

QE 29

Ymchwiliad i Fil Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru)

Inquiry into the Health and Social Care (Quality and Engagement) (Wales) Bill

Ymateb gan Gymdeithas Feddygol Brydeinig Cymru

Response from British Medical Association Wales

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

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

Response from BMA Cymru Wales

1 August 2019

INTRODUCTION

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

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

RESPONSE

Executive Summary

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

and how the proposals in the Bill can deliver an independent mechanism to provide clinical advice and assurance on substantial change proposals.

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

General response

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

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

Part 2 – Improvement in health services

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

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

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

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

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

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

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

addressed. We would therefore urge the committee and Welsh Government to acknowledge within the legislation that there is a clear link between these two factors.

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

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

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

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

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

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

Part 3 – Duty of Candour

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

We have previously articulated our support for such a complementary organisational duty of candour² as a means to change the culture of the NHS where many of our members feel discouraged from speaking up. Doctors are accustomed to being open and honest, as per the principles of the GMC's *Good medical practice*, but many NHS organisations operate a defensive culture in our experience with little means for them to be held to account.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part 5 – Miscellaneous and general

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

Additional proposal – regulation of non-clinical health service managers

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

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

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

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- ¹ BMA Cymru Wales (2015). Response to Welsh Government Green Paper, *Our health, our health service*. Available at: <https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/policy%20and%20lobbying/welsh%20council/pa-ourhealthourhealthservice-27-11-2015.pdf?la=en>
 - ² BMA Cymru Wales (2017). Response to Welsh Government White Paper, *Services Fit for the future*. Available at: <https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/influence/uk%20governments/wales/services-fit-for-the-future.pdf?la=en>
 - ³ Robert Francis QC (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Available at: <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry>
 - ⁴ NHS England (2013). Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. Available at: <https://www.nhs.uk/nhsengland/bruce-keogh-review/documents/outcomes/keogh-review-final-report.pdf>
 - ⁵ National Advisory Group on the Safety of Patients in England (2013). A promise to learn – a commitment to act: Improving the Safety of Patients in England. Available at: <https://www.gov.uk/government/publications/berwick-review-into-patient-safety>
 - ⁶ June Andrews and Mark Butler (2014). *Trusted to Care: An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board*. Available at: <http://www.wales.nhs.uk/sitesplus/863/page/73970>
 - ⁷ Keith Evans (2014). A review of concerns (complaints) handling in NHS wales: “Using the Gift of Complaints”. Available at: <http://www.wales.nhs.uk/usingthegiftofcomplaints>
 - ⁸ NHS Scotland (2012). *Staff Governance Standard*, fourth edition. Available at: <https://www.staffgovernance.scot.nhs.uk/what-is-staff-governance/staff-governance-standard/>