OUR HEALTH, OUR HEALTH SERVICE

Welsh Government Green Paper

Response from BMA Cymru Wales

26 November 2015

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Welsh Government’s Green Paper entitled, ‘Our Health, Our Health Service’.

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 over 153,000, which continues to grow every year. BMA Cymru Wales represents over 7,500 members in Wales from every branch of the medical profession.

RESPONSE

BMA Cymru Wales welcomes the opportunity to respond to this very wide-ranging Green Paper, which raises a significant number of questions in relation to the future of health provision in Wales moving forward.

Owing to the number of questions posed, this response does not seek to address every issue raised. Instead, we have concentrated our submission on the issues within the Green Paper which are of most relevance to our membership.

For clarity, we have listed our responses under the chapter headings which were presented within the Green Paper. Where appropriate, we have mapped our answers directly to questions posed in the Green Paper. In other sections, however, rather than answer the specific questions posed (which in some cases are quite narrow in focus) we have instead presented our views on the general topics that have been put forward.
Chapter 1: Quality first and foremost

Questions 1 & 2. Should further changes to the law be made to strengthen local collaboration in planning and meeting people’s health and wellbeing needs closer to home? If so, what changes should be given priority?

An important issue that we believe needs to be addressed is how to ensure that an appropriate shift in resources, or allocation of additional investment, matches any transfer of hospital-based services to primary or community care settings. Whilst we are unsure if this is a matter which should specifically be addressed through legislation, it is nonetheless an important issue for which a solution is required. We feel it is key to ensuring that services which have been traditionally hospital-based can be delivered in more appropriate settings that may be more convenient to patients. There could perhaps be a requirement put in place to give consideration to how resourcing issues are addressed when such service transfers are undertaken.

It is also the view of BMA Cymru Wales that clinicians must be fully involved in any decisions that are taken regarding such transfers of services.

Question 3. Is there anything else we should do to strengthen legislation to ensure agencies work together to plan to meet people’s health and wellbeing needs?

BMA Cymru Wales has been calling on the Welsh Government to ensure that health considerations are brought fully to the fore in policy- and decision-making by public bodies in Wales. We feel this would help in ensuring that health and wellbeing needs are considered more widely across the board in service planning and provision, and this could therefore contribute to ensuring agencies work together to better plan to meet people’s health and wellbeing needs.

As outlined in our recent responses to the Public Health (Wales) Bill\(^1\) and the draft statutory guidance for the Well-being of Future Generations (Wales) Act\(^2\), we believe this should be done through the adoption of a sufficiently robust ‘health in all policies’ approach for Welsh public bodies which is linked to a statutory requirement for Health Impact Assessments (HIAs) to be undertaken in appropriate circumstances.

We suggest that this statutory requirement for the use of HIA should apply in the first instance to Strategic and Local Development Plans certain larger scale planning applications; the development of new transport infrastructure; Welsh Government legislation; certain statutory plans such as Local Wellbeing Plans; new NHS developments (e.g. new hospitals) and health service reconfiguration proposals.

In relation to the draft guidance for the Well-being of Future Generations (Wales) Act, we have also called for there to be a further guidance document which outlines the required Welsh approach to the application of ‘health in all policies’ in appropriate detail. This should specify the actions that would be required to deliver a ‘health in all policies’ approach, rather than merely advising what could be done as a matter of good practice.

Further information regarding our case for placing HIA on a statutory footing in Wales is contained within Appendix 1 of our response to the Public Health (Wales) Bill.\(^1\) And whilst we hope that Assembly Members and Welsh Ministers will shortly agree to include this provision within the Public Health (Wales) Bill, should this not be the case then we would hope that the matter would be addressed in future Welsh legislation.

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**Question 4. Are there ways in which the law could be reformed to shape service change?**

In our response to Ann Lloyd’s ‘Lessons Learned Review’ of health service reconfiguration, we highlighted what we saw as a repeated inability to deliver a joined up approach, provide detailed financial analysis or adequate modelling of the consequence of proposed changes through a lack of credible data. We feel it is important that this is addressed so that consultation and engagement can be meaningful through being undertaken from an informed, balanced and impartial perspective where the impact of different options under consideration on service delivery is properly understood.

As we have highlighted above, we are calling for service reconfiguration proposals and the development of new hospitals to be subject to a mandatory HIA. We feel this would be an invaluable tool, not only for maximising health benefits and minimising adverse impacts as proposals are developed, but also for significantly aiding better understanding of the extent to which proposed changes may or may not be beneficial and how they might compare to the current pattern of provision. We would also suggest that the Welsh Government could give consideration to committing through legislation to greater openness and transparency through which service reconfiguration proposals are agreed.

It is also vitally important, in our view, that there is effective engagement with frontline clinicians in the processes concerning both service reviews and service reconfiguration. The importance of gaining the perspective of those currently undertaking direct clinical practice cannot be underestimated, including by ensuring that there is local clinical engagement in local service development. Further information can be found in our previously published position papers on service reviews and service reconfiguration.

BMA members in Wales have also raised the need for more honesty in the language that may be used. The Welsh Government and Welsh health bodies need to be more upfront in acknowledging that resources are finite. The discussion and implementation of rationing should therefore be more overt so that patients can be clear upfront what services can or cannot be provided. It may also be helpful to provide greater transparency to patients regarding the actual costs of treatments.

**Question 6. Do you support the idea of a national expert panel to which referrals might be made rather than referral to Ministers? If so, how might the law be reformed to constitute such a panel? What rules should govern the process of referral in such an arrangement?**

In relation to service reconfiguration proposals, we believe there could be merit in the exploration of such an idea as it may help in avoiding conflict between decisions based on observed political expediency and those which may be in the longer-term interests of improved service provision for patients.

It would be important, however, to ensure that such a panel could be seen to be truly independent from the health bodies putting forward proposals for service reconfiguration. The panel would also need to be able to take decisions that would be both recognised and accepted as being in the best interests of patients.

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4 BMA Cymru Wales (2013) Service reviews: what are they, their aims and how should they happen. Available at: http://bma.org.uk/-/media/files/pdfs/about%20the%20bma/how%20we%20work/uk%20and%20national%20councils/welshcounсilsercereviewpaper.pdf

The difficulty in a country the size of Wales is to find a truly independent view, and perhaps the best way to achieve this would be to acknowledge conflicts of interest and develop a mechanism where diverse views and interpretations of the evidence are worked through collaboratively as part of an open and transparent process.

**Chapters 2 & 3: Enabling quality; Quality in practice**

A fundamental issue that we feel needs to be addressed is how we can ensure there is an environment within the NHS in Wales in which staff feel confident at all times, and in all circumstances, that they can raise concerns about patient safety issues without fear that they might personally suffer any adverse consequence as a result and with the confidence that appropriate action will be taken to properly consider and deal with their concerns.

We have previously highlighted significant concerns that, all too often, such a desirable state of affairs does match the experience of our members in their day-to-day working environments. Indeed, as we have previously reported, many doctors report overwhelming feelings of disempowerment and isolation, saying that they feel unable to pursue their concerns or to press effectively for change because their organisations operate in what they perceive to be a ‘state of denial’.

A survey we conducted earlier this year of secondary care doctors in Wales highlighted some deeply worrying findings. It showed, for instance, that 58.6% of respondents said that had raised a patient safety concern during the previous three months, but that 39.8% of those that had done so had no knowledge that any action had been taken as a result. Equally worrying was the fact that 60.2% of respondents reported having experienced bullying or harassment as a result of having raised a patient safety concern at some point in their career.

The NHS in Wales needs to develop a culture that avoids serious concerns developing in the first place. We believe this requires a change in attitude and values within senior management and those with leadership responsibilities. We need to move to a situation where raising concerns is welcomed so that it becomes routine, and it is accepted that it is everyone’s business to identify and put right early concerns wherever they occur. Wales must take a whole system approach and be willing to accept responsibility for analysing and correcting system failures. We are, however, hugely encouraged by the current work that is being undertaken on embedding values into the NHS in Wales.

One way to help address the need for a change in culture would be to ensure that those in senior management positions, or serving as board members, spend a proportion of their time (e.g. one day a week) working at the frontline. That would give them a genuine opportunity to experience first-hand what the problems are that need to be addressed to ensure the most effective provision of patient care.

We would also call for the Welsh Government to fully explore what legislative safeguards could be put in place to protect staff when they raise concerns so as to remove any fear they might have in doing so. Indeed, we also believe we should also look at how a system could be introduced that goes further by actually showing appreciation to those who speak out, rather than rewarding those who avoid ‘rocking the boat’.

Whilst we recognise there would need to be appropriate safeguards against vexatious complaints, what we would like to see would be a move to a system where potential concerns are dealt with in a timely manner and any required changes are then made without fuss as part of the everyday functioning of NHS teams.

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Consideration should also be given to having an independent body or individual with appropriate powers to investigate complaints from staff. This could possibly be achieved by extending the powers of the ombudsman. It is also important to ensure there is an open, transparent and timely system within health boards and trusts for dealing with complaints – something that could perhaps be underpinned through appropriate standards set out in legislation.

We would also suggest that any staff leaving the employment of the NHS in Wales should be subject to an exit interview. This can help in identifying areas that might need addressing by giving staff an opportunity to raise issues they might have been fearful of raising during the time of their employment.

Another issue which we believe should be explored would be to ensure that non-clinical managers are subject to a system of regulation in the same way that clinical staff are regulated by professional bodies. A doctor who fails badly in his or her conduct runs the risk of being struck off, and thereby prevented from working again as a doctor. In contrast, a manager who presides over significant failure may then go on to secure a new management position in a different part of the NHS.

We believe that the Welsh Government should explore how this regulatory imbalance could be addressed. Where a manager has presided over failure that is of sufficient magnitude, and which can be directly attributed to their performance in their role, we would suggest they should also be subject to a regulatory system which could prevent them from taking up a new management position elsewhere within the NHS. This could prove to be a helpful safeguard that could, in time, lead to more effective management of the NHS in Wales. It could also help create a system where non-clinical managers share in the risks that clinicians have to accept, and become more accountable for the role that they play in healthcare delivery.

Delivering more effective clinical engagement in the day-to-day running and planning of the NHS in Wales is something that we believe should also be seen as a priority. Better engagement between health service leaders, managers and doctors should achieve a more coherent and long term vision of health service provision, as well as ensuring there is a consistent focus on high quality care. Frontline clinicians should therefore play a greater role in developing the strategic direction and delivery of services, rather than the current reliance on non-clinical managers who appear at times to be determining service configuration more from the viewpoint of delivering financial savings. We also believe that local doctors working at the frontline should be involved more in day-to-day decision-making given that they can bring greater understanding regarding the clinical impact that such decisions might have.

Another issue we would like to raise is the need to ensure that targets are based on clinical evidence. We recognise the political necessity for targets, and acknowledge that they can help to focus activity and measure progress. However, we are also aware that targets may at times act against clinical priorities.

An example of this is where the existence of referral to treatment targets means that priority is given to those newly referred by a GP to a consultant over and above those waiting for a second or subsequent appointment, for which there is no specific target time by which they should be seen. This can lead to follow-up appointments being delayed because a health board needs to prioritise those with first appointments in order to meet its target. The consultant may be unaware that such follow-up appointments are being deferred by the health board until he or she next sees an affected patient, and we are aware of occasions when this has led to an irreversible deterioration in a patient’s condition in the intervening period.

We are aware, as a result of previous lobbying by BMA Cymru Wales, that a pilot was being undertaken within ophthalmology by Betsi Cadwaladr University Health Board and Abertawe Bro Morgannwg University Health Board to inform the development of clinically-led intelligent targets, with the aim of ensuring that those patients who need to be treated in secondary care who have the greatest clinical need are seen in a timely manner.
These pilots can hopefully inform the adoption of the wider application of clinically-appropriate targets, and this something that we would call on the Welsh Government to implement.

Improving the quality of clinical data should also be regarded as a priority for the NHS in Wales. This should include greater use of data based on outcomes, with more outcome data being routinely collected. We would therefore advocate that there should be a review undertaken to determine where it would be beneficial for more outcome data to be collected. This could be greatly beneficial in terms of monitoring service performance within the NHS in Wales using meaningful measures.

**Chapter 4: Openness and honesty in all that we do**

In line with the position previously expressed by the BMA at UK level, we support the principle underlying the idea of a duty of candour and believe that all NHS staff must be honest and transparent in everything that they do in order to best serve and protect their patients.

These standards are underpinned by the existing professional duties on doctors to be open and honest with patients about their care, and the sanctions for any failure. There are already a number of ways in which healthcare workers, including doctors, can be prosecuted using both criminal and civil proceedings in connection with dishonest behaviour or action endangering patients.

We therefore believe the introduction of a statutory duty of candour with criminal sanctions for individuals would not add anything substantive to the existing routes and could have the opposite effect of that intended. The threat of criminal prosecution for an act committed in the course of treating a patient (whether accidentally, negligently or purposefully) could, instead, worsen the culture of fear amongst professionals that prevents people speaking out.

However, we do support placing statutory duty of candour on organisations as we believe that the existing mechanisms for holding providers to account require strengthening.

It is our observation that members of the medical profession have been encouraged to be open and honest with patients when things go wrong, but that health bodies have become more secretive and less open with patients. This is leading patients and their families to complain and assert that aspects of their care are being concealed or covered up. We perceive this is often related to fear of litigation or public criticism by health boards, but we feel this needs to be addressed; health bodies need to recognise that they work for patients, and not the other way around.

Further information regarding the BMA’s view on a statutory duty of candour are available in a BMA briefing paper.8

**Chapter 5: Better information, safely shared**

**Question 21. What are the issues preventing healthcare bodies from sharing patient information?**

It is unclear whether this question refers to sharing information for direct patient care or non-direct patient care (often termed secondary uses of data). This lack of clarity is reinforced by the accompanying text in chapter 5 which fails to draw a distinction between the two concepts. For example, paragraphs 71–76 appear to refer to information sharing between organisations for the purposes of direct care, building towards reference to the Caldicott seventh principle (paragraph 76); this is immediately followed by a paragraph which discusses sharing information about complaints (paragraph 77). Paragraph 78 relates to information sharing ‘to deliver effective services’.

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This suggests that sharing for direct care and sharing for complaints and service delivery can be seen as similar concepts. This is not the case. Using patient information to address complaints and to deliver services falls clearly into the category of secondary uses of data and cannot be seen as part of direct patient care. In our view, it is unhelpful to blur the distinction to between uses of data for direct care and secondary uses as different legal and ethical rules apply for their disclosure. Failure to draw a clear demarcation risks causing confusion leading to confidential data being shared without a clear legal basis.

Our response to this question is therefore in two parts. The first part of the response relates to information sharing for direct care; the second part highlights some areas of concern we have in relation to specific statements in the Green Paper around non-direct patient care or secondary uses of information.

**Direct patient care**

Given the importance of striking the correct balance between appropriate sharing and appropriate protections for patient data, our answer to this question goes beyond the question of issues which might prevent sharing but considers information sharing for direct care within the context of the existing legal and ethical framework.

Information sharing to facilitate direct patient care is a principle which can be supported by all. All doctors already have clear professional obligations to share information for safe and effective care under General Medical Council (GMC) guidance. Other healthcare professionals are subject to similar requirements by their respective regulators. Support for this principle does not, however, negate confidentiality and privacy interests and the importance of securing a clear legal basis for sharing confidential information. We are concerned that this section makes only cursory reference to these interests which the sharing of confidential information will necessarily engage.

The implication of this section is that the Welsh Government is considering a statutory duty to share information for direct care. BMA Cymru Wales would oppose such a duty on the grounds that, if a statutory duty on providers replaces consent as the legal mechanism by which confidential data are shared, patient autonomy and control over information sharing will be undermined and eroded.

It is of particular concern that paragraph 80 refers to ‘governance issues’ which might prevent sharing. It must not be forgotten that much of the governance is in place to ensure a confidential health service. We hope the Welsh Government, in its laudable intentions to improve patient care, does not intend to encroach upon confidentiality through more widespread sharing of unnecessary information. As is made clear in Dame Fiona Caldicott’s review of information governance, only relevant information about patients should be shared on a ‘need to know’ basis between those individuals who are part of the healthcare team providing or supporting patient care, in-line with current legal and professional obligations.

BMA Cymru Wales fully supports the sharing of relevant information for the provision of direct care and we certainly recognise that there are circumstances when information is not being shared when it would be entirely appropriate and necessary to do so. Given that professional obligations already exist in relation to sharing information for direct care, it seems unlikely that a statutory duty to share will address this problem. Better training and education in information governance would, in our view, be a far more effective solution.

The Green Paper asserts that one of the chief causes of the failure to share appropriately is the ‘daunting’ legislative landscape which governs the sharing of health data. We would agree with this view. Whilst the legal complexities are more obvious in data sharing for purposes other than direct care, they also exist in

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9 General Medical Council (2009) Good Medical Practice paras 50 – 51.

10 Dame Fiona Caldicott (March 2013) Information: to share or not to share? The information governance review.
relation to direct care. This problem is exacerbated by the lack of training in information governance for healthcare professionals and this issue is considered in more detail in our response to question 22.

**Non-direct patient care (referred to as secondary uses of data)**

Our overall views on secondary uses of data are covered in question 23. Here we raise some specific concerns with the proposals mentioned in the paper.

As previously indicated, paragraphs 77–79 relate to information sharing for secondary uses. The purposes referred to in paragraph 79 include research and management with the suggestion that the introduction of statutory duties to share patient identifiable might be considered.

Recourse to legislative steps for requiring identifiable data should not be taken before it has been established that identifiable data are actually necessary and justified for the purpose. We are not aware that the Welsh Government has undertaken any work in this area and therefore suggestions of legislative proposals seem premature. It is worth pointing out that in her review of information governance, Dame Fiona Caldicott is clear that, for commissioning purposes, only a small percentage of situations require identifiable data.11 We are aware that in England, there are well-established mechanisms for collecting data for medical research, for example the process under the Health Service (Control of Patient Information) Regulations 2002. These include a fast-track route for applications where appropriate.12 Our understanding is that these Regulations also apply in Wales, so the use of this existing legislation might be an area the Welsh Government wishes to explore.

Before considering new legislation, consideration should be given to whether technological solutions can be used – such as linking pseudonymised data at source, or use of accredited safe havens/controlled environments13 and ‘black box’ technology.14 All these solutions reduce reliance on using identifiable data and must be considered before recourse to the ‘easy’ option of requiring identifiable data through the law. Such discussions need to include considerations of what type of data are necessary to achieve the purpose e.g. pseudonymous data may be identifiable in some contexts but if handled in a secure, controlled environment they may be considered non-identifiable. We are also aware of the work of the Secure Anonymised Information Linkage (SAIL) databank at Swansea University and we will return to this in our response to question 23.

We observe that the quality of clinical information in secondary care is highly variable, and that the NHS in Wales has failed to deliver a paperless patient record in secondary care which might form the basis of clinical validation of patient information. Therefore, with current poorly validated data, such as that informing handling companies such as CHKS15, there is a risk that errors are compounded by further analysis.

Paragraph 77 refers to a statutory duty on health boards and trusts to ‘routinely share complaints information’. Again, this raises concerns about confidentiality and patients losing control over their health information. It is difficult to see why the sharing of information about individual patient complaints cannot be easily achieved with consent. If it was made clear to patients who would need to see information in order for the complaint to be escalated, and the safeguards in place to minimise risks to confidentiality, then consent could be obtained at the outset of the process. This would provide a secure legal and ethical basis for the sharing and be in line with patient expectations.

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11 Dame Fiona Caldicott (March 2013) *Information: to share or not to share? The information governance review* p75.
12 Further information can be found at: [http://www.hra.nhs.uk/about-the-hra/our-committees/section-251/](http://www.hra.nhs.uk/about-the-hra/our-committees/section-251/)
13 See discussion in Dame Fiona Caldicott (March 2013) *Information: to share or not to share* pages 63 – 68. See also Information Commissioner’s Office (2012) *Anonymisation: code of practice*, chapter 7.
14 Where electronic data flows into a computer system which automatically undertakes processing of the data within the system to render those data pseudonymised before they are viewed by persons undertaking research or work on the data.
15 [http://www.chks.co.uk/home](http://www.chks.co.uk/home)
Should circumstances arise where there is a complaint of such a serious nature which requires investigation and a patient refuses consent for further sharing, then there are likely to be grounds for sharing in the public interest in order to prevent serious harm.

**Question 22. How can we consider breaking down any barriers?**

For the purposes of our answer to this question we have assumed that it refers to barriers which can prevent information sharing for direct patient care.

In our view there is a lack of consistent information governance training and this can lead to misunderstandings amongst healthcare staff about when it would be appropriate to share and inappropriate to share. It is our view that better training and education is a more appropriate solution to breaking down barriers than the creation of a statutory duty to share which may risk undermining confidentiality.

It is important that organisations ensure that information governance, and the training that supports good practice, is given a high profile so that staff understand its importance. For some organisations, this may require a cultural change so that information governance training is not seen as a one-off ‘tick box’ exercise but a continuous process. Organisations should have formal mechanisms in place to ensure every member of staff is up to date with appropriate training in information governance. This should include those who work on a temporary basis such as locums and doctors who are on rotation.

The key issue is to ensure that staff are able to understand the basic principles in-line with their professional role and are therefore adequately prepared to apply their knowledge to different scenarios in their daily working routines. We recognise that this may not always be easy due to the complex nature of information governance and therefore it is also important that staff know from whom in their organisation they can seek advice where there is uncertainty.

We note that most NHS organisations in England are required to complete an annual assessment of information governance practice using the UK Department of Health’s online Information Governance Toolkit to provide assurance of compliance. The Health and Social Care Information Centre in England provides an online Information Governance Training Tool which covers the Data Protection Act as well as other relevant legislation. This training might offer a useful starting point for health bodies in Wales.

**Question 23. What are your views on the collection and sharing of patient identifiable information for non-direct patient care, such as research? What are the issues to be considered?**

We are supportive of uses of data for non-direct patient care (often termed secondary uses of data) with appropriate safeguards and transparent processes in place. In 2014, we set up a UK-wide task and finish group which considered the issues which arise in relation to this topic. The group’s conclusions were informed through consultation with doctors, members of the public and key stakeholders. One of the outcomes of the work was the development of a BMA vision in relation to secondary uses of data.

### The BMA’s vision in relation to secondary uses of health data

The BMA’s vision is for doctors and patients to see improving healthcare and public health (through research, education, innovation and the effective management of healthcare resources) as a shared endeavour, in a society where:

- patients recognise that the main purpose of collecting medical information is to assist their direct care, and also have a good general understanding of how it can be used for the

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16[https://www.igtt.hscic.gov.uk/igte/index.cfm](https://www.igtt.hscic.gov.uk/igte/index.cfm)
continuing improvement of health care and public health, and support such use within an agreed framework;
- all data uses are fully transparent and in line with patient expectations;
- there is trust in the safeguards in place to prevent inappropriate disclosure or use of patient data;
- the benefits that can arise from appropriate secondary uses of data are understood and promoted;
- anonymised data are readily available for secondary uses; pseudonymised data can be easily accessed within an appropriate governance framework; and there are practical mechanisms in place to obtain the required authorisation for the use of personal confidential data where such use is necessary;
- within the established frameworks, doctors are confident to release personal confidential data for secondary uses where the patient consents or other legal authority exists;
- information is easily available to the public promoting their understanding of medical research and encouraging opportunities to participate where appropriate—either through active involvement or the use of their data; and
- it is recognised that the full benefits can only be realised where medical records are accurate, appropriately structured and coded and kept up-to-date.

We recognise that there are a number of practical challenges with the current system for collecting and using data for secondary uses and we would be happy to discuss these in more detail if this would be helpful.

As a specific point, we are aware of the SAIL databank which supports research and the improvement of health services in Wales. We support the principles of this model which extracts data from GP practices using a ‘twin track’ approach and use of Audit+. Audit+ separates identifiable demographic information and clinical information at practice level and generates a ‘join key’ which can link the two files back together once the anonymisation process is complete.

Demographic information is sent to NHS Wales Informatics Service (NWIS) and the clinical data are transferred to SAIL. The demographic data undergo anonymisation at NWIS before they are linked with the clinical data in SAIL using the join key. This means that no party ever has access to both demographic and clinical data files in identifiable form. This process allows data to be used for valuable purposes with minimal risk to confidentiality.

Chapter 6: Checks and Balances

Healthcare Inspectorate Wales (HIW)

BMA Cymru Wales submitted a written paper to the Marks Review of Healthcare Inspectorate Wales (HIW) a little over twelve months ago. It sets out the considered view of the profession across a range of HIW’s regulatory and inspection functions. That paper should therefore be read in conjunction with this current response.

The specific points we have to make on HIW are, however, outlined below.

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

17http://www.saildatabank.com/
18Examples of the major projects undertaken using the SAIL databank can be found here: http://www.saildatabank.com/major-projects
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, Community Health Councils (CHCs) etc.

We are not best placed to comprehensively assess the merits, or otherwise, of HIW merging with the Care and Social Services Inspectorate Wales (CSSIW) – a central proposal in the Green Paper. However, such a merger, might work to re-focus the inspectorates to better reflect the reality of how services are now planned and delivered in Wales – albeit, those services are far from fully integrated currently. Generally, we believe that rearranging organisational structures through mergers is often not absolutely necessary, or even sufficient, to produce genuine joint working and more coordination. Instead, the emphasis might be better placed on good information sharing and effective, professional relationships across disciplines and organisations. With that in mind, there is definitely more scope for joint working and information sharing between HIW and other inspectorates and organisations (CHCs for example). However, getting the fundamental principles and mechanisms of inspection and regulation correct – for both health and social care – should come before any operational merger. We look forward to commenting on this proposal in the future should further details become available.

The issue of independence clearly needs to be carefully considered. We would advocate that HIW needs to operate wholly independently of government and, thus, full statutory independence needs to be expressly built in to any new legislation underpinning it. This is an obvious prerequisite for the profession having confidence in HIW and, thus, in order for HIW’s work to carry credibility. As part of this, we believe that HIW should not have to obtain the permission of Welsh Ministers to enact its powers to place organisations in special measures.

It is apparent that HIW needs more resources and more capacity. This is especially needed to aid the identification of priorities – to ensure a robust balancing its inspection and regulatory functions, and to better engage clinicians at the coal-face when inspecting or responding to a concern.

HIW is said to be the ‘third line of defence’ against serious failures, but it 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 we have good quality care. We agree that we cannot rely on HIW alone to provide this assurance, but equally it should not function in isolation. Each of the three lines of defence must work seamlessly – and, in our opinion, HIW has the ability to ‘set the tone’ and provide the leadership needed in order to drive shared learning and establish a culture where staff 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, the potential for it to play a positive role in ‘culture-setting’ in NHS Wales organisations must not be overlooked. Our vision of HIW being reconstituted towards an improvement agenda would strongly underpin moves to create an improved culture within the NHS in Wales – one of much greater openness, support and transparency.

Given the above, we believe that there is a strong case to be made for HIW to play a proactive and supportive role in healthcare improvement. This could include supporting organisations through a learning/improvement process; exporting best practice across Wales; and focusing on clinician (staff) engagement in the workplace (e.g. one element of inspections could involve seeking the opinion of relevant staff about how ‘engaged’ they feel by their managers; when the manager was last on the ward; how often they are seen etc.)

The particular areas in which our members envisage HIW playing a key ‘improvement’ role are:
1) Highlighting incidences of overstretched services (including appropriate staffing levels) across primary and secondary care and making recommendations – given the clear link with patient safety, quality of care and patients’ experiences of receiving care.

2) Improving the quality and accuracy of data collection within health boards (for example on whole-time equivalent workforce numbers and on staff vacancies) and enabling national standardised data sets to be collected. Integrated IT systems (which deliver real time outcome data) are a clear requirement.

3) Assessing how engaged frontline staff are in the design and delivery of services and how they are supported to raise concerns about patient safety.

4) Investigations into other systematic failures, in conjunction with other inspectorates/bodies such as CSSIW and CHCs (such as where the board of the LHB is detached from the reality of the ward, or where staff and patient concerns have not been acted upon).

HIW is a complex regulator as Ruth Marks also acknowledges in her review. It is responsible for regulating and inspecting a substantial number and variety of health bodies across the NHS and the independent sector. However we believe that its inspections, whilst very necessary, must be fair, lean and rare.

We would suggest that the Welsh Government could consider how an inspection regime can be put in place that may be seen as being less designed to root out and punish poor performance, and more to identify how best practice can be more widely shared.

Consideration should also be given to how it can be more effectively ensured that recommendations of inspections are acted on by health boards and trusts, and not simply ignored. This could involve looking into how such recommendations could be made binding.

General practice is subject in particular to an increasing number of administrative and compliance activities (e.g. appraisal, revalidation, CHC inspection, clinical governance toolkit – though not mandatory most do comply – LHB annual inspection, QOF visits, annual inspection, health and safety visits). While these may be seen as necessary, they do take time away from providing direct clinical care. There is a real risk of over-inspection and duplication (not to mention the possible impact on workforce morale, which is already at an all-time low).

Generally, we believe that there remains an NHS-wide uncertainty about what early warning systems and escalation procedures are in place to identify poor care or outlier services. Such systems are fundamental in providing the necessary assurances that standards of care are being met.

Our last comment in relation to HIW is to suggest that any reform should avoid the approach of aggressive micromanagement adopted by the Care Quality Commission (CQC) in England.

Community Health Councils (CHCs)

In relation to CHCs, we expressed concern earlier in the year in response to a Welsh Government consultation on changes to aspects of their governance that what was being proposed could be seen as amounting to the creation of a ‘top down’ policing system for CHCs.20 We are concerned to subsequently learn that CHCs have since lost the right to make individual decisions on referring service change proposals they have concerns about to the Minister for Health and Social Services. We understand that they now need prior approval for such referrals from a committee of the CHC Board. This suggests our concern about a ‘top down’ policing system is being borne out.

We are alarmed by suggestions in the Green Paper that the remit of CHCs could be scaled back to exclude inspections and, perhaps more importantly, service change proposals. We feel this would be a retrograde

step and could remove an important safeguard which currently offers an opportunity for poorly thought through decisions by health boards in relation to service change proposals to be re-examined. We also feel this could further undermine public confidence in how such decisions are made by removing an established mechanism through which the concerns of patients are able to be heard. Furthermore, we do not believe that reducing the mechanisms by which such decisions can be scrutinised will lead to better decisions. It is more likely in our view to have the opposite effect.

Sir Michael Marmot, a former president of the BMA, has previously highlighted the need to consider not just the causes of health inequalities (e.g. behaviours and biological risk factors) but also the causes of the causes.\(^{21}\) In addition to their association with health inequalities, we would note that such social determinants of health (e.g. deprivation, poor educational attainment and poverty) may also be associated with groups of patients who may lack the ability to easily raise concerns for themselves. CHCs can therefore play a vital role in acting as the voice for such groups when challenging decisions taken by health boards that may be target- or finance-driven, rather than serving the needs of patients. CHCs can therefore help ensure that health inequalities are narrowed rather than widened, and our view is that we should not therefore be seeking to curtail their abilities to act in the needs of those less able to speak up for themselves.

**Chapter 7: Finance, functions and planning**

Whilst we do not offer a specific view on some of the financially-based questions posed in the Green Paper, we would like to make clear would be strongly opposed to any further geographical-based restructuring or reorganising of the NHS in Wales. In our view, previous reorganisations have led to significant upheaval but this has not necessarily led to greater accountability or improved service provision.

In relation to the planning undertaken by Welsh health boards, as we previously suggested in our response to the Welsh Government consultation on the draft version of its primary care workforce plan,\(^{22}\) we believe the variability of the Integrated Medium Term Plans (IMTPs) that they are required to submit to the Welsh Government requires urgent redress. In our view, each should contain detailed data on the primary care workforce and clearly outline how the local needs analysis by GP clusters has informed both strategic decisions and strategic direction. IMTPs should be subject to scrutiny at both national and local level (including by cluster), with an agreed format and standard of data sets to enable effective comparisons to be undertaken.

With regards to workforce planning, we feel it is important for the Welsh Government and Welsh health bodies to take a whole-system strategic approach across primary, community and secondary care. We recognise that high-quality patient care goes hand in hand with a highly-motivated and committed workforce. But the reality reported all too often by our members is that they feel increasingly de-professionalised, repeatedly devalued and worryingly isolated. It is therefore essential that the Welsh Government provides the resources, policy and structures for professionalism to flourish, with workforce planning taking into account the changing service demands and composition of the workforce – in particular, the challenges of an ageing workforce. Action needs to be taken to address urgent recruitment and retention challenges, ensuring we have the right staff in the right place at the right time. High-quality undergraduate education, postgraduate training and continuing professional development need to remain priorities.

Another issue that we believe needs to be addressed to assist in effective workforce planning is the current lack of collection and publication of meaningful data on vacancies. We understand that such data has not been routinely published since 2011. As such, we have had to resort in more recent times to the


use of Freedom of Information Act requests in order to obtain such data. Even then, the responses we received would appear to be highly inaccurate – largely due to the use of a fundamentally flawed definition which means a vacancy is only counted as such when an active process is underway to fill it. We fail to understand how health boards and trusts can undertake effective workforce planning when those in charge don’t appear to be effectively monitoring the extent to which vacancies are impacting on workforce provision.

Not only do we feel that this needs to be addressed by returning to a system whereby data on vacancies is routinely and regularly published, but steps also need to be taken to ensure that workforce data is meaningful and therefore able to be used for effective comparison. This includes publishing workforce data that accurately captures staff numbers expressed in terms of whole time equivalents (WTEs). We realise in certain cases, e.g. in relation to GPs, the definition of what exactly constitutes a WTE is not always straightforward and we are grateful for work that is being undertaken in relation to primary care to identify a suitable methodology for arriving at an acceptable definition for a WTE GP. With many doctors increasingly choosing to work on a less than full-time basis, however, it is important that accurate WTE data is readily available. That way workforce data can be properly understood in a way that enables workforce planning to be more effectively undertaken.

Chapter 8: Leadership, governance and partnerships

Leadership and governance

This chapter refers to some issues we have touched upon earlier in this response. For instance, as we covered in our response in relation to the previous chapter, BMA Cymru Wales would be strongly opposed to any further geographical-based restructuring or reorganising of the NHS in Wales. We consider that previous reorganisations have led to significant upheaval but not necessarily to greater accountability or improved service provision.

In relation to leadership, another suggestion we put forward earlier in this response is our idea that those in senior management positions, or serving as board members, spend a proportion of their time (e.g. one day a week) working at the frontline. As we said, we believe that would give them a genuine opportunity to experience first-hand what the problems are that need to be addressed to ensure the most effective provision of patient care.

Effective leadership, in our view, requires the fostering of a culture that is supportive of staff and provides appropriate opportunities for frontline clinicians to input into decision-making. As we have referred to earlier, we need to create a culture which encourages staff to speak out and raise concerns without fear of recrimination. At the same time, it should also support staff being easily able to put forward suggestions for improvement which can be acted upon and shared. Such a supportive culture needs to be driven from the top, and should therefore be regarded as an important aspect of the leadership we would like to see within the NHS in Wales.

Another aspect of creating such a supportive culture, would be to ensure that those who do raise concerns can receive appropriate feedback. As we previously reported, one of the issues that leads to some doctors failing to raise patient safety concerns is a lack of belief that anything will be done. Ensuring there is an effective system for feeding back when such concerns are raised would be key to helping address that. We believe that Welsh health boards and trusts should move to adopt a system of continuous feedback to staff on concerns being raised. This would help significantly by ensuring that concerns aren’t overlooked. It would also encourage more staff to raise concerns so they can be addressed, and provide greater reassurance to staff that they are working in an environment that is genuinely supportive.

We would also suggest that culture change is required to address the issue of workplace bullying which should have no place in a modern NHS. Bullying can occur at many levels but we need to take action to promote a working environment where all forms of harassment and bullying are regarded as
unacceptable, and any incidents arising from such behaviour are not tolerated. Managers and supervisors need to lead by example by treating all employees with dignity and respect. Management also needs to be on the lookout for behaviour that may be construed as bullying or harassment, and must work effectively and quickly to resolve any instances where harassment and bullying have been alleged and ensure there is no victimisation or recurrence after a complaint has been seen to be resolved.

Indeed, the NHS in Wales might consider adopting a lesson from NASA in acknowledging that successful teams utilise ‘leadership’ and ‘followership’ at different times in tacking mission-critical tasks. Adopting such an approach might avoid automatic hierarchical assumptions as the role of leader is then shared between team members, and this can lead to improved performance when operating in high-risk environments.

Advisory structure

In 2014, BMA Cymru Wales submitted responses to both a review and subsequent consultation by the Chief Medical Officer (CMO) on proposals to revise the health advisory structures for Welsh Government and the NHS in Wales.23,24 As we indicated in these responses, we support the retention of the current advisory structure, albeit recognising that there are aspects of the current bodies which could be reviewed in order to enhance the provision and effectiveness of statutory independent medical advice.

Whilst we note that the proposals that were then subject to consultation have not so far been progressed, we would nonetheless maintain our opposition to the suggestion of replacing the National Joint Professional Advisory Committee, the seven Statutory Advisory Committees (including the Welsh Medical Committee) and the 24 National Special Advisory Groups (NSAGs) with a single joint professional council.

We remain concerned that should such proposals be implemented, they would serve to substantially erode the provision of independent and professional clinical advice to the Welsh Government and this would be detrimental to the ability of the Welsh Government to take key decisions on the provision of health services for the people of Wales from a properly informed perspective.

Moving to an appointed body for the provision of advice would also undoubtedly lead to suspicion – whether it is actually the case or not – that any individuals appointed to such a body have been hand-picked in order to facilitate Welsh Ministers or health boards being able to obtain the advice that they would wish to receive, rather than advice which can be unquestionably regarded by outside observers as coming purely from an impartial and professional viewpoint.

The current structure allows a diversity of views to be put forward, with the Welsh Medical Committee then able to distil such diverse views from different specialists and different specialties. This approach fits with the belief that the best way to obtain effective advice on a matter as complex as the development of a health service is to collect a diversity of expert views.

We also remain concerned at the possibility of abolishing the 24 NSAGs as we are aware of a number of examples of tangible improvements in health service provision in Wales that have been developed as a result of clinical advice put forward through this route. Examples include the bowel cancer screening programme and the provision of low vision aids through the Low Vision Service Wales (LVSW). Such initiatives were brought forward after initially being discussed in relevant NSAGs and such opportunities to effect positive change in service provision in specific areas could therefore be lost in future. It is also worth remembering that the regulation of tanning parlours in Wales was in part developed through

23http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/SJX5ILFY2IGC7XYRPSFML4JIE4QPB.pdf
discussions undertaken within the current health advisory structure, including by the Welsh Medical Committee.

A separate, but related, issue we would like to raise is the need to strengthen the links between Welsh Government policy and the standard-setting work of the Royal Collages. We feel that this is something which should also be considered.

Other issues

Whilst the Green Paper covers a wide-range of issues, there are other points we would wish to raise which do not necessarily fit within the categories covered. In particular, we would like to highlight a number of priority areas where we would like to see the Welsh Government taking action to support people in Wales to lead healthier lives. We want the public to be better supported to make healthy lifestyle choices.

In order to tackle persistent inequalities in health, and to protect the most vulnerable in society, we believe that health and wellbeing implications should to be prioritised in all aspects policy making. There should also be a clear focus on enabling individuals to develop an increased awareness of, and sense of responsibility for, their own health and wellbeing.

It is important that everyone has adequate opportunities to make informed choices. Welsh Government policies should therefore prioritise challenging the link between poverty and poor health outcomes, in order to address the socio-economic causes of ill health head-on. As part of an overarching strategy, evidence-based policies to tackle behaviours that are strongly linked to health inequalities should be implemented.

We have already highlighted our call for HIA to be placed on a statutory footing which we hope will be achieved within the Public Health (Wales) Bill. In addition to this, we would call on the Welsh Government to:

- **Provide a culture where alcohol is enjoyed safely**
  To achieve this we would support the devolution of further relevant powers enabling 1) minimum pricing at no less than 50p per unit; 2) enforcement of responsible retailing and clear labelling (including calorie content); 3) greater emphasis on the provision of treatment for alcohol misuse; and 4) a restriction on advertising (including sponsorship).

- **Provide more smoke-free open places**
  Despite positive interventions, smoking in Wales remains the leading single cause of serious illness and avoidable early death. We are therefore supportive of the Welsh Government in its aims to create more smoke-free open places, as well as to restrict the use of e-cigarettes in enclosed public places whilst implementing a regulatory framework for their sale and use.

- **Safeguard against the damaging effect of physical inactivity and poor diet**
  Individuals who are overweight and physically inactive have an increased risk of a wide range of serious life threatening and chronic diseases. There are substantial health and social care costs associated with the treatment of obesity, and it is close to 100 per cent preventable. The Welsh Government should therefore develop policy to 1) implement interventions to curb the promotion and availability of unhealthy foods; 2) ensure sufficient and convenient opportunities for sport and exercise; and 3) provide a comprehensive strategic approach to nutrition and exercise.

- **Improve levels of literacy and numeracy**
  Education can be a major determinant of social wellbeing and health and we are concerned by the poor levels of educational attainment in Wales and its implications for the health of the nation. The
Welsh Government should act quickly to improve the levels of literacy and numeracy in Wales to similar levels as those enjoyed by the other UK nations.