Welsh Government White Paper: Services fit for the future

Quality and Governance in health and care in Wales

Response by BMA Cymru Wales

29 September 2017

INTRODUCTION

BMA Cymru Wales welcomes the opportunity to respond to the proposals put forward in this consultation on quality and governance across health and care in Wales.

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of approximately 160,000. BMA Cymru Wales represents over 7,100 members in Wales from every branch of the medical profession.

RESPONSE

Owing to the wide-ranging nature of the proposals in this White Paper, this response does not seek to address every issue raised. Instead, we have concentrated our submission on the issues which are of most relevance to our membership and which build on our response in 2015 to the Green Paper: Our Health; Our Health Service.

1. Effective Governance

As recognised by the 2016 OECD report, there is clearly a case for change in the governance of NHS organisations in Wales. The report observed that local health boards are showing less signs of innovation and fewer radical approaches to quality assurance and system change than would be expected at this stage, it also made a number of suggestions which set out how government and NHS organisations might make further progress.


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Listed as a Trade Union under the Trade Union and Labour Relations Act 1974.
One suggestion was that centre (i.e. Welsh Government) should “play a more supportive – and prescriptive – role” and that there should be “an ambitious workforce strategy, which includes planning, piloting and evaluating innovative staffing models”. We are not persuaded that the proposals in the White Paper go far enough to deliver on this. We also do not feel that the current planning process, via the Integrated Medium Term Plans (IMTPs) is prescriptive enough, given their variability in both detail and quality. In our view, each should contain detailed data on the workforce (including primary care) and clearly outline how the local work and analysis by primary care clusters has informed both strategic decisions and strategic direction – this should include how the boards will support innovative and collaborative working at cluster level. We believe that IMTPs should be subject to more effective scrutiny at both national and local level (including by cluster), with an agreed format and standard of data sets to enable effective national monitoring and allow for continual improvement, shared decision making and joint working. There are obvious benefits to be gained from joining up the planning processes, especially in aligning the term (e.g three years) over which they run. We also question the amount of all-Wales planning which currently takes place – particularly in relation to workforce planning and service sustainability.

Whilst the make-up and constitution of the board is obviously important, for us an engaged and transparent leadership is paramount. We welcome the proposal for Core Key Principles for NHS Organisations outlined on page 13 of the White Paper; the focus on openness and transparency in the first principle is particularly well-placed and reinforces the, already agreed, NHS Wales Core Principles. Indeed, it seems an omission not to incorporate the existing Core Principles directly.

The principles on leadership, quality improvement, and partnership working are equally welcomed. However, we feel that the principles for staff engagement are not sufficient:

- ‘the board to involve and are supported by the senior management below the Executive Directors to ensure wider professional and staff engagement’.
- ‘a well-functioning and supporting committee structure that ensures it involves and receives views and input from a wide range of stakeholders including the professions and patients’.

It is well-recognised that high-quality patient care goes hand in hand with a highly-motivated and committed workforce. As we said in response to the Green Paper, the reality reported all too often by our members is that they feel increasingly de-professionalised, devalued and isolated. It is therefore essential that the Welsh Government provides the resources, policy and structures for professionalism and engagement to flourish.

When looking at governance arrangements - legislative or otherwise - for NHS Wales organisations we believe that the opportunity to improve engagement with staff should not be lost, and that mechanisms to reduce the ‘board to ward’ gap should be firmly embedded in any changes. We view this as particularly important given the evidence of the correlation between medical engagement, patient care and organisational effectiveness:

“There is clear and growing evidence supporting the hypothesis that there is a direct relationship between medical engagement and clinical performance. The evidence of that association underpins our argument that medical engagement should not be an optional extra but rather an integral element of the culture of any health organisation and system. It should therefore be one of the highest priorities for NHS boards and leaders”\(^2\).

As such we believe that there should be more effective clinical engagement in the day-to-day running and planning of health and social care in Wales, and that frontline clinicians should play a greater role in developing the strategic direction and delivery of services; in turn therefore boards should be better appraised of what is happening on the ground. To reiterate a suggestion made in our response to the

\(^2\)King’s Fund, J Clark and V Nath, *Medical engagement: A journey not an event*, 2014
Green Paper, those in senior management positions, including those serving as board members, could spend a proportion of their time (e.g. one day a week) working at the frontline. This would give them a genuine opportunity to experience first-hand the provision of patient care in their health board – engaging closely with patients and with staff.

The findings of the Medical Engagement Surveys carried out in 2016 for all NHS Wales organisations (except Powys) painted a poor and patchy picture across Wales. The results prompted the passing of the following motion at the BMA’s annual UK policy making meeting earlier this year:

That this meeting recognises the acknowledged links between poor medical engagement with risks to patient safety and poor outcomes for patients and:-

i) recognises that promoting greater medical involvement in the design and planning of healthcare is crucial in ensuring that improved patient services are properly designed and effectively implemented;

ii) calls for radical change of the management culture in the NHS from the current hierarchical focus on narrowly based targets towards a clinically based system adapted to the needs of patients;

iii) calls for all NHS organisations to agree and sign up to a new medical engagement charter that will facilitate the positive involvement and engagement of doctors who are willing to work in close cooperation with other clinical and non-clinical healthcare staff.

At a joint event between BMA Cymru Wales, the NHS Wales Confederation and NHS Wales Employers in May 2017 it was agreed with NHS organisations would develop - working with the local medical profession via LNCs - action plans to address the poor survey findings, and also that the survey would be repeated at an interval of three years. We remain committed to working in partnership to deliver measurable improvements in this important area, and thus in the culture of the NHS in Wales. To that end, a further joint event is currently being planned with the additional involvement of the General Medical Council.

The lack of primary care representation at board level is very concerning and not reflective of the ‘integrated’ way in which health boards should be working and constituted. We have raised the fact that this oversight is to the detriment of strategic planning and decision making on a number of occasions with Welsh Government and with health boards. The 2016 OECD report also recognised this where it concluded: “to ensure high quality health care at every encounter and continuously improving care across the system, Wales should put primary care front and centre as a force for dynamic system change”. It goes on to make a number of specific suggestions, including that “a robust and high quality primary care sector is needed to effectively manage patients in the community” and that Wales’ Primary Care Clusters have the “potential to be an important resource” in developing ambitious new models of care – an observation which resonances with our own, well documented, views.

We are keen to support stronger and improved governance mechanisms for NHS boards. Broadly, we would support the concept of there being a number of ‘fixed’ positions on the membership of boards, one being the position of vice-chair, and for the specific position (and function) of board secretary to be independent. There is an obvious requirement for consistency in certain ‘core’ positions across organisations. As a minimum we would expect there to be specific representation for both the medical and primary care directors; and would strongly support independent professional members from within the health service having a fixed input at board level. For the position of board secretary in particular, and as guardian of good governance and principal advisor to the board, we would support a strengthening of the statutory protection around this independent role to provide consistency and since so little is known or understood about the role currently. For significant issues of concern we believe that the Board Secretary should have access to more avenues where these can be raised – i.e. the ability to report to the Chief Executive or Board Chair is not sufficient. There is certainly a strong case for improved and more visible accountability of organisations, for which this role should be central.
For time-limited periods, and in specified circumstances (where an organisation is underperforming or under escalation procedures, as suggested) Welsh Government Ministers should have the authority to appoint additional members to the Board – for those specific purposes only.

Finally, many of our members report a degree of frustration when individuals in key health board posts change regularly or are retained on an ‘interim’ basis and that this can lead to a loss of momentum and loss of focus, as well as a degree of uncertainty around future service planning or strategic direction. Whilst recognising that such circumstances are sometimes unavoidable, we would wish to see this considered and addressed where possible (in operational guidance for instance). Like with the ability for Welsh Ministers to appoint additional members for time limited periods in specified circumstances, the number of interim or transient post-holders in key positions may indicate that more rigorous care should be taken in the initial recruitment process – i.e. to get the right people into substantive posts, and retain them.

2. **Duties to Promote Cultural Change**

2.1 **Duty of Quality for the Population of Wales**

The BMA strongly supports the pursuit of the highest standards of care for patients and the important role which clinicians play in this. Quality, and subsequently quality measures, should represent what is important, as well as the challenges, in a health service.

Rather than measure performance against centrally imposed targets which can have unintended consequences, distort clinical priorities and harm patients, the BMA believes that NHS performance should be measured against quality, equity and outcomes of patient care. Together these inter-related areas build a picture of how well the NHS is performing and the NHS needs to balance all three areas in order to deliver the highest standards of care.

We acknowledge that a duty of quality already exists for NHS bodies in Wales. However, aside from noting that the legislative underpinning around this duty as it currently stands is in need of review, the White Paper does not appear to consider why this existing duty has not worked, why it is not adequate, or what more could be done to make the current duty effective.

We would certainly support any moves which would require health boards to work in partnership across their geographical boundaries when planning care and care services. We would also support a broader focus so that a duty of quality would cover entire services and entire populations (local, regional, or all-Wales). By way of example, many of our GP members, report frustration that when referring patients into secondary care that they are not always able to refer to the nearest hospital or service (i.e. one which would be most convenient to the patient) as this would require referring into a neighbouring health board area and that a degree of patient choice would be welcome.

However, there is a notable lack of detail in the White Paper about what the proposed new duty of quality would look like, and particularly what would be put in place to ensure that the co-operation between organisations occurred, what that could deliver, and what the relationship with national level service planning would be (including workforce planning).

Overall, we believe that this duty to co-operate is not sufficient as a marker of quality; and that other markers, in a broader setting of care and wellbeing, need to be considered. The OECD definition of quality, for instance, focuses on effectiveness, safety and patient-centeredness. This definition recognises that quality is part of a wider context, as it includes areas such health determinants, access

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and cost. We therefore consider that health and social care in Wales is in need of a robust quality management system (and that such a system would, as a number of reviews and publications\(^4\) attest, have staff engagement and improved organisational culture at its core). We note the recent publication by the Bevan Commission calling for a universal and mandatory quality management system which would “ensure that should reforms, management changes and reorganisations supervene (as they have in the past) the quality of care is not adversely affected”\(^5\) we look forward to engaging as the debate around this proposal develops pace.

The work of the joint research programme between the Nuffield Trust and the Health Foundation in England, QualityWatch, is relevant when considering quality measures – it has identified over 300 care quality indicators to monitor the standards of the NHS and social care.\(^6\) These quality indicators are subdivided into six domains (safety, patient centred care and experience, equity, effectiveness, access and capacity) and are tracked to find out whether health and social care quality is improving or getting worse.

We believe that a duty of quality would need a robust mechanism to monitor and evaluate effectiveness (to include quality, equity and outcomes) and manifestly facilitate engagement - so that the duty delivers genuine change (not only expanded workloads and ‘box-ticking’).

More detail on the proposed duty of quality is needed in order to form a view on the likely impact on service planning and delivery.

2.2 Duty of Candour

We support the principles underlying the proposed duty of candour across health and social services in Wales. Such principles already underpin the existing professional duties on doctors to be open and honest with patients about their care through ‘Good Medical Practice’\(^7\), which describes what is expected of all doctors registered with the GMC. A failure to follow the principles and values set out in this guidance will put a doctors’ licence to practice at risk.

We support a statutory duty on organisations aligned to, and complimentary of, existing professional duties; this is important for delivering positive cultural change at all levels. Annex 1 outlines the relevant extracts of the GMC’s Good Medical Practice relating to the duty to be honest and open – as this shows, being open and honest will be second nature to most doctors.

The BMA believes that in order to change the underlying culture that discourages people from speaking up, there should be a new duty on employers and NHS organisations to listen to staff when they do report concerns, and to protect them if necessary. Staff should be encouraged and recognised for following their professional guidelines, and more training may be necessary to help doctors communicate more effectively with their patients about when, for example, treatment has not gone as well as expected or an error has occurred in the process of their care. More effective policies preventing and addressing incidences of bullying may also be necessary.

As Keith Evans reported there is also a need to “address the lack of infrastructure to accommodate the current levels of concerns and complaints that have positively increased through the intention of the Putting Things Right process when launched in 2011. I have seen very committed staff attempting to maintain responses in the face of growing demand; however, I do not think the resources have yet been aligned to allow this to be undertaken in a personal, compassionate and comprehensive way”\(^8\).

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\(^5\) Bevan Commission, Achieving Profound and Sustainable Improvement in Quality in NHS Wales, 2017
\(^7\) Good Medical Practice, General Medical Council
\(^8\) A Review of Concerns (Complaints) Handling in NHS Wales, “Using the Gift of Complaints”, Sir Keith Evans 2014, Executive Summary
There is no detail in the White Paper about how the duty will operate or how it will be enforced — for instance: What will the sanctions be for any breach? Will the duty apply to all ‘adverse events’ or will there be a ‘threshold’ for when the duty applies? What will the duty stipulate in terms of process? how will adherence to that be monitored? Is it to apply in general practice settings (and dentistry / pharmacy) and then how will that transition be managed in terms of meeting any new administrative requirements of compliance? These are high-level questions which need answering — for the more detailed questions it is worth looking to the Scottish Government’s Duty of Candour FAQ’s.

3. **Person-Centred Health and Care**

3.1 **Setting and Meeting Common Standards**

As we have set out above, the OECD definition of quality focuses on effectiveness, safety and patient-centeredness. Our response to question 2.1 on a proposed Duty of Quality should therefore be considered as part of our response to this section on setting common high-level standards across health and social care.

We would be supportive of common high-level standards being established across both health and social care, in order that service users can expect to receive the same high-level standard of safe and quality care regardless of where they receive it. It is important to note that any standards will need to be supportive of the principles of prudent healthcare, co-production and patient-centeredness (which dictate that standards and experiences cannot be the same in every environment or encounter).

We look forward to engaging with Welsh Government and fellow stakeholders on what these standards will look to provide; and on what mechanisms will be developed to measure and evaluate their continued effectiveness (it is essential that health and social care professionals are included in developing the common standards so that they are aligned to professional regulations, and that they carry the support and confidence of those working to them).

3.2. **Joint Investigation of Health and Social Care Complaints**

We largely agree with the findings and recommendations in the Evans report in this area — in particular that there is a need for “all of the various aspects of social services, primary and secondary care, the ambulance service, Community Health Councils all need to be organised to provide a seamless experience.” We would therefore support health and social care organisations working together when investigating complaints, and when putting them right – so that complainants only need to complain once. Joining up the different complaints systems which currently exist into an operationally effective, and user-friendly, single process is a complex task; and more detail around how this will be achieved is needed.

We are aware that there are some pockets of joint work in Wales, and operational agreements between HIW and the board of CHCs for instance, however, the OECD report noted that some of the work by CHCs duplicated the activities of other bodies and organisations, such as inspections.

Importantly, if organisations are to work together, the observations in the Evans report about the wide variations in the reported experiences from users despite the intentions of the Putting Things Right process and guidance will need to be addressed. The report also highlighted the need for NHS Boards to have clear lines of accountability in place so that they are sighted on - and can act on - patient feedback, complaints and concerns. These wider concerns should be considered in detail as part of the proposals.

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10 A Review of concerns (complaints) handling in NHS Wales, *Using the Gift of Complaints*, Evans 2014, p12
11 OECD, *OECD Reviews of Health Care Quality: United Kingdom 2016: Raising Standards*
for joint investigations. Any new joint working arrangements would need to be clearly set out and communicated to organisations, staff, patients and relatives, and be appropriately resourced.

We would broadly be support a joined up system, and as we mentioned in response to section 3.1, this would need to be consistent with existing professional regulatory bodies in the UK so that professionals can be confident in the system and that lessons are learned, at all levels, as a result – i.e. not lost in the myriad of organisations. Professionals need to be assured that complaints, and the provision of timely feedback, are handled in a consistent and fair manner, preferably with one owner, rather than via multiple routes.

4. **Effective Citizen Voice, Co-production and Clear Inspection**

4.1 **Representing the Citizen in Health and Social Care**

We agree that the views of patients and the public should inform service design and delivery. We also believe that the time is right, as a number of commentators and reports have suggested, to review the effectiveness of current arrangements for the provision of this.

Since Community Health Councils (CHCs) are organised along geographical lines, coterminous with health boards, this causes potential problems for service pathways which operate across health board boundaries – and, as the White Paper identifies, when service change from one health board area to another is proposed. Our members report that CHC co-ordination at an all-Wales level has, to date, largely failed. We would therefore be supportive of a new national arrangement to represent the citizen voice, so that the realities of the regional and national needs of individuals are recognised and catered for but whereby local engagement and advocacy is also effective. This is an importance balance, and supports other proposals in the White Paper, such as the ‘Duty of Quality’, which requires Health Boards to work together across their geographical boundaries. We note the reference within the document to the new body potentially having some similarity to the Scottish Health Council (SHC). The SHC "promotes patient focus and public involvement in the NHS in Scotland "and exists structurally as an arm of Health Improvement Scotland. The SHC was criticised by the Scottish Parliament’s Health and Sport Committee for being insufficiently independent in scrutinising major service changes12. Lessons should be learned from the SHC when considering the structure and governance of any new Welsh body.

In our submission to Ruth Marks’ independent review of Healthcare Inspectorate Wales (HIW)13, and also in our response to the Welsh Government’s 2015 consultation on the future of Community Health Councils14, we noted that a growing number of activities within general practice around areas such as inspections, appraisal and revalidation – when taken together – were leading to a real risk of over-inspection and duplication. We went on to call for organisations such as CHCs and HIW to work better together and for their remits to more appropriately complement each other so as to avoid duplication and embed the patient voice.

We would therefore broadly support the proposals in this section of the White Paper.

Clear operational structures and governance arrangements would be needed to guarantee the independence of any new model to replace CHCs, and to balance the various aspects of its work (so that

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it is not tied to an agenda of inspections) but one which would enable joint working where it is needed.
As already noted, we particularly welcome the requirement for the new arrangement to engage closely
with local community organisations whilst ensuring national coordination.

The Evans report\textsuperscript{15} said: "I was really struck to hear in an evening session set up to share patients’ views
how many were unaware of the Community Health Councils in Wales and the specific independent
complaints advocacy service they lead. In fact many were unaware of the broader role that Community
Health Councils play. There may be a need to clarify their role and make them more visible even within the
hospital or service space. Communicating the system and its structures is, for me, as important as
commenting on the improvements to the system."

As such, we would expect that any new arrangement would work to increase the visibility and voice of
the patient voice in health and social care and work to engage more individuals and community groups to
shape the design and delivery of services. It would be necessary for the new arrangement to have a
variety of mechanisms and resources at its disposal to allow it to balance robust local engagement and
accessibility within a national and coordinated framework. The membership of the new organisation
must be as diverse and representative as possible and it must be able to operate in a wholly independent
way, with clear accountability lines to the public and to local populations.

The White Paper notes that one of the functions of this new national citizen’s voice body would be "to
monitor and evaluate the way in which health and social care organisations involve local people, probably
in accordance with agreed standards" we would suggest that these agreed joint standards are agreed
and are clearly specified and communicated.

The important advocacy role currently provided by CHCs should be maintained and protected, with
increased visibility; we would support the extension of this to cover social care – which we believe would
support the objective of creating person-centred services. Measures to increase the service’s visibility,
and also its remit, will need to be appropriately resourced.

4.2 Co-producing Plans and Services with Citizens

The White Paper proposes “to establish an independent mechanism to provide clinical advice and
assurance on substantial change proposals” and yet gives no further details as to what this might look
like, how it might function, where it would sit, its relationship with existing bodies and structures for the
provision of professional and clinical advice – such as Welsh Medical Committee and other local and
national advisory structures. It would, for obvious reasons, not be acceptable for NHS organisations to be
involved in constituting a body for the provision of medical advice.

We would support health boards being required to demonstrate that they have listened to clinical
evidence and to the views of citizens and staff in any proposals for change. We feel that a standardised
approach to this would be beneficial, including clear and agreed thresholds for what would constitute a
’substantial’ proposal. Listening to the views of clinicians and citizens should be part of a continuous
process, and in our view is a keystone of everyday good governance (i.e. not only required in exceptional
circumstances or when a threshold of a proposal has been met).

We note with concern that, should a new national citizens voice body be established to replace CHCs, this
proposal could affect the mechanism by which disputed service changes proposals are referred to the
Cabinet Secretary – this mechanism, or a robust and independent alternative to it, needs to be put in
place as part of any new arrangements for the citizens voice. Based on the limited details of this proposal
in the White Paper, we believe that it is not adequate for Welsh Ministers to only intervene as a ‘last
resort’ when health boards are unable to reach a decision on proposals for service change.

\textsuperscript{15} A Review of concerns (complaints) handling in NHS Wales, \textit{Using the Gift of Complaints}, Evans 2014, p12
We also believe that requiring heath boards to decide if their own proposal meets the criteria of being ‘substantial’ enough (a clear and agreed definition for which would be needed) in order that the independent scrutiny mechanism is triggered, is far from adequate - checks and balances on the meeting of the criteria, and the triggering of appropriate further scrutiny, would need to be established. There is no mention of how the meeting of this criteria will be monitored or scrutinised which is unacceptable, potentially dangerous and undermines efforts to embed co-production, transparency and openness. All partners must have confidence in the process by which decisions are reached.

We believe that clinical evidence must be the guiding principle when considering options and proposals for service change and reconfiguration; and we would agree that engaging and involving the public from the start, in an honest discussion, gives such proposals a greater chance of success. It is notable that there is no mention of engaging with staff or local healthcare professionals in relation to any substantial proposals for change (other than in figure 1 on page 34 where the health board sets out its plans). This very unfortunate oversight undermines efforts to realise coproduction, promote professionalism and embed the Core Principles. Our response to question 1.2, on the importance of medical engagement, is relevant here.

We would also suggest that any proposals for substantial service change undergo a Health Impact Assessment (HIA), which – if well performed – would offer a robust options appraisal process and would inform any formal consultation process (since most areas of controversy will have been covered and addressed, with reasonable solutions developed to problems identified). Public Health teams may be well placed to assist with the conducting of HIAs, and with the involvement of stakeholders.

There are many unanswered questions in this section, and a need for further clarity.

4.3 Inspection and Regulation and single body

BMA Cymru Wales provided evidence to both the Marks Review of Healthcare Inspectorate Wales (HIW)\(^\text{16}\) and the Green Paper: Our Health, Our Health Service\(^\text{17}\) outlining the views of the medical profession across a range of HIW’s regulatory and inspection functions. Those papers should therefore be read in conjunction with our response here – however, the specific points we would like to make are outlined below.

We would support an aligning of the system of regulation and inspection across health and social services, and we are also supportive of steps being taken which increase the alignment between sectors. We have previously expressed the view that a full merger of the functions of HIW and CSSIW might work to re-focus the inspectorates to better reflect the reality of patient pathways (although services are far from fully integrated) but we have also highlighted that rearranging organisational structures through mergers is often not absolutely necessary, or even sufficient, to produce genuine joint working and increased coordination. Instead, we believe that the emphasis is often better placed on good information sharing and effective, professional relationships across disciplines and organisations. The White Paper appears to support that approach, but does not clearly outline what is preventing HIW and CSSIW in particular from more effective joint working presently – and if, for instance, a revision of the legislative underpinning for HIW might offer an opportunity to facilitate that.

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We would strongly support the proposal to ensure HIW has a clear, single legislative framework to work to. In relation to the proposal to overhaul HIW’s underpinning legislation we would reiterate what we have previously said on this matter, i.e. that: “HIW’s responsibilities and functions are presently drawn from a number of legislative sources. We believe that these should be consolidated into one single statute – thereby giving HIW a clear and unified remit, and moving it on from the complex, piecemeal and reactionary manner in which it has evolved over the last decade towards a future that is more proactive and standard-setting. This would also offer the opportunity to strengthen its remit, streamline its operations and address any gaps or duplication in how it works with other bodies – e.g. the Wales Audit Office and Community Health Councils (CHCs)” 18

We have also previously expressed the view that HIW requires more capacity and resources. It is not clear in the White Paper if “a pooling of significant exiting resources” would deliver what is required to balance HIW’s workload and functions, support it to identify priorities, better engage clinicians at the coal-face when inspecting or responding to a concern and undertake joint work with CSSIW and the new national citizens voice body. If the proposal to establish a new Welsh Government Sponsored Body were to be taken forward - which would include HIW, CSSIW and the new citizens voice body - then a full analysis of the resourcing requirements and options would be needed which could look at combining certain functions. This arrangement may also help to address the concerns about their independence from Government and could possibly improve the overall visibility and understanding of inspection and regulation of health and social care in Wales. It might also be judicious to consider other options for reassuring the independence of regulation and inspection – such as increasing the level of public scrutiny these bodies are currently subject to.

Regulators and inspectors are often said to be the ‘third line of defence’ against serious failures, but it also has significant influence on the ability of the ‘first line’ of defence (frontline professionals) and the ‘second line’ of defence (boards/managers in NHS Wales organisations) to operate effectively in assuring that there is good quality care. Each of the partners across the three lines of defence must work together, seamlessly and provide the leadership needed in order to drive shared learning and particularly to establish a culture where staff, patients and relatives are confident that they will be supported to raise concerns (and that when they do, something will be done about it). In looking to reform and strengthen HIW and CHCs in particular, the potential for them to play a positive role in ‘culture-setting’ in NHS Wales organisations should not be overlooked.

There is certainly a strong case to be made for further consideration of how HIW, CSSIW and the new citizens voice body could offer reassurance and scrutiny with regard to the governance of health boards, by ensuring parity with the standards and scrutiny to which health and social care professionals are subject.

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ANNEX 1 Extracts from GMC Good Medical Practice

Contribute to and comply with systems to protect patients

22. You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:
   a. taking part in regular reviews and audits of your work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary
   b. regularly reflecting on your standards of practice and the care you provide
   c. reviewing patient feedback where it is available.

23. To help keep patients safe you must:
   a. contribute to confidential inquiries
   b. contribute to adverse event recognition
   c. report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another person, at risk
   d. report suspected adverse drug reactions
   e. respond to requests from organisations monitoring public health.

When providing information for these purposes you should still respect patients’ confidentiality.

Respond to risks to safety

24. You must promote and encourage a culture that allows all staff to raise concerns openly and safely.

25. You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.
   a. If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.
   b. If patients are at risk because of inadequate premises, equipment* or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken.
   c. If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.

Act with honesty and integrity

Honesty

65. You must make sure that your conduct justifies your patients’ trust in you and the public’s trust in the profession.

66. You must always be honest about your experience, qualifications and current role.

67. You must act with honesty and integrity when designing, organising or carrying out research, and follow national research governance guidelines and our guidance.

Communicating information

68. You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.
69. When communicating publicly, including speaking to or writing in the media, you must maintain patient confidentiality. You should remember when using social media that communications intended for friends or family may become more widely available.

70. When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit patients’ vulnerability or lack of medical knowledge.

71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading. a. You must take reasonable steps to check the information is correct. b. You must not deliberately leave out relevant information.