

## **Introduction**

	The Welsh NHS Confederation response to the Health, Social Care and Sport Committee's inquiry into the Health and Social Care (Quality and Engagement) (Wales) Bill.
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1. The Welsh NHS Confederation welcomes the opportunity to respond to the Health, Social Care and Sport Committee's inquiry into the Health and Social Care (Quality and Engagement) (Wales) Bill ('the Quality Bill').
2. The Welsh NHS Confederation represents the seven Local Health Boards, three NHS Trusts and Health Education and Improvement Wales (HEIW). Our response to the Bill has been developed through engaging with our members and receiving detailed information from the Chairs and Chief Executives.

## **Summary**

3. The Welsh Government's long-term plan for health and social care, *A Healthier Wales*, sets out a whole-system approach to the provision of services that is based on health and wellbeing and preventing illness. The proposed Quality Bill is a lever to achieve this vision, particularly in relation to developing a shared understanding of how the health and social care system will operate in future.
4. In our written responses to the '*Our Health: Our Health Service*' Green Paper ('the Green Paper') in November 2015 and the '*Services Fit for the Future*' White Paper ('the White Paper') in September 2017, we emphasised that any legislation in this area would need to support the planning and delivery of a truly integrated health and social care system that supports the long-term aims of the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015. Our position is that the proposed Quality Bill achieves this vision and we therefore broadly support the general principles of the Bill.
5. However, there are a number of areas where further information and guidance is required and without these points of clarification we would stop short of fully supporting the proposed legislation in its current form. Specifically, the Bill does not clarify how the duties of quality and candour will be applied to social care services in an increasingly integrated health and social care system. In addition, it is not clear what the definition of quality within the Bill is and within the current proposals what it will mean for patients and service users (particularly those receiving integrated services).

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

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

## **General principles of the Bill**

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

6. We are broadly supportive of the proposed duty of quality. However, there are a number of areas where further clarity is required, for example: what do we mean by 'quality'; how will quality be measured; and how the proposed duty will interlink with other reporting frameworks and requirements placed on an increasingly integrated health and social care system.
7. If we are to ensure that we put the needs of people at the centre of our plans and services, then a duty of quality is fundamental and integral to the ways in which we work with organisations that deliver health and care services. In our response to the White Paper in 2017, we questioned whether such a duty was needed given that NHS Wales has adequate legislation that clearly sets out how organisations need to work in partnership to deliver high quality, person-centred services. However, we support the Bill in as far as it demonstrates a clear commitment to focus on quality and safety in all areas of service delivery.
8. NHS bodies in Wales have been under a duty to make arrangements for the purpose of improving the quality of health and care services since 2003 under section 45(1) of the Health and Social Care (Community Health and Standards) Act. Although the 2003 Act requires NHS bodies to make arrangements to monitor and improve the quality of service, it has largely been interpreted as requiring NHS bodies to have quality assurance (control) arrangements in place across their organisations to monitor and improve the quality of service. This is a

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

9. The duty of quality set out in the 2003 Act has succeeded in providing some focus on improvement in quality and safety in NHS Wales. The clearest example of progress has been the development of an infrastructure that provides assurance that improvement is taking place, namely through the establishment of Quality and Safety Committees at every Health Board and Trust. These Committees report directly to their respective Health Board/Trust Board and provide robust arrangements for the reporting, investigation and learning from patient safety incidents and concerns. Reporting mechanisms of this kind are beneficial because they allow bodies that are subject to the duty of quality to demonstrate how their functions have been exercised to secure improvement in the quality of services provided. Moreover, such mechanisms are a transparent way of demonstrating how the organisation has taken steps to comply with the duty.
10. It is positive to see within the Bill that there is a focus on patient experiences as well as outcomes and the application of consistent quality, safety and experience standards across Wales. This will support the implementation of the Quality Improvement Framework. It is positive also to see that the patient experience aspect of the proposed duty of quality supports the drive for transformational change through values that underpin the NHS in Wales.
11. The duty of quality is also welcomed from a Health Education and Improvement Wales (HEIW) perspective. HEIW recognise that they have a lead role to play in the delivery and commissioning of education and training in respect of this duty for undergraduates, postgraduates and the professional workforce in the NHS.

#### **Areas where clarification is required**

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

#### **What do we mean by ‘quality’?**

13. Firstly, we need to be clear what we mean by ‘quality’, not just from an NHS perspective, but from a social care perspective too. Delivering continuous quality improvements should not be a priority that is exclusive to the NHS but should be considered a health and social care priority as well. Health and social care should work towards the same quality standards and targets, and these standards and targets should be agreed by the Welsh public. The drive towards treating patients as active participants in their care, rather than passive recipients (as per the Prudent Healthcare agenda) is a positive step in this direction. The challenge now is to go a step further and open up a debate with the wider Welsh public about what the health and social care sector should be prioritising.
14. The Social Services and Well-being (Wales) Act 2014 is a useful lever to accelerate progress through its emphasis on a citizen-centred approach to the design and delivery of services, partnership working and integration. Having a precise definition of quality is also important

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

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

### **How will quality be measured?**

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

### **What are the aims of the duty of quality?**

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

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

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

#### **Enabling services**

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

#### **b. Placing a duty of candour on NHS organisations**

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

22. We recognise also that the introduction of this duty would bring Wales into line with jurisdictions in England and Scotland and there will be opportunities for NHS Wales to learn from those systems when Regulations are drafted. The duty of candour is also an excellent opportunity to achieve uniformity across health and social care in Wales.
23. The Francis Report of 2013, which reported on the series of failures in patient care at Mid Staffordshire NHS Foundation Trust, made nearly 300 recommendations around organisational culture and values that should be upheld to maintain high quality performance, quality and safety standards. Specifically, the Francis Report recommended that *“the NHS, and all those who work for it, must adopt and demonstrate a shared culture in which the patient is the priority in everything done”*. This is a significant statement as it implies that the duty to act in an open, honest and transparent manner should be imposed not only to individuals who work within a health and social care system, but also to the system as whole (in other words, it should be applied both individually and systematically). The report argued for *“fundamental change”* in the culture of the NHS to make sure that patients are put first.
24. Set against the conclusions of the Francis report, the proposed duty of candour is to be welcomed. The duty will improve service user experience, communication and engagement between NHS Wales and service users. It will build on the work that has already been undertaken to ensure NHS bodies in Wales are open and honest when things go wrong through the ‘Putting Things Right’ process and has the confidence and trust of service users. Our members also welcome the proposed duty of candour insofar as it supports recommendation six of the Parliamentary Review of Health and Social Care in Wales, namely to develop a system that’s always learning and enhancing the infrastructure and leadership required to support it.
25. It is important to recognise however that steps have already been taken towards developing a culture of openness in the NHS. These include the introduction of new arrangements for handling complaints in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011; improved reporting and investigation of serious incidents; reviews of all deaths in hospitals; and the publication of Annual Quality Statements by Health Boards, NHS Trusts and the Welsh Government.
26. We support the proposition that the principles of openness and candour be extended beyond the current requirements set out in the ‘Putting Things Right’ regulations to include the design of care plans as well as the delivery of health and social care services. Like the proposed duty of quality, emphasis needs to be on embedding the associated values and behaviours of the duty of candour into the fabric of NHS Wales organisations without exception (that is, from the board to frontline staff). This needs to be done from the design and agreement of plans and care plans, not exclusively as part of investigations or redress. If NHS Wales and the social care sector apply these principles in the earliest stages of service design, the expectations of patients, their families and their carers should be more clearly understood.

#### **Areas where clarification is required**

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



### **How will the duty of candour support integration?**

28. Firstly, it must be remembered that health and social care services in Wales are operating under an increasingly integrated system, and so greater clarity is needed in terms of how this duty will apply in practice to social care. While it is relatively clear how the proposed duty will apply to NHS Wales organisations, the fact that the duty seems to apply only on an organisational level, rather than on an individual level, means it is unclear how this will work in practice when a patient receives an integrated service. It is similarly unclear how the duty will apply to partnership arrangements.
29. Further clarity is also required around accountabilities and responsibilities and how the inspection regime might work in practice. This means providing further information around how the duty will take into account the current social care regulatory landscape and the arrangements for assurance work that extend across health and social care partners.

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

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

### **Primary care**

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

### **Defining ‘candour’**

32. Clearly, the precise definition of candour as it applies under the Quality Bill will need to be carefully considered. Candour is defined in the Francis Report as: *“the volunteering of all relevant information to persons who have, or may have been, harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made. Prompt apologies and explanations, with a reassurance they will not reoccur, may prevent a claim being brought at all”*.
33. Some of the wording under this section of the Quality Bill is imprecise, which could lead to differences in interpretation. For example, paragraph 4(2)(a) under Part three of the Bill requires NHS bodies to give notification to the service user that the duty of candour has come into effect when the NHS body “first becomes aware” of this. It would be difficult to pinpoint the exact moment that a member of staff becomes aware that the duty has come into effect, and subsequently, the exact moment that this should be communicated to the service user.

34. Another related challenge here is that use of the word “apology” could lead to defensive behaviour on the part of NHS Wales bodies. Section 2 of the Compensation Act 2006 makes it clear that an apology is not intended to amount to an admission of liability for the purposes of negligence claims. This should be reflected in the Bill because the current wording may bring about situations where NHS staff are deterred from apologising for fear of litigation.
35. Definitions, thresholds and triggers need to be very carefully defined, and the process of defining them needs to be done while considering the potential impact on the service user. Moreover, section 11(5) of the Bill does not consider the commissioning responsibilities of Health Boards within or outside of Wales, which we feel ought to be reflected.
36. Recommendation 181 of the Francis Report provides that there should be a statutory obligation of candour on healthcare providers, registered medical practitioners, nurses and other registered health professionals where there is a belief or suspicion that any treatment or care provided to a patient by or on behalf of their employing healthcare provider has caused death or serious injury. These definitions are accepted. Indeed, candour is a two-way process as it requires that any patient who is harmed by the provision of less than safe care is informed of the that fact and is offered appropriate remedy, regardless of whether they have made a complaint or questioned the care the care they have received.
37. It is acknowledged that social care professionals are already subject to the standards and codes of conduct set out in [“Openness and honesty when things go wrong: the professional duty of candour”](#). This guidance is intended as a practical tool to aid social care professionals (social workers, social care managers and residential child care workers registered with Social Care Wales) in their practice. Implicit in this guidance is an expectation that employers will actively promote an open, supportive and fair culture in the workplace, with an emphasis on continuous improvement and learning from mistakes. Consideration should be given to developing similar guidance that embeds the duty of candour across NHS Wales and social care organisations.

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

38. We recommend that there needs to be an independent authority for NHS and social care staff to turn to if they feel their concerns are not being listened to or acted upon. It is not enough to simply provide staff with the ability to respond to systemic problems or instances of poor care through a formal mechanism.
39. Consideration should be given to introducing a similar service to that of the National Guardian’s Office (NGO) in NHS England, which was introduced following the publication of the Francis Report. The NGO was established as an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes ‘business as usual’. The NGO is not a regulator, but is sponsored by the Care Quality Commission, NHS England and NHS Improvement, and is supplemented by a network of local Freedom to Speak Up Guardians across all NHS Trusts. The NGO also has a key role in reviewing Trusts’ ‘speaking up culture’ and the handling of concerns in instances where the Trust has not followed good practice. If Wales is to consider a similar body, greater clarity will need to be provided around how such a system would work in an increasingly integrated system. A key priority in



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

### **A recent case of the duty of candour in England**

40. We should also consider the recent case of duty of candour in NHS England. The case related to a baby who died after being admitted to Bradford Royal Infirmary in July 2016. Although the Trust had recorded the baby's care as a Notifiable Safety Incident – which triggered the operation of the duty of candour - the family were not informed of this and did not receive an apology or explanation until October of that year. The Trust was fined for breaching the duty of candour by the Care Quality Commission.
41. The Care Quality Commission guidance document '[Regulation 20: Duty of Candour March 2015](#)' states clearly that the duty of candour applies to all "*unintended or unexpected incidents*" if they result in the requisite level of harm, even if they are recognised (and consented) as complications of the treatment. Significantly, there doesn't have to be a failing in the care provided for the duty to come into effect.
42. This prosecution is a sign that the Care Quality Commission exercises its authority to ensure compliance with certain minimum standards – standards below which care must never fall – and serves as a reminder that healthcare providers must be open and transparent with patients and their families not only in cases where something goes wrong, but also in cases where there is no suggestion that a failure in patient care has occurred.
43. The Care Quality Commission's chief inspector of hospitals, Professor Ted Baker, said: "*The action that we have taken against Bradford Teaching Hospitals does not relate to the care provided to this baby, but to the fact that the Trust was slow to inform the family that there had been delays and missed opportunities in the treatment of their child. Patients or their families are entitled to the truth and to an apology as soon as practical after the incident, which didn't happen in this case.*"
44. The case is a timely reminder that the duty of candour is not just about the receipt of clinical services – it is equally about the way that NHS staff communicate with patients and manage the patient-NHS relationship, even in cases where there has been no failing in the care provided. The case is also a reminder that the duties will likely be invoked in cases where there is a delay in care or incorrect advice being provided, not just the receipt of services.

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

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

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

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

46. As a health and social care sector, we recognise and value the patient voice to support, plan and deliver high quality health and social care services. The Welsh NHS Confederation values the role of citizens' (the public and patients) voice and the contribution that CHCs have made to the improvement of healthcare services. However, in our response to the Welsh Government's Green Paper in 2015 and the White Paper in 2017, we emphasised that we believe the citizen's voice could be strengthened due to the more integrated way health and social care are working, either by reforming CHCs or establishing an altogether new body that builds on the strengths of the current system. The proposed Citizen's Voice body under the Quality Bill is closely associated with this suggestion, and we therefore support this proposal.
47. While we support the Citizen's Voice body however, it should be emphasised that Health Boards continue to have positive and constructive relationships with CHCs in their respective areas. Despite some challenges, the relationships Health Boards have maintained with CHCs have ensured that both organisations work collaboratively in the interests of patients and service users. Our members also welcome that the proposed body will not be dependent on NHS Wales hosting arrangements for its pay and rations, which has caused unnecessary complications in the past.

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

48. Currently the way the seven CHCs are configured enables them to represent the public's interest in the NHS. This is not reflective of an increasingly integrated approach to service delivery because there is no specific statutory body for citizen engagement in social care. Local authorities are under a duty to promote user-led services and to involve people in the design and provision of services, but the fact remains that no CHC-equivalent body exists for social care. Effective citizen engagement is an expectation within the Social Services and Well-being (Wales) Act 2014 and the new proposed national arrangement will ensure this without duplication between health and social care issues.
49. Health Boards already have strong mechanisms in place for involving the citizen's voice in the design and delivery of health and care services, including patients' fora, community engagement and public consultations on service change (e.g. the Transforming Clinical Services programme at Hywel Dda UHB). Regional Partnership Boards (RPBs) are another example of this. Under the Social Services and Well-being (Wales) Act 2014, RPBs must include as core membership:
- **At least two** persons who represent the interests of third sector organisations in the area covered by the RPB; and
  - **At least one** person who represents the interests of *national* third sector organisations in the area covered by the RPB.
50. The Social Services and Well-being (Wales) Act 2014 also requires Health Boards to work with Local Authorities to jointly carry out an assessment of the needs for care and support

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

51. The first population assessment reports were published in May 2017. A supporting Code of Practice makes clear that these assessments must include a combination of quantitative and qualitative information that clearly sets out the care and support needs in relation to various core themes. Population needs assessments underpin the integration of health and social services by producing a clear and specific evidence base to which RPBs are expected to respond. They also inform a range of other operational and planning decisions in relation to care and support services e.g. they inform, and are informed by, Integrated Medium Term Plans (IMTPs).
52. In undertaking these assessments, there is a requirement for partners to engage with citizens, as well as the third and private sectors, to ensure that their voice is heard in the planning of services. This is an example of how NHS Wales is already using the existing framework to involve the people of Wales in the design and delivery of services.
53. In addition to the integration agenda, Health Boards are working in a more integrated way across organisational boundaries and services are increasingly being provided regionally, particularly specialist health services. This has the potential to cause problems when there are structural changes to Health Boards that impact organisational boundaries. CHC's attachment to a defined geographical area means that challenges can arise when cross-boundary working or changes to service delivery are proposed because rather than considering the wider health and wellbeing benefits put forward by the proposed service change, CHCs will exclusively consider the potential impact on their local populations. This could lead to scenarios where innovative proposals for transformation of services are rejected even in cases where alternative proposals to deliver improvements are lacking. An all-Wales body, like the one proposed in the Quality Bill, avoids these potential challenges.

### **Areas where clarification is required**

#### **Advocacy services for complaints**

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

#### **Raising awareness of the Citizen's Voice body**

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

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

### **Welsh language**

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

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

### **Clear governance framework to support public trust**

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

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

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

### **Children and young people**

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

## **d. Strengthening the governance arrangements for NHS Trusts**

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

### **Conclusion**

65. We broadly welcome the proposed introduction of the Health and Social Care (Quality and Engagement) (Wales) Bill. While there are a number of areas around the duties of quality and candour where further clarification is required, our position is that embedding these duties into legislation is a significant step towards achieving a system-wide approach to quality and candour in health and social care for future generations. We are also broadly supportive of the Bill's proposition to establish a Citizen's Voice body, which consolidates the commitment of the health and social care sector in Wales to put people's voices at the heart of the design, delivery and improvement of services which supports the long-term vision in *A Healthier Wales*.
66. These developments build on the work that has already been done in Wales but provides a more streamlined approach to achieving an integrated health and care system that places patients at the heart of everything it does, is continuously learning and improving, and is working towards being fit for the future. Our members look forward to providing further detail to the Committee at the oral evidence sessions on 19<sup>th</sup> September 2019.