



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

Dai Lloyd AM
Chair, Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

8 July 2019

Dear Dai,

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

Following my appearance before the Finance Committee on 3 July to discuss the financial aspects of the Bill, I thought it may be helpful to provide further information prior to my appearance before the Health, Social Care and Sport Committee on 11 July.

At Finance Committee, it became apparent that, while there is general support for the broad policy intent behind the proposals, there is interest in how the objectives and benefits will be realised specifically in relation to the duties of quality and candour.

Context for the Bill:

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. It also draws together the other changes included in the Bill including the duty of candour and strengthening the voice of the citizen to support quality improvement.

The Parliamentary Review of Health and Social Care in Wales in 2018, recommended the vision for health and care in Wales should aim to deliver against the four mutually supportive goals of the “Quadruple Aim”, which are to continually:

- improve population health and well-being through a focus on prevention;
- improve the experience and quality of care for individuals and families;
- enrich the well-being, capability and engagement of the health and social care workforce; and
- increase the value achieved from funding of health and care through improvement, innovation, use of best practice, and eliminating waste.

The provisions in the Bill aim to help realise these ambitions in a number of inter-connected ways by placing improvement in quality as the central concept underpinning the provisions within the Bill.

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

The intent set out in the Bill aligns with the ‘Quadruple Aim’ by ensuring quality is a consideration across all the functions of health bodies in Wales. 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.

Duty of quality:

Background:

NHS bodies have been under a duty to make arrangements for the purpose of improving the quality of health care since 2003, under section 45(1) of the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act").

Although this Act requires NHS bodies to make arrangements to monitor and improve the quality of health care, it has largely been interpreted as requiring NHS bodies to have quality assurance (control) arrangements in place to monitor and improve the quality of healthcare provided rather than a comprehensive focus on the three aspects of a quality system as described by the parliamentary review:

- quality planning;
- improvement; and
- control to ensure a focus on quality services at a wider population level.

The new provision places a focus on quality of services at a wider population level and embeds quality considerations so that they are at the heart of decision making processes.

The new provision is, therefore, about ensuring a whole system approach to quality, and not only to be simply related to clinical services which have assurance (control) arrangements in place or need to meet quality standards – it is and must be much wider to drive sustained quality improvements and outcomes.

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

Additionally, the Welsh Ministers have responsibility for oversight of the NHS in Wales and many of the policies that are developed by the Welsh Ministers, whether legislative or otherwise, have an impact on how NHS bodies in Wales operate. However the 2003 Act does not place a duty of quality on the Welsh Ministers in the exercise of their health related functions. The Bill addresses this gap.

Finally, the 2003 Act lacks any reporting mechanisms. Reporting mechanisms are beneficial as 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. Additionally, reporting also provides a mechanism for holding bodies to account as well as supporting evaluation and assessment of benefit over time and is a transparent way of demonstrating how the duty has been complied with.

Expected outcomes:

Reframing the duty of quality to require NHS bodies and the Welsh Ministers to exercise their functions with a view to securing improvements in the quality of services they provide will shift the focus of decision making and represent a further step on the journey towards ever-higher standards of person-centred health services in Wales.

It 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.

The new duty reflects the fact that all parts of the system can contribute to quality improvement and outcomes. For example, Velindre NHS Trust who hosts NWIS (NHS Wales Informatics Service) can improve the quality of health services by improving its digital services and this in turn can improve the effectiveness of health services overall and the experience of the service user. The duty therefore reflects the quality of clinical services can be improved through improvements to backroom services such as these.

Another example might include reporting on actions taken to improve safety by reductions in hospital acquired infections or improvement in the detection of sepsis which will in turn result in improved outcomes for patients.

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.

This approach supports the five ways of working within the Future Generations 2015 Act. It encourages long-term thinking and integrated and collaborative action that works to achieve the well-being goal of a healthier Wales.

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.

Duty of candour:

Background:

All health and social care providers have a shared goal to deliver high quality care.

It is important to recognise that various steps have already been taken with the aim of 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, better reporting and investigation of serious incidents, reviews of all deaths in hospitals and the publication of Annual Quality Statements by LHBs, NHS Trusts and the Welsh Government. Additionally, as in England and Scotland, we have also sought to learn lessons from real cases where harm has been

caused together with the recommendations of various reports and reviews.

It is therefore apparent that a great deal of work has been done to develop and support a culture of openness within the NHS in Wales. This work has placed health organisations in a favourable position to implement a more formal duty of candour, which is the next logical step in the series of measures already undertaken to improve quality and openness.

Expected outcomes:

There is 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.

A statutory duty of candour, set at an organisational level for NHS bodies in Wales, will:

- help create a whole system approach to candour;
- promote a culture of openness and improve the quality of care within the health service by encouraging organisational learning, avoiding future incidents;
- reducing staff fear associated with institutional repercussions or blame;
- support NHS bodies to build on the work under the Putting Things Right process to embed candid behaviour, making openness and transparency with people in relation to their care and treatment a normal part of the culture across these bodies in Wales; and
- encourage organisational reflection and learning - requiring bodies to report on an annual basis.

Placing the duty at organisational level, helps 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. This is something which has been welcomed by providers of NHS services.

Recent events in Cwm Taf provide real evidence for why an enhanced and strengthened duty of quality and an organisational duty of candour is needed. These duties will require Boards to be more transparent in their decision making, to actively consider quality and identify where improvements are needed and take steps to remedy them.

The duties are part of a suite of legislative and non-legislative measures which, taken together, put in place arrangements for improving and protecting the health of the population by placing improvement in quality as the central concept. It will not, on its own, prevent poor quality care but it will go some way to help ensure the health service has quality at the heart of its decision making and is continually improving and learning.

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

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

Yours sincerely,

A handwritten signature in dark ink, reading 'Vaughan Gething'. The signature is written in a cursive, flowing style.

Vaughan Gething AC/AM

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