

## **Welsh Ambulance Services NHS Trust**

### **Response to the National Assembly for Wales Consultation on the Health and Social Care (Quality and Engagement) (Wales) Bill**

#### **Introduction**

1. The Welsh Ambulance Services NHS Trust (WAST) welcomes the opportunity to contribute to the Health, Social Care and Sport Committee's inquiry into the general principles of the Health and Social Care (Quality and Engagement) (Wales) Bill. We note that the Bill intends to:
  - place quality considerations at the heart the NHS in Wales;
  - strengthen the voice of citizens across health and social services;
  - place a duty of candour on NHS organisations; and
  - strengthen the governance arrangements for NHS Trusts.
2. The Committee seeks to understand a range of issues raised within the Bill, and we will focus our submission on key issues related to:
  - potential barriers to the implementation of the provisions and whether the Bill takes account of them;
  - unintended consequences arising from the Bill; and
  - the financial implications of the Bill.

#### **The Principles of the Bill**

3. 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.
4. We particularly welcome the proposed changes to the appointment of Vice Chairs for NHS Trusts. This will strengthen Board level assurance and governance, and will support the drive toward improved quality in the services we provide, as well as placing NHS Trusts on a comparable footing with Local Health Boards in relation to a statutory vice-chair role appointed by the Minister.
5. We will comment further on barriers and potential unintended consequences of the duty of candour and the quality duty in this submission.

#### **Quality Duty**

6. The duty to secure improvements in health services ('the quality duty') is also welcome, as this will make improving quality the key consideration for healthcare providers and for Ministers.
7. WAST has put considerable effort into developing our Improvement and Innovation Network (WIIN), building capacity and capability across the organisation with a platform for our staff to share their ideas for improvement and supporting quality improvement training and capturing quality metrics. We have

had some success in driving improvements to our response times and publish these in our Annual Quality Statement. WAST also has a range of improvement plans in place e.g. on mental health, dementia, falls etc. and these plans are delivering tangible benefits for the public.

8. We do wonder whether the Bill as set out currently will have a significant impact on 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). We believe that, as opposed to a blanket duty to improve services, that a more specific duty to secure improvement for those most in need, or a duty to secure improvements to health equity may actually help organisations or Public Services Boards (PSBs) and Regional Partnership Boards to identify health inequality in the services they deliver, and improve the health of disadvantaged communities across Wales.
9. We note that PSBs have an existing duty to undertake Wellbeing Assessments for the populations they represent, but that the Future Generations Commissioner notes that many PSBs remain tentative in nature. We feel that a duty to secure improvement in health equity at a PSB level may add value, as many of the improvements we seek to achieve can only be delivered if work is undertaken in partnership with NHS, social care, wider public service and voluntary sector organisations.
10. We believe that if the Committee feels a blanket improvement duty should be imposed, that a duty to collaborate to secure improvement may actually strengthen and reinforce the principles of the Bill, and should be considered. This will also help the NHS and partners to work outside traditional boundaries and encourage collaboration and integration.
11. A duty to collaborate to secure improvement would require a more sophisticated approach to reporting, for example by PSBs/RPBs reporting annually on how they have achieved system-wide improvements for patients. This would go beyond the current annual reporting requirements.
12. We think the duty to secure improvement should also be mandated to the 1000 Lives programme within Public Health Wales, with a particular focus on ensuring that improvement is benchmarked across Wales and in particular that innovations and improvements designed in one area are spread and scaled across the whole of Wales.
13. We believe that it is right to ensure that organisations report annually on their improvements, and would like to see greater clarification on whether this report will be in addition to the Annual Quality Statements, Annual Reports and other quarterly/yearly documents produced across the NHS in Wales. This will have a significant impact on resourcing, and whilst this would ordinarily be a matter for

statutory guidance, it would be helpful to know what the Government's intentions are on streamlined reporting as early as possible, to enable planning.

14. We would also welcome a refresh of the existing Health and Care Standards in light of *A Healthier Wales* and the shift towards prevention and earlier intervention. This will clarify which framework all organisations are required to plan and report against.

### **Duty of Candour**

15. Placing a duty of candour on NHS organisations (similar to the existing system in social care) builds upon the existing Putting Things Right (PTR) framework. This duty goes further to ensure that anyone who has had an adverse outcome that has arisen in the process of healthcare, and that outcome was non-trivial, will be notified, apologised to and informed of any further action to be taken.
16. WAST has worked with a positive focus to ensure that our staff report errors and near misses as they arise, and that we as an organisation learn from these without undue blame or punishment. We support a duty of candour on organisations (as opposed to individual clinicians), but barriers do exist to putting this into practice.
17. Firstly, and perhaps most importantly, we believe that our staff are already honest and candid with people when things go wrong, and do their best to put things right at the time that errors occur. We have striven to move away from undue blame when things go wrong, but changing cultures across organisations takes time and thought. It is evident that the Bill alone will not change culture, and that all organisations will have to redouble their efforts to change their cultures to be even more open and honest when things go awry.
18. We think that the explanatory note to the Bill needs to set clearer parameters around what will and will not trigger the duty of candour, ideally before the passage of the Bill, to enable all organisations to plan for what could be a significant new administrative responsibility. We also feel that the inter-relationship between the proposed duty of candour and the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 needs further clarification. We note that there is an existing duty to make an apology in those regulations, and once we have identified that something has gone wrong and we have started to investigate, we will contact the patient concerned and apologise.
19. WAST provides a quarterly Quality Assurance report to our Quality, Patient Experience and Safety Committee using the Health and Care Standards as a reporting and monitoring framework. From September 2019, WAST will be redesigning our quarterly Integrated Highlight Report into the public domain through our Trust Board. This outlines our quarterly complaints and concerns,

safeguarding and health and safety information, including the learning from these incidents. We are not clear what the interaction is between this, a duty of candour report and other reports such as the Annual Quality Statement.

### **Closing Remarks**

20. While the Welsh Ambulance Service welcomes the introduction of the Bill and supports its passage into legislation, it is clear that its introduction will require a number of concomitant revisions to extant guidance, for example a review of the Health and Care Standards, as well as a focus on the cultural aspects of the legislation's implementation.
21. The latter will need to be managed carefully and sensitively to ensure that the full gamut of intended benefits is realised and that both registered and non-registered elements of the NHS Wales workforce feel supported to work within the spirit and requirement of the legislation.