National Assembly for Wales
Health, Social Care and Sport Committee

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

November 2019

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About the Committee

The Committee was established on 28 June 2016. Its remit can be found at: www.assembly.wales/SeneddHealth

Committee Chair:

Dai Lloyd AM
Plaid Cymru

Current Committee membership:

Jayne Bryant AM
Welsh Labour

Angela Burns AM
Welsh Conservatives

Helen Mary Jones AM
Plaid Cymru

Lynne Neagle AM
Welsh Labour

David Rees AM
Welsh Labour

The following Member attended as a substitute during this inquiry.

Siân Gwenllian AM
Plaid Cymru

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Recommendations

1. Introduction

1. On 17 June 2019, Vaughan Gething AM, Minister for Health and Social Services ("the Minister) introduced the Health and Social Care (Quality and Engagement) (Wales) Bill[1] (the Bill) and accompanying Explanatory Memorandum[2]. He made a statement on the Bill[3] in plenary on 18 June, and provided a Statement of Policy Intent[4] indicating his intentions for regulations that will set out the procedure to be followed when the duty of candour is triggered.

2. At its meeting on 21 May 2019, the Assembly's Business Committee agreed to refer the Bill to the Health, Social Care and Sport Committee (the Committee) for consideration of the general principles (Stage 1), in accordance with Standing Order 26.9. The Business Committee agreed that the Committee should report by 15 November 2019.[5]

Terms of reference

3. The Committee agreed the following framework within which to scrutinise the general principles of the Bill:

To consider—

- the general principles of the Health and Social Care (Quality and Engagement) (Wales) Bill and the extent to which it will contribute to improving and protecting the health, care and well-being of the population of Wales by,
  - placing quality considerations at the heart of all the NHS in Wales,
  - strengthening the voice of citizens across health and social services,
  - placing a duty of candour on NHS organisations, and
  - strengthening the governance arrangements for NHS Trusts;

[1] Health and Social Care (Quality and Engagement) (Wales) Bill
[2] Explanatory Memorandum
[3] Record of Proceedings, 18 June 2019
[4] Statement of Policy Intent, 19 June 2019
[5] National Assembly for Wales, Business Committee, Report on the timetable for consideration of the Health and Social Care (Quality and Engagement) (Wales) Bill, June 2019

- any potential barriers to the implementation of the provisions and whether the Bill takes account of them;
- whether there are any unintended consequences arising from the Bill;
- the financial implications of the Bill (as set out in Part 2 of the Explanatory Memorandum);
- the appropriateness of the powers in the Bill for Welsh Ministers to make subordinate legislation (as set out in Chapter 5 of Part 1 of the Explanatory Memorandum).

The Committee's approach

4. Between 19 June and 2 August 2019, the Committee conducted a public consultation to inform its work, based on the agreed terms of reference. 43 written responses were received and published. The Committee also heard oral evidence from a number of witnesses. The schedule of oral evidence sessions is published on the Committee's website.

5. In addition, the Committee ran a public survey on the proposals in the Bill to abolish Community Health Councils and replace them with a single Citizen Voice Body. The survey was promoted via the Committee's and Assembly's social media channels. 178 responses were received. A summary and analysis of the responses is available on the Committee's website.

6. The Committee would like to thank all those who have contributed to its work.

Other Committees' consideration of the Bill

7. The Assembly's Finance Committee took evidence from the Minister on the financial implications of the Bill on 3 July 2019. It reported on its conclusions on 15 November 2019.

8. The Assembly's Constitutional and Legislative Affairs Committee took evidence from the Minister on the appropriateness of the provisions in the Bill that grant powers to make subordinate legislation on 30 September 2019. It reported on its conclusions on 15 November 2019.

2. General principles and the need for legislation

Background to the Bill

9. The Welsh Government first consulted on proposals between July and November 2015 as part of the Green Paper, "Our Health, Our Health Service", which had sought views on matters relating to the quality of health services and its governance and functions.

10. In July 2017, the Welsh Government published a White Paper consultation: "Services fit for the future, quality and governance in health and care in Wales". The White Paper contained a wide range of proposed measures including:

- Measures to promote stronger governance and leadership - proposals about the composition of NHS boards, as well as statutory protection for the Board Secretary role;
- Duties to promote cultural change across health and social care – a duty of quality for the population of Wales focused on quality at a local level as well as supporting regional and national collaborative working; and a new duty of candour to place citizens at the heart of decisions and information sharing;
- Common processes to underpin person-centred health and care, promote further integration – proposals for high level common standards across health and social care, and the joint investigations of complaints which span health and social care, irrespective of setting;
- 'A strengthening of the voice of citizens in the way services are planned' – proposals to replace the current model of Community Health Councils with new independent arrangements across health and social care to represent the interest of the public;
- "A future-proofed inspection and regulation service", potentially sitting with the citizen voice arrangements as part of a newly formed independent body.
- 'A clearer process for service change'

11. In July 2018, the then First Minister committed to bringing forward an NHS Quality Bill over the next year.

Overview of the Bill

12. The Bill contains 5 Parts, including an Overview of the Act in Part 1.

13. Part 2 reframes the duty of quality to require NHS bodies and Welsh Ministers (in relation to health functions) to exercise their functions with a view to securing improvements in the quality of services they provide.

14. Part 3 introduces a duty of candour on all NHS bodies at an organisational level.

15. Part 4 establishes a new independent Citizen Voice Body for health and social care (replacing Community Health Councils).

16. Part 5 gives Welsh Ministers powers to appoint a Vice-Chair on NHS Trust Boards and contains other general provisions, including consequential amendments to other legislation and provision about when and how the Bill comes into force.

The Bill's purpose and intended effect

17. The Bill proposes to introduce changes that:

- Place quality considerations at the heart of all the NHS in Wales;
- Strengthen the voice of citizens across health and social service, with a new Citizen Voice Body for health and social care (replacing Community Health Councils);
- Place a duty of candour on NHS organisations at an organisational level, requiring them to be open and honest when things go wrong; and
- Strengthen the governance arrangements for NHS Trusts, by introducing a formal Vice Chair role for each Trust.

Evidence from stakeholders

18. The majority of responses were broadly supportive of the aims of the Bill; particularly of the moves to improve quality, candour, allow Vice Chairs to be appointed by NHS Trusts and for the new Citizen Voice Body to cover both Health and Social Care.

19. Social Care Wales welcomed the rationale behind the Bill and supported its broad principles. It stated that the Bill is "significantly health-focused with the

emphasis very much on improving NHS performance". It highlighted the strong legislative and regulatory footing that exists currently in the social care sector, and welcomed the "Bill's aims to provide some of that foundation in to the health arena".[6]

20. The Welsh Ambulance Service Trust (WAST) stated:

> "the general principles of the Bill are sound and represent a continuation of the trend towards greater transparency and accountability across the NHS Wales system. The strengthening of the voice of citizens across health and social services will add value to that cause."[7]

21. However the majority of respondents also felt that the duties of quality and candour in the Bill should be strengthened, and suggested a number of ways to do so, including the use of sanctions.

22. They also expressed concerns about aspects of the new Citizen Voice Body. Many respondents said that action should be taken to ensure the new body will have local representation across Wales; sufficient powers and "teeth" (including rights of access for unannounced visits and a right to a response from public bodies).

23. The Welsh NHS Confederation said that, while it was broadly supportive of the aims of the Bill, there were a number of areas where further information and guidance was required, including how the duties of quality and candour will be applied to social care services in an increasingly integrated health and social care system. It said that without these points of clarification it would stop short of fully supporting the proposed legislation in its current form.[8]

24. Some of the key themes that came through in the responses included:

- a lack of clarity in relation to the duty of quality provisions, with many questioning what would be measured, and how compliance would be monitored, given the lack of sanctions in the Bill;
- that quality of staff training and the definitions developed for the duty of candour would be crucial to the success of the duty (with many noting

[6] Written evidence, QE5
[7] Written evidence, QE24
[8] Written evidence, QE43

that legislation alone will not change the culture of the NHS). Many also felt that sanctions were required for breaches/non-compliance;

- uncertainty as to how the duties would align with social care; some also questioned the logic of the duties only applying to the health service given the increasingly integrated health and social care systems;
- that the new Citizen Voice Body must be sufficiently resourced; have a local/regional presence across Wales; a right of access and to make unannounced visits; and a right to a response to representations made;
- that the new body needed to be representative of society. Some suggested that various groups need to be represented including people with disabilities, people with mental health issues, young people and people with dementia.

25. The themes are explored in more detail in the following Chapters of this report.

Evidence from the Minister

26. In his oral statement to introduce the Bill, the Minister said:

> "The Bill builds on the assets that we already have in Wales, to strengthen and futureproof our health and social care services, facilitating a stronger citizen voice, improving the accountability of services to deliver improved experience, better quality of care and better outcomes for people in Wales."[9]

27. In setting out the context for the Bill, the Minister stated that "quality must be at the heart of every aspect of health care provision, and placing quality in a prominent position in the NHS Wales Act, underlines the policy intent to ensure quality is at the heart of decision making in the health service in Wales". He said that it also drew together other changes in the Bill including the duty of candour and strengthening the voice of the citizen to support quality improvement".[10]

28. He highlighted the work of the Parliamentary Review of Health and Social Care in Wales in 2018, which recommended that the vision for health and care in Wales should aim to deliver against the four mutually supportive goals of the "Quadruple Aim".[11] The provisions in the Bill, he said, "aim to help realise these

[9] RoP, Plenary, 18 June 2019
[10] Letter from the Minister for Health and Social Services, 8 July 2019
[11] These four goals are reproduced in the Minister's letter, 8 July 2019

ambitions in a number of inter-connected ways by placing improvement in quality as the central concept underpinning the provisions within the Bill":[12]

> "It will improve service user experience, communication and engagement between the NHS and its service users. Allowing us to build on the work that has already been undertaken to ensure NHS bodies in Wales are open and honest when things go wrong, and support the drive towards a system that is always learning and improving and has the trust and confidence of patients and service users."[13]

29. We asked the Minister whether the Welsh Government had tested the principles of the Bill against real life scenarios, like the former Cwm Taf UHB maternity services failings, and whether it would have made a difference to the outcomes in those case. He told us:

> "Yes, it really should've made a difference. So, for example, the duty of candour and the duty of quality should both have made a difference in maternity services in the way in which challenges were highlighted, the way in which there was an organisational duty to address them and the way in which they should then have been able to set out, in response to concerns that have been raised: 'Here's the current view on quality, this is what we're currently doing to improve that, and to secure improvement this is what we're doing.' To set out in those terms how you secure quality improvement I think will make a difference."[14]

30. He went on to say that "the introduction of a duty on day 1 doesn't change overnight the way an organisation works".

31. He confirmed that, in preparing the Bill, the Welsh Government had "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"[15]:

> "Therefore, the actions we as a government are taking to improve the quality of services must be viewed as a package of measures

[12] Letter from the Minister for Health and Social Services, 8 July 2019
[13] Letter from the Minister for Health and Social Services, 30 August 2019
[14] RoP, 11 July 2019, paragraph 221
[15] Letter from the Minister for Health and Social Services, 30 August 2019

> implemented through primary legislation, secondary legislation, directions and guidance."[16]

32. He also confirmed that the Welsh Government would evaluate the Bill following enactment:

> "we've committed, for three years post-delivery of the Act and implementing changes, to actually review the impact it's had. And that will be available for this or a successor committee to undertake that post-legislative scrutiny about what difference it has made."[17]

Our view

33. This Bill is one component of a suite of measures aimed at improving and protecting the health, care and well-being of the population of Wales. The Bill has been some years in the making, and has been shaped by the findings of the Parliamentary Review of Health and Social Care in Wales.

34. Its principal purposes – to ensure that quality becomes a driver of a system-wide way of working in the health service; to require health organisations to be open and honest when things go wrong; and to strengthen the voice of citizens across health and social services – are laudable, and represent an important step towards greater transparency and accountability across health and social services in Wales.

35. Of course, any form of cultural change takes time to be achieved, and requires more than just legislation; the underlying policies in this Bill are no different. The successful implementation of the Bill will demand real commitment and drive both from NHS leaders, and also from the Welsh Government. They must clearly set out, from the beginning, their expectations as to the culture and service standards to be delivered, and ensure that the right system architecture is in place to sustain this.

36. Much will also depend on the detail in the guidance to be produced by the Welsh Government, and the provision of quality training and support for staff.

37. We were pleased to hear that the Welsh Government has committed to review the implementation of the Act – this will be a matter of interest to our successor committee. We ask that the Minister writes to us in due course with details of his plans for this review.

[16] Letter from the Minister for Health and Social Services, 30 August 2019
[17] RoP, 11 July 2019, paragraph 223,

38. In terms of the specific provisions in the Bill, although stakeholders were broadly supportive of the Bill, we did receive a considerable amount of evidence calling for its provisions to be both clarified and strengthened.

39. We have considered this evidence and made a number of recommendations to the Welsh Government for amendments to the Bill. These are set out in the following chapters of this report. We urge the Minister to give his full consideration to these recommendations as the Bill proceeds.

Recommendation 1. We recommend that the Assembly agrees the general principles of the Bill.

3. Duty of quality

Background

40. The Bill introduces a new broad duty to require Welsh Ministers and NHS bodies to exercise their functions (in relation to health) "with a view to securing improvement in the quality of health services".

41. Welsh Ministers and NHS bodies must all publish separate annual reports detailing the steps they have taken to comply with the duty, and include an assessment of the extent of any improvement in outcomes achieved. The Welsh Ministers must lay a copy of the Welsh Government's report before the National Assembly for Wales

42. The Bill states that "quality" includes, but is not limited to, quality in terms of—

- the effectiveness of health services;
- the safety of health services;
- the experience of individuals to whom health services are provided.

Evidence from stakeholders

43. Many respondents, while welcoming the aim of the Bill and recognising the need to improve quality, felt that the duty of quality should be clarified and strengthened, that quality needed to be defined more explicitly on the face of the Bill, and that there should be provision for sanctions for non-compliance.

Clarity and measurement of the duty

44. A common theme that came through in the evidence was that stakeholders felt that the Bill was not sufficiently clear on what basis the provision of quality would be judged, other than in the broadest of terms.

45. The NHS Confederation stated that, although there was an existing "quality duty" under the 2003 Act, it had 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, rather than delivering continuous improvement. It argued:

> "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."[18]

46. BMA Cymru Wales and others, including NHS bodies, believed the Bill should be amended to better define how quality in service provision would be assessed and judged, and how a failure to deliver insufficient improvements in service quality would be addressed:

> […] 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.[19]

47. The BMA suggested that amendments could be agreed to introduce requirements for regulations and/or guidance to be produced by Welsh Ministers to provide more detail, to better define how quality in service provision would be assessed and judged, and how a failure to deliver insufficient improvements in service quality would be addressed.

> "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."[20]

48. The NHS Confederation believed that 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.[21]

49. Powys Teaching Health Board said that the duty of quality was currently focused on the provision of services. It believed the duty must also cover the planning and commissioning of services, not just direct provision.[22]

[18] Written evidence, QE43
[19] Written evidence, QE29
[20] Written evidence, QE29
[21] Written evidence, QE43
[22] RoP, 23 October 2019, paragraph 328

50. Public Health Wales said there was a lack of coherence and clarity in terms of a Quality Framework for the NHS in Wales that the NHS had to be assessed against and demonstrate improvements. It went on to say "it is unclear why the opportunity to address regulatory improvements has not been taken". It also stated that the annual reporting of quality improvement "appears to be a relatively weak control and therefore it raises the question if an annual report provides a robust demonstration of assurance".[23]

51. Leonard Cheshire welcomed the intended improvement of quality of care, but also felt there was a lack of clarity as to how this would be measured or policed in delivery. It also said there was no reference to benchmarks for quality, or how an organisation would demonstrate an "improved outcome".[24]

52. The Welsh Ambulance Service Trust (WAST) similarly highlighted the need to ensure that improvement was benchmarked across Wales and in particular that innovations and improvements designed in one area were spread and scaled across the whole of Wales. It suggested this should be mandated to the 1000 Lives programme at Public Health Wales.[25]

53. Evidence from Prof. Vivienne Harpwood, Chair of Powys Teaching Health Board and Chair of the Welsh The NHS Confederation Management Board was critical of the proposed duty in the Bill. She said that there was a strong argument that a duty to bring about improvements in the quality of health and care services already existed and that additional statutory duties were unnecessary. She went on to say that "Part 2 is a classic example of "aspirational" legislation and is difficult to enforce".[26]

54. Prof. Harpwood also argued that the duty in the Bill risked the 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."[27]

[23] Written evidence, QE42
[24] Written evidence, QE36
[25] Written evidence, QE24
[26] Health, Social Care and Sport Committee, 19 September 2019, Paper 7
[27] Health, Social Care and Sport Committee, 19 September 2019, Paper 7

Sanctions for non-compliance

55. Much of the evidence received highlighted the omission of any sanctions or consequences for non-compliance with both the duties of quality and candour.

56. The BMA noted there were no mechanisms to suggest that anything would happen if the bodies subject to this duty have not delivered sufficient improvement in the quality of health services. It said that this needed to be addressed.

> "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."[28]

Integration and co-operation between health and social care

57. A number of respondents, including the Older People's Commissioner for Wales, questioned how the duty of quality would interact with existing duties and quality standards in social care.[29] The Commissioner, and others, believed that health and social care systems needed to work towards a shared view of quality that also reflected the views of the people of Wales.

58. Care Inspectorate Wales (CIW) said it would be beneficial to consider how the Bill's quality duty aligned with the requirements within the Social Services and Well-being (Wales) Act 2014 which focused on well-being outcomes and what matters to people. CIW stated that alignment would be important in the context of greater integration of health and social care and the increasing development of multidisciplinary service delivery.[30]

59. Age Cymru called for the Bill to include a duty on health bodies and local authorities to co-operate on quality across the health and social care systems. It said that not including such provision was:

> "a missed opportunity for addressing cross-boundary service quality issues, particularly in relation to transfers of care and the lack of clinical skills available in care homes, where knowledge and skills need to flow

[28] Written evidence, QE29
[29] Written evidence, QE9
[30] Written evidence, QE18

> across organisational boundaries to ensure the best possible outcome for the person".[31]

60. It argued that a duty to co-operate across health and care systems would drive integrated care provision by making clinical skills more widely available in care homes.

61. The Welsh Ambulance Service Trust (WAST) similarly called for an amendment to the duty of quality in the Bill, suggesting a more specific duty, or a "duty to collaborate to secure improvement". WAST questioned whether the Bill as set out would have a significant impact on what it said was a major challenge for the NHS in Wales; reducing inequality of access to health services, and reducing the impact of the inverse care law (where healthcare is least available to those most in need).

62. WAST believed that, as opposed to a blanket duty to improve services, a more specific duty to secure improvement for those most in need, or a duty to secure improvements to health equity could be more beneficial. WAST went on to say that if a blanket improvement duty were be imposed, a duty to collaborate to secure improvement should be considered, to strengthen and reinforce the principles of the Bill, and encourage integration.[32]

Workforce and staffing levels

63. The BMA and the Royal College of Nursing (RCN) both believed that the Bill should be amended to reflect the link between staffing levels and quality, based on Scottish legislation, and that the opportunity should be taken to "progress with the principles of the Nurse Staffing Levels (Wales) Act 2016 and broaden their applicability"[33].

64. The RCN told us that it believed the duty of quality needed an explicit link to workforce planning in order to make it meaningful, as "you cannot provide a quality, safe, clinical service without the right level of skill and the right number of people". It provided some suggested wording for an amendment to achieve this, drawn from the Health and Care (Staffing) (Scotland) Act 2019.[34]

65. The RCN said that examination of all Health Board agendas for 2018 and 2019 revealed no discussion at Board level of workforce recruitment or retention strategies. As a result of the Nurse Staffing (Levels) Wales Act 2016, papers on

[31] Written evidence, QE1
[32] Written evidence, QE24
[33] Written evidence, QE37
[34] Written evidence, QE37

compliance with this legislation are regularly presented to Boards but these papers rarely reference any wider recruitment or retention plans, and "high vacancy levels are instead presented as an unalterable fact".[35]

66. BMA Cymru Wales similarly believed the Bill should recognise a clear link between service quality and the provision of appropriate staffing levels, including for medical staff. It suggested that this could be achieved by incorporating similar duties to many of those contained in the Health and Care (Staffing) (Scotland) Act 2019. It noted that, in Scotland, this duty is underpinned by the publication of the NHS Scotland Staff Governance Standard, and it advocated a similar approach for Wales.[36]

Improving health and health care outcomes

67. Healthcare Inspectorate Wales (HIW) stated that, despite including an explicit responsibility for bodies to undertake planning to meet future population need, it was difficult to see how the Bill would encourage and/or facilitate cross-border working in the broader interests of the Welsh population.

68. Public Health Wales made a similar point, saying that it was important that greater emphasis was placed on the matter of improving health and health care outcomes for citizens/patients, communities and the population. It said that the elements of improving population health do not stand out in the Bill overall, which was a missed opportunity. It goes on to talk about regulation:

> "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."[37]

69. Public Health Wales told us that it "would like to see more explicit reference on the face of the Bill because public health, public protection, is the bedrock of

[35] Written evidence, QE37
[36] Written evidence, QE29
[37] Written evidence, QE42

any effective health system to make sure that we do what we can to mitigate any avoidable harm and to promote health and well-being".[38]

Implications for performance management

70. Public Health Wales told us that, following the introduction of the legislation, there would be a need to change the whole approach to performance management and performance management across the system:

> "because the definition of quality—the approach to quality—will be much broader, all the different duties will be much broader, and the whole performance management regime will need to be redesigned to ensure that bodies are held to account against the new requirements."[39]

Evidence from the Minister

71. The Explanatory Memorandum sets out the purpose of the duty of quality provisions in the Bill:

> "to reframe and broaden the current duty of quality within the [Health and Social Care (Community Health and Standards Act] Act 2003 to ensure quality becomes a system-wide way of working and that focus is placed on outcomes.
>
> The new duty will reframe the concept of "quality" to ensure that it is used in its broader definition, not limited to the quality of services provided to an individual nor to service standards.
>
> The Bill will ensure the Welsh Ministers (in relation to their health functions) and NHS bodies exercise all their functions with a view to securing improvement in the quality of health services"

72. In setting out the purpose of the Bill, the Minister noted that NHS bodies have been under a duty to make arrangements for the purpose of improving the quality of health care since 2003, under the Health and Social Care (Community Health and Standards) Act. However, "the 2003 Act does not place a duty of quality on the Welsh Ministers in the exercise of their health related functions. The

[38] RoP, 19 September 2019, paragraph 205
[39] RoP, 19 September 2019, paragraph 308

Bill addresses this gap" by shifting the focus of this duty to ensure "a whole system approach to quality".[40]

73. Quality, he said, "should be viewed as more than just meeting service standards; it is a system-wide way of working to enable safe, effective, person-centred, timely, efficient and equitable services in the context of promoting a learning culture".[41]

74. He also noted that the 2003 Act lacked any reporting mechanisms, which were beneficial as they allowed bodies that were subject to the duty of quality to demonstrate how their functions had been exercised to secure improvement in the quality of services provided". [42]

75. The Minister stated that reframing the duty of quality

> "will require NHS bodies and the Welsh Ministers to think and act differently by applying the concept of 'quality', not just to services being provided, but to all decisions and arrangements within the context of the health needs of their populations.
>
> By requiring NHS bodies to consider the wider implications of how their decisions will improve health outcomes for their population, the proposed duty encourages Local Health Boards to work with their neighbours and cross sector partners to reduce unwarranted variation and health inequality. It will encourage the sharing of resources and expertise which will in turn unlock opportunities to improve the effectiveness, safety and quality of services." [43]

76. He confirmed that "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, put forward by the then Institute of Medicine".[44] These domains are:

- Safe: Avoiding harm to patients from the care that is intended to help them;

[40] Letter from Minister for Health and Social Services, 8 July 2019
[41] Explantory Memorandum, paragraph 10
[42] Letter from Minister for Health and Social Services, 8 July 2019
[43] Letter from Minister for Health and Social Services, 8 July 2019
[44] Letter from Minister for Health and Social Services, 30 August 2019

- Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively);
- Patient-centred: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions;
- Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care;
- Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy;
- Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

77. We questioned the Minister about the evidence we had heard calling for the Bill to include a definition of "quality" on its face, and to make specific reference to further duties, such as workforce planning, focusing on prevention and improving health and health care outcomes. The Minister said that these were matters better suited to guidance:

> "you have to separate out what needs to be on the face of the Bill and what commitments you'll look for about how that duty of quality will be developed,
>
> The danger is, if you think about all the different things you've just gone through, if we took on board all of those, we'd very quickly expand the front of the Bill and I'm not convinced that that is the right way to deal with the legislation because we'll end up having a book and we'll have to describe in that how you'd apply the duty of quality in a number of different circumstances.
>
> Well, actually, that's why we're talking about issuing guidance, because you can then describe a number of circumstances in an illustrative way and I don't think the front of the Bill is the place to do that."[45]

78. He went on to say that matters relating to improving public health were clearly set out in paragraphs 11 and 12 of the Explanatory Memorandum, "but, I

[45] RoP, 9 October 2019, paragraph 123

don't think you'd want paragraphs 11 and 12 to be translated into clauses in the Bill".[46]

79. The Minister has written to the Committee confirming that the Welsh Government will produce guidance to support and assist NHS bodies in the implementation of the duty of quality (and the duty of candour), and has provided a draft outline of that guidance[47]. He stated:

> "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."[48]

80. There is no provision in the Bill for the issuing of guidance relating to the duty of quality. As such, guidance issued on this matter would be non-statutory.

Annual reporting requirement

81. In relation to the annual reporting requirement, the Minister told us:

> "The reporting requirement will require the Welsh Ministers (in relation to their health related functions) and NHS bodies to assess the improvement in outcomes achieved during the reporting year, demonstrating how we are improving the quality of health services in Wales.
>
> The requirement to report annually will make explicit how the delivery of the duty has led to improvements in quality, providing a baseline to measure and monitor future improvement, and adding to the openness and transparency of the system. The Welsh Minister's report will be laid before the Assembly allowing it to be scrutinised by Assembly Members and the public."[49]

Sanctions

82. We questioned the Minister about the evidence we had heard of the need for a bespoke sanctions regime for failure to comply with the duty of quality (and

[46] RoP, 9 October 2019, paragraph 124
[47] Letter from Minister for Health and Social Services, 30 August 2019, Annexes 2 and 3
[48] Letter from Minister for Health and Social Services, 30 August 2019
[49] Letter from Minister for Health and Social Services, 8 July 2019

candour – discussed in the next Chapter of this report). He said he was "not persuaded" of the need for such sanctions:

> "we're looking for people to implement duties around quality and candour that are about a different way of working and behaving that requires more openness. The challenge I think then is that, if you have a pretty straight-line approach to sanctions, you can end up driving people away from that.
>
> Rather than being more open, you end up having incentives to try and avoid the sanction, which doesn't necessarily lead to the openness and improvement that we're looking for across the system."[50]

83. He went on to say:

> "It isn't as if there is a light-touch approach to understanding what the health service does already. If we want to have a sanction regime on top of that, I'd need to be persuaded, and I'm not at this point, that it would actually help us to deliver our objectives, because I don't think the regime of fines that takes place across the border has a great record in terms of delivering on quality and candour."[51]

84. He also confirmed that any concerns would be raised and considered under the NHS Escalation and Intervention Arrangements.[52]

NHS-commissioned services

85. The Minister confirmed that NHS bodies, as commissioners of services, would "certainly have to consider how the duties [of quality and candour] apply". His official stated:

> "commissioning is a huge role that the LHBs play, so we need to make sure it then expands the duty beyond the direct provision of services."[53]

Our view

86. As a Committee, we are fully supportive of any measures that seek to improve the quality of services provided by the NHS to its patients. To this end, we support the shift in focus, proposed by the Welsh Government via this Bill, to a

[50] RoP, 9 October 2019, paragraph 131,
[51] RoP, 9 October 2019, paragraph 132
[52] RoP, 9 October 2019, paragraphs 141, 142, and letter from the Minister for Health and Social Services, 30 August 2019
[53] RoP, 9 October 2019, paragraph 135

system-wide way of working that will require Welsh Ministers and NHS bodies to exercise all of their functions with a view to securing improvement in the quality of health services

87. We were, therefore, disappointed to hear from stakeholders, particularly NHS bodies, that the Bill was not strong enough in setting out how quality in service provision would be assessed, how an organisation would demonstrate an improved outcome, and how a failure to deliver improvements in service quality would be addressed. These are matters that must be dealt with by the Welsh Government.

88. To this end, we note the Minister's intention to issue guidance about the duty of quality to support and assist NHS bodies in the implementation of this duty, and that he has provided a draft outline of that guidance. We accept his argument that guidance is the more appropriate vehicle for the level of detail he intends to provide on this matter.

89. We do, however, believe that the guidance to accompany the duty of quality provisions in the Bill is central to the success of these provisions and, as such, should have statutory authority. There is currently no provision in the Bill for the Welsh Government to issue guidance specifically on the duty of quality.

Recommendation 2. We recommend that the Minister amends the Bill to make provision for the issuing of statutory guidance relating to the duty of quality. Such guidance should, amongst other things, clearly set out how the duty of quality in service provision will be assessed and how an organisation would demonstrate an improved outcome. It should also include details of how innovations and improvements designed in one area will be spread and scaled across the whole of Wales.

90. Further, we feel that the duty of quality provisions, as currently drafted, have insufficient focus on prevention and improving population health. Given that the first of the "quadruple aims" in the Parliamentary Review of Health and Social Care is to improve population health and well-being through a focus on prevention, we believe this is a matter which must be addressed.

Recommendation 3. We recommend that the Minister amends the Bill to make explicit reference to the need to focus on prevention and improve population health as part of the duty of quality.

91. We heard strong evidence about the need for a clear link between service quality and workforce. We support this. In our view, it is impossible to separate out the issue of quality from the provision of appropriate staffing levels – they are

inextricably linked. In order to deliver quality in service provision, the requisite staffing must be in place.

Recommendation 4. We recommend that the Minister amends the Bill to make specific provision for appropriate workforce planning/staffing levels as part of the duty of quality.

92. Further, we believe that improving service quality and reducing health inequalities are also inextricably linked. This link must be more clearly provided for on the face of the Bill.

Recommendation 5. We recommend that the Minister amends the Bill to make specific provision for a duty to secure improvements to health equity as part of the duty of quality.

93. In relation to sanctions, we heard strong evidence of the need for a clearer indication of how failure to deliver service improvements will be addressed. To this end, we believe there should be clear consequences for non-compliance with the duty of quality, and that this should be provided for on the face of the Bill. Such sanctions should not have a detrimental impact on the financial position of the organisation. We agree with the Minister that the NHS Escalation and Intervention arrangements are an appropriate mechanism.

Recommendation 6. We recommend that the Minister amends the Bill to make specific provision for the consequences of non-complicance with the duty of quality.

94. We heard evidence from a number of stakeholders questioning how the duty of quality will align with existing social care duties, and how it will support the integration agenda. We believe that closer alignment of these duties to support joint working is desirable for better patient outcomes, and that the Minister should ensure this is addressed in guidance.

95. We also heard evidence that the Bill should include a duty on health and social care to co-operate/collaborate to secure improvement as part of the duty of quality. Again, we believe that this is desirable.

Recommendation 7. We recommend that the Welsh Government ensures that guidance on the Bill clearly sets out how the duty of quality will align with existing social care duties, and how it will support the integration agenda

Recommendation 8. We recommend that the Welsh Government amends the Bill to make specific provision for a duty on health and social care providers to co-operate in order to secure improvements for services users.

96. Finally, we agree with the evidence that there will be a need to redesign the performance management regime as a result of the duty of quality to ensure that bodies are held to account against the requirements in the Bill. The Minister should give consideration to this, and provide us with an update on his position as part of the stage 1 debate.

4. Duty of candour

Background

98. The Bill places a new duty of candour on NHS bodies at an organisational level. The duty of candour is triggered if it appears to the NHS body that both of the following conditions are met:

- A service user has suffered an adverse outcome (unexpected or unintended harm that is more than minimal); and
- The provision of the health care was or may have been a factor in the service user suffering that outcome.

99. The Bill then sets out details of "the candour procedure" which must be followed (section 4(2)). The Explanatory Memorandum clarifies that "the provisions will place a duty on NHS bodies at an organisational level, and not onto individual health care staff".

100. The Bill also sets out duties on primary care providers to prepare an annual report for Local Health Boards (LHBs); and all NHS bodies to prepare annual reports on whether the duty of candour has come into effect (and if so, provide the details, and any steps taken to prevent the situation from happening again).

101. In social care, a duty of candour already exists for providers and responsible individuals of regulated services. While work has been carried out to develop and support a culture of openness in NHS in Wales, there is no corresponding duty of candour for health boards. The Welsh Government considers that introducing a duty of candour is "the next logical step in the series of measures already undertaken to improve quality and openness".[54]

Evidence from stakeholders

102. Stakeholders were broadly supportive of the duty of candour, but many commented that the quality of staff training and the definitions developed for the duty (including in relation to "harm that is more than minimal") will be crucial to the effectiveness of the duty, and that legislation alone will not change the culture of the NHS.

103. The Royal College of Psychiatrists supported the duty of candour and "the principle of demonstrating trust and honesty with patients. In its view, "the

[54] Explanatory Memorandum, paragraph 58

implementation of the duty of candour is necessary in order to acknowledge that some clinical errors may be the result or responsibility of wider organisational processes".[55]

104. The Royal College of GPs (RCGP) welcomed the duty of candour, but said it was important to ensure that appropriate training was provided along with support for all clinicians to ensure that this was done well for all involved. In its view, it would be essential that the definition of candour also allowed for proportionality for it to be effective.[56]

105. The NHS Confederation welcomed the principle of the duty, but called for clarification in a number of areas, particularly how the duty will support integration and what the duty on social care organisations will be. The NHS Confederation stated that health and social care services in Wales were operating under an increasingly integrated system, so greater clarity was needed in terms of how the duty of candour would apply in practice to social care. It also said that the fact that the duty seemed to apply only on an organisational level, rather than on an individual level, meant it was unclear how this would work in practice when a patient received an integrated service, and how the duty would apply to partnership arrangements.[57]

106. The CHCs welcomed the duties of quality and candour, noting that in the case of the recent failings in Cwm Taf UHB maternity services, there was not only a failure to provide high quality services but also to behave openly and transparently when responding to concerns raised about those services. The Board of CHCs said:

> "It will be important that the way in which the new requirements are introduced provides the catalyst to deliver real and long lasting cultural change. This must include recognising the key role organisational leaders have in setting the right tone and acting swiftly and decisively when things go wrong.
>
> The Welsh Government will need to give sufficient attention to leadership development and the responsibility and accountability of senior managers in the NHS."[58]

107. Both HIW and CIW were broadly supportive of the aims of the duty of candour, although HIW raised an issue about when the duty would apply:

[55] Written evidence, QE40
[56] Written evidence, QE7
[57] Written evidence, QE43
[58] Written evidence, QE35

> "Part 3 paragraph 3 sets out the conditions under which the Duty of Candour would apply. We feel that the second condition[59] is potentially too narrow since it refers to an adverse outcome as a result of the 'provision of care'.
>
> This may be interpreted to exclude those circumstance in which a service user may suffer an adverse outcome due to their inability to access care. For example, due to the length of time waiting. We feel that instances such as this should also be covered under the duty."[60]

108. The BMA said that robust guidance was 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."[61]

Monitoring and scrutiny

109. As with the duty of quality, many respondents, including the BMA and RCN, queried how compliance with the duty of candour would be monitored and the reports scrutinised. The Children's Commissioner for Wales stated:

> "I am concerned that the Bill in its current form gives little detail of how both the duty of quality and the duty of candour elements will be properly monitored, other than through the annual reporting mechanism from Ministers, and Health Boards and Trusts."[62]

110. Leonard Cheshire (and others) believed it was crucial that the annual reports produced by service providers were acted upon by the Welsh Government to ensure proactive approaches to working. It sought clarity on a number of matters

[59] The second condition referred to is: "The provision of the health care was or may have been a factor in the service user suffering that outcome".
[60] Written evidence, QE17
[61] Written evidence, QE29
[62] Written evidence, QE14

related to the annual reports and the opportunities provided for ensuring consistiency nationwide, including:

- How the information within these reports will be used once compiled?
- How many times will a duty of candour be triggered relating to a particular service before action is taken to reassess whether there are adequate levels of care?
- How will service providers who fall below standards be held accountable?
- Will the duty of candour outlined in this Bill be tracked for progress against the current duty of candour for social care?

Sanctions for non-compliance

111. Another common theme in the evidence was the need for sanctions for failure to comply with the duty. Many stakeholders, including the BMA, RCN and RCP, questioned how organisations could properly be held to account without the availability of such sanctions.

112. The Royal College of Physicians believed "it is vital that the Welsh Government consider how they will hold health and social care organisations to account in the event that the duty of candour is not met, given the lack of specified sanctions in the current draft Bill".[63]

113. The NHS Confederation said that the absence of any sanctions suggested that the new duty of candour may achieve little over and above the duties that NHS Wales organisations and healthcare professionals are already subject to.[64]

114. LHBs supported the provision of sanctions, albeit to be used with caution, and as a last resort. Aneurin Bevan UHB told us:

> "Basically, if everything else has not worked, then you have to think about, 'Well, what is the final step that needs to be taken to ensure the protection of the public?' So, I think that sanctions have to be used with great care but, at the end of the day, have to be used, because there must be a power to act."[65]

[63] Written evidence, QE15
[64] Written evidence, QE43
[65] RoP, 19 September 2019, paragraph 260

115. The BMA suggested either including provisions for sanctions within the Bill, or including a regulation-making power to set out details of sanctions for non-compliance.[66]

116. In contrast, the RCN questioned whether the Bill "could (...) require an automatic escalation in the health organisation status in monitoring/intervention from the Welsh Government". In its view, a breach of the duty of candour would seem serious enough to promote a governance review.[67]

117. Prof. Vivienne Harpwood stated that NHS England had taken "more emphatic steps" than Wales is proposing in the Bill by introducing regulations by means of which criminal sanctions can be imposed for non-compliance with the duty of candour.[68]

Freedom to Speak Up Guardians

118. A number of respondents (including professional bodies and NHS bodies) suggested the appointment of independent Freedom to Speak up Guardians, who could ensure that staff concerns were voiced effectively and that NHS organisations investigated and acted on concerns appropriately.

119. The Royal College of Physicians said that it supported the appointment of independent Freedom to Speak up Guardians in each employing health and social care organisation with a National Guardian answering to an independent organisation such as HIW:

> "All staff must be clear about where they can go to raise serious concerns without fear of reprisal."[69]

120. However Do No Harm Wales (an independent group of healthcare professionals who have experience as whistleblowers) suggested that Welsh Government should distance itself from the current guardian scheme run by NHS England:

> "We feel it is very important to get the scheme in Wales right from the beginning, as loss of confidence has undermined the English FTSU [freedom to speak up] system possibly beyond repair.

[66] Written evidence, QE29
[67] Written evidence, QE37
[68] HSCS Committee, 19 September 2019, Paper 7
[69] Written evidence, QE15

> Wales should consider completely renaming the guardian role to avoid any doubt that the Welsh FTSU scheme is different, but most importantly ensure that those in the guardian role are not employed by health boards. Their neutrality and the confidentiality of those wishing to make protected disclosures is absolutely sacrosanct to the process being trusted by healthcare staff."[70]

121. Do No Harm Wales said the scheme in England "is distrusted by the majority of whistle blowers and appears to have done little to prevent retribution". It considered that an outside independent agency of Healthcare and Whistle Blowing Investigation (HAWBI) was essential. It believed that guardians must be skilled at healthcare investigation, the principles of confidentiality, and have the power to impose sanctions at any level to any staff involved in whistle-blower reprisal or the undermining of the investigatory process.

Impact on primary care providers

122. GP representatives including the BMA and Royal College of GPs, while generally supportive of the duty, raised concerns about the potentially burdensome impact of the Bill on primary care providers.

123. The BMA felt that the reporting mechanisms, which apply to small-scale independent practitioners in the same manner as large health boards, could 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."[71]

Individual duty of candour

124. Do No Harm Wales believed that all individuals working in the context of health and social care should operate under an individual duty of candour.

> "Individuals should uphold the values of the organization in exercising their duties, and there should be accountability if they fail to do so. Currently individuals can and do mislead, withhold information and

[70] Written evidence, QE22
[71] Written evidence, QE29

> dissemble without any comeback. This lack of accountability particularly in managerial posts, leads to frustration and poor staff morale, loss of confidence in the organisation, and contributes to the failure of NHS organizations to change."[72]

Evidence from the Minister

125. In setting out the policy objectives of the duty of candour, the Minister stated that the Welsh Government's intention was to:

> "ensure that whether a person receives care from the NHS, from a regulated provider of social care services or from a regulated independent health care provider, that person can be assured that should something go wrong with their care or treatment they will be dealt with in an open and honest way. The Bill provides the platform to achieve this for NHS bodies."[73]

126. He told us that a great deal of work had been done to develop and support a culture of openness within the NHS in Wales, and that this work had placed health organisations in a favourable position to implement a more formal duty of candour. This, he said, was the next logical step in the series of measures already undertaken to improve quality and openness".[74]

127. He said there was evidence that increased openness, transparency and candour are associated with the delivery of higher quality health and social care:

> "Organisations with open and transparent cultures are more likely to spend time learning from incidents, rather than responding defensively, and they are more likely to have processes and systems in place to support staff and individuals when things go wrong." [75]

128. In terms of placing the duty at an organisational level, he argued that this helped to create the conditions for individual health professionals to act with candour and should help provide the support of the body within which they work to be open and honest with individuals. [76]

129. We questioned the Minister on the evidence about the duty being too narrowly drawn, and not necessarily being able to reflect a situation where

[72] Written evidence, QE22
[73] Explanatory Memorandum, paragraph 60
[74] Explanatory Memorandum, paragraph 58 and letter from the Minister for Health and Social Services, 8 July 2019
[75] Letter from the Minister for Health and Social Services, 8 July 2019
[76] Letter from the Minister for Health and Social Services, 8 July 2019

someone suffers an adverse outcome as a consequence of their inability to access care, for example because of long waiting times.

130. The Minister confirmed that the duty was broad enough to cover any person engaged in healthcare, "in the system", but waiting for treatment.[77]

131. In terms of monitoring compliance, the Explanatory Memorandum states:

> "Compliance with the duty will form part of the matters considered by Healthcare Inspectorate Wales when inspecting and reviewing the NHS. The annual reporting requirements will also provide information to the public and the Welsh Government about the duty which will help to make the process transparent."[78]

Regulations and guidance

132. In the EM, the Minister stated that 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.[79]

133. It further states that these regulations, which will be the subject of public consultation, will be supported by statutory guidance. Section 10 of the Bill makes specific provision for this guidance.[80]

134. The Minister subsequently confirmed that:

> "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."[81]

Sanctions

135. As discussed in the previous Chapter[82], the Minister told us that he was not persuaded by the use of sanctions for non-compliance with the duties of quality or candour. Instead, he confirmed that any failure to meet those duties would be part of the consideration for escalation of those health boards.

[77] RoP, 9 October 2019, paragraphs 145 - 152
[78] Explantory Memorandum, paragraph 68
[79] Explanatory Memorandum, paragraph 4
[80] Explanatory Memorandum, Table 5.2
[81] Letter from the Minister for Health and Social Services, 30 August 2019, Annexe 3
[82] See paragraphs 82-84

A safe environment to speak up

136. In the EM, the Minister acknowledged the "known barriers to disclosure", which he said included "fear, a culture of secrecy and/or blame, a lack of confidence in communication skills, fears that people will be upset and doubt that disclosure is effective in improving culture". Further, the EM states that disclosure is also inhibited by professional or institutional repercussions, legal liability, blame, lack of accountability and negative family reactions.[83]

> "Factors that facilitate disclosure are an emphasis on accountability, honesty, restitution, trust and reduced risks of claims."[84]

137. We asked the Minister what was being done to ensure there would be a safe environment for staff to speak up as part of the duty of candour. His official said that "most of that comes down to the training and the awareness and the support".[85] The Minister went on to say:

> "this is something about saying we want people to be more open, there's got to be more acceptance. There's a challenge for staff on the front line, but also at leadership levels as well, to reinforce the values we expect in the service.
>
> And this is a culture change, so I wouldn't artificially say, 'It'll all be done and dusted within 12 months of the Bill being implemented.' I think it will take a longer period of time. For me, it's important that there's honesty about that as well and about the varying stages of progress we make to get to where we all want to be."[86]

138. Specifically on the Freedom to Speak Up Guardians, the Minister's official told us that this was a different issue to discharging the duty of candour, and re-iterated the point about the training that will be provided to "support staff in how to have those difficult conversations". She went on:

> "it's not a one size fits all, there's a whole load of things we need to put in the system to make it easier to have a more open, supportive culture."[87]

[83] Explanatory Memorandum, paragraph 46
[84] Explanatory Memorandum, paragraph 46
[85] RoP, 9 October 2019, paragraph 163
[86] RoP, 9 October 2019, paragraph 164
[87] RoP, 9 October 2019, paragraph 166

Impact on primary care providers

139. We challenged the Minister on the evidence that the reporting mechanisms could place a disproportionate burden on primary care providers. Responding to this, he said there was a balance to be struck, but that there should not be different standards:

> "if we say there's a different duty that applies if you have a single-handed GP than if you go to a general practice with four GPs and a range of other healthcare professionals, what we couldn't have is that there'd be a different duty and a lesser duty applying."[88]

140. The Minister's official confirmed that the Welsh Government was "doing a lot of work to reduce the burden around reporting, to make it easier to report", and that the guidance being produced to support the duty would assist GPs.[89]

Our view

141. We fully support the policy objective of a duty of candour, and the cultural shift towards greater openness and transparency within the health service that should flow from it. When things go wrong in health settings, patients and their families should be able to expect to be dealt with in an open and honest way. Equally important is that organisations have in place a culture that encourages and supports learning from mistakes, and creates the right conditions for this to happen.

142. Whilst the Bill sets out the conditions to be met for the duty of candour to be triggered, so much of the detail about the practical operation of this will be a matter for regulations and guidance. It will be the regulations that will set out the process to be followed once the duty has been triggered.

143. As such, we welcome the commitment from the Minister to hold a public consultation on the regulations and to support them with statutory guidance. Further, we welcome his commitment to establish a working party of clinicians and service user representatives to collaborate on the development of this guidance.

144. As with the duty of quality, we heard strong evidence of the need for sanctions for non-compliance with the duty of candour. To this end, we believe there should also be clear consequences for non-compliance with the duty of

[88] RoP, 9 October 2019, paragraph 157
[89] RoP, 9 October 2019, paragraph 157,

candour and that this should be provided for on the face of the Bill.Again, these sanctions should not have a detrimental impact on the financial position of the organisation. Instead, we believe that this is a matter that can be appropriately addressed via the NHS Escalation and Intervention arrangements.

Recommendation 9. We recommend that the Minister amends the Bill to make specific provision for the consequences of non-compliance with the duty of candour.

145. We heard very real concerns from stakeholders about barriers to disclosure and legitimate fears for health service staff about speaking out. It is vitally important in achieving the sort of cultural change promoted by this Bill that staff have a safe environment to be open and transparent, without fear of recrimination. There will be a significant role for NHS leaders in creating this environment, and we note that training will be provided to enable staff to understand what is expected of them and the support they can expect to receive.

146. Whilst we support these actions, we are not fully persuaded that they are sufficient. We believe there is merit in further exploring a more independent and robust system of support for staff that enables them to feel safe in raising concerns and whistleblowing. .

147. In relation to concerns of the reporting mechanisms placing an undue burden on primary care providers, we acknowledge the Minister's argument that there is a need for consistent standards across the board, and that the guidance being produced to support the duty of candour will assist GPs in this matter.

148. We agree with stakeholders that it is not currently clear how the candour reports, once produced, will be monitored and scrutinised to drive improvement and address any failings. There is only purpose in having these reports if something meaningful happens as a result of them.

Recommendation 10. We recommend that the Minister clarifies his intention in regard to what will happen to candour reports, once produced, including how they will be monitored and scrutinised.

5. The Citizen Voice Body for health and social care

Background

149. Sections 12 to 21 of the Bill establish the Citizen Voice Body for Health and Social Care, Wales (the Body). This new body will represent the interests of the public in relation to health services and social services. It will abolish existing Community Health Councils (CHCs) which currently carry out these functions in relation to health services. The new body, unlike CHCs, will cover both health and social services. It will not have the power of entry and inspection currently held by CHCs, nor duties to scrutinise service change.

150. The Body:

- must take steps to promote awareness of its general objective and functions, and publish a statement setting out how it proposes to promote its general objective and seek the views of the public for its general objective;
- may make representations to local authorities and NHS bodies on anything it considers relevant to the provision of health or social services, and, where it does so, the local authority or NHS body must have regard to its representations; and
- may provide advocacy services to any individual making, or intending to make a complaint.

151. Local authorities and NHS bodies must make arrangements to bring the activities of the Body to the attention of people who are receiving or may receive health or social services. Unless the law prevents it, local authorities and NHS bodies are also required to provide the Body with such information as it might reasonably request for the purpose of carrying out its functions.

Evidence from stakeholders

Independence of the Citizen Voice Body

152. Paragraph 2 of Schedule 1 provides for the Members of the Citizen Voice Body to be appointed by the Welsh Ministers. However, a number of witnesses suggested that it was inappropriate for the new Citizen Voice Body to be appointed by (and accountable to) Welsh Ministers. Stakeholders believed that, in

order to give the public confidence, the new body should be entirely independent of Welsh Government, with some suggesting it could instead be accountable to the National Assembly for Wales.

153. The Public Services Ombudsman for Wales (the Ombudsman) felt particularly strongly that the new body should be independent. He said that:

> "Welsh Ministers having an effective veto on the appointment of the Chief Executive and controlling remuneration and terms and conditions of staff, [ ] coupled with control of funding of the new body, called into question not only the independent status of the Citizen Voice Body but also, as importantly, the perception of its independence."[90]

154. BMA Cymru also raised concerns about the move away from current CHC appointment arrangements (which are nominations by different sources, including Welsh Government, local authorities and third sector organisations) to a new body which was fully appointed by Welsh Government. It said "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".[91]

155. Similarly, the NHS Confederation told us that governance arrangements were not just about accountability but 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."[92]

156. Aneurin Bevan University Health Board (UHB) said:

> "if this body is to be really successful and add real value [ ] it has to be seen to be independent. It has to have a different function and a different reporting line so that people really do believe that it could act as an advocate for them."[93]

[90] Written evidence, QE6
[91] Written evidence, QE29
[92] Written evidence, QE43
[93] RoP, 19 September 2019, paragraph 283

157. The Ombudsman told us that he believed it would be more appropriate for a wholly independent body, such as the National Assembly for Wales, to make or oversee appointments and decisions.

158. This was a view supported by the RCN who said that, if the new body was to be seen as truly independent, it needed to establish from the outset that it was prepared to be rigorous and robust and engage with all communities equally. In the view of RCN, making it accountable to the National Assembly for Wales could deliver this.

Visits and right of access

159. Currently, Community Health Councils (CHCs) are able to access health and care settings to hear directly from people whilst they are accessing care, and without first requiring the permission of health and care bodies to visit their premises. The new Body will not have such powers of access.

160. CHCs noted that the citizen voice bodies in England (Healthwatch) and Northern Ireland (Patient and Client Council) have a right of access to health and care settings to hear directly from people who are receiving care. They may also do so without giving prior notice in certain circumstances (restrictions apply).

161. Probably the clearest message that came through the evidence we received was that a right of access was needed to enable the new Body to speak directly to people receiving services, without first requiring permission. 73% of respondents to our survey either strongly disagreed or disagreed with the proposal that the new body would not have powers to enter and inspect premises:

> "The right to carry out unannounced visits is a vital element in ensuring that the citizens voice is truly being not just heard but acted on. without this power it has no teeth."[94]

162. CHCs told us about the benefit of them being able to enter premises quickly, and be responsive to individual's needs. They told us that "the ability to have unfettered access to an experience as it's happening is critical to having a proper understanding to then challenge the provider":

> "It's about understanding the experience that somebody is going through at that point in time. So, if a concern is raised, currently (…), community health councils would organise, on occasion, a same-day or

[94] Health and Social Care (Quality and Engagement) (Wales) Bill Survey Summary

> a following-day visit and is able to speak to someone about the issue that's being raised.
>
> Now, if the new organisation is in a situation where they would have to have permission to enter and that permission took time, then you're actually witnessing and receiving an account from someone that's not necessarily coterminous with the issue that was initially raised."

163. The Older People's Commissioner said she was concerned over the loss of the right of access as "this function of the CHCs can be flexible, responsive and act as an "early warning system" where concerns may be identified before an inspection by Healthcare Inspectorate Wales (HIW), alongside providing invaluable 'lay' insight".[95]

164. Similarly, evidence from an individual stated that the announced and unannounced visits to health and social care establishments to collect the views of patients where they are receiving care had an entirely different function from those carried out by HIW:

> "The current CHC members' visits take place at much more frequent intervals than those organised by HIW and can be rapidly organised where patients or visitors report concerns. The visits often pick up things that can be fairly easily rectified by the Health Board such as buzzers not working, store rooms not locked, patients with inadequate numbers of blankets."[96]

165. Hengoed Crafters told us that patients were often reluctant to voice their concerns to health and social care employees but would usually willingly talk to volunteers, who were independent of statutory services, because they knew that their comments would be anonymous. It also made the point that CHC volunteers could react very quickly to concerns raised by patients, family members or visitors.[97]

166. Aneurin Bevan UHB told us that it had found the CHC in Gwent extremely helpful in conducting interviews in accident and emergency to find out what people thought about waiting and their treatment:

> "the information that they were gathering was far more valuable to us than anything if we'd have just put our own people in there, because it really felt a little more independent and people spoke more freely. So, I

[95] Written evidence, QE9
[96] Written evidence, QE13
[97] Written evidence, QE12

> think that it's important for them to be able to access our services and our patients and clients if they are to represent the voice of the people."[98]

167. CHCs told us that HIW's report on its inspection of the Assessment Unit in the University Hospital of Wales[99] was a good example of the importance of the right of access. The CHC conducted an unannounced visit and raised concerns around poor patient experience and lack of care and dignity, advising HIW of these issues. HIW then decided to undertake an inspection of the service, and identified some immediate concerns about patient safety which were dealt with under its immediate assurance process.

168. However, both the WLGA and Board of CHCs raised concerns over the powers of access in relation to people who receive health and care services in their own homes and need to protect their right to privacy. The WLGA said:

> "… most healthcare settings are not people's homes. The vast majority of social care is delivered in people's homes. So, when we're talking about power of access, we just need to be very careful that we're not talking about an institution; we're talking about someone's home."[100]

Right to make representations

169. The Bill as currently drafted allows for the Citizen Voice Body to make representations to local authorities and NHS bodies on anything it considers relevant to the provision of health or social services.

170. Witnesses, including the Board of CHCs and RCN Cymru, called for this right of representation to be extended to include Welsh Ministers. The Board of CHCs said:

> "If the aspiration of the parliamentary review and 'A Healthier Wales' of actually putting the citizen's voice at the centre and driving the development and delivery of health and care services—we think the new body should have that right of representation at a national level [ ].
>
> It's more than about making written representations and getting written answers. It's about being in the room when conversations take place. It's about driving the agenda with policy makers and with

[98] RoP, 25 September 2019, paragraph 287
[99] HIW, Hospital Inspection (Unannounced) University Hospital of Wales, Cardiff and Vale University Health Board, Emergency Unit and Assessment Unit".
[100] RoP, 9 October 2019, paragraph 50

> planners about what health and care systems need to look like in the future. If we're not in that room, if we don't have that right of representation when those conversations take place, the new body is left responding to consultations when planners have decided what needs to happen."[101]

171. RCN Cymru proposed an amendment to Section 15(2) of the Bill to include "Welsh Ministers (insofar as the exercise of their functions relates to the provision of health and social services)". RCN stated that the decisions of the Welsh Government and other bodies influence the provision of health services, therefore it is logical for the CVB to be able to comment on this.[102]

172. The Bill also places a duty on the NHS and local authorities to have regard to the representations made by the Citizen Voice Body, and to demonstrate that they have done so.

173. However, witnesses felt that it was not clear how NHS bodies and local authorities would be required to demonstrate that representations had been taken into account as there is no requirement for a formal response to representations.

174. The Board of CHCs considered that health and care organisations should be required to respond to representations made by the Citizen Voice Body acting in the interests of people and communities, and that it should do so in public where this is appropriate.

> "if someone is sharing their experience with the organisation, then it would seem only right that they have an understanding of how that organisation then uses that information.
>
> So, the right of response from the provider actually gives you that opportunity to say, 'This is how the information was used, and this is what that organisation is now prepared to do as a result of that to actually improve the experience of having that service or make it safer."[103]

175. Further, it believed that such a requirement should include a responsibility on a health and care body to set out its reasons in circumstances where, having

[101] RoP, 25 September 2019, paragraph 124
[102] Written evidence, QE37
[103] RoP, 25 September 2019, paragraph 54

considered representations made by the Citizen Voice Body, it has disregarded some or all of the representations made.[104]

176. Gelligaer Community Council agreed, saying health and social care organisations should be "required" to respond to representations made by the new body acting in the interests of people and communities, rather than just "having regard" to them, as this would give the new body more teeth and demonstrate to the public that their voice had been heard and taken account of.[105]

Need for local representation

177. The EM states that "it will be for the Body to determine the structure that it will need to enable it to perform its functions on a national, regional and local basis".[106]

178. Many responses highlighted the need to ensure that the new body would have a local presence across Wales. We were also told that "the new Body should be based on the solid foundations built up by the Community Health Councils; build on its strengths; not take backward steps".[107] This view was shared by respondents to the survey, who said:

> "It is important to ensure that the knowledge and experience of existing CHC members is not lost."[108]

179. Hywel Dda UHB, while welcoming the strengthening of arrangements for the voice of citizens across health and social care, urged caution that the local accountability and knowledge currently brought by Community Health Council (CHC) members was not lost.[109]

180. The Board of CHCs said that as the Bill was currently drafted:

> "it would be possible for the Citizen Voice Body to cease to have a local presence and become a wholly centralised organisation – with no safeguards in place which preserve the important principle of localism

[104] Written evidence, QE35
[105] Written evidence, QE11
[106] Explanatory Memorandum, paragraph 114
[107] Written evidence, QE3
[108] Health and Social Care (Quality and Engagement) (Wales) Bill Survey Summary
[109] Written evidence, QE10

> that is so strongly referenced throughout the bill's supporting documents."[110]

181. Age Cymru[111] and the Board of CHCs[112] emphasised the importance of the Citizen Voice Body being accessible to everyone, particularly those who cannot leave the place where they are receiving care in local communities and need support.

182. Alzheimer's Society Cymru maintained that there must be some form of local representation that sits beneath the Citizen Voice Body, as this local knowledge was central to understanding the challenges that were faced in different health board areas:

> "We are aware that many of the larger issues will be Wales wide, but the nuances that affect these will vary greatly by city, town and village, let alone health board area, and so we would advocate strongly for some form of local representation to remain underneath the proposed board."[113]

183. Similarly, the Public Services Ombudsman said there would be different issues arising in different areas reflecting, for example, the local service model, rurality, GP provision, demographics and healthcare capacity. He considered that "freedom to operate locally, whilst retaining the benefits of a clear strategic direction, national standards and consistent approaches across Wales, is important".[114]

Volunteers

184. Closely linked to the need for local representation is the role of volunteers. The EM states that "the body will be able to directly recruit volunteers and our expectation is that it would actively seek to encourage volunteers from all sectors of society to contribute to a diverse volunteer base that is representative of the users of health and social care services in Wales".[115] However volunteers are not mentioned on the face of the Bill.

185. The Board of CHCs was clear that "volunteer membership is critical to the success of the new body". In its view, "the citizen voice body must be accessible

[110] Written evidence, QE35
[111] Written evidence, QE1
[112] Written evidence, QE35
[113] Written evidence, QE4
[114] Written evidence, QE6
[115] Explanatory Memorandum, paragraph 145

locally and its activities properly supported by a strong framework of volunteer membership, so that intelligence and knowledge gathered locally informs the priority agenda both locally and nationally".[116]

186. Further, it told us:

> "We recognise that there's lots of talk about it in the explanatory memorandum, but, actually, we think that needs to be enshrined on the front of the Bill."[117]

187. Social Care Wales welcomed the provision for the Citizen Voice Body to recruit volunteers, but highlighted the importance of volunteers receiving sufficient training and support from the outset to fulfil their duties effectively. It also said that volunteers should receive ongoing support and have a clear understanding of their role, expectations and how to access training and support.[118]

188. Similarly, the Board of CHCs said:

> "We also know that [...] if we are to attract and retain volunteer members who we're asking a lot of, in terms of engaging with people and representing their interests, they really, really need to be equipped and supported, and that comes with quite an extensive support, learning and development programme, and that's fundamental."[119][120]

Duty to co-operate

189. We heard evidence that health and social care bodies should have a duty to co-operate with the Citizen Voice Body in carrying out its activities, for example facilitating the engagement process with service users for the purpose of collecting feedback about health and care services[121].

> "if there's going to be a proper relationship between the new organisation and the providers of social and health care, then the right of co-operation should be part of that arrangement, so that we're

[116] Written evidence, QE35
[117] RoP, 25 September 2019, paragraph 101
[118] Written evidence, QE5
[119] RoP, 25 September 2019, paragraph 103
[120] Letter from the Minister for Health and Social Services, 30 August 2019
[121] Written evidence, QE35

> dealing with parity of esteem rather than almost a master and slave situation."[122]

190. CHCs felt that "co-operation shouldn't be in the gift of any individual, that there should be a duty". It said that, whilst CHCs generally enjoyed good co-operation with health boards currently, this had "not always been the case in the past and sometimes we have to have difficult conversations, but we need to continue our relationship after we've had those. So, a duty of co-operation (…) is really important".[123]

Resource allocation

191. The ongoing operational cost of the new body is estimated to be £4.7 million per year with an additional recurring cost of £0.06 million for the Welsh Government for its ongoing sponsorship. These costs compare with the existing cost of CHCs of £4.1 million per year.[124]

192. A number of responses commented on the need to ensure the Body was sufficiently resourced, particularly given its enhanced role across the health and social care sectors. The Older People's Commissioner said it was essential that the new Citizen Voice Body is given sufficient resource and support to operate across both health and social care.[125]

193. Similarly, the Royal College of Physicians called for the new Body to be equipped with the resources and support it needed to be rigorous in its scrutiny of the NHS and local authorities in Wales.[126]

194. The Board of CHCs evidence said "its funding must enable it to effectively operate across both health and social care without reducing the citizen voice that already exists in the NHS through CHCs".[127]

195. However, it told us:

> "we don't think the proposals currently provide sufficient resources to establish and run a new organisation that is going to work across health and social care."[128]

[122] RoP, 25 September, paragraph 10
[123] RoP, 25 September 2019, paragraph 132,
[124] Explanatory Memorandum, paragraph 387
[125] Written evidence, QE9
[126] Written evidence, QE15
[127] Written evidence, QE35
[128] RoP, 25 September 2019, paragraph 102

196. It went on to say that, while it recognised the proposals were "a starter for 10 from the Welsh Government", it did not think this was enough.[129]

Evidence from the Minister

Independence of the Citizen Voice Body

197. The Minister told us that, in his view, the new body would be "significantly more independent" than the current arrangements. He did not share the view that the appointment process should be independent of the Welsh Government:

> "What we are proposing is a significant step forward in genuine independence, where they operate and undertake their functions. [ ] it isn't going to be a Minister [ ] deciding to appoint their favoured friend. It's a proper public appointment process, and it will work in exactly the same way as lots of other bodies, where you don't question their independence."[130]

198. In relation to concerns around the public perception of the appointment process, he said that he did not think that the public was really aware of how CHCs were currently appointed.[131]

199. He subsequently confirmed that:

> "The precedent for Ministerial appointment to 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."

Visits and right of access

200. The Minister reiterated his concerns about the right to enter a premises where health or social care was being delivered in someone's home:

[129] *ibid*
[130] RoP, 9 October 2019, paragraph 173
[131] RoP, 9 October 2019, paragraph 176

> "So, if you are having a district nurse visit you, that's healthcare provision in your home. You can't have someone from the CHC saying, 'I'm coming in.' Equally, if your home is a room in a residential care home. But equally, there's nothing that would prevent a representative from the citizen voice body who was engaging with a person from being present in someone's home in any event."[132]

201. He said that although it would be possible to include powers of entry on the face of the Bill, he did not believe it was appropriate:

> "... if you just have a blanket power of entry to wherever health and care are being provided, you're essentially saying that a citizen voice body can enter someone's home, and I don't think that's an appropriate balance to strike."[133]

202. However, he thought it would be preferable to develop a code of practice, which would set out a range of different circumstances where it would be appropriate for access to be readily provided.[134]

203. He subsequently confirmed:

> "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."[135]

Right to make representations

204. In response to calls for the Citizen Voice Body to be able to make representations to Welsh Ministers, the Minister told us that if the Citizen Voice

[132] RoP, 11 July 2019, paragraph 282
[133] RoP, 9 October 2019, paragraph 193
[134] RoP, 9 October 2019, paragraph 194
[135] Letter from the Minister for Health and Social Services, 30 August 2019

Body wrote to Welsh Ministers raising a significant concern, Ministers were not likely to ignore this:

> "... we aren't trammelling the powers of a new body to say 'You're not allowed to ever try and talk to the Government' [ ]. So I don't quite recognise the challenge about how the powers are drawn and what the body is and isn't prevented from doing, because they're going to be the voice of the public."[136]

205. He said that he would be setting out some process points about statutory responsibilities, but "Welsh Ministers, of course, are going to take, as they would any stakeholder across health and care, seriously what the citizen voice body says at a national level".

206. Similarly, the Minister said that in the event of the Citizen Voice Body raising concerns with Welsh Ministers, it would be unusual for a government not to respond to such a representation.

Need for local representation

207. We asked the Minister for his views on the evidence about the need for strong local and regional arrangements. He told us that he expected 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".[137]

208. Further, he said:

> "I don't want to get into prescribing something on the face of the Bill, because, otherwise, if we prescribe that for all time, you might legitimately want to rearrange local, regional and national functions."

209. The Minister told us that the Welsh Government's initial remit letter, as part of the setting up of the new Body, could set out an "expectation that they set out how they'll deal with their national, regional and local functions. And they will need to provide a scheme to set out how they'll have that local, regional and national presence".[138]

Volunteers

210. In relation to the appointment of volunteers, the Minister stated:

[136] RoP, 9 October 2019, paragraph 209
[137] Letter from the Minister for Health and Social Services, 30 August 2019
[138] RoP, 9 October 2019, paragraph 221

> "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."[139]

211. The Minister suggested that appointment of volunteers could be a matter that was covered in the Welsh Government's remit letter.

Resource allocation

212. The Minister told us that the regulatory impact assessment provided in the Explanatory Memorandum was the Welsh Government's best understanding of the costs the new Body was likely to incur.

213. He said that in comparison to similar bodies in Scotland, England and Northern Ireland, "the per-head funding is better than common bodies in the rest of the UK". As such,

> "... we think that there is a fair estimate of what we'd expect them to do and the resources to enable them to do that." [140]

Our view

214. Over the past 45 years, Community Health Councils have played an invaluable role in reflecting the views and representing the interests of their local communities in the delivery of health services in Wales.

215. There are, however, a number of challenges with the existing statutory framework that governs their operation, and CHCs themselves have acknowledged this. As such, reform in this area is needed and we therefore support the proposal to replace CHCs with a new Citizen Voice Body that will cover both health and social services.

216. In doing so, however, it is important that the strengths of the CHCs, including their ability to represent the voice of local people, are not lost in any new structure, but built upon and developed. The new Body must be properly

[139] Letter from the Minister for Health and Social Services, 30 August 2019
[140] RoP, 9 October 2019, paragraph 225

equipped to be strong, independent and effective in representing the interests of local people.

217. To this end, we believe that the appointment of members of the Citizen Voice Body should be entirely independent of the Welsh Government. The public must have confidence that the new Body is able to represent their best interests in health and care services across Wales, and the manner of its appointments has an important part to play in this.

218. We, therefore, believe that the members of the Body should be appointed by the National Assembly for Wales and not the Welsh Ministers.

Recommendation 11. We recommend that the Minister amends the Bill to make provision for the members of the Citizen Voice Body to be appointed by the National Assembly for Wales.

Visits and right of access

219. The ability to undertake announced and unannounced visits has been an important part of the work of CHCs, and has enabled them to engage directly with people whilst they are accessing services. It has been a valuable and inexpensive way of checking on service quality and provision.

220. Such visits can bring to light and address what can appear to be relatively minor issues but have a huge impact on the service user or their family, as well as more significant issues to bring to the attention of the inspectorates.

221. In fact, it was an unannounced visit to the Assessment Unit at the University Hospital of Wales that flagged concerns to HIW and led to swift action to address patient safety and service quality.

222. We therefore believe that the new Body should have a right of access to health and care settings to visit people receiving services. Without this, there is a risk that quality and safety issues are less likely to be identified and acted upon. This should not take the place of the formal inspection regime, but should supplement it, in the same way that the current arrangements do.

223. We recognise the issues raised about access to people's homes, especially where this is in a residential care setting. However, we are not proposing unfettered access to people's private rooms. Rather, we support the ability of the new body to enter premises to speak to service users, and carry out reasonable and proportionate checks on the care being provided. For this, a qualified right of access to the communal areas within social care settings would be needed.

224. We do not believe that a code of practice, as suggested by the Minister, is sufficient. We believe that a qualified right of access must be included on the face of the Bill, with appropriate conditions or restrictions on its use prescribed in regulations or statutory guidance (as is the case in England). Such conditions or restrictions would confirm that no right of access could be exercised where the Citizen Voice Body considers that it would compromise the effective provision of health and social care or the service user's safety, privacy or dignity.

225. We are aware of a number of other organisations that have statutory duties that allow them to enter a person's home. As such, we maintain that it should be possible to draft the legislation in a way that safeguards the rights of individuals whilst allowing proportionate rights of access.

Recommendation 12. We recommend that the Minister amends the Bill to make provision for the Citizen Voice Body to have a qualified right of access to health and social care settings for the purpose of speaking to service users, and carrying out reasonable and proportionate checks on the care being provided. Specific conditions or restrictions on the use of this power could be set out in detail in accompanying regulations or statutory guidance.

Right to make representations

226. We believe that the Citizen Voice Body should have a right to make representations to Welsh Ministers. This will be important in enabling the Body to be actively involved in, and influence, the design of future health and care systems, rather than just responding to decisions taken in its absence.

227. Whilst we agree that it is unlikely that Welsh Ministers would ignore representations of the Citizen Voice Body, establishing this right in legislation would provide the Body with sufficient powers to give the public confidence that it can make a difference.

228. Similarly, we believe that the provision relating to the duty to "give due regard" to representations made by the Citizen Voice Body needs to be strengthened to make it a requirement that a formal response from the appropriate body must be given to representations made by the Citizen Voice Body. We believe there should be specific provision for this on the face of the Bill. Statutory guidance to accompany this provision should require the response to be provided within a reasonable time, and should include details of what is considered to be a reasonable time.

Recommendation 13. We recommend that the Minister amends the Bill to include the Welsh Ministers on the list of persons to whom the Citizen Voice Body may make representations.

Recommendation 14. We recommend that the Minister amends the Bill to require a response from the appropriate organisation to any representation made by the Citizen Voice Body.

Need for local representation

229. In setting its structures, the Citizen Voice Body must ensure that it has a presence within local communities. This is essential, and is one of the strengths of the current model. As such, we do not believe it is sufficient for local representation to be dealt with by way of a remit letter, as proposed by the Minister. It is our view that the principles of localism should be enshrined on the face of the Bill.

Recommendation 15. We recommend that the Minister amends the Bill to require the Citizen Voice Body to make arrangements for internal local structures.

230. Further, we believe that the role of volunteers is crucial in supporting the work of the Citizen Voice Body. Their local knowledge and expertise, along with their willingness to give up their time to help their communities, is invaluable in ensuring the voice of people in Wales is heard. Their contribution should be recognised and provided for on the face of the Bill.

Recommendation 16. We recommend that the Minister amends the Bill to make provision for volunteers to be recruited to the Citizen Voice Body. This should include a requirement to build a diverse volunteer base that represents all sectors of society.

Duty to co-operate

231. Full and active co-operation between health and social care bodies and the new Citizen Voice Body will be important in enabling it to carry out its functions effectively. Whilst it is not envisaged that a legislative requirement to co-operate will need to be relied on regularly, we believe it is an important fall-back position.

Recommendation 17. We recommend that the Minister amends the Bill to include a duty on health bodies and local authorities to co-operate with the Citizen Voice Body.

Resource allocation

232. We share witnesses' concerns about the level of resources allocated for the new Citizen Voice Body. There will inevitably be costs associated with establishing a new Body to work across both health and social care sectors, not to mention putting regional structures in place.

233. We feel there is a weight of expectation on the new Body, particularly given its extended role to represent the public interest across the health and social care sectors. We do not believe the resource allocation is sufficient to enable it to live up to these expectations.

Recommendation 18. We recommend that the Minister reconsiders the resources set aside for the establishment and operation of the Citizen Voice Body, with a view to increasing them. Any changes in this area will need to be reflected in the Regulatory Impact Assessment.

6. Appointment of Vice Chairs to NHS Trusts

234. Section 22 of the Bill contains provisions for the appointment of Vice Chairs of boards of directors of NHS trusts.

235. The constitutional and membership arrangements for Trusts and Local Health Boards (LHBs) are not currently consistent. Schedule 2 to the 2006 Act provides that Vice Chairs can be appointed to the Board of LHBs where the Welsh Ministers consider it appropriate. However, there is no equivalent power for the Welsh Ministers to appoint a Vice Chair to the Board of NHS Trusts

236. The Bill makes provisions to give Welsh Ministers an equivalent power to appoint a Vice Chair in NHS Trusts, as they already have for LHBs.

Evidence from stakeholders

237. The proposals to formalise the Vice Chair roles in NHS Trusts were welcomed by respondents. NHS bodies (and other organisations) supported these provisions in the Bill. The NHS Confederation said that further clarity was needed around whether the proposed Vice Chair would be considered an additional Independent Member of the organisation (which would be the Confederation's preference) or taken from the existing composition of the Board.

238. Public Health Wales made a similar point, saying:

> "We would stress the importance of a dedicated Vice Chair position being in addition to the existing number of Independent Members."[141]

239. Public Health Wales also called for flexibility to be afforded to each NHS Trust to stipulate the requirements for the role in relation to the organisations needs when the job description was being developed.

240. Professor Vivienne Harpwood said that clarity was needed on whether trusts would use the same appointments process as that currently in place for Vice Chairs' appointments in Health Boards.[142]

241. HEIW said that, as a special health authority, it would like to see the provisions extended to enable Welsh Ministers to appoint Vice Chairs at Special

[141] Written evidence, QE42
[142] HSCS Committee, 19 September 2019, Paper 7

Health Authorities, which would bring HEIW's governance structure in line with the current position of Health Boards and the proposed position of NHS Trusts.[143]

242. The Royal College of Surgeons also strongly supported the provisions. It believed that these arrangements could be further strengthened by ensuring formal clinical and patient representation on all NHS Trust and Health Board boards:

> "We believe lay or patient representation should also be sought at all levels of the NHS, especially on NHS trust boards, specifically in developing standards. This would help the patient voice to be heard at the highest levels in the NHS, to ensure the focus of decision-makers is on improving patient care."[144]

Evidence from the Minister

243. The EM states that the inconsistency in the constitutional and membership arrangements provided for in relation to Trusts and LHBs "has potential to hamper efforts to embed consistent approaches to leadership, quality, and governance".

244. It further states:

> "Vice Chairs will give NHS Trust boards the ability to operate more effectively, efficiently and consistently throughout Wales. The Vice Chair will share responsibilities with the Chairs. This clarity will improve the governance arrangements for Trusts, leading to efficiencies in leadership which will cascade throughout the Trusts' structures, and impact positively on service quality standards and improve patient experience."[145]

245. In response to HEIW's evidence regarding the appointment of Vice Chairs to special health authorities, the Minister confirmed that the Welsh Ministers already have those powers.

Our view

246. We recognise that the role of Vice Chair has become increasingly important to the leadership and governance of local health boards over recent years.

[143] Written evidence, QE28
[144] Written evidence, QE39
[145] Explanatory Memorandum, paragraph 135

247. We find it surprising that, while Welsh Ministers are able to appoint Vice Chairs to local health boards, no equivalent power exists in relation to NHS trusts. We believe this inconsistency needs to be addressed and the constitutional and membership arrangements for NHS Trusts placed on an equal footing. As such, we support the provisions contained in the Bill.

7. Matters not included in the Bill

A single, integrated health and social care inspectorate

248. Many respondents reported disappointment that the Bill does not strengthen the legal and regulatory framework of HIW, nor make any provisions for a single, integrated health and social care inspectorate.

Evidence from stakeholders

249. Social Care Wales and Public Health Wales[146] referred to this as "a missed opportunity".

250. Social Care Wales also raised concerns about how the Bill would help to achieve parity between the two Inspectorates. It stated:

> "The distinction between regulation and inspection between the two sectors is becoming increasingly unclear, as the work of the sectors becomes ever closer and more integrated. The Bill appears to offer no progress in reducing the legal and resource gap between HIW and CIW, leaving a critical impediment to a shared approach across the health and social care sectors."[147]

251. The Older People's Commissioner said that, in light of the growing recognition that people use and depend on health and social care services in an integrated and fluid manner, she thought it was now time to consider the creation of an independent, and integrated health and care inspectorate.[148]

252. Similarly, HIW told us that:

> "if we're serious about a direction of travel towards more integrated models of health and social care, and thinking about integration in terms of the way services are being delivered to the public, then it's probably fair to say that I think an associated direction of travel would be towards more integrating the inspector and regulation system to oversee those services."[149]

[146] Written evidence, QE42
[147] Written evidence, QE5
[148] Written evidence, QE9
[149] RoP, 25 September 2019, paragraph 138

253. It went on to outline some of the challenges in moving towards greater integration, such as the different cultural standards and environments for health and social care, and:

> "...the care inspectorate [ ] have moved over, under the Regulation and Inspection of Social Care (Wales) Act 2016, to a different system of regulation of the independent sector, whilst we remain underneath the Care Standards Act 2000, so we're still establishment-based regulation. So, we operate within very different legal frameworks."[150]

254. On this point, CIW said:

> "Where you've got integrated health and social care services, of course it makes sense to have integrated inspection of those services. [ ] But bringing two inspectorates together in and of itself is probably not going to deliver seamless health and social care services for people."[151]

255. Both Inspectorates confirmed that they would prefer to take their time to ensure arrangements for integrating health and social care inspection were robust rather than rushing into it as part of this Bill.

Evidence from the Minister

256. The Minister confirmed that consideration had been given to the creation of a single integrated health and social care inspectorate, in the development of the Bill:

> "... if we wanted to consider a single inspectorate—if we wanted to think about further integration between the two inspectorates, that's a pretty significant piece of work in itself, and we'd have had a monster Bill, and I don't think we'd have been able to bring forward that Bill as is."[152]

257. He said that a single integrated inspectorate was "certainly part of what a future Government, I'm sure, will want to consider".[153]

258. The Minister subsequently confirmed that work had begun to "scope the legislative requirements mapping out the regulatory gaps and considering the type of inspectorate/regulator needed".[154]

[150] RoP, 25 September 2019, paragraph 139
[151] RoP, 25 September 2019, paragraph 142
[152] RoP, 9 October 2019, paragraph 232
[153] RoP, 9 October 2019, paragraph 233
[154] Letter from the Minister for Health and Social Services, 30 August 2019

259. He went on:

> "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." [155]

Our view

260. We agree in principle with the need for a single integrated health and social care inspectorate. This is, however, a significant and complex piece of work which will require considerable planning. As such, it should not be rushed.

261. We recognise the Welsh Government's decision not to introduce provision for a single inspectorate in this Bill, but we believe this is an important matter for the future. We were pleased to hear that preparatory work is underway within the Welsh Government on this, and we ask the Minister to report back to us on progress with this work in 12 months.

Recommendation 19. We recommend that the Minister reports back to us on progress with work to reform the system of regulation and inspection across the health and social care services. He should do this within 12 months.

Alignment of the NHS and Social Services complaints procedures

Evidence from stakeholders

262. The Public Services Ombudsman told us he was disappointed that the Welsh Government had 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. (...) I consider that it is vital that the complaints

[155] Letter from the Minister for Health and Social Services, 30 August 2019

> process for the citizen is as seamless as possible, particularly when services are jointly delivered by different public bodies."[156]

263. Similarly the Board of CHCs told us:

> "for individuals who are in receipt of services, service boundaries don't mean anything at all. And we think that creating a situation where individuals have to navigate different complaints routes just doesn't make any sense, especially when we're likely to see these services becoming more closely linked."[157]

264. Further, it said:

> "We're also concerned, if you're operating two separate complaints systems, who looks at the complaints where some things fall between the gap between health and social care provision? Where's that being picked up?"[158]

Evidence from the Minister

265. The Minister confirmed that his officials would 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 health and social care.

266. In particular, consideration would be given to utilising existing legislative powers to enable someone who wished to make a complaint about health and social services matters to only have to make one complaint to trigger both procedures.[159]

Our view

267. We share the disappointment of stakeholders at the lack of integration between the health and social care complaints processes.

268. We agree with the need for alignment of the NHS and Social Services complaints procedures in Wales. However, we recognise this is not a straightforward piece of work so we urge the Welsh Government to continue working with stakeholders to find ways to simplify the process.

[156] Written evidence, QE6
[157] RoP, 25 September 2019, paragraph 109
[158] RoP, 25 September 2019, paragraph 114
[159] Letter from the Minister for Health and Social Services, 30 August 2019

Regulation of non-clinical NHS managers

Evidence from stakeholders

269. The BMA Cymru Wales suggested that additional proposals should be added to the Bill to introduce a system of regulation for non-clinical health service managers, in order 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."[160]

270. Do No Harm Wales stated that it would welcome registration for every single health care professional within the healthcare industry in Wales.

> "This would allow Wales to address the recycling of staff between Health Boards & Trusts found to be in breach of professional ethics and allow a fairer equity between clinical and non-clinical staff. This would be of benefit in terms of safeguarding. The National Register of Taxi Licence Revocations & Refusals (NR3) is a good demonstration of how such a scheme might work practically."[161]

271. The Minister said that he was not persuaded that a regulatory framework set out in the way that had been proposed was necessary, but "the points about the duty of quality and candour are about raising up the visibility of this agenda within the service, and managers and leaders needing to proactively respond to that and take that forward".[162]

Our view

272. We agree with the need for equity of treatment for non-clinical health services managers and clinical staff. Where a doctor who fails in their conduct can

[160] Written evidence, QE29
[161] Written evidence, QE22
[162] RoP, 9 October 2019, paragraph 237

be struck off, and thereby prevented from working again as a doctor, a manager who presides over significant failure may go on to secure a new management position in a different part of the NHS.This is not an equitable position.

273. The Assembly has already indicated its support for this in voting in favour of the Member's legislative proposal put forward by Helen Mary Jones, on health service management, which would establish a legal duty of candour to apply to all health professionals including managers.

Recommendation 20. We recommend that the Welsh Government brings forward proposals in the future to address the regulatory imbalance between clinical staff and non-clinical managers in the NHS. This is not a matter for this Bill.

Revised codes of conduct, training and development of managers

Evidence from stakeholders

274. Health boards reported that there had been a deterioration in professional development for NHS management since the collapse of the NLIAH (National Leadership & Innovation Agency For Healthcare).

275. Aneurin Bevan UHB told us:

> "Managers used to have a very, very clear structure of education and experience that they had to have before they were able to venture up to the top of the tree.
>
> We had our own professional qualifications that meant that it didn't matter what your other degrees and diplomas might be; you had to have the health service management qualifications before you started on the track of being a manager.
>
> You also had to have a particular range of experience [ ] to have the accreditation of managers and their re-accreditation. So, you had to do your continuous professional development, you had to be able to comply with the standards, and I issued a code of conduct for managers [ ] with which people had to comply."[163]

[163] RoP, 19 September 2019, paragraph 226

276. Public Health Wales added that, in 1985 general management was introduced to health service management in Wales, which

> "opened the gates to people coming in from different professions to general management, and we welcomed our colleagues coming in from professional disciplines different from management, but we then lost that exclusivity in terms of the IHSM qualification."[164]

277. Health boards called for the codes of conduct and training and development opportunities for managers to be reinstated, as they were a good way of ensuring that the standards were maintained and that people were properly mentored and supported.

Evidence from the Minister

278. The Minister confirmed that he had held discussions with NHS chairs and chief executives about how to invest in the future of leaders and managers and the values expected of them:

> "... there's active consideration of how we improve the quality of leadership and management within the health service, but I don't think that needs to feature in the Bill for us to get that right."[165]

Our view

279. We support the calls for improved training and development for NHS managers. We note the work being undertaken by the Welsh Government with NHS representatives, and urge them to consider reinstating the codes of conduct and training and development opportunities for managers. We ask the Minister to report back to us on the work being undertaken in this area.

Recommendation 21. We recommend that the Minister reports back to us on the work being undertaken to improve the quality of leadership and management within the health service. He should do this within 6 months.

[164] RoP, 19 September 2019, paragraph 232
[165] RoP, 9 October 2019, paragraph 239