the duty of quality extends to all of NHS provision. Section 11 of the Bill specifically identifies that the promotion and protection of Public Health is included in the definition of health care.

- The Bill extends to Health and Social Care, although there appears to be little mention of the approach to be taken with regard to Social Care currently.

- The Bill does not clarify the consequences of not meeting the duty.

- All NHS organisations in Wales will be required to publish an annual report to demonstrate how they have performed in securing quality improvement.

If the intention of the Bill is to shift Health and Social Care to drive a culture of improvement and learning, simply focusing on an annual reporting requirement appears to be somewhat unambitious. To move the system in any meaningful way towards this ambition it requires a change of emphasis in planning for quality, a requirement for timely and accurate data reporting and quality performance monitoring and a complete overhaul of our regulatory arrangements.

There is a lack of coherence and clarity in terms of a Quality Framework for the NHS in Wales that the NHS has to be assessed against and demonstrate improvements. It is unclear why the opportunity to address regulatory improvements has not been taken.

Despite the title of the Bill including Social Care, the legislation appears to refer only to NHS bodies which could miss opportunities to improve the quality of health and care provision, particularly in a context where there is expectation of much greater integration between health and Social Care.

A supporting letter to the introduction of the Bill from the Health Minister, highlights the duty to be placed on all decisions and arrangements for the health and outcomes of populations and improvements are to include 'backroom' services. The Bill itself does not appear to have reference to these issues. From the perspective of the Public Health Institute for Wales and the views of Board members, it is important that the Bill and subsequent guidance is more explicit about how this proposed legislation will include a duty on all public health functions.

More broadly across Public Health, Health and Social Care while we would support the focus on improvement, it is important that greater emphasis is placed on the matter of improving health and health care outcomes for citizens/patients, communities and the population. The elements of improving population health do not stand out in the Bill overall, which is a missed opportunity if it is intended to be a lever to implement the intention to improve health outcomes at a population level as identified in *A Healthier Wales*.

There is an absence of any reference in the Bill of an intention to address current gaps in regulatory functions of the Health Inspectorate arrangements or a revisiting of the Health and Care Standards, or equivalent overarching standards framework for NHS Wales. What would organisations be expected to assess themselves against? There appears to a lack of recognition of the importance of the whole regulatory system needing to connect together with other legislative and policy drivers in order to make improvements across health and social care.

In the Bill it is proposed that there will be an annual reporting of Quality improvement by NHS bodies, which appears to be a relatively weak control and therefore it raises the question if an annual report provides a robust demonstration of assurance. Therefore what should be measured and how would compliance against this duty be measured? One suggested approach could be to adopt an inter-organisational peer review process against clearly defined and measurable standards, alongside other measures and approaches.

There is a risk that bringing in more regulation which needs to be complied with could add more burden to organisations to demonstrate this, leading to competing demands on already stretched resources to deliver services and achieve outcomes that will make a difference to the people of Wales.

Innovation dovetailing in to an improvement approach is critical to the transformation that the NHS and Social Care need to make, to ensure public health, health and care is sustainable over the coming decades. Any supporting guidance will need to place emphasis on the need to support innovation, identifying new models for public health, health and care that can be tested. Some level of risk is inherent in innovation and there needs to be an understanding that this exists and will need to be managed as part of an approach to improving quality.

2.2 Part 3: Duty of Candour

When considering the introduction of a new duty on health services, it is important to recognise that various steps have already been taken with the aim of developing a "culture of openness" in the NHS (Wales) Regulations 2011, better reporting and investigation of serious incidents, by Health Boards (HB), NHS Trusts and the Welsh Government.

Putting Things Right (PTR) regulations have been in place since 2011 and encompass processes for raising, investigating and learning from concerns. Concerns include complaints, claims and incidents. In addition reviews of all deaths in hospitals and the publication of Annual Quality Statements are a requirement of all the organisations in NHS Wales.

The principle of 'Being Open' is placed at the heart of the PTR arrangements and was intended to build trust between the people using NHS Services and the organisations.

The duty to be open already exists through the PTR regulations, however there is still a general lack of transparency in relation to data which the Information Commissioner is attempting to change in the Public Sector. Early detection of relevant concerns need to be escalated to the appropriate levels of the organisation as part of overarching governance arrangements. It is not clear how this legislation will improve this, having timely access to data as a key enabler to improvement.

The Duty of Candour is said to build upon and strengthen the existing PTR arrangements. The key difference is that the current PTR regulations applies once a concern has been reported and the initial investigation has been conducted and the service user is identified as suffering harm.

In the proposed duty of candour legislation, the point at which a service user is notified is brought forward to the point that the NHS body is first aware that minimal harm may have been caused and the duty of candour has been triggered. NHS bodies have to make all reasonable efforts to contact the service user or their representative and identify their preferred method of communication and provide appropriate ongoing support.

In addition to the existing PTR arrangements both the General Medical Council (GMC) and the Nursing Midwifery Council (NMC) are already expected to comply with a professional duty of candour. The Bill makes no acknowledgment of the interdependency with the regulations at a UK level placed on all regulated health professionals which are an aspect of providing high quality and safe services. Indeed the duty appears to apply to organisations and not staff so it is not clear how staff would be protected if they raise concerns about the quality and safety of services.

It is anticipated that the supporting guidance to the new regulation will cover situations which cross different providers and where more than one incident has occurred to a service user.

It would be helpful if supporting information around the introduction of the Bill, provided understanding and learning from the experience of other places in the UK and other countries that have introduced the duty of candour having adopted transparent and open processes.

While we would support the general principles of the 'Duty of Candour' there will inevitably be a level of complexity which could arise in the context of Public Health Wales.

Examples of this could be in the context of some screening programmes which have built in regular audit arrangements as part of learning and fail safe arrangements, which by the very nature of screening will sometimes identify false positives and false negatives. The understanding of this is complex and nuanced and the impact on the quality assurance arrangements could be impacted and an unintended consequence may be that cancer audits undertaken to learn may cease.

In addition, if the duty of candour is a trigger for incidents classified as minimal the impact on clinical teams will be considerably increased and could detract the clinical resource away from providing ongoing safe and effective services.
In situations of outbreak management in health protection should an incident come to light, at times there could be some genuine risks posed to the wider community if the application was expected to be strictly applied without a more in depth understanding of what has led to an incident in this context.

A more general point to be made is that often initial concerns raised can be very different than the actual facts identified, once the opportunity to undertake an initial investigation has been completed. By informing the service user at the outset, it could be argued that at times insufficient information would be available to provide the person with the level of reassurance that they are seeking and could create undue anxiety.

It is important to acknowledge that despite the current PTR arrangements having been in place since 2011, there remains many challenges in achieving the expected standards consistently and difficulties in achieving a seamless experience for service users where an incident crosses more than one organisation. The Evans review (A Review of Concerns (Complaints) handling in NHS Wales identified at least ten different versions of the implementation of PTR. He also highlighted the complexity of the system and the need to simplify it.

Learning from the implementation of PTR and having not yet achieved the open learning culture that is necessary to drive improvement in service user experience and outcomes, it is important that there is clarity and consistency in the implementation of any new legislation in this area. The Once for Wales Concerns Management project has been attempting to take forward some of the recommendations arising from the Evans review.

However we acknowledge and concur with the evidence which shows that service users and their families ultimately want an apology, a willingness to explain and an open approach to learning from mistakes.

2.3 Part 4: Citizen Voice Body

The proposal to create a national organisation to strengthen citizens voices, ensure individuals are supported with advice and assistance and ensuring the service user experience is used to drive forward improvement is welcome. A stronger national body to bring consistency of approach across Wales is positive, although the emphasis should be on local engagement.

Public Health Wales welcomes falling within the jurisdiction of such a body.

There is a need to build in independence for the new body, to provide autonomy and assurance to communities that it truly represents their views and can hold services to account. It would be important for the body to be independent of Welsh Government and NHS/Social Care bodies and therefore not hosted by any existing body.

Consideration needs to be given as to how the body will link in to the social care sector especially in relation to regulation and inspection. Currently, Elected Council Members represent the views of local communities for Local Authorities including social care, there is a potential risk of duplication or tension in terms of engagement in this area.

Clarity is also required on the lines of accountability, for example will the body report to Welsh Government or the National Assembly for Wales.

It is vital that the new body reflects the population it serves, its governance structures should be established to reflect this. Clarity is required on the future role of Health Inspectorate Wales (HIW).

We also note the response provided by the Welsh NHS Confederation and would particularly reinforce the comments made in relation to the regulation of management.

Public Health Wales is supportive of the introduction of the Citizens Voice Body, however further clarification is required on how the body will work, accountability arrangements and how it interlinks with other NHS and Local Authority/Third sector bodies.

2.4 Part 5: Vice Chairs for NHS Trusts

The proposed new powers within the Bill providing for Welsh Ministers to appoint a specific Vice Chair role on the boards of NHS Trusts is welcomed. We recognise this will enable Vice Chairs to contribute further to the work of NHS Trusts, strengthen the capability of their Independent Membership, improve governance and decision-making processes, and provide consistency across Wales.

Public Health Wales recognises the importance of this role and as such has appointed a Vice Chair, remunerated for 8 days per month and appointed from the existing complement of Independent Members. The Vice Chair currently chairs the Quality, Safety and Improvement Committee and given the increased focus on Board scrutiny, oversight and assurance we see the demands on this Committee only growing.

Given that the Public Health Wales Chair position is a nominal 3.5 days per week (15 days per month), Public Health Wales would advocate that an additional Vice Chair post be appointed on a nominal 2.5 days per week (10/11 days per month) and remunerated as such. This would also increase the number of Independent Members for Public Health Wales to 8.

We would stress the importance of a dedicated Vice Chair position being in addition to the existing number of Independent Members. We would also request that some flexibility be afforded to each NHS Trust to stipulate the requirements for the role in relation to the organisations needs when the job description is being developed. It is not necessarily beneficial for this position to have a consistency of responsibilities across the NHS Trusts.

Contacts:

Rhiannon Beaumont-Wood
Executive Director Quality, Nursing and Allied Health Professionals.

Helen Bushell
Board Secretary and Head of Board Business Unit

Hywel Dda University Health Board Consultation response: Health and Social Care (Quality and Engagement) (Wales) Bill

The following comments have been collated on behalf of Hywel Dda University Health Board and have been summarised under sub-headings.

Duty of Candour news

- In respect of the Duty of Candour, this duty is welcomed and will help us build on the work that we have been doing under the Putting Things Right Process and our Being Open Policy and believe this will support the cultural and attitudinal shift.
- Being open and transparent and dealing promptly with news bulletins has been our hallmark over the past 5 years.
- In terms of staff, consistent application of the process within organisations is crucial to the success of this and there will be resource implications both in terms of training staff, opportunity costs for releasing staff, and supporting staff with those difficult conversations where this is required.
- Wider training on communication skills, skills in managing escalating behaviour and supporting staff involved in adverse incidents, will need to be reinforced to ensure that this process is carried out in the best possible way for both staff and the patients/families involved. It is envisaged that training will need to be more than an online module, and arrangements in place for monitoring not only compliance but the quality of the engagement process.
- It is anticipated that there will be an increased workload for redress teams/concerns teams, incident teams, in ensuring early involvement in cases where the duty applies. In regard to the definition of 'more than minimal harm' it is noted that a clear definition of this will be provided and we welcome the establishment of the working group, prior to implementation of the Bill to ensure that there is consistent application of the duty across all bodies.
- The Duty extends to reporting on non NHS bodies from which the Health Board commissions and therefore appropriate mechanisms need to be set up to enable this. This links with delivering Value Based Healthcare. There are likely to be more actual costs in the system that need to be understood.
- It is important to note that the Duty extends to the exercise of all the Health Board's functions to secure improvement.

Citizen’s Voice

- The new Citizen’s Voice Body is welcomed and will support the work already in place on continuous engagement. We would raise a query in relation to s7, page 20, to the appointment of a Chief Executive and we wonder whether this should be a ministerial appointment?
- The Citizen’s Voice body will be a positive step forward and likely to align with our Regional Partnership Board boundaries, however, from a health perspective there are often health service focused pieces of work that may align along the M4 (through WHSCC or the NHS Collaborative - recent examples include Major Trauma, Thoracic services) or on an all Wales basis. It would be helpful if this could be taken into account.
- We welcome the strengthening of arrangements for the voice of citizens across health and social care and further connecting them with the organisations that provide them with services but do not want to lose the local accountability and knowledge that local Community Health Council (CHC) members bring and hope that this will be retained.
- It helps underpin A Healthier Wales’ objectives and strongly links with the Health Board’s aims and ambitions.
- The Stake holder Reference Group (SRG) is already aligned and now supports both the University Health Board and Regional Partnership Board agendas. The Bill makes no mention of Stake holder Reference Groups - they seem obsolete now. Clarification is needed as to whether there is an intention to remove the need for Stakeholder Reference Groups and how this would work with public and carers representation and with the Local Authority scrutiny committees i.e. in addition to, instead of or merged? Legislation does not change their roles so there is a possibility that we will have multiple scrutiny for health and social care and this could be confusing - this could be a challenge for Local Authorities as they are enshrined in democratically elected members representation - if they no longer have those members on the CHC then they may double their scrutiny efforts through their committees. It would be beneficial to have a steer on how we envisage this working.

Organisational Considerations/ General Comments

- There will be a number of organisational considerations to ensure compliance with the new duty, involving strengthening of a number of the current processes and assurance functions, however this does not need to be addressed as part of the Welsh Government consultation and can be considered by the Quality, Safety and Experience Assurance Committee; a risk assessment process and preparedness plan will need be worked on with input from all relevant services.

- There is a mention of the NHS Wales 2006 Act but not the Welsh Government Guidance on Engagement and Consultation on Changes to NHS Services which provides a duty on Health Boards to continuously engage with the population it serves and outlines clearly the role of the CHC. This places a higher expectation/ level of engagement than is placed on local authorities or social care and needs to be taken into account when we are developing a joint approach for health and social care.
- The University Health Board would want to know what is expected in terms of rolling out the training and awareness raising and how much of the resource identified is allocated to us. This will be a large exercise in communications and has obviously been planned in minute detail in the appendices but it is not clear what is expected of the UHBs.
- Our UHB duty is to listen to the citizen’s voice and continually engage - how does this link with the new CHC role to represent the citizen voice - is there scope for confusion?
- The UHB will need to link our equality work and quality work much more closely going forward to meet the bill - welcome the chance to do this and think we are already in a strong place.
- There will be a future bill on co-production - would be beneficial to know the timescales.

Overall, Hywel Dda University Health Board support the implementation of the Bill and believe that it will support the application of our Healthier Mid and West Wales Strategy, the Quality Improvement Framework and the Patient Experience Charter. It is positive to see within the Quality duty that there is a focus on experience as well as outcomes and application of consistent quality, safety and experience standards across Wales.

In summary, we hope the comments above outline the support for the Bill in general and highlights the areas that require more detail and clarity.

Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-24-19 Papur 10 / Paper 10

GIG CYMRU
NHS WALES
Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

Our Ref: DB/02/08/2019

Date: 2 August 2019

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Dear Sirs,

Re: Response of HEIW to the consultation in respect of the Health and Social Care (Quality and Engagement) (Wales) Bill ("Quality Bill")

To assist the Health, Social Care and Sport Committee in its undertaking of a consultation process in respect of the above Quality Bill, I am pleased to outline below the response of HEIW's Board in respect of the matter.

Strengthen duty of quality. HEIW welcomes the proposal and recognises that it will also have a lead role to play in the delivery and commissioning of education and training on this duty for the post graduate medical, undergraduate health professional workforce of NHS Wales.

Organisational duty of candour. HEIW welcomes the proposal. While HEIW will not have a direct contact with patients, we recognises that we will have a lead role to play in the delivery and commissioning of education and training on this duty for the post graduate medical, undergraduate health professional workforce of NHS Wales.

Enabling the appointment of Vice Chairs for NHS Trusts by Welsh Ministers. HEIW would respectfully request that the Quality Bill also enable Welsh Ministers to appoint the Vice Chairs for Special Health Authorities. As HEIW is a Special Health Authority this would enable Welsh Ministers to appoint our Vice

Chair. This would have the advantage of bringing HEIW in line with the current position for Health Boards, together with the proposal under the Quality Bill for NHS Trusts.

New Citizen Voice Body for Health and Social Care in Wales. We recognise and welcome the role of the new Citizen Voice Body. We feel the new body should be adequately resourced and that the right level of access and co-operation should be strengthened. It is further recommended that there should be a clarity in respect of the mechanisms to deal with fundamental disagreements between local, regional and national matters.

Yours faithfully,

[redacted]

Board Secretary
HEIW

Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-24-19 Papur 11 / Paper 11

Agenda Item 6.1

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA(P)VG/2593/19

Dr Dai Lloyd AM
Chair, Health, Social Care and Sport Committee

Llyr Gruffydd AM
Chair, Finance Committee

John Griffiths AM
Chair, Equality, Local Government and Communities Committee

National Assembly for Wales
Cardiff Bay
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15 July 2019

Dear Chairs,

I am writing to update your respective committees about the work of the Inter-Ministerial Group (IMG) on Paying for Social Care, which was set up last year by the then First Minister to consider a potential social care levy to help meet the increasing cost and demands for social care. I am now chairing the group.

The group is considering the report by Professor Gerald Holtham about a social care levy as the basis of its work. Professor Holtham's report is available at: https://gov.wales/paying-social-care. The group's remit is to explore further the potential for a social care levy, or an alternative mechanism, to raise additional funds for social care in the medium to long term.

Membership of the group currently comprises, the Minister for Finance and Trefnydd, the Minister for Housing and Local Government and the Deputy Minister for Health and Social Services, and is supported by policy officials from across the government.

The IMG will undertake an initial assessment of the viability and effectiveness of introducing a levy or an alternative mechanism by early 2020. While Professor Holtham focused his attention on social care solely for older people, the IMG's work is taking a broader approach and is considering the overall demand and pressures social care faces in the round.

To progress its considerations the IMG has created five distinct work streams. These are:

- Raising the finance – to identify the mechanism through which additional funds could be collected in the future;

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- Distributing the finance – to identify the most effective model for distributing additional funds;
- Utilising the finance – to consider the priorities for any funds raised in the context of seamless health and social care as set out in *A Healthier Wales.* This work stream also includes defining the nature of the offer to people in return for paying a levy or new tax introduced;
- UK Government interface – to look at the context of our proposals in the wider non-devolved pensions and welfare benefit system, and the plans the UK Government has for social care in England. Initial engagement has centred on the UK Government's proposed Green Paper on social care in England. This paper has been delayed several times. I believe we cannot afford to delay our own considerations in Wales and should continue to move ahead with these;
- Communications – to establish a strategic communications and engagement approach to ensure stakeholders are kept informed of progress and have opportunities to input as appropriate.

In addition to the above, two pieces of research have been commissioned. The first will identify and quantify the demand and funding pressures on social care in the short to medium term. This is due to report this summer.

A second research project will analyse health and social care spending over the medium to long term and the relationship between the two. This is currently out to tender and the intention is for the research to be completed by next spring. Both of these will provide the IMG with a strong evidence to inform its decisions.

The IMG had an opportunity to meet Clive Betts MP and discuss the House of Commons Health, Social Care and Housing and Communities and Local Government committees' report *Long-Term Funding of Adult Social Care*, which he co-chaired. This set out recommendations for the way social care in England should be provided and funded in the future. It is available at:

https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/768/768.pdf

I would be keen to meet with you, as chairs of a policy committee with an interest in the long-term funding of social care in Wales, to discuss these matters and the IMG's work further. I would also like to offer your committees a technical briefing about the IMG's work before the Christmas recess.

Yours sincerely,

Vaughan Gething

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

National Assembly for Wales
Health, Social Care and Sport Committee

Kirsty Williams AM
Minister for Education

18 July 2019

Dear Kirsty

Draft Curriculum for Wales 2022

As you know, the Health, Social Care and Sport Committee recently published its report on the physical activity of children and young people. One of the recommendations in that report was 'that the Welsh Government makes the recommended 120 minutes of physical education in schools a minimum statutory requirement' (recommendation 8).

The evidence we heard as part of our inquiry made it very clear that physical activity is not given sufficient priority in schools. The majority of schools are not meeting the recommended 120 minutes a week for physical education, and curriculum pressures often mean that the time allocated to physical education in primary and secondary schools is reduced. A statutory minimum requirement would guard against this and protect time within the school week for physical activity as part of a broad and balanced curriculum.

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In your response to our report, you indicated that you did not accept this recommendation. We note your aspiration for the new curriculum to provide flexibility for schools to tailor-make their curricula and provide the freedom for practitioners to use their professionalism and creativity to meet the needs of all learners. However, we remain concerned that schools are not currently giving physical activity the attention and priority it deserves and believe that, to not address this as part of the curriculum review, is a missed opportunity.

We therefore ask that you re-consider our recommendation.

Kind regards

Dr Dai Lloyd AM
Chair, Health, Social Care and Sport Committee

Kirsty Williams AC/AM
Y Gweinidog Addysg
Minister for Education

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-P/KW/2781/19

Dai Lloyd AM
Chair
Health, Social Care and Sport Committee
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14 August 2019

Dear Dai

Thank you for your letter of 18 July regarding the Health, Social Care and Sport Committee's recent report, Physical Activity of Children and Young People.

You asked that I review the Welsh Government response to recommendation 8, proposing that the recommended 120 minutes of physical education in schools be made a minimum statutory requirement.

The response on this recommendation outlined that proposed legislation to support the new curriculum is intended to reaffirm the principle outlined in *Successful Futures* of a new curriculum for Wales and that the legislation should define a broad set of duties rather than detailed prescription of content, so providing practitioners with the freedom to use their professionalism and creativity to meet the needs of all learners. I am grateful for your Committee's support in acknowledging the importance of this flexibility within the curriculum.

A specific statutory duty would not guarantee that physical education would be embedded well or appropriately in the curriculum. The focus needs to be on enhancing the quality of provision and on enabling schools and practitioners to maximise the opportunities to promote physical activity.

Schools will be under a duty to develop a broad and balanced curriculum which will support learners to realise the four purposes, one of which is for learners to develop as healthy, confident individuals. This purpose-led approach puts health and well-being, and physical education, as a key part of that, at the heart of the curriculum. It is not optional, and securing the four purposes will require meaningful provision to be offered and all learners being enabled to access it.

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Each of the Areas of Learning and Experience (AoLEs) are mandatory parts of the new curriculum. The Health and Well-being AoLE has a clear focus on the importance of physical activity for our children's physical and mental well-being, supporting their development, and ensuring that they grow up to be healthy and confident individuals. The Health and Well-being AoLE is also designed to develop all learners' understanding of the factors that affect physical health and well-being, including physical activity.

The Health and Well-being AoLE framework provides that all learners should experience:

- a range of ongoing, daily opportunities to be physically active;
- opportunities to be physically active in a variety of environments (including indoor; outdoor; different surfaces; heights; in and around water).

The AoLE has been designed in a manner that empowers practitioners to plan provision that best meets the needs and abilities of learners, encouraging them to develop the dispositions and motivation to lead lifestyles which support their physical health and well-being. This gives them the flexibility to choose a range of physical activities and sports that will support children and young people to develop the confidence, skills and motivation to be physically active for life.

The new curriculum will enable schools to consult with learners on the choice and range of physical activities available to them. The Health and Well-being AoLE will not specify sports or areas of physical activity; the school, in consultation with learners, will take decisions on these areas.

The Health and Well-being AoLE is one of six AoLEs in the new curriculum, and schools will need to treat this AoLE with parity to the other five areas. This means that supporting learners to develop the skills, knowledge and experience to maintain good physical health will be central to our new education system.

The draft AoLE guidance has been extensively informed by experts in this area. It will provide the framework from which teachers can select the most appropriate experiences to support a child's learning throughout the 3-16 continuum of learning.

The Welsh Government will set a high-level national framework, but schools will develop their own school-level curriculum, supported by statutory guidance, to ensure that learners get a broad and balanced education. Practitioners will be given more flexibility to choose the specific content and resources which meet the needs of their learners in their specific context. The *Successful Futures* report made clear that how the AoLEs translate into day-to-day activities should be determined creatively, at school-level. It challenged us to re-think our approach to the curriculum; it makes it clear that a high degree of prescription and detail at a national level inhibits "the flow and progression in children and young people's learning". However, schools will not be given complete autonomy in terms of their own school-level curriculum, and what is taught in the classroom. Although there will be greater flexibility about what to teach and how it is taught, this will be within clear national expectations for scope and progression.

I want to provide all schools with the freedom to explore flexible and adaptable models of delivery to support full curriculum implementation from 2022. It will therefore be down to schools to determine the amount of time being allocated for all areas of the new curriculum.

I published the draft Curriculum for Wales 2022 in April, for feedback; the feedback period closed on 19 July and a wide range of responses have been received. That feedback is now being considered before further refinement work takes place in the autumn.

I expect to publish the revised Curriculum for Wales in January 2020, and this will be clearer in terms of national expectations for schools and settings. A report on the feedback that was received and how it has been used will be made available alongside the revised curriculum in 2020.

I hope this provides assurance to the Committee that provision for physical activity will be an integral element in the new curriculum as well as clarifying why there are no plans to allocate a minimum statutory time for physical education within the new curriculum.

Yours sincerely

Kirsty Williams AC/AM
Y Gweinidog Addysg
Minister for Education

Agenda Item 6.4

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Our Ref: GJ/ses Direct Line: 01633 435958 2 August 2019

Dr Dai Lloyd, AM
Chair, Health, Social Care & Sport Committee
National Assembly for Wales
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Dear Dr Lloyd

Thank you for your letter dated 18 July, requesting further information following attendance at the Health, Social Care and Sport Committee on 11 July 2019. I detail the Health Board's response as below.

- **Elective Care**

The Health Board have made significant improvements in access to elective treatments, with the number of patients waiting longer than 36 weeks falling from over 2,600 (March 2016) to 112 (March 2019).

The Health Board has achieved these improvements through a combination of:

- Targeted initiatives to reduce waiting list backlogs, supported by specific funding – including the use of mobile theatres and MRI scanners, waiting list initiatives and commissioning elective treatments with other healthcare providers, and
- Service improvements aimed at delivering more sustainable solutions – this includes reviewing service models as part of the Clinical Futures Programme and the Health Board's value based approach to delivering healthcare.

Delivering the performance targets in orthopaedics and ophthalmology remain the Health Board's main areas of concern. We have externally commissioned additional ophthalmology treatments, for a two year period, to enable more sustainable solutions to be developed in the interim. In terms of orthopaedics our plan is to deploy additional locums and additional consultant sessions locally to address the backlog.

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Pack Page 409

NHS WALES GIG CYMRU
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Aneurin Bevan University Health Board is the operational name of Aneurin Bevan University Local Health Board

The impact of the current pensions/tax regulations, on an increasing number of our medical staff, is now emerging as a material risk and we are assessing the potential impact in order to identify mitigating plans, where possible.

- **Cancer**

The increase in cancer referrals and subsequent demand on services is between 20-30% across all tumour sites with the exception of Lung cancer. The Health Board diagnosed and treated 11% more cancer patients in 2018/19 (3,710) compared to 2017/18 (3,329).

We have undertaken work with public health colleagues and the NHS Delivery Unit to understand the factors which are resulting in such a material increase. This would suggest that the reasons are multi-factorial and include:

- Increased awareness and access to screening,
- Lifestyle choices,
- Increased co-morbidity, and
- An ageing population.

A number of actions are being undertaken to improve outcomes for patients and these include:

- Screening Champions Programme – volunteers signposting and motivating family and friends to undertake more well-being activities as part of a preventative approach,
- Targeted approach to identifying and working with parts of our communities where there is lower awareness and participation in screening,
- Piloting a symptomatic FIT test for suspected bowel cancer,
- Developing pathways for vague symptoms clinics,
- Improving access to CT diagnostics for suspected lung cancer,
- Prehabilitation schemes,
- Promoting early access to diagnostics including straight to test for flexible sigmoidoscopy, colonoscopy and ultrasound scanning,
- A well-established acute oncology service in place, and
- Better use of outcomes data and other intelligence to improve services for patients.

- **Winter preparedness**

The Health Board is taking a number of actions to improve A&E performance and ambulance handover times, which includes more effective service delivery across the whole urgent care system, including prior to hospital admission, care in the hospital and effective and timely discharge from hospital. This is against a backdrop of increased attendances to our Emergency Departments, where the number of attendances during July 2019 has risen by about 5%, compared to the same period last year.

Many of the actions we undertook during the winter period, we have evaluated and continued during this year. The winter plans include the following:

- Clinical Practitioners in ED - increased capacity and support in the rapid assessment area of the ED
- Increased senior medical cover in Assessment Units – e.g. Surgical Assessment Unit
- Discharge Lounge – extended capacity and flexibility to support improved patient flow in the hospital
- Expansion of Elderly Frail Unit (EFU) – increased capacity and access, including ambulatory care
- Home First - an integrated approach to supporting people to be cared for at home and avoiding hospital admission through the use of a trusted assessor role. This model works across the Health Board and five local authorities in Gwent
- Graduated care step up services – provision of hot clinics, community frailty/assessment units and step up beds
- Graduated care step down services – the use of nurse-led units to support appropriate step down and discharge of patients from hospital
- Access to primary care and out-of-hours service – increased capacity and resilience across the Health Board area
- Advanced Care Planning and Stay Well plans - keeping people safely at their usual place of residence, supported by ongoing work to identify frequent attenders/admissions from care homes and in reach nursing support, falls training and access to equipment
- Effective communication with the public and our local communities – e.g. increased promotion of "Choose Pharmacy", the Common Ailments scheme and appropriate sign-posting to healthcare services

The Winter Plan, in 2018/19, was designed involving all key stakeholders and partners, with the aim of increasing resilience across the system. The Plan has been evaluated, using a number of quantitative and qualitative measures to inform future service provision and to support preparations for 2019/20.

In addition to increasing the range and capacity of healthcare services, the Health Board also provided increased well-being support for staff and identified additional incentives to encourage and support staff during busy periods.

- **Digital and Data**

The Health Board recognises the significance of digital in the delivery of services and the opportunities it presents in transforming the way we deliver care. Investment has been increased significantly over the last three years in terms of priority clinical systems, mobile devices, Wi-Fi, infrastructure, and in upskilling the digital workforce. A new digital strategy has recently been approved by the Board and work is now underway to review further capability, ambition and pace in terms of our Clinical Futures strategy and a Healthier Wales.

For some time the Health Board has been delivering a Digital Health Record Programme with most patient records (over 300,000) now digitally available to clinicians across the Health Board.

Electronics forms are being developed to create "digital borne" documents, with standards being used to ensure the data in the forms can be reused, reducing data entry burden and allow better decision making.

The Health Board is a key partner in the implementation of the Welsh Community Care Information System (WCCIS) - a joint programme hosted by NWIS, but delivered in partnership with social care colleagues. In Gwent, a strong regional approach has been fostered under the leadership of the Regional Partnership Board with the ambition of a truly shared record across Health and Social Care. This Programme represents the biggest digital investment ever made by the Health Board (circa £16m over the life of the programme). The programme has experienced a number of issues recently, in terms of delay, but the Health Board remains an active partner in progressing this key programme.

The Health Board also hosts a National Programme Office for Technology Enabled Care and is piloting the use of "Clinical grade" video conferencing to support care homes in Gwent, which is due to go live in September 2019 for Out of Hours GP services. Through the Regional Partnership Board the programme should enable a Gwent approach to investment decisions and shared learning from across organisations.

The Health Board was the first Health Board in Wales to invest in technology to capture and use Patient Reported Outcomes Measures (PROM) directly from patients. The uptake has been encouraging with up to 82% completion rates. The data collected enables clinicians and patients to co-produce care and identify what matters to patients at the heart of planning and delivering care. The next iteration of digital development will enable the clinician to see the patient record directly in their clinical dashboard (Clinical Workstation) and the collection of Patient Reported Experience Measures (PREM).

Citizen empowerment and "people powered health" is now a cornerstone of the new digital strategy for the Health Board. A new Programme is being developed and will include collaboration with the Wales Co-op in delivery of capacity to tackle digital exclusion.

The Health Board collaborates with national partners to drive forward the digital agenda across Wales. This includes Emergency Department, Critical Care, Patient Flow and Welsh Community Care Information systems. It has also been a development partner in key programmes such as the Electronic GP Record.

There is a strong clinical and service appetite for delivering innovative change within the Health Board. Whilst the Health Board's local strategy is consistent with national strategies and supportive of the "Once for Wales" principles, recent WAO and PAC reports highlight some of the current challenges and issues that need resolving, to achieve the right balance for national standards and direction and enabling local agility and innovation. The Health Board has contributed positively and fully to these reviews.

- **Brexit preparations**

The Health Board has established an EU Transition Group that is working with national, regional and local partner organisations to plan and prepare for BREXIT. The Transition Group coordinates the activities to plan for BREXIT and our actions to mitigate risks within the control of the organisation and our partnerships.

Engagement and planning work has already been undertaken via Business Continuity leads through the Local Resilient Forum. The Health Board's Business Continuity Model is based on the potential implications for a 'no-deal' BREXIT and a risk assessment/ plans have been produced to mitigate any impact and include the following areas: workforce, procurement, medicines, equipment and machinery, research and collaboration, ICT and communication.

Access to stock has been a specific concern identified across a number of medical specialities. The Health Board has been in contact with supplying companies to determine resilience stock levels, timeliness of support and transportation options. There are ongoing concerns in relation to short shelf-life products and national work is underway through national procurement arrangements to resolve this.

In relation to the health and social care workforce, the initial analysis undertaken of nursing and residential homes and domiciliary care agencies, suggest that the number of EU national employees and patients should have a limited impact. This is similar to the workforce analysis for the Health Board, however, we continue to work with local authorities and with our Divisions, support staff and patients in accessing the Settled Status Scheme. The Health Board has now received guidance on Mutually Recognised Briefing which sets out transitionary arrangements for health care professionals from the EU to enable them to professionally transfer to the UK.

- **Managed Practice premium rates**

In answer to the question raised during the Committee meeting, the total premium cost of operating the managed practices is £1.3m, of which £680k (52%) relates to the GP/locum premium. If the doctors were employed in substantive posts, the premium would reduce to about £620k which is a premium of 19%.

I hope these responses fully answer your questions, but if you require any further information please let me know.

Yours sincerely

Glyn Jones
Cyfarwyddwr Cyllid a Pherfformiad/Dirprwy Brif Weithredwr
Director of Finance & Performance/Deputy Chief Executive

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref MA(P)VG/2643/19

Dr Dai Lloyd AM
Chair
Health, Social Care and Sport Committee
National Assembly for Wales
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6 August 2019

Dear Dai,

Thank you for your letter of 9 July requesting an update on progress following the publication of the Health, Social Care and Sport Committee (HSCSC) report on the use of antipsychotic medication in care homes.

You will be aware that following this report a group was established to review current data collection and reporting of antipsychotic prescribing in care homes and to make recommendations for improving surveillance. I wrote to you on 19 February providing you with a copy of the group’s report.

The Chief Pharmaceutical Officer has since written to NHS organisations asking them to consider the report’s findings and instructing them to take appropriate action to address them.

Progress has already been made on a number of the group’s recommendations and this, along with variation in antipsychotic use, will continue to be monitored by the Welsh Government on a quarterly basis. This will ensure that any concerns regarding the prescribing of antipsychotics can be raised and acted upon in a timely manner

In regards to Recommendation 1 of the HSCSC report, we intend to further amend the National Prescribing Indicator which measures antipsychotic use. This is so that the report published annually by the All Wales Therapeutics and Toxicology Centre will allow us to not only monitor the number of patients aged 65 or over prescribed an antipsychotic but also the number of those patients who are also resident in a care home. We are continuing to work with the NHS Wales Informatics Service to identify how routinely collected data can be used to further improve the prescribing indicator. Health boards now receive quarterly data on the number of patients over 65 prescribed an antipsychotic. Plans are in place to make this data available to GP practices in real time through of the Quality Assurance and Improvement Framework being introduced as part of the General Medical Service contractual changes I announced in June.

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Recommendation 2 refers to the compliance of health boards/trusts in relation to National Institute for Health and Care Excellence (NICE) guidelines on dementia. As the guidelines are based on the best available evidence, health boards and trusts recognise they are expected to adhere to this guidance. NICE and the Welsh Government continue to encourage organisations to use guidelines to inform their delivery of services and patient pathways.

In addition, we have established a task and finish group who are working to assist learning and development approaches that will support alternative approaches to antipsychotic medication.

In regards to an update to Recommendation 8, Health Education Improvement Wales is currently undertaking the Strategic Review of Health Professional Education which is looking at the future arrangements for the commissioning process. This will include Speech and Language Therapists.

In addition, the Dementia Action Plan identified the need to develop an All Wales Allied Health Professional Dementia consultant. This post is currently being advertised and will focus on enabling people to live as independently as possible for as long as possible through individualised care plans. It will drive change in the way we enable people with dementia to retain control over their own lives and manage their condition for as long as possible.

Yours sincerely,

Vaughan Gething

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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Welsh Government

Ein cyf/Our ref MA/P/VG/2847/19

Dr Dai Lloyd AM
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9 August 2019

Dear Dai,

Thank you for your letter of 25 June 2019 regarding the Health, Social Care and Sport Committee's Report on progress towards achieving elimination of Hepatitis C in Wales.

The attached document provides my formal response to each of the Report's recommendations. You will note I am content to accept, or accept in principle all of the recommendations which have been made.

Please pass on my thanks to the Committee and everyone else involved in supporting your inquiry and producing your final report.

Yours sincerely,

Vaughan Gething

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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Written response by the Welsh Government to the report of the Health, Social Care and Sports Committee on progress towards achieving Hepatitis C elimination in Wales

The Welsh Government is signed up to the World Health Organization elimination agenda for hepatitis B and C, which includes targets to reduce viral hepatitis incidence by 90% and to reduce mortality due to hepatitis B and C by 65% by 2030.

There are an estimated 12,000 Welsh residents who are either unaware they have hepatitis C or are not engaging with services for treatment (modelling for Wales is in the process of being finalised and this figure could change). In response to this challenge, a Welsh Health Circular (WHC/2017/048) was issued to NHS Wales in October 2017, which set out the framework of actions needed at a local level to support elimination.

WHC/2017/048 emphasised the importance of developing effective and sustained outreach services to engage with individuals not currently in contact with traditional services. It also emphasised the importance of improved testing and treatment delivered in settings and environments in which these individuals are familiar and comfortable with so they are more likely to attend and accept treatment.

To support the local action required, a wide range of national actions are currently being progressed to support elimination which include:

- BBV opt-out testing which was introduced in prisons in Wales in 2016.
- A national hepatitis C patient re-engagement exercise has commenced which involves re-contacting patients who were diagnosed at a time when either treatment wasn’t available or wasn’t well tolerated. So far in 2019, over 600 letters inviting patients for re-testing, have been issued and further letters will be issued as patient data is quality assured.
- A national specification for testing in community pharmacies has been developed and from April 2019 is being piloted in Cardiff and Vale and Cwm Taf Health Boards before being rolled out across Wales.
- A Key Performance Indicator (KPI) for Area Planning Boards, focusing on the offer of a BBV test annually to all those accessing substance misuse services, has been agreed and introduced from April 2019. A Welsh Government Task and Finish Group has been established to support and oversee its introduction and progress.
- NHS Wales has negotiated with the pharmaceutical industry to agree a new funding deal for hepatitis C treatments from April 2019.

The above actions are all essential components of an elimination strategy.

I would like to thank the members of the Health, Social Care and Sports Committee for their report on progress towards achieving hepatitis C elimination in Wales. I have set out my response to the Report’s individual recommendations below.

Detailed Responses to the report's recommendations are set out below:

Recommendation 1. We recommend that the Welsh Government produces a comprehensive national elimination strategy for hepatitis C, with clear ambitious targets, and workforce planning built in, and provides sustainable funding until elimination is achieved. This must be done as a matter of urgency, given that the current plan will end this year, and funding for dedicated posts is only confirmed until 2021.

Response: Accept in principle

Welsh Government policy has moved away from very specific disease strategies because their limited focus, together with the administrative burden of a formalised strategy, create limitations. This inquiry focused specifically on hepatitis C and whilst clearly important, even within hepatitis, there are other actions, such as the need to eliminate hepatitis B (another WHO target). There are also a wide range of other diseases/health protection policy issues that do not have specific strategies and yet significant work is being undertaken in these areas without the administrative burden of a formalised strategy.

Key activity in relation to hepatitis C (and B) was previously part of the BBV Action Plan, which ran until 2015, is now part of the broader Liver Disease Delivery Plan, which is due to run until March 2021. Irrespective of its inclusion in wider strategies, it is known what is required to successfully eliminate hepatitis C: increased testing and treatment in the community.

The process to increase testing and treatment in the community is underway and we anticipate significant improvements through the introduction of the KPI for Area Planning Boards in relation to testing for BBVs in substance misuse services. Further to this, the Welsh Government will introduce formal health board hepatitis C testing and treatment targets as part of the NHS Delivery Framework for 2020/21.

Welsh Government will produce periodic Welsh Health Circulars for NHS Wales outlining progress and highlighting specific actions necessary to eliminate hepatitis C by 2030 at the latest. Performance against these requirements (including targets within the NHS Delivery Framework) will be scrutinised and monitored through existing NHS performance management arrangements.

Whilst it is agreed that key national posts will be required beyond March 2021 if we are to successfully achieve elimination, any decision for funding beyond the period for which we have a settlement will be taken around the appropriate budget planning round.

Financial Implications: None. Delivering the local actions required to achieve elimination of hepatitis B and C as a public health threat will be absorbed from within existing programme budgets and NHS allocations.

Recommendation 2. The strategy must include a targeted awareness raising campaign to reach out to at risk communities and also provide for education and training for health professionals.

Response: Accept in principle

Targeted awareness raising already happens in Wales through a variety of channels. Welsh Government would need clear evidence that a national campaign is effective at reaching these hard to reach groups.

Fundamental to progress, is health board investment in effective and sustained outreach services to engage with individuals not currently in contact with traditional services. Hepatitis C patients are often hard to reach, which is why a dedicated resource is needed within health boards to assist with targeted case finding in the community.

Education and training for health professionals is already available – this will be reviewed and re-communicated as part of a wider package around liver disease.

Financial Implications: None. Delivering the local actions required to achieve elimination of hepatitis B and C as a public health threat will be absorbed from within existing programme budgets and NHS allocations.

Recommendation 3. The Welsh Government must write to Local Health Board Finance Directors and Chief Executives to emphasise that national treatment targets for hepatitis C must be considered as minimum targets, to be exceeded wherever possible, if the elimination target of 2030 is to be achieved in Wales.

Response: Accept

The Welsh Government will write to Health Board Finance Directors and Chief Executives to confirm the formal introduction of national testing and treatment targets for hepatitis C. It will be made clear that such targets must be considered as minimum targets, to be exceeded wherever possible.

Financial Implications: None. Delivering the local actions required to achieve elimination of hepatitis B and C as a public health threat will be absorbed from within existing programme budgets and NHS allocations.

Recommendation 4. We recommend that the Welsh Government provides additional investment to improve Hepatitis C testing in Welsh prisons.

Response: Accept in principle

While Welsh Government is aware that hepatitis C testing rates in prisons needs to be improved, it needs to be improved for a range of diseases. An inquiry is currently underway in relation to the provision of all health and social care services in prisons in Wales and the outcome of this will be taken into account in terms of action around improved testing in prisons. The number of people screened for BBVs in prison settings is regularly monitored – and Welsh Government has recently asked for assurance around the offer of BBV screening to all those accessing substance misuse services in prisons. Welsh Government has also allocated additional funding this year to improve health services in prisons.

Financial Implications: Unknown at present. Welsh Government will take into account the outcome of the wider inquiry into health and social care in the prison estate – and the extent to which costs to improve the health outcomes amongst prisoners can be met from existing programme budgets and NHS allocations. This will be addressed in discussions with health boards.

Agenda Item 6.7

Comisiynydd Cenedlaethau'r Dyfodol Cymru
Future Generations Commissioner for Wales

By email

09/08/2019

Re: Involvement in the first Future Generations Report

Dear Dai,

Producing a Future Generations Report is one of my duties in the Well-being of Future Generations Act. It must provide advice on improvements public bodies should make in order to set and meet well-being objectives which are the commitments they chose to make to improve the economy, society, environment and culture of their area. My report will also include information on the progress to date and on what should happen in the future. The Report will be published in May 2020.

This will be the first Future Generations report and will include the following main chapters: 'considering where we are and should go culturally (5 Ways of working and 7 core areas); where we are and should go in achieving the well-being goals (including objectives and steps); a particular consideration of our areas of focus (transport, planning, housing, ACEs, skills, alternative models for the health system, decarbonisation, budgeting and procurement); recommendations and ideas.

Using the five ways of working we intend to follow the involvement principle and in addition to our national conversation 'Our Future Wales' and our online stories forum, 'The People's Platform', I would like to give you an opportunity to help shape the content of my report and my recommendations. I also want to flag in the report, the resources which would be most useful to public bodies and would welcome suggestions as to reports, documentations and recommendations your committee would like to point out.

I would be grateful of you could send us any information or comments you would like me to consider by the 1st of November 2019. I am interested in particular in concerns, observations, opportunities or recommendations you think are most important, as well as a list of issues you think are of greatest importance to current generations and then to future generations to see if they differ.

I look forward to hearing the views of your committee.

If you wanted to talk in person, we could seek to organise a meeting with my colleagues who will also be visiting Ty Hywel's cafeteria in the autumn with Positif Politics and further information will be sent to you about this opportunity. We would welcome the opportunity to meet with you and your colleagues.

My office will also contact every Assembly Member separately to ask for their personal opinions and we are also preparing tailored 'Assembly Members briefing packs' that provide further information on my work to date and the priorities for the year ahead. You will receive this separately and individually. It will also include some examples of how the Act is being delivered in your area.

If you have any further questions, please don't hesitate to get in touch.

Regards,

Sophie Howe
Future Generations Commissioner for Wales

Comisiynydd Cenedlaethau'r Dyfodol Cymru
Future Generations Commissioner for Wales

Mick Giannasi
Chair of the Independent Maternity Services Oversight Panel
Cadeirydd y Panel Trosolwg Annibynnol ar Wasanaethau Mamolaeth

Eich cyf/Your ref **IMSOP-SE-004-19**
Ein cyf/Our ref **IMSOP-SE-004-19**

Dr Dai Lloyd AM,
National Assembly for Wales,
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21 August 2019

Dear Dr Lloyd,

Cwm Taf Morgannwg Independent Maternity Services Oversight Panel

Thank you for your recent letter following on from the Panel's appearance before the Health, Social Care and Sport Committee on 17 July 2019.

Members of the Committee wanted to know how a 'serious incident' would be defined for the purposes of the Panel's Clinical Review work and having consulted with my clinician colleagues, I am pleased to be able to provide the following information.

Although the Panel is independent, it is important the Panel's work aligns with the overarching policy and guidance of Welsh Government. As such the definition of 'serious incident' which is being used is the definition provided in paragraph 9.2 of the 'Putting Things Right' guidance. The guidance states that:-

> *A serious incident is defined as an incident that occurred during NHS funded healthcare (including in the community), which resulted in one or more of the following:-*
>
> - *unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;*
> - *a never event (all never events are defined as serious incidents although not all never events necessarily result in severe harm or death);*
> - *a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;*

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- *allegations, or incidents, of physical abuse and sexual assault or abuse; and/or loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.*

As you will see, the definition is quite broad. However, the first and second elements of the definition are those which are most relevant to the Panel’s work.

In order to enhance the specificity of the definition for use in a maternity care setting, the Panel’s Midwifery and Obstetric Leads are developing a set of more specific inclusion criteria which are being used to scope the first phase of the clinical review programme and which will include the 2016-2018 cases identified in the Royal Colleges’ report.

The inclusion criteria will be taking account of national quality improvement programmes designed to reduce the incidence of poor outcomes for mothers and babies. This includes the Each Baby Counts programme developed by the Royal College of Obstetricians and Gynaecologists and MBRRACE which is a national surveillance programme managed by the Nuffield Department of Public Health at Oxford University.

The inclusion criteria are currently the subject of consultation with Welsh Government, the Health Board and other key stakeholders. However, the information is not yet in the public domain due, in part, to the need to communicate directly with the women and families affected by the clinical review process.

It is anticipated that the criteria will be signed off shortly and included in the publication of the Panel’s First Quarterly Report by the Minister for Health and Social Services. I will, of course, write to you again once the information is available.

I hope that assists. In the meantime, if there is anything further I can do to inform the Committee’s deliberations, please do not hesitate to contact me.

Yours sincerely,

Mick Giannasi
Chair, Independent Maternity Services Oversight Panel

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA/P/VG/3024/19

Dr Dai Lloyd AM
Chair, Health, Social Care and Sport Committee
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29 August 2019

Dear Dai,

Thank you for your letter dated 29 July 2019 seeking clarity on the coherence of the interventions that are underway in Cwm Taf Morgannwg University Health Board (CTMUHB).

Since publication of the Royal Colleges' report on 30 April 2019, a number of measures have been put in place to drive improvements. You will recall that I placed the maternity services into special measures, whilst at the same time placing the overall organisation into targeted intervention given a number of quality and governance concerns that had emerged. Clearly there are a number of interdependencies between these two areas which will need to be considered together when determining if sustainable improvement is being achieved. I therefore welcome the opportunity to set out the current strands of intervention and describe how I see these being complementary.

I must clarify that the work of Healthcare Inspectorate Wales (HIW) and Wales Audit Office (WAO) are independent from Welsh Government and I have not initiated these. Nevertheless, their outputs will inform and be a key element in identifying and assessing the improvements needed. In summary the overarching strands are:

1. Independent Maternity Services Oversight Panel (IMSOP)
   This is the maternity specific intervention which I announced on 30 April 2019. The Panel's role is to provide oversight, challenge and scrutiny to ensure the health board implements the Royal Colleges' and associated recommendations. The terms of reference also include conducting independent multi-disciplinary clinical reviews of cases between 2010 and 2018. The full terms of reference are available here. As you are aware, the Panel will produce quarterly public facing progress reports, the first of which I will receive in the autumn. I expect further information regarding the performance monitoring and assessment framework being used to evidence improvement, together with their clinical review and engagement strategy to be available at this time. I will be publishing this report in full.

2. Governance Advice and Support
   Earlier in the year a number of quality and governance concerns had emerged in addition to the concerns within maternity services at the former Cwm Taf UHB. In the

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main, this related to findings of inspection reports from both HIW and the Human Tissue Authority, as well as the annual structured assessment undertaken by the WAO. All of these issues raised questions about the effectiveness and reliability of the clinical/quality governance arrangements within the health board. I therefore asked David Jenkins, former Chair of Aneurin Bevan University Health Board, to provide advice and support to the Chair and Board of CTMUHB. His role includes providing advice to the Board on its governance and assessing the Board's ability to deliver improvements needed. He will advise me on whether any further actions are required. In support of this work, a Board Development Programme has been commissioned and will begin imminently.

3. NHS Delivery Unit (DU) Intervention
   The DU's work includes ensuring that there are effective arrangements for the reporting, management and review of patient safety incidents and concerns. The work will build on previous reviews and recommendations made by the DU, including initial concerns that emerged in maternity services.

4. HIW/WAO Joint Review of Quality Governance Arrangements
   A joint review to examine quality governance arrangements within the health board is in train. The review will look at how CTMUHB's overall governance arrangements support delivery of high quality, safe and effective services, and will include a specific focus on arrangements within the surgical directorate. The terms of reference can be found here. A joint report of findings and recommendations is anticipated at the beginning of autumn.

The findings from the HIW/WAO review, together with the other governance interventions will be used to finalise an improvement framework which will then be used, aligned with the maternity improvement plan where appropriate, for progress to be monitored.

In terms of day to day collaboration and coordination between all the strands, I have put in place a designated CTMUHB Intervention Team led by a Deputy Director experienced in healthcare quality and safety. The team's role is to align all the separate strands of intervention; encouraging joint working with openness and transparency. In addition to this, David Jenkins, HIW, WAO and DU attend the monthly IMSOP formal meetings along with Welsh Government. This provides opportunity for all key stakeholders to brief each other and appropriately share intelligence.

In respect of maternity services, I expect all health boards in Wales learn from this. In addition to the immediate assessment that I asked all boards to undertake I am pleased that HIW has commenced a National Review of Maternity Services. The terms of reference can be found here. A report will be produced following each maternity inspection and a national maternity services report will be published in summer 2020.

I hope this information is helpful. I will be providing regular updates on progress.

Yours sincerely,

Vaughan Gething

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
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Dyddiad/Date:	22 August 2019

Dr Dai Lloyd AM
Chair
Health, Social Care and Sport Committee
National Assembly for Wales
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By email: SeneddHealth@assembly.wales

Dear Dr Lloyd

Re: Health, Social Care & Sport Committee: 13 June 2019

Thank you for your letter of 19 June 2019 following the above Committee evidence session. I hope you found our evidence session of interest.

Mental Health

1. *Could you provide more information on the measures in place to deal with the growing demand for assessment of children within the CAMHS service, including those waiting longer than the target times.*

   There is currently no waiting list for children and young people for assessment following referral to Specialist Child and Adolescent Mental Health Services (S-CAMHS); the Health Board is meeting all its performance targets to date.

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Cadeirydd /Chair
Miss Maria Battle

Prif Weithredwr/Chief Executive
Mr Steve Moore

Bwrdd Iechyd Prifysgol Hywel Dda yw enw gweithredol Bwrdd Iechyd Lleol Prifysgol Hywel Dda
Hywel Dda University Health Board is the operational name of Hywel Dda University Local Health Board

Mae Bwrdd Iechyd Prifysgol Hywel Dda yn amgylchedd di-fwg Hywel Dda University Health Board operates a smoke free environment

Where there have been variants in respect of Primary Care referrals, this is attributable to sickness absence within the local teams, resulting in the assessments or interventions not being delivered within the 28 day performance standard.

The Health Board operates a Single Point of Contact for all referrals, which ensures every referral is screened for urgency and then forwarded to the appropriate mental health service for assessment. This could be direct to Primary Mental Health or to Secondary Mental Health services. Where there is extreme urgency, the Crisis Team will undertake an assessment.

The Health Board is monitoring the demand on the S-CAMHS Service, and considering additional means of providing services, which includes extending working hours. At present, the Crisis Team operates 24/7, and consideration is being given to providing a 7-day a week Primary Mental Health Service.

The Health Board's Neurodevelopment Service provides diagnostic assessments for Autistic Spectrum Disorder (ASD) for children and young people, and is not meeting performance targets fully. Due to a high demand for this service, the Health Board is working with Welsh Government to develop a 12-month Recovery Plan to address the waiting list to ensure that the future service model is resourced to meet this growing demand, which will have a positive impact on the 26-week Welsh Government target.

2. *What progress has been made in implementing the new model of care for mental health services (referred to in the Health Board's written evidence) and what evidence is there of improved outcomes for patients?*

In January 2018, the Health Board approved the implementation of the co-designed *Transforming Mental Health* (TMH) model. A Transforming Mental Health and Learning Disabilities (TMHLD) programme group was established to oversee the implementation of TMH, and includes representation from a wide range of stakeholders.

The implementation phase of TMH to date has been centred on reconfiguring adult mental health services to develop:

- A 24/7 Community Mental Health Centre (CMHC) in each county. These centres will provide
    - A 'drop in' facility offering a minimum of four 'crisis' or 'recovery' beds;
    - The availability of a local assessment suite for the use of Section 136 of the *Mental Health Act 1983* (where the police can take a person they believe has a mental health illness and needs care or control to a place of safety); and
    - The potential to offer a social enterprise that adds value to the local community.

  These also include new roles for the Third Sector, embracing the values and experiences of those with a lived experience of mental health problems.
- A Central Assessment Unit (CAU) and Central Treatment Unit (CTU) in Carmarthenshire that will provide a greater presence of senior clinicians, alongside increased input from the Third Sector, to assist people with their recovery. The CAU will also provide a designated Section 136 assessment facility to help meet the needs of the Crisis Care Concordat and the *Policing and Crime Act 2017*.

- A Single Point of Contact to improve access for everyone.
- Improved transport provision.

This is a significant service change, with £17m of revenue funding within adult mental health services and £900k of commissioned services that support adult mental health service delivery. It directly affects around 400wte staff who work within the service. The roles of the workforce must be developed clearly and with sensitivity for the needs of staff, as many of these roles will see changes to their working hours and working practices in order to deliver the future vision for the service.

Retaining co-production at the heart of the programme's implementation affects the pace of change, to give due consideration to the voices of others. Implementation of the programme in this way reduces the risk of resistance to major service change and increases the chances of embedding the cultural change required from our workforce and partners in the longer term. Over the last 18 months, significant progress has been made with our service users and key stakeholders:

- The Estates and Infrastructure group has developed a critical pathway and timeline for capital and estates that describes when each Community Mental Health Centre and inpatient unit is anticipated to be fully operational. Welsh Government has invited the Health Board to develop an outline Business case, which has recently been finalised. In addition, staff and stakeholders are identifying, designing and co-developing the buildings identified within the TMH model.
- The Transport group has co-designed a new transport system to support the access and outreach options for mental health staff, service users and carers following transition to the new service model. This will streamline the existing booking process to ensure a single point of contact for booking requests on a 24/7 basis, with the ability to monitor and report on all transport activity filtered through the system. It will also identify a range of community transport and outreach options for people using all elements of the proposed new service.
- The Workforce and Cultural Change group has written revised job descriptions for a number of new roles within the model. A 'TMH Champions Day' to raise awareness of the work being undertaken has had a noticeable impact on the workforce within adult mental health service. Currently, the group is modelling the workforce requirements for the model in order to progress an Organisational Change Process.
- The Pathways Group has designed a high level pathway for the new model and is working to progress a Single Point of Contact with Local Authority colleagues.

On the ground the following changes have been seen:

- Developing a **24/7 mental health drop in facility in Aberystwyth**, with a designated place of safety. The Community Mental Health Team (CMHT) in Gorwelion, Aberystwyth operates 9-5 Monday to Friday, excluding bank holidays. CMHT staff are currently working collaboratively to merge existing primary care and secondary care teams. Capital investment has also been secured to ensure the environment in the building is suitable. Whilst an Organisational Change Process (OCP) is being developed with staff, the CMHT is running a drop in service during weekdays and early feedback from this has been really encouraging.

Service users are reporting feeling more comfortable in attending appointments and engaging with CMHT staff more positively. The service is expected to be fully operational on a 24/7 basis from **January 2020** and the team will be gradually phasing up its hours of operation until that time.

- The **Primary Care Mental Health practitioner pilot** in Pembrokeshire will build upon a successful pilot in Cardiff & Vale UHB that has reported significant improvements in mental health care and a reduction in referrals to primary and secondary mental health services. Two GP surgeries in Pembrokeshire have been identified to run the pilot and the practitioner has now been appointed and were due to commence in post from **July 2019**.
- A **Twilight drop-in centre in Llanelli** provided by the Third Sector for low level mental health needs between 6pm – 2am, Thursday – Sunday, which demand mapping has shown are peak hours for crisis activity. The Health Board is working jointly with Hafal/Llanelli Mind, Llanelli CMHT/Crisis Team, WAST and Dyfed Powys Police to run the service from Llanelli town centre. The service will become operational in **July 2019**.

Eye Care

3. *We discussed the performance-against-waiting time figures in relation to eye care, and the number of patients experiencing delays in follow-up treatments. We note the funding measures you now have in place to develop solutions to the backlogs in this area. Could you provide us with figures for the number of patients whose eyesight has been lost or damaged as result of delayed treatment.*

   Over the last two years, the Ophthalmology Team has reported 12 incidents of harm relating to delay in follow up that resulted in patients' eyesight having been lost or damaged. The Health Board has a strong ethos of reporting harm and has set up an Incident Management Group, which meets monthly to review and monitor the improvement action. This group includes the Clinical Lead, Senior Nurse Manager and Service Delivery Manager for Ophthalmology.

Digital and Data

4. *In what ways is the Health Board maximising the use of digital technology to improve the delivery of care and patient outcomes? Is there a sufficiently joined-up, strategic approach to digital innovation at health board level and nationally.*

   The recent Wales Audit Office (WAO) report on the Informatics Systems in NHS Wales fairly reflected the current digital challenges in NHS Wales, and provided a focus for improvements going forward. In response to the Public Accounts Committee, and also the questions raised by this Committee, the Health Board has met the NHS Wales Informatics Services (NWIS) at a Director to Director level to develop an implementation plan to greater improve our usage of the nationally available systems.

   The Health Board has implemented all national systems currently available, and is now working to improve the usage of such systems, which will in turn improve the digitisation of a number of services affecting patient care. The publication of our Health and Care Strategy: *A Healthier Mid and West Wales – Our future generations living* *well* recognises that the digital landscape is a key enabler. For example, the Health Board has agreed to invest in a pilot to deliver the Welsh Community Care Information System (WCCIS), which integrates community health and social care staff, mobilising them to provide care in the patient's home.

Coupled to this is the development of a number of new Community Care Hubs, with the latest digital technology included, to provide a blueprint for a digital hospital. As a result, our Digital Strategy has been reviewed as part of the annual planning process and will continue to be adapted to reflect emerging technology, the national digital plan, and current thinking of the Strategy.

The Health Board is leading the way for Patient Reported Outcome Measures (PROMs), and is using technology to allow patients either to enter the information at our clinics or at their home. All of which is presented back to the clinical teams to improve services.

In order to provide clinical leadership in digital, the Health Board has appointed a Chief Clinical Information Officer (CCIO), and an Interim Chief Nursing Information Officer (CNIO), who are now helping to both shape and support the Digital Strategic Plan. The CCIO and CNIO represent the interests of all clinical/nursing staff groups on digital projects. At the simplest level, they provide clinical leadership and input on national and local digital projects, and ensure that digital projects are designed with healthcare users firmly in mind. These are critical roles that unite the digital agenda with clinical practice, ensuring the Health Board uses information and digital in the transformation of healthcare.

The recently announced Transformation Fund has allowed the Health Board, with its partners, to progress the development of Technology Enabled Care (TEC). This is truly a transformation programme with digital technology at the centre of its development. It will provide a seamless platform for all care givers to provide the support to the patient when required. Therefore, our digital aim is to provide a patient-centric, modern, efficient healthcare system for the population of Hywel Dda UHB. At the heart of this system is a modern, robust digital infrastructure, recognising the social care and GP record at the core, with interoperability into each of the neighbouring electronic systems that interface with a patient's journey through the NHS and wider community, such as social care services.

Brexit Preparations

5. *What have been identified as the key areas of risk within the Health Board, i.e. what services, systems, etc. are likely to be most affected by the UK's withdrawal from the EU?*

A series of risk assessments against targeted high risk and cross cutting areas was undertaken to determine the potential impact to business continuity and understand the collaborative contingency planning arrangements that are required for preparedness, response and recovery for a 'no deal' scenario.

Together with a number of table top exercises at local, regional and national levels, these have led to the identification of the highest risk areas: Supply Chain; Workforce; Financial Impact; and knock on impact from partner social care providers and primary care contractors.

Specific business continuity plans have been developed which reflect contingency arrangements in the event of a no-deal scenario, and link to on-going preparations by NHS Wales Shared Services Partnerships.

The Health Board continues to maintain a Brexit Steering Group (which leads on planning, preparing and responding to the consequences of Brexit) and participates in preparations at regional (Local Resilience Forum) and national (Welsh Government) levels.

I trust this information is of assistance and addresses the points raised by the Committee.

Best wishes
Yours sincerely

Steve Moore

Steve Moore
Chief Executive

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Ein cyf/Our ref: MA - P/VG/3161/19

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4 September 2019

Dear Dai,

Thank you for your letter of 22 July requesting details of UK common policy frameworks being developed within my portfolio. I am very grateful for the Committee's continued support in these uncertain times and deal with their points in the order you raise them:

- *what steps have been taken to develop frameworks within your portfolio areas, and at what stage of development those frameworks are?*

Health and Social Services policy officials have been engaged with their counterparts from the UK Government, Scottish Government and Northern Irish Civil Service since November 2017 in order to develop frameworks. Over this time officials have been able to establish where Frameworks will be required and an initial position on the type of Framework required. The progress of this work was most recently reflected in the UK Government's Framework Revised Analysis on April 2019. Some policy areas were identified as needing priority consideration such as Reciprocal Healthcare and Nutrition related labelling, composition and standards covered by the Nutrition Common Framework which is at an advanced stage of development. In other policy areas, meetings have been held to begin to develop Framework 'Outlines'. These will set out the scope and approach of the Framework agreement. For blood, organs, tissues and cells, we have agreed to develop a framework with the UK Government and the other devolved countries which will look to maintain UK-wide standards in the first instance. The area of Mutual Recognition of Professional Qualifications which sits under the Education Minister includes the EU MRPQ Directive covering health professions. The current priority in this area is to ensure that preparations for any 'No Deal' scenario are in place.

- *the evidence base to support decisions on frameworks?*

Decisions as to whether a Framework will be necessary in any given area are being taken on the basis of discussions between policy officials who are liaising closely with their counterparts in Department of Health and Social Care (DHSC). These discussions are taking into account the impact and likelihood of divergence in the area; the volume of work which the Framework would consider; and the benefits derived from formalised cooperation. None of these decisions are final at this stage; areas which had previously considered as requiring a Framework have, on further reflection, been left for informal cooperation between the Administrations. For Reciprocal Healthcare, the provisions of the Healthcare (European Economic Area and Switzerland Arrangements) Act 2019 will be brought together with an underpinning MOU to eventually form the reciprocal healthcare framework.

- *intergovernmental structures that have been or are being established, e.g. Ministerial forums etc.?*

The JMC(EN) was established in October 2017 and acts as the Ministerial oversight for the Frameworks Programme. Some Ministerial Quadrilateral meetings, including one covering the health and social care sector, have been established to consider policy specific issues as they arise. These fora consider, but are not limited to, issues arising from Frameworks. MOUs are in place setting out the nature of engagement with Devolved Administrations. Planning has also been put in place for a UK body (UK Nutrition and Health Claims Committee) to be established to undertake functions currently undertaken by the European Food Safety Authority.

- *what end output(s) are anticipated from the frameworks, both legislative and non-legislative?*

Frameworks will develop an intergovernmental system for cooperation between the four Administrations. These systems will provide formalised procedures for decision-making and communication. Many of these systems will be set out and agreed through concordats supported by a Framework Outline Agreement.

- *how the frameworks link with existing or proposed Welsh Government action, both legislative and non-legislative (including where frameworks cross-over with other portfolios)?; and*

Frameworks are being developed on an ongoing policy development basis with ’no deal’ preparation and Future Economic Partnership work firmly in mind. The Frameworks and associated governance arrangements will be flexible to future decisions in relation to EU and international discussions and policy developments. They will also provide a platform for these discussions in a way which ensures parity of participation and decision-making and, very importantly, protection of devolved competence. For example, much of reciprocal healthcare is either led on a UK basis or falls within the area of international relations and is therefore is not devolved. However there is devolved competence for some aspects of reciprocal healthcare and officials are ensuring that devolved areas are highlighted and taken fully into account by the DHSC.

- *how each framework area will be managed in the event of the UK leaving the EU without a deal?*

Departments, including my own, have undertaken no-deal approaches to governance, including interim working level agreements. These set out inter-governmental approaches to imminent issues which might arise as a result of ‘no-deal’. These working level agreements operate under some of the same or similar structures to the Frameworks structures, such as the Ministerial Quadrilaterals. Within some policy areas, an interim working level arrangement could overlap with a particular Framework and its development may have drawn upon the Framework discussions that have already taken place. No deal arrangements are purposely short term and interim, so as not to set any precedent for Frameworks. In the case of a ‘no deal’ situation, Welsh Ministers including myself expect the Frameworks programme to be priority work area so as to ensure properly considered and scrutinised arrangements are put in place as soon as possible.

I hope you and your Committee colleagues find this reply helpful. I would be happy to elaborate on the detail of individual framework areas should you require further information.

Yours sincerely,

Vaughan Gething

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Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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Ein cyf/Our ref: MA-L/VG/0420/19

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30 August 2019

Dear Dai,

The Health and Social Care (Quality and Engagement) (Wales) Bill

Thank you for your letter dated 23 July setting out the matters on which I agreed to provide further information during my appearance before the Heath, Social Care and Sport Committee on 11 July. I am pleased to include the following information which covers these areas and also provide further clarity and explanation on some other areas touched upon during the Committee session. I hope this will assist the Committee in its ongoing scrutiny.

The Welsh Government's *A Healthier Wales: Our Plan for Health and Social Care* outlines how quality will be key to making the health and social care system in Wales fit for the future and sustainable for the long term. Consequently, we have made quality improvement the central concept underpinning the provisions in the Bill.

However, the provisions included in the Bill only tell part of the overall story. As I explained before Committee, we have adopted the well accepted approach of only including provisions in the Bill where existing primary legislative powers are insufficient to enable us to achieve the policy intent. Therefore, the actions we as a government are taking to improve the quality of services must be viewed as a package of measures implemented through primary legislation, secondary legislation, directions and guidance.

In the White Paper, *Services Fit for the Future, Quality and Governance in Health and Care Wales,* we consulted on a number of proposals that have quality improvement at their heart. **Annex 1** sets out the work that is ongoing to deliver the proposals that do not appear on the face of the Bill because we are able to use our existing powers to deliver the change. The exception to this will be any fundamental changes to the legislative framework underpinning Healthcare Inspectorate Wales.

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Bill provisions

Duty of Quality

Turning to the provisions in the Bill, the Explanatory Memorandum sets out the evidence base for adopting a new, broader duty of quality[1] and the benefits the new duty will bring to individuals, healthcare professionals and NHS bodies[2]. Improvements in quality will benefit patients on a population as well as an individual basis.

As we discussed, the new duty is broader in scope and different in nature to the current duty of quality within the Health and Social Care (Community Health and Standards) Act 2003. The new duty takes us beyond the current duty's rather narrow focus on service standards and quality of services provided to the individual. It will require NHS bodies and the Welsh Ministers (in relation to health matters) to exercise their functions in a particular way, considering how, through all the decisions they make, they can improve the quality of health services. Through this approach, quality improvement will become an embedded and integral part of their decision-making.

As explained to the Committee, the bodies subject to the duty will need to comply in a system-wide way, based on the internationally accepted definition that outlines six domains of health care quality[3], put forward by the then Institute of Medicine.

As I have advised the Committee, it is intended that we will produce guidance to support and assist NHS bodies in the implementation of this duty. The nature of the guidance will be similar in many respects to that which supported the introduction of the Well-being of Future Generations (Wales) Act 2015. For example, it will include a range of case studies to show how NHS bodies could demonstrate they have applied the principles of quality in order to secure improvement. A draft outline for the guidance is enclosed at **Annex 2**.

Duty of candour

In relation to the duty of candour, this will build on work that has already been undertaken by the Welsh Government and the NHS in Wales to ensure our NHS providers are open and honest when things go wrong and will support the drive towards a system that is proactively learning and improving.

In the Explanatory Memorandum we have set out why an organisational duty of candour is required, the policy objectives we wish to achieve by its introduction and the purpose of the legislation[4]. There is evidence to demonstrate that increased openness, transparency and candour are associated with the delivery of higher quality health and social care[5].

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[1] See pages 10-16 and 50-51.
[2] See pages 66-67.
[3] See page 11.
[4] See pages 17 to 23.
[5] World Health Organization, Organisation for Economic Co-operation and Development, and The World Bank. Delivering quality health services: a global imperative for universal health coverage. [Internet]. Geneva; 2018. Available from: https://apps.who.int/iris/bitstream/handle/10665/272465/9789241513906-eng.pdf?ua=1
Department of Health and Social Care and The Rt Hon Jeremy Hunt MP. Good care costs less [Internet]. GOV.UK. 2014 [cited 1 April 2019]. Available from: https://www.gov.uk/government/speeches/good-care-costs-less

However, there are also purely human considerations behind my decision to introduce the duty. We know the overwhelming majority of providers of both health and social care want to deliver a high quality, safe and compassionate service. However, equally, we know that despite these intentions, from time to time, things can and do go wrong and people suffer harm.

In both health and social care, service users have an ongoing relationship with their care or treatment provider. How the provider reacts when something goes wrong can have a huge impact on the quality of that vital relationship and the level of trust the service user has in the organisation. The introduction of the duty of candour for NHS providers will extend and strengthen the framework for informing and supporting individuals who experience an adverse outcome and will help to preserve the integrity of that ongoing relationship.

I have already provided the Committee with the Statement of Policy Intent for the regulations required at section 4 of the Bill that will set out the duty of candour procedure[6]. In addition to this, enclosed at **Annex 3** is a draft outline of the statutory guidance, which will be produced and published to support the introduction of the duty. The regulations, will be the subject of consultation and scrutiny by the Assembly. This work will be developed with the aid of a working group comprised of clinicians, other professionals concerned and lay representatives.

I have also, in **Annex 4,** set out how the duty is approached in England, Scotland and social care here in Wales. This includes our rationale for the approach taken in the Bill.

Sanctions

In the Committee sessions to date, we have also discussed why I am not proposing to introduce a bespoke sanctions regime to support the duties of quality and candour. This is because we are aiming to create a culture where improvements in quality and an ethos of openness, transparency, learning and improvement are paramount. I support placing an emphasis on creating the right environments for change and systems leadership, which is wider than financial incentives and blunt sanctions alone. The mandatory annual reports, providing an account of how NHS bodies and providers have responded to the duties, will add to existing sources of intelligence used by the Wales Audit Office and Healthcare Inspectorate Wales to assess the governance and delivery of quality services. Any concerns will be raised and considered under the NHS Escalation and Intervention Arrangements.

In the wider context, one of the actions within *A Healthier Wales* was to introduce a range of ‘levers for change’. These are being developed with a focus on creating the conditions for systems and behaviour change.

A report by the Wales Centre for Public Policy “Supporting Improvement in Health Boards”[7] published in April 2019 recognises that a whole systems approach is required to improve performance (in its widest sense) by health boards, supported by the right conditions and environment for change.

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[6] http://www.senedd.assembly.wales/documents/s90279/Statement%20of%20Policy%20Intent.pdf

[7] https://www.wcpp.org.uk/wp-content/uploads/2019/04/Supporting-improvements-in-health-boards.pdf

The learning from the report will be considered as the proposals for Levers for Change evolve and are applied in tandem with the establishment of the NHS Executive.

Citizen Voice Body

In relation to the Citizen Voice Body provisions, we spent some time at Committee considering the current structure of the Board of CHCs in Wales, appointments to the Board and how voluntary members are appointed to the local Community Health Councils. Comparisons were drawn and questions were asked about how the Board of the proposed new Citizen Voice Body will be appointed and what arrangements will be in place for the recruitment of volunteer members. **Annex 5** summarises the current CHC arrangements and those proposed for the Citizen Voice Body.

In addition, as part of my commitment to set out to the Committee what guidance we intend to issue, I enclose at **Annex 6** a draft outline of my key expectations for how the Citizen Voice Body will operate. This outline takes full account of the fact that the new Body, given the nature of the functions it will exercise, will be operationally independent of the Welsh Government.

Implementation timescales

It is anticipated, that if passed, the Bill will receive Royal Assent in April 2020.

As indicated in the Regulatory Impact Assessment, we intend to commence the provisions that will bring the new duty of quality into force in summer 2021. This will give us sufficient time to ensure the guidance, as outlined at Annex 2, is developed in partnership and is fit for purpose and that all staff have completed the training that is necessary to successfully implement the duty. It is also our intention to commence the power to appoint Vice Chairs of NHS Trusts at this time.

For the duty of candour, we are working towards a commencement date in spring 2022. Before we can bring the duty into force we will prepare and consult upon the candour procedure regulations and, as explained in Annex 3, we will also make the necessary amendments to the existing Putting Things Right regulations. Again we will need to ensure that all staff complete the necessary training and the statutory guidance is finalised prior to commencing these provisions. As previously stated, within the Explanatory Memorandum, it is also our policy intention to bring forward regulations under the Care Standards Act 2000 to place a duty of candour on regulated providers of independent health care in Wales. We will also consult on these and the intention is to bring them into force at the same time as the candour provisions in the Bill.

In terms of the Citizen Voice Body, it is intended to establish the new Body with operational effect from October 2021. As with the establishment of any new Body, it will take time to engage with staff over staff transfers, source appropriate accommodation and follow due procurement process for contracts, including for ICT and services.

I look forward to providing further evidence to the Committee in due course.

I am copying this letter to the Chairs of the Finance Committee and the Constitutional and Legislative Affairs Committee.

Yours sincerely,

Vaughan Gething

Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Annex 1

Areas consulted on in the White Paper but not brought forward in the Bill	How will this be taken forward?
Health board membership and composition; and the role of the board secretary	Health Boards and NHS Trusts are now operating in a different landscape to when they were first established. The long term plan - "A Healthier Wales" looks to bolster and reinforce the existing planning (IMTP) system, but advocates for a transformation in the way health and care services are delivered in Wales. Legislation such as the Well-being of Future Generations 2015 has also set the path for a shift in the way services are delivered in Wales and NHS Boards must be organised in such a way they can most effectively meet future challenges. Changes to NHS Board membership and composition will require amendment to existing regulations and establishment orders. Board structures should reflect organisational structures which, in turn, should reflect what and how health and care services are provided for and accessed by patients. Any changes to board structures, however, should be managed carefully, so not to compound issues we are looking to remedy. Therefore, changes to overall board size and composition of NHS bodies needs to be considered within the wider context and systems. Further policy work is being undertaken on this basis with the purpose of developing a series of options for consideration and discussion with partner organisations. We want to progress with involving and engaging key stakeholders in the development of policy on future proposals. We can consider then what we need to do, if anything, about the membership and composition of boards, with a view to taking forward any required changes to secondary legislation by Spring 2021. Any changes to the regulations will be subject to a separate Explanatory Memorandum and Regulatory Impact Assessment and consultation. With regard to NHS Board Secretaries, the role of the Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within boards and is a key source of advice and support to the Chair and other board members. The Board Secretary acts as the guardian of good governance. We are investigating, through engagement with the NHS, how Model Standing Orders may be amended to provide a clearer role for the Board Secretary, support the integrity of the role and prevent the role from being compromised. We are taking this work forward with a view to introducing any changes in 2020/21.
Reform of the Inspectorates/ Healthcare regulation and inspection; and	We want to ensure the system of regulation and inspection across health and social services is aligned and future-proofed in order to provide the relevant assurances to support improvement within organisations from a person-centred perspective. There should be a consistent approach to inspection and to examining the quality and safety of services received. People expect the

common standards	inspectorates to work together where health and care services overlap. Work has begun to scope the legislative requirements mapping out the regulatory gaps and considering the type of inspectorate / regulator needed; whether light touch/compliance-focussed/supports improvement etc. and how the context will align to A Healthier Wales and proposals for integration and the new citizen voice body. To ensure the legislative framework is fit for purpose and will meet the need of continually evolving healthcare service provision, it was determined that this area would be considered separately. In the interim, we intend to utilise existing powers to incrementally develop HIW's capacity and capabilities, to achieve a more sustainable position, allowing it to be ready to respond to any future new legislative framework. Work is already underway to enable this and further proposals, when developed, will be subject to full consultation. As part of this we can again consider whether HIW should be established as an independent body and indeed whether it should merge with CIW, to further support the integration of health and social care.
Joint complaints handling	The consultation on the White Paper indicated that there was some support for the idea of joint investigations, but many respondents appeared not to have grasped the proposal related to complaints that span health and social care. Officials will be further engaging with NHS Wales organisations, local government and other bodies to discuss ways of making the process simpler for people who have complaints that span both areas. In particular, consideration will be given to utilising existing legislative powers to enable a person who wishes to make a complaint about health and social services matters to only have to make one complaint to trigger both procedures.
Service change	In the area of service change, further work determined that proposals can be delivered under existing powers using a mixture of guidance and ministerial directions. The current guidance needs fundamental change to ensure it is fit for the future. The new service change policy needs to work in the context of the changing legislative landscape, including the Well-being of Future Generations (Wales) Act 2015, and the Bill provisions on quality and the replacement of the CHCs with the new Citizen Voice Body. It will also need to be framed to take account of the recommendations of the Parliamentary Review of Health and Social Care and the Welsh Government's response to those recommendations in "A Healthier Wales". The intention is to bring new guidance into force to coincide with the establishment of the new Citizen Voice Body in Autumn 2021.

Annex 2

HEALTH AND SOCIAL CARE (QUALITY & ENGAGEMENT) (WALES) BILL

DRAFT OUTLINE: GUIDANCE ON THE DUTY OF QUALITY FOR NHS BODIES

Background

The Health and Social Care (Quality & Engagement) (Wales) Bill (“the Bill”) includes a duty of quality (“the duty”) that requires NHS bodies – local health boards, NHS Trusts and special health authorities – in Wales to exercise their functions view to securing improvement in the quality of health services.

This includes, but is not limited to:

(a) the effectiveness of health services;
(b) the safety of health services; and
(c) the experience of individuals to whom health services are provided.

In order to comply with the duty, NHS bodies will need to demonstrate that they are outcome focused when making decisions across their functions and, as part of the reporting process mandated within the Bill, will have to assess the extent to which they have led to an improvement in outcomes. This means that NHS bodies will have to be able to evidence how the actions they have taken have resulted in improved outcomes for service users.

This aims to ensure a whole system approach to quality, replacing the current duty within Section 45(1) of the Health and Social Care (Community Health and Standards) Act 2003 which has been too narrowly interpreted as simply relating to clinical services and putting assurance (control) arrangements in place to monitor these.

Enacting this broader duty of quality, more in keeping with how we now want NHS bodies to work, will strengthen actions and decision making to drive improvements in quality that will focus on the outcomes for the people of Wales.

Welsh Ministers will also be under this duty in respect of their health related functions.

This document sets out a draft outline for those areas we would expect the guidance for NHS bodies to cover.

Whilst the primary audience of this guidance will be those to whom it will apply, i.e. all staff within NHS bodies, including Board Members, its development will be informed by the views of, and it will be written in such a way as to be understood by, service users (and the wider public).

Introduction

This section will set the overall context for the new duty and how it is a key lever in helping realise the expectations and vision set out in *A Healthier Wales* and its key emphasis on driving change and improvement. Notably a whole system approach that will be equitable, delivering the same high quality of care and achieving more equal outcomes for everyone in Wales.

It will particularly describe the overall quality framework that bodies must have in place to help achieve and evidence this: quality planning, improvement and control (assurance).

In order for NHS bodies to act in the desired way there needs to be a clear understanding of the duty. This involves understanding the that the new duty is broader than the current duty in the 2003 Act and more in keeping with how we now want NHS bodies to work. This will strengthen actions and decision making to drive improvements in quality.

This section would specifically provide:

- an overview of the duty;
- an explanation as to why the duty is being introduced and the key policy objectives, including how it helps to achieve a system-wide focus on quality and continuous improvement;
- a high level overview of how the duty builds on the existing quality assurance infrastructure within the Welsh NHS;
- how it is intended the duty would form part of the Welsh Government's wider and continuous approach towards a health and social care system that is always striving to secure improvement in the quality of services, and therefore outcomes for service users; and
- how it supports the five ways of working under the Well-being of Future Generations (Wales) Act 2015, by encouraging long-term thinking and collaborative action.

Aim of the guidance

This section would explain the aims and purpose of the guidance. It would include detail on:

- how the Bill (Act) and guidance should be read together, to fully understand the expectations of the duty;
- how implementation of the duty should be supported by training and processes within NHS bodies; and
- how the guidance has been developed in partnership with clinicians, patients and members of the public, so as to contain illustrative examples and case studies and to ensure it is clear and capable of being understood by all.

It would also address the key implementation issues which may be experienced as a result of the introduction of the new duty, including learning from other parts of the UK (where comparable), and would provide good practice case studies where appropriate.

Finally, it could also include information about how the guidance will be reviewed and updated.

Understanding the meaning of ‘quality’

This section would further describe what is meant by ‘quality’ as to ensure the intent of the Bill is fully understood, in a practical sense.

This would need to cover details on:

- the definition of quality in the context of the duty i.e. the internationally accepted

definition embracing six domains: safe, effective, person centred, equitable, efficient and timely.
- how it should apply i.e. to whole processes and across all functions of an NHS body, within the context of the health and well-being needs of their populations;
- what it means for considerations and decisions made by Boards, as well as what it means for frontline staff in their day to day work; and
- how the new duty is broader in scope and different in nature to the current duty of quality in Section 45 of the Health and Social Care (Community Health and Standards) Act 2003.

How will the duty work in practice?

The new duty will require NHS bodies to exercise their functions in a particular way and consider how they can improve quality on an ongoing basis when they exercise all of their functions. Improving quality will have to become embedded and an integral part of their decision-making. This section would provide supporting detail on how the duty is intended to work in practice.

It will provide details on:

- how the quality of all services should be considered at a wider population level – embedding quality considerations at the heart of decision-making processes;
- how broadening the consideration of quality will encourage bodies to:
  - work with their neighbouring health boards and cross-sector partners to reduce unwarranted variation and health inequality, including tackling inequity within its open population and working with partners to address this; and
  - promote the sharing of resources and expertise which will in turn unlock more opportunities to improve the effectiveness, safety and quality of services.
- the need for NHS bodies to become much more outcome-focused when making decisions and to think in a different way when considering what steps they will take to secure improvements in services – including how they deliver improvements which create services that influence the whole life course, improving health and well-being outcomes, reducing health inequalities and ultimately reducing demand on statutory services;
- how the duty applies to NHS bodies that do not directly provide clinical services – reflecting the impact that improvements in the quality of health services can be achieved through improvements to backroom services, such as procurement processes or ICT capability; and
- how it is expected that NHS bodies should include within local commissioning arrangements the need for data on quality/outcomes from their providers.

It will also illustrate how complying with the duty will contribute to and influence the existing quality assurance infrastructure and inform quality planning and improvement priorities. This should inform:

- progress towards the national objectives associated with the Well-being of Future Generations (Wales) Act 2015;
- NHS bodies' own Quality and Safety Committees and Board meetings;
- the annual NHS planning process - Integrated Medium Term Plans (IMTPs);
- progress against the NHS delivery and outcome framework requirements; and
- compliance with health and care standards and relevant guidance, set by the Welsh Ministers.

Finally, this section will also need to provide illustrative examples and case studies around how organisations could apply the principles of duty in order to secure improvement. For example a visible difference will be within Board and Committee papers and minutes, as decisions made by NHS bodies will be clearly documented so as to demonstrate how they are being informed by service improvement considerations. This will help contextualise and reinforce any learning points.

The duty to report

The reporting requirements represent a considerable step forward, as the existing duty has no such reporting requirement, and should be seen as an important lever in further increasing transparency and accountability of NHS bodies in regard to their decisions, identified priorities and the allocation of resources to do so. It is an important mechanism in helping to address the findings of the OECD quality review in 2016 where they concluded that LHBs were showing less innovation and fewer radical approaches to system change and quality improvement than might have been expected.

The reports will need to make explicit how the delivery of the duty has led and will continue to lead to improvements in quality - including an assessment of the extent of any improvement in quality outcomes including the effectiveness and safety of services, along with the patient experience, achieved during the reporting period. This will also enable improvements in quality to be monitored over time with milestones set as required where improvements are likely to a number of years to secure the anticipated improvements in outcomes.

This section would therefore provide guidance on how NHS bodies can demonstrate they have complied with the duty via their annual quality reports, mandated in the Bill. This section will therefore provide details on:

- the timescale for the reports to be produced and how and where they should be published;
- the format in which the reports should be published;
- further details on the expected content of the report, for example, including how key decisions and actions taken within the reporting period have led to service improvements and better outcomes and how the NHS body intends to secure improvement in identified areas over the next year (or more); and
- how NHS bodies should record, maintain and monitor improvements in services and outcomes so as to be able to reference robust evidence in demonstrating how they have complied with the duty and secured improvements in outcomes for service users.

This section would also explain how the new reports will replace and build on the current Annual Quality Statements, to reflect that the new reports will become a whole system document – one which has a wider focus and greater rounded evidence to demonstrate quality improvement across an organisation and in some cases across organisational boundaries, where the provision of services are arranged through other NHS bodies within Wales.

Staff training and support

Moving NHS bodies to a position where they are more routinely and actively focusing on quality and continuous improvement is likely to involve a combination of leadership, cultural and behavioural changes. The Explanatory Memorandum at paragraphs 180-189 detail a range of training and resources to embed these new ways of working at all levels. This section would outline our expectations of NHS bodies in relation to changes required, including signposting training and support for staff in respect of the duty.

It may also provide an overview of what NHS bodies should consider when developing any local policies to support the duty.

FAQs

This section would set out a series of anticipated common questions, supported by answers. It could also reference any training or additional information for further learning.

Annex 3

HEALTH AND SOCIAL CARE (QUALITY & ENGAGEMENT) (WALES) BILL

DRAFT OUTLINE: STATUTORY GUIDANCE ON THE DUTY OF CANDOUR

Background

The Health and Social Care (Quality & Engagement) (Wales) Bill (“the Bill”) includes the power to make regulations which detail the process to be followed by NHS bodies when the duty of candour has been triggered. The regulations, which will be the subject of public consultation, will be supported by statutory guidance.

The intention is to convene a working party made up of clinicians (representing primary, secondary care) and service user representatives to collaborate in the development of the statutory guidance to ensure it is complete, relevant, clear and accessible to the service and the public.

Evidence demonstrates that increased openness, transparency and candour are linked with the delivery of higher quality health and social care. It shows organisations with open and transparent cultures are more likely to spend time learning from incidents, rather than trying to hide or be overly defensive about issues, and they are more likely to have processes and systems in place to support staff when things go wrong.

For patients, when something goes wrong, the majority of individuals and their loved ones want to be told honestly what happened, receive appropriate after-treatment care and support, be reassured that everything is being done to learn from what went wrong and trust that the same thing won’t happen again. The duty of candour will help achieve this.

The proposed duty of candour will require NHS bodies to follow a set process when an adverse outcome occurs and the duty is triggered. The duty is placed at organisational level which will help create the conditions for health professionals to discharge their professional duties of candour by ensuring they have support of the organisation they work for. In order for organisations to meet the obligations placed on them in the Bill, all staff will need to act in a way that complies with the duty. All NHS bodies will need to have comprehensive policies and procedures in place to enable staff to do so effectively.

This document sets out a draft outline for those areas we would expect the statutory guidance to cover.

Introduction

In order to create a whole system approach to candour; encourage organisational learning; encourage staff to speak openly about concerns and to support NHS bodies to build on the work underpinned by Putting Things Right[1], there must be a fundamental understanding of the intent behind the duty of candour. Therefore, this section of the guidance would seek to set out the legislative framework and explain the policy intent behind the duty in a straight forward and accessible way.

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[1] Information about Putting Things Right [Internet]. Putting things right. 2018 [cited 4 April 2019]. Available from: http://www.wales.nhs.uk/sites3/page.cfm?orgid=932&pid=50738

This section would provide:

- an overview of the duty of candour (“the duty”) within the Bill and the supporting regulations which set out the procedure to be followed when the duty is triggered;
- how it is intended the duty would form part of the Welsh Government's wider and continuing approach towards a health and social care system that is always listening, learning and improving - which has the trust and confidence of service users and their families;
- an explanation as to why the duty is being introduced and the key policy objectives, including how it helps to achieve a system-wide approach to being open and honest when things go wrong;
- details of how the duty builds on the “Being Open” principles that are embedded within the existing Putting Things Right arrangements (which set out process for managing concerns, including complaints and serious incidents within NHS Wales); and
- how the guidance has been co-produced with clinicians and patient representatives and contains illustrative examples and case studies to ensure it is clear and able to be understood by all.

This section would also explain that the duty is ultimately to serve service users by ensuring that when an adverse outcome occurs, service users are informed, provided with an apology and offered support, and subsequently provided with feedback on investigations and the steps taken to prevent a recurrence, and separately to ensure organisational learning.

It would also underline the importance of ensuring staff who have provided treatment that has triggered the duty can also receive support from their employer.

The new duty aims to foster and promote a culture of openness and learning within NHS organisations. It is not about preventing bullying, victimization or harassment, nor is it about protecting whistleblowers. The law, guidance and best practice in relation to these matters are dealt with in separate legislation and within existing NHS processes and procedures. However, it is anticipated the duty will make it easier for individual staff members to be open and honest with service users when things go wrong and to receive support to enable this.

Aim of the guidance

This section would explain the aims and purpose of the guidance. It would also explain that, in accordance with section 10 of the Bill, when exercising any functions connected with the duty of candour, an NHS body must have regard to guidance issued by the Welsh Ministers.

This section would explain how the guidance aims to provide a framework of best practice that would assist providers of NHS services in the implementation of the duty. It would seek to guide NHS providers to develop local policies, guidance and procedures to support local implementation of the duty in a manner that is tailored to the particular services they provide. Ultimately being open with patients and their representatives, when things go wrong, should feel like the right thing to do.

It would also address the key implementation issues which may be experienced as a result of the introduction of the new duty, including learning from other parts of the UK, and would provide good practice case studies where appropriate.

This section will include detail on:

- how the guidance and regulations have been developed in collaboration with the Wales Partnership Forum (which is made up of representatives from the NHS workforce, employers and Welsh Government) and Trade Union engagement with a view to it being used as an 'All-Wales model' in support of a consistent approach throughout health board areas;
- how the Act, regulations and guidance should be read together, and how the duty will be aligned with the Putting Things Right arrangements; and
- how the duty is designed to create an environment that is supportive of staff with concerns, feeling able to raise these with their employer and be sure they would not suffer any detriment as a result of voicing those concerns.

It could also include information about how the guidance would be reviewed and updated.

Finally, it will explain how the duty is separate from the All Wales Staff Raising Concerns (Whistleblowing) Policy[2], which is in place in every Local Health Board and NHS Trust in Wales.

Trigger for the duty

The Bill sets out two conditions which must be met for the duty to be triggered:

- the person to whom health care is being or has been provided by a NHS body has suffered an adverse outcome; and
- the health care was or may have been a factor in the service user suffering that outcome.

A service user is to be treated as having suffered an adverse outcome if he or she experiences or the circumstances are such that he or she could experience any unexpected or unintended harm that is more than minimal.

The guidance would provide clarity on the range of circumstances under which the duty can be triggered and what this would mean for the people to whom the duty applies.

We have pursued a deliberate policy of not defining what “more than minimal” harm means on the face of the Bill or in regulations. Instead, we have learned from the experience of England and Scotland where attempts were made in legislation to define the thresholds of harm needed to trigger their duties. We intend to define what is meant by more than minimal harm in the guidance.

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[2] NHS Confederation employment policy and procedures [Internet]. [Cited 25 July 2019]. Available from: https://www.nhsconfed.org/regions-and-eu/welsh-nhs-confederation/nhs-wales-employers/our-work/employment-policy-and-procedures

There are a number of reasons for this. Firstly we think it is right the threshold that triggers the duty should be developed with the assistance of a working group comprised of clinicians and service users. Secondly, the description of ‘more than minimal harm’ is complex due to the range and nature of care provided across the NHS. It is possible to provide a much more meaningful definition, backed by illustrative examples and case studies, in guidance. The key aim is to ensure the definition is fit for purpose across all NHS settings, assists in the successful implementation of the duty and is accessible to service users and clinicians. Ultimately it is to promote a culture of openness and honesty with services users and enable staff to focus on learning and improvement.

It is expected the threshold would be developed having regard to existing definitions of harm currently in use in the NHS in Wales such as those used in the National Reporting and Learning System[3] (the system for reporting patient safety incidents in England and Wales), or if applicable, its successor system.

It is also intended that the guidance will provide worked examples of cases where the duty will be triggered. The intention here is to provide a range of examples from the obvious through to scenarios where the application of the duty is, perhaps, less obvious. Here, for example, the guidance will make it clear the duty is triggered not only when more than minimal harm is known to have occurred but in cases where such harm might occur in the future. Two examples may include:

- If a person suffers a fall and a fracture is not identified on the x-ray while in A&E, but is identified on a review of the x-ray a week later. In this case the duty of candour would be triggered at the point at which the body becomes <u>aware</u> the x-ray results showed a fracture <u>not</u> when it is known whether the patient has suffered harm from the failure to make a timely diagnosis. A person suffers an adverse outcome if that person suffers more than minimal harm or the circumstances are such that the person could experience any unintended or unexpected harm that is more than minimal. Clearly in the example mentioned there is potential for the delay in treatment to have caused more than minimal harm that was unintended or unexpected and so the duty is triggered.

- An error in the administration of medication on discharge may not result in a patient suffering immediate harm. However the duty of candour would be triggered at the point at which the body becomes <u>aware</u> of the error <u>not</u> when they become aware of any harm being suffered by the patient. Again this is because a medication error, unless it is very minor, clearly has the potential to cause unexpected or unintended harm that is more than minimal.

This section could also address some of the particular circumstances that may arise in triggering the duty, and how the NHS body should deal with them, such as:

- if the adverse outcome trigging the duty is brought to the attention of the NHS provider by the patient or their family member/advocate;
- the case is ‘borderline’ and a judgement is required as to whether the threshold has been met, and the duty triggered;
- where there is more than one NHS provider involved in an incident;

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[3] Patient safety Welsh Government services and information [Internet]. GOV.WALES. 2019 [cited 25 July 2019]. Available from: https://gov.wales/patient-safety

- where more than one incident or a chain of events has occurred;

Finally, the guidance would need to provide detail on when the duty will not be triggered. Such instances would include:

- when a near miss has occurred. A “near miss” is an event that might have resulted in more than minimal harm to the patient but the error that would have caused the harm is noticed and rectified before harm can be caused. By their very definition, near misses are not covered by the duty of candour as there is no potential for any harm to be caused to the patient. However, it is important to learn from near misses and the guidance will clearly signpost the action that NHS bodies need to take to respond to and learn from near misses to prevent recurrence; or
- when harm occurs as a result of the medical condition itself and is solely attributable to the person’s underlying illness or condition.

Notification

It is commonly recognised that when things go wrong, patients and their families expect three things:

- be told honestly what happened;
- to know what would be done to deal with the harm caused; and,
- to know what would be done to prevent the same thing happening again.

These expectations are the cornerstone of the duty of candour and form the basis underpinning the ‘candour procedure’ which would be set out in regulations. It is expected the regulations would set out detail such as the form, content and timing of the notification, such as:

- the timescale for the notification to be given;
- how the notification should be provided;
- detail of what should be included e.g. that the duty has come into effect and what this means;
- the identity of the ‘nominated individual’ who will be the service user’s point of contact in respect of the notification;
- detail of any further enquiries or reviews to be carried out by an NHS provider in respect of the circumstances in which the duty came into effect;
- the need to keep records; and
- the requirement to report annually on the discharge of the duty.

In support of these regulations, it is expected the guidance would provide further supporting detail on how the duty is aligned with other processes, such as the Serious Incident Framework contained within the Putting Things Right guidance[4].

It is also expected that the guidance will need to cover how the notification element of the duty works in practice. This may include detail on apologising and where a service user or their representative can obtain further information, for example:

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[4] Putting Things Right guidance [Internet]. Putting things right. 2018 [cited 4 April 2019]. Available from:http://www.wales.nhs.uk/sitesplus/documents/861/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20%20-%2020140122.pdf

- apologising - what an apology means in the context of the duty, when to apologise and how to deliver a meaningful apology; and
- further enquiries – the need to offer the service user, or their representative, the opportunity to express their views, for example considering any questions they would wish to have answered through a review of the circumstances.

It will also include detail on the types of records which should be kept.
It may also address some of the particular circumstances that may arise during the notification process:

- the identification of an appropriate representative for notification purposes (“notified individual”) in cases where this is not the service user themselves e.g.:
    - where the service user is a child or lacks mental capacity;
    - where a provider is unable to contact the service user;
    - where the service user does not wish to be contacted; and
    - where the service user has died.
- best practice advice on determining who should be the nominated point of contact for the NHS provider. They would be responsible for ongoing communication with the service user or their representative:
    - including where more than one NHS provider is involved in an event – namely that a single nominated individual should act on behalf of all relevant organisations
    - situations where it may be deemed reasonable or necessary for Local Health Boards to provide support and assistance to, primary care providers to help them discharge the duty.

- if other than the nominated point of contact, determining who is the appropriate person to notify the individual of the triggering of the duty – this may involve:
    - consideration of the nature of the incident;
    - their relationship with the service user or their representative;
    - the skills and experience of the nominated point of contact; and
    - any specific requirements the service user or their representative may have, such as preferred method or language of communication, appropriate to their age, level of understanding and taking into account any specific conditions which may be relevant.
- how the notification process would work if the adverse outcome trigging the duty is brought to the attention of the NHS body by the patient or their family member/advocate.
- what to do if some information is not yet available or if the NHS provider needs information from the service user, or their representative, as part of their enquiries; and
- instances where there is a delay in notification.

Support for the service user at the notification stage

Some service users may find it distressing to learn an adverse outcome they have experienced may have been the result of treatment they received, and there will also be situations where some service users may have difficulty understanding the information provided in the notification.

This section of the guidance will seek to outline how a provider of NHS services can ensure it is offering appropriate and proportionate support to service users as part of the notification process. This may include:

- when it may be appropriate for an NHS provider to offer support to a service user, even though in many cases it will not be required;
- practical examples of the nature and level of the support and remedial care that may be appropriate in different circumstances;
- how some service users may have difficulty understanding information provided in the notification;
- an explanation of how the duty links to the arrangements currently in operation as part of Putting Things Right; and
- sign posting to support services such as specialist advice and advocacy or arranging communication support or interpreters.

Communication with the notified individual post notification

Effective communication is about more than just exchanging information. This section of the guidance would seek to provide guidance for NHS bodies on how they should maintain communication with service users, or their families, post notification to ensure messages are clear, avoiding, wherever possible, frustration and conflicts. It could include details on:

- engaging with the service user, or their representative, to discuss the content of the notification;
- understanding and managing expectations around the further enquiries or reviews the NHS provider should undertake and communicating realistic timescales;
- ensuring that appropriate support, where needed, has been put in place
- making arrangements for ongoing communication including involvement in any subsequent inquiry/review;
- communicating the outcomes or results of any further inquiries /reviews;
- how to handle requests for further information from the service user, or their representative;
- where the service user, or their representative, contacts someone other than the ‘nominated individual’;
- how to conduct communications where more than one NHS provider is involved in the inquiries;
- signposting to the Putting Things Right arrangements and advocacy support;
- what to do if the service user, or their representative, decides to take legal action following notification; and
- the requirement to keep records.

Enquiries/ reviews

All cases in which there is an adverse outcome that triggers the duty will require some level of inquiry or review to be undertaken, in order for the body to understand and explain what has happened and why. In line with Putting Things Right principles, an enquiry/investigation that is proportionate to the harm caused will need to be conducted.

This section would make links to the Putting Things Right guidance which includes serious incident reporting requirements, and would clarify the steps to be taken by a NHS provider under the duty when either inquiries or an investigation is required as a result of an adverse outcome experienced by a service user. The Putting Things Right regulations will be amended to ensure the duty of candour procedure is embedded within its process.

This section would also outline the intent behind the duty; namely that investigations should not be used to highlight individual failures or apportion blame, but to enable learning and improvement. It would provide guidance in support of investigations being conducted in keeping with this intent, including how they can be used as tools to support organisational reflection and learning and to help ensure openness and honesty is a normal part of organisational culture across the NHS in Wales.

It would also provide guidance on how bodies can document investigations to collate the types of evidence required to demonstrate compliance with the duty while ensuring a supportive environment whereby all staff in NHS Wales are actively encouraged to be open and honest and feel safe and supported when indicating the duty should be triggered.

Reporting

This section would highlight how being open and honest:

- provides opportunities for both the reporting body and other providers to learn from what happened;
- contributes to generating the cumulative data and evidence required to drive improvement; and
- encourages decisions about services to be based on what matters most – the outcome for current and future service users and their families.

Requiring bodies to report on an annual basis will encourage individuals and organisations to reflect and learn; promoting a culture of openness and transparency in the system, which will in turn promote patient trust in the health service; and provide an annual baseline to help identify where services need support to improve with a view to avoiding future incidents.

This section would provide guidance for NHS bodies on the reporting requirements under the duty as set out within the Act. This would include further details on:

- whom the duty to report falls upon, including in circumstances where more than one NHS body was involved in the provision of the care and treatment;
- when to produce the report i.e. as soon as practicable after the end of each financial year;
- the content of the report including, as required within the Bill, how many times the duty has been triggered, a brief description of the circumstances in which the duty came into effect, and any steps taken by the provider with a view of preventing similar circumstances arising in the future;
- the requirement for primary care providers to prepare a report and supply this to any Local Health Boards they have arrangements with to provide NHS care;
- collation and incorporation of primary care providers' annual reports within those produced by a Local Health Board;
- alignment with the annual Putting Things Right Report; and
- the requirements for publication of the report and to make it easily accessible.

This section may also set out the processes for record keeping, including that all incidents triggering the duty should be recorded on local incident management systems in line with their local policies, and are coded as triggering the duty.

This section may also set out:

- how Local Health Boards and NHS Trusts should use the data gathered, through reporting annually on candour, to help inform the new annual quality reports; and
- how providers of NHS care can evidence they are promoting a culture that encourages candour and learning that stems from it.

Separately, this section would set out that the expectation that NHS providers should include, within local commissioning arrangements, the need for data on candour from the provider.

Staff support and training

When something has gone wrong, the feelings of staff should not be forgotten as although an investigation will be carried out sensitively, staff may feel they are at fault and consequently be less ready to ask for assistance if they are feeling under pressure or distressed. Whilst some investigations can be handled quickly, some can take months. In these circumstances, an organisation must be aware of the impact this may have on the wellbeing of their employees.

This section would outline our expectations of NHS providers in relation to providing support for staff on an ongoing basis; providing an overview of what providers should consider when developing local policies for managers of staff involved in traumatic/stressful events and the staff themselves. It would reinforce how the health and wellbeing of the NHS workforce is paramount to delivering effective patient care and fulfilling the visions set out in A Healthier Wales and in particular the Quadruple Aim. For example this could include signposting:

- the intended training, additional materials and supporting documentation which would be publicly available (details of these are contained within the Regulatory Impact Assessment supporting the Bill at paragraphs 261-279);
- well-being support for staff who may have been involved in incidents that result in harm; and
- how NHS providers can work collaboratively with Trade Unions to ensure that staff feel confident to raise concerns freely.

Technical section

This section would explain what is meant by the term “NHS body” in the Bill i.e. which bodies are subject to the duty of candour. It would also explain which organisation is responsible for complying with the duty in situations where one body provides services on behalf of another body.

It would also explain that the Welsh duty of candour applies in relation to treatment provided by NHS providers in Wales. However, if a Health Board makes arrangements for a Welsh resident to receive NHS care in England, it is the English duty of candour that would apply.

It would also make clear that the triggering of the duty does not mean the treatment provided was negligent. Section 2 of the Compensation Act 2006 which applies in relation to England and Wales provides that an apology, offer of treatment or other redress shall not of itself amount to an admission of negligence or breach of statutory duty.

FAQs

This section would set out a series of anticipated common questions, supported by answers. It could also reference any training or additional information for further learning.

This section could use case studies to help contextualise and reinforce any learning points.

Annex 4

How the duty of candour operates in other UK countries

The duty of candour in the Bill seeks to provide an overarching framework which will be underpinned by regulations and guidance. It is purposely prescribed in this way as we have learnt from the duties already in place in England and Scotland i.e. in Scotland a large amount of detail is contained within primary legislation, making it unduly inflexible.

A table showing the different legislative approaches taken in England, Scotland and the Bill:

	England	Scotland	Bill
Powers	**Primary legislation** Health and Social Care Act 2008	**Primary legislation** Part 2 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016	**Primary legislation**
Trigger	**Regulations** Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20		**Regulations and statutory guidance developed with the assistance of clinicians and service users.**
Procedure		**Regulations** Duty of Candour Procedure (Scotland) Regulations 2018	
Notification			
Threshold			

English duty of candour:

The regulatory system in England is significantly different compared to Wales. In England, the duty of candour is imposed in regulations that apply to all services registered by the Care Quality Commission ("CQC"). Under the Health and Social Care Act 2008 ("HSCA 2008"), all providers of "regulated activities" must be registered with the CQC and must comply with the requirements of registration. "Regulated activities" are activities that relate to the provision of health and adult social care and that are set out in set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (SI 2014/2936).

The CQC monitors compliance with registration requirements. This registration includes the nomination of a 'Registered Person' who is ultimately accountable –this would usually be the Chief Executive or another senior officer.

The English duty of candour is applied only to this Registered Person. However the guidance supporting this duty explains that: *"the approach taken hopes to encourage a culture of openness and transparency within health and social care services, at all levels within organisations"*.

Whilst this approach to the duty is different to what is proposed in the Bill, it intends to achieve the same effect – an organisation-wide duty of candour. The difference in approach is simply due to the fact that in Wales we do not register NHS bodies or require the nomination of a registered person.

Scottish duty of candour:

In Scotland a duty of candour was provided for in Part 2 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (the Scottish Act). The duty came into force on 1 April 2018.

The duty itself is placed on the face of the Scottish Act in section 21. Section 21 describes incidents which give rise to the duty of candour procedure. The Scottish duty of candour applies to a ‘registered person’, which is defined within Section 25 of the Scottish Act as including a health board or someone entering into a contract with a health board to provide health services (i.e. primary care providers). This is consistent with the approach taken in Bill as it places the duty at an organisational level.

Social care duty of candour:

In Wales, the duty of candour in social care is set out within regulations made under sections 27 and 28 of the Regulation and Inspection of Social Care (Wales) Act 2016 (the Act). For example, within the Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017 (“the 2017 Regulations”), Regulation 13 requires providers of regulated services to act in an open and transparent way with individuals (service users) and their representatives. Regulation 83 places the same duty on a service provider’s designated ‘Responsible Individual’ who in respect of a body corporate ,under section 21(2) of the Act, must be a ‘director or similar officer’ of the body.

This regulatory duty is supported by statutory guidance which further clarifies expectations, including that service providers have policies and procedures in place to support a culture of openness and transparency, and ensure that all staff are aware of and follow them. These requirements and expectations underpin inspections undertaken by Care Inspectorate Wales. This approach seeks to embed a service-wide culture of honesty and openness – not just when things go wrong.

In addition there are a number of other requirements in the 2017 Regulations which support the duty, such:

- having systems in place to record incidents (and complaints);
- the keeping of records and a requirement to document events that would be classed as harm events; and
- that continuous improvement is demonstrated via quality of care reviews, undertaken at least every six months.

During the Health, Social Care and Sport Committee evidence session on 11 July, it was suggested that the duty of candour in social care is more specific than the duty proposed within the Bill. The approach taken in social care is broadly aligned with the Bill’s candour provisions, in that it provides organisational requirements placed on the service provider and/or responsible individual - demonstrating that service providers have a culture of improvement through continuous analysis of incidents, notifiable incidents, safeguarding matters, whistleblowing, concerns and complaints.

Cross border care:

In terms of cross border care, we have considered the application of the duty of candour within the Bill on Welsh patients who receive healthcare in England and vice versa.

Where a Welsh resident receives care from a service in England the duty of candour in England will apply rather than the Welsh duty. This arrangement will be reciprocal for English residents accessing NHS services in Wales.

The system has to operate in this way or we would have providers being subject to both the English and Welsh duties when a patient from one country receives treatment in the other, generating unnecessary duplication.

Duty of Candour Bill provision

The duty within the Bill is placed on NHS bodies and primary care providers at an organisational level and not placed on individual health care staff. However, in practice, in order to ensure the legal duty is being discharged organisations must ensure that all staff, including managers, clinicians and administrators, act in a way which complies with the duty. All organisations will need to have a comprehensive policy in place setting out how it will operate and comply with the duty and how it will expect and support its staff to do so.

An organisational duty will ensure that it is a priority, at every level within an organisation, to help achieve the behavioural change necessary to successfully implement the duty. This will support an environment, not only where professionals are acting in an open and honest manner but where organisations are actively encouraging and are receptive of this behaviour.

Whilst professional ethics and obligations are crucial, they are insufficient by themselves to ensure a culture of candour throughout an organisation and, in any case, not all staff are covered by such professional duties. Placing the duty at an organisational level helps create the conditions for all staff – clinical and administrative –both to act and be supported to act in an open and candid manner.

As set out above the approaches taken in England and Scotland to the duty of candour, and that taken in social care in Wales, align to the intent of the Bill in that they all seek to achieve an organisational approach to candour.

Furthermore, enabling the Welsh Ministers to set out the candour procedure in regulations maintains sufficient flexibility to ensure the procedure is workable and can respond to any potential need to adapt, as a result of feedback and learning from both the NHS and service users, without the need to amend primary legislation. For example, the detail may need to be amended in response to changes in models of care and working practices, to learn from the experiences of service users and to take into consideration how the procedure operates in more complex cases.

The threshold of harm that needs to be met before the duty of candour will be triggered is set within Section 3(4) of the Bill, as harm which is ‘more than minimal’. However, it is considered that in order to define this in a way that is comprehensive, is straightforward to apply to different types of care and is presented in a way that is understood by both clinicians and users of services the description of this will be covered in statutory guidance, provided for in Section 10 of the Bill. A working group will be established to develop the guidance, which will include clinicians, other professionals concerned and lay representatives. This will help ensure it is clear to both providers and service users what level of harm must occur before the duty of candour is triggered.

Both England and Scotland have produced guidance to support their duty of candour legislation. Compared to England, Scotland took a much more prescriptive approach which included the inclusion of case studies. We have learnt from this inclusion of practical examples and will use it as a model to frame the planned guidance in Wales so that our expectations in different circumstances are clearly understood.

A draft outline of this planned statutory guidance to support the duty of candour has been produced and is enclosed at **Annex 3.**

Annex 5

Change in approach to appointing board members

Current position with Community Health Councils (CHCs)

CHC Board Members

The national CHC Board is comprised of 12 members:

- the chair and two independent members are appointed by the Welsh Ministers through the public appointments process;
- seven members are the persons elected as chair of each of the seven regional CHCs[5]; and
- two CHC staff members, who are employed by Powys Teaching Health Board. These are the chief executive of the Board of CHCs and a CHC staff member who is appointed by fellow CHC staff members.

Volunteer members

Under the current CHC arrangements, the Welsh Ministers appoint 50% of volunteer members through the public appointments process, 25% are appointed by local authorities and 25% by voluntary organisations. They are appointed for a term of up to four years and may serve a maximum of two terms. In addition, CHCs may appoint co-opted members (who do not have voting rights) for a maximum period of two years.

It is becoming increasingly difficult to attract volunteer members. We know from having spoken to applicants and from discussions with the CHCs that many people find the public appointments process, which requires a formal application process and panel interview, off-putting and many able would-be candidates are deterred from applying.

In recent years we have struggled to recruit sufficient members to fill Welsh Minister-appointed vacancies on CHCs. In 2017/18 we appointed 43 members which was insufficient to fill the 55 vacancies across Wales. In our 2019 recruitment we only had 8 applicants for 34 vacancies which meant we had to extend the application period for a further four weeks. The extension only yielded a further 13 applicants.
The low number of applicants persists despite investment on funding adverts in both the print media and online and concerted efforts by both the CHCs and Welsh Government to publicise the vacancies and encourage applications.

Bill proposals

Board of Citizen Voice Body

The Bill proposes that the Welsh Ministers appoint the Board of the Citizen Voice Body. Concerns were raised at Committee and in Plenary that this approach may compromise the independence of the new Body. However, the precedent for Ministerial appointment to

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[5] In accordance with regulation 15 of the Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010, the members of a CHC must elect one of their number to act as chair for a period of up to three years.

Welsh Government Sponsored Bodies is well established with, for example, the Welsh Ministers appointing the Boards of Social Care Wales, Qualifications Wales and the Higher Education Funding Council for Wales.
In addition, all appointments will be governed by the Governance Code on Public Appointments which requires all Ministerial appointments to public bodies to be the subject of open and fair competition, with appointment based on merit. The ultimate responsibility for appointments to the Body rests with the Welsh Ministers who are accountable to the National Assembly for Wales.

Paragraph 2 of Schedule 1 to the Bill governs appointments and provides that the Board shall be comprised of a Chair, a Deputy Chair and at least 7 but no more than 9 members in total.

Volunteer members of the Citizen Voice Body

As an independent body corporate, the new Body will have the power to appoint its own volunteer members. The members appointed by the Body will not be subject to the public appointments process, nor will there be imposed limits on the amount of time a person can serve as a member. Therefore, with the new Body we are removing some of the current actual and perceived barriers to membership. This has been welcomed by the current CHCs.

We have already spoken to the Wales Council for Voluntary Action and they have agreed to give us the benefit of their experience and lend us their help and support in developing a volunteering model for the new Body that is sustainable, [builds on existing networks] and helps to attract volunteers that are representative of the users of health and social services.

We have also spoken to the Patient and Client Council in Northern Ireland, a body that exercises similar functions as to those intended for the Citizen Voice Body. They have established a successful membership model that may provide a useful precedent. Their model operates on a number of levels with a large online membership who support calls for evidence, complete consultations, surveys etc. and members who are physically present and active in the work of the Body.
An active, committed and representative volunteer member base is essential to support the work of the new Body and, as set out above, consideration is already being given to how, when we are establishing the Body, we can ensure, from the outset, the membership model is fit for purpose.

As set out at paragraph 505 of the Explanatory Memorandum, in order to support the establishment of the new Body the intention is to set up an Implementation Board. One of the workstreams will be tasked with consideration of the volunteer membership model and will be comprised of representatives from the current CHCs, the WCVA, when appointed, the senior team of the new Body and other key stakeholders, including Welsh Government. As well as recruitment of members, this group will also look at matters such as training needs of volunteers.

Annex 6

Expectations for the Operation of the Citizen Voice Body

The Citizen Voice Body (“the Body”) needs to play a vital role in ensuring the citizen voice is represented in all matters related to health and social services at a national, regional and local level.

The Body will need to engage with and develop constructive relationships with partners in Wales. That includes members of the public, health boards, trusts, special health authorities, local authorities, Regional Partnership Boards, Public Service Boards, the inspectorates, statutory commissioners, Social Care Wales, the third sector and others to ensure the voice of the citizen is represented and heard.

It will be especially important for the Body to develop strong relationships with its partners so they can share knowledge and learning of the outcomes that emerge from the views they obtain from people.

The Body will need to work with, rather than replace, fora that already exist for representing the views of citizens in matters related to health and social care, such as Citizen Panels established under the Regional Partnership Boards.

A key part of the Body’s role will be to gather and represent the views of citizens with a view to providing those with responsibility for the provision of health and social care with information on the views and experience of service users to help drive improvement and achieve better outcomes.

Legal Framework

- It will be established as a Body corporate, able to employ staff and enter into contracts and leases.
- Its functions are set out on the face of the Bill.
- The Board is appointed by the Welsh Ministers through the public appointments process.
- The chief executive has accounting officer status. Welsh Ministers will specify the accounting officer’s responsibilities in relation to the Body’s accounts and finances.
- The Auditor General for Wales will supply the external audit function.
- The Body has the power to appoint its own volunteer members, outside the public appointments process.

Remit Letter

- Like all Welsh Government Sponsored Public Bodies, the Body will have a remit letter.
- The remit letter will set out the funding the Body is to receive from Welsh Government.
- The letter will also set out the “key deliverables” for the Body in terms of, for example, delivering its functions across health and social care services, providing services to the population of Wales on a local and national basis; being an

organisation that is ambitious and learning and supports a culture of learning and improvement amongst staff and members etc.

- Given the nature of the functions the Body will exercise and due to the requirement in paragraph 19 of Schedule 1 to the Bill for the Body to set its objectives and priorities for the year following consultation, the remit letter will respect the need for the Body to be operationally independent, for example, having freedom to determine for itself areas for thematic reviews and engagement etc.

Annual Plan and Annual Report

- Paragraph 19 of Schedule 1 to the Bill requires the Body to produce an annual plan setting out how it proposes to exercise its functions during the coming year.
- The expectation is that the Body will give equal weight to the exercise of its functions across both health and social services.
- The plan must include a statement of the Body's objectives and priorities for the year.
- The Body is under a duty to consult with such persons it considers appropriate on its proposed objectives and priorities.
- Paragraph 20 of Schedule 1 requires the Body to produce an annual report setting out how it has exercised its functions during the year. A copy of the report must be given to the Welsh Ministers and a copy laid before the National Assembly for Wales so the actions of the Body are open to scrutiny.

Implementation Board

- The target date for establishing the new Body is 1 October 2021.
- There will not be any time lapse between the abolition of the CHCs and the establishment of the new Body. The clear expectation is for CHCs and health bodies to operate on a "business as usual basis" until the new Body is established.
- To facilitate the establishment of the new Body, an Implementation Board will be established. The core group will be comprised of representatives from Welsh Government, Powys Teaching University Health Board (as employer of CHC staff), representatives from the current CHC and, when appointed, the Board and chief executive of the new Body.
- Individual work streams will be established to consider matters such as transfer of staff, accommodation, IT procurement, volunteer membership, governance etc.
- The core group will be supplemented with people with expertise in the areas covered by the individual work streams.

Location/accommodation

- The Bill does not prescribe a structure for the Body.
- We want the Body to have the ability to determine where it needs offices, based on its own assessment of need.
- The expectation is that the Body will be organised in such a way as to enable it to perform its functions at a local as well as a national level.

- The regulatory impact assessment bases the Body's accommodation needs and costs on current CHC accommodation location and costs: 12 offices of varying sizes across Wales.
- Current thinking, and this will be the subject of discussion at the Implementation Board, is that the new Body needs a different accommodation strategy to the CHCs. CHC offices are often based on industrial parks which are not particularly accessible to the population who wish to use their services. Going forward there is merit in exploring smaller town centre premises for the Body's offices and/or co-locating the Body's offices with other providers of public services such as community hubs or libraries. This will make the Body more accessible to the public.

Relationship with partners

- The Body will need to establish itself as a key partner in the health and social care fields. It will need to agree with partners such as the inspectorates, health boards, local authorities, the voluntary sector, Regional Partnership Boards, Social Care Wales, the Commissioners etc how it will work with them.
- This is something that Welsh Government can help to facilitate as part of the Implementation Board arrangements: assisting the Body to make connections with partners.
- High level discussions have already been held with the inspectorates (HIW and CIW) who are supportive of the potential for partnership working agreements between themselves and the new Body. The partnership agreements would cover matters such as information sharing and escalation of concerns.
- The expectation is for NHS bodies and local authorities to have clear arrangements in place for making use of the information provided to them by the Body. NHS bodies would, for example, need to have clear systems in place to ensure any feedback on patient experience/quality of services received from the Body was reported to and considered by their Quality and Safety Committees.
- The Welsh Government, drawing on the experience of those involved in the Implementation Board, can also produce guidance on how Health Boards, Trusts, Special Health Authorities and Local Authorities can fulfil their duty under section 17 of the Bill to promote the activities of the Body.

- There are some legislative changes that Welsh Ministers propose to make to help frame the relationship between the Body and existing partners who work in the areas of health and social care as a positive one of partnership and co-operation:

    - The Body will have the status of "other partner" on Public Service Boards (PSBs) established under the Well-being of Future Generations (Wales) Act 2015. 'Other partners are individuals or bodies considered to be important providers and representatives of public services. A PSB must seek the advice of their other partners and involve them in the activities of the PSB in the manner, and to the extent, that the board considers appropriate. This may include seeking their partners' advice on, or involving them in, the preparation, implementation and delivery of local well-being plans. The Body will therefore be able to comment on PSBs action plans from both a health and social services perspective, adding a greater integrated focus.

  - Regional Partnership Boards (RPBs) are established under the Social Services and Well-being (Wales) Act 2014 to oversee the partnership arrangements put in place between health boards and local authorities for the delivery of integrated and sustainable care and support services. It is proposed to amend the Care and Support (Area Planning) (Wales) Regulations 2017 and the Care and Support (Population Assessments) (Wales) Regulations 2015 to require bodies under partnership arrangements to consult with the Citizen Voice Body in the preparation of these assessments and plans. The Body will therefore have a key role in supporting the RPBs by ensuring the population assessments are continually informed by information gathered by the Body on the views of the public. To do this, the Body will also need to make linkages with the Citizen Panels that support the work of the RPBs.

Complaints advice and assistance

- The Body will be able to provide complaints advice and assistance to a broader range of people than the current CHCs.
- Stakeholders with whom we have discussed the Bill, have indicated it would be useful if there was guidance to set out:

    - which complaints the Body is able to assist with;
    - which it cannot;
    - circumstances when the Body may need to co-operate with other providers of advice and assistance; and
    - arrangements for signposting people to other options for advice and support.

The expectation will be that the Body will provide information to inform the public, seeking views from the voluntary sector.

Membership

- As a Body corporate, the Body is able to recruit its own volunteer membership, outside the public appointments process.
- It is important to have the membership model up and running from the outset as the Body will need the support of its volunteers to perform its functions.
- Consequently, it is intended that the Implementation Board will assist in the development of the model.
- Officials have approached the Wales Council for Voluntary Action who have agreed to lend their support in the development of a model that is sustainable and aims to attract volunteers who are representative of users of health and social services.

Representations

- The Body has the power to make representations to a Health Board, Trust, Special Health Authority or Local Authority about any matter connected with the provision of a health service or social services.

- Those bodies are placed under a legal duty to “have regard” to the representations. The legal duty to have regard to representations and the development of appropriate mechanisms for taking the substance of the representations into account will ensure the voice of the citizen is built into the decision making process and heard by and listened to by decision makers

- This means that the representations **must** be taken into account by these bodies when they are exercising functions relevant to the representations.

- The expectation is that NHS bodies and local authorities will consider how each representation is best taken into account. This may involve sharing representations with Quality and Safety Committees, or scrutiny committees or sharing relevant representations with partners such as RPBs and PSBs so that the voice of service users is truly embedded and taken into account in the decision making process. Representations may, for example, relate to service changes proposed by NHS bodies or local authorities and may also be taken account in relation to the planning process, they could also take the form of thematic reviews of services.

- The expectation is that the Body will not make representations about matters relating to identifiable individuals. Concerns about care or treatment of individuals should be made through the relevant complaints procedure.

- The new duty of quality in the Bill places a duty on NHS bodies to exercise their functions with a view to securing improvement in the quality of health services. Quality includes, but is not limited to, quality in terms of the experience of individuals to whom health services are provided. There are clear linkages between the way NHS bodies can demonstrate quality improvement and consideration of representations from the Body.

- The expectation is that the Body will engage with and develop constructive relationships with NHS bodies and local authorities and having regard to representations will form part of the on-going and continuous engagement with these bodies. CHCs have called for NHS Bodies and local authorities to be required to formally respond to representations made by the Body. Officials have met and are engaging with the Board of Community Health Councils in Wales to further discuss this.

Visiting

The clear expectation is that the Body will be able to access service users at the point of delivery of care for the purposes of seeking their views about matters related to health and social services. This is one of many ways that the new Body will be able to seek the views of the public.

Officials have had constructive discussions with the Board of Community Health Councils in Wales over the summer to explore how the CHCs currently use their power of entry and to discuss how we might enable access to health and social care premises for the Body.

These discussions are ongoing.