GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

Llywodraeth Cymru Welsh Government

Public Consultation on the Introduction of the Duty of Quality Summary Report

April 2023

Contents

1. Introduction & Background

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 ("the Act") was passed in March 2020 and received Royal Assent in June 2020.

The Act makes provision about several interrelated proposals relating to quality and public engagement in health and social care. Taken together, the provisions are intended to have a cumulative positive benefit for the population in Wales and to put in place conditions which are conducive to improving health and well-being.

The Act contains four main parts with part 2 placing a statutory Duty of Quality on Welsh Ministers with regards to their health-related functions and NHS bodies in Wales.

Introducing a Duty of Quality highlights the Welsh Government's commitment to improving the quality of health services. The objective is for the new Duty of Quality to require NHS bodies to exercise their functions in a way that requires them to consider how they can improve quality on an on-going basis. The aim is that improving quality, and therefore outcomes, will become an embedded and integral part of decision-making processes.

The Welsh Ministers will be under a corresponding Duty of Quality to ensure that their decisions support and contribute to the system-wide approach to quality that is needed.

A comprehensive programme of work was undertaken to develop a guidance document to support NHS bodies in understanding and preparing for the Duty of Quality. A series of workstreams were established with support from colleagues within Welsh Government and across the NHS. Governance mechanisms were in place to provide appropriate oversight to the work from a broad range of stakeholders.

The guidance set out a definition of quality and described the overarching requirements to strengthen our quality management systems with quality-driven decision-making and planning. The vision is that this will strengthen our learning and sharing responsibilities and opportunities.

To build clear connections between the Duty of Quality and standards, and to fulfil the duty on the Welsh Ministers to review standards, the guidance proposed incorporating Quality Standards within the Duty of Quality guidance that would replace the Health and Care Standards (April 2015). We anticipate this will promote improved embedding of standards by NHS bodies in their ways of working. This approach ensures there is clear alignment between the Duty of Quality, high-level standards and quality management systems.

Healthcare is increasingly complex, and the NHS is facing unprecedented challenges. Our vision and ambition are to achieve ever-higher standards of person-centred health services in Wales. The Duty of Quality guidance sets out the practical steps that NHS bodies must take, applied to their local strategic context, to achieve the vision and ambition.

2. Consultation Details

The Duty of Quality consultation ran from 25th October 2022 to 20th January 2023.

Responses could be received in several ways:

- Online via the Smart Survey portal; and
- Submitting a hard copy of the consultation via email.
- Via postal submission

It was explained that the Duty of Quality means0 NHS organisations and Welsh Ministers have a duty to:

- create a culture of quality within organisations.
- focus on improving the quality of health services and outcomes for the population on an ongoing basis; and
- actively monitor progress of improvement and routinely share this information with their population.

The consultation wanted participants views on:

- How we introduce the Duty of Quality to NHS organisations and Welsh Health Ministers through new statutory guidance.

All consultation documents were available on the following page: The duty of quality | GOV.WALES and a list has been provided below. An informative video about the Duty of Quality was also produced and available via the link above. The documents comprised:

- Consultation document.
- Easy read consultation document – easy read;
- The Duty of Quality Statutory Guidance 2023 and Quality Standards 2023.

3. Analysis Methodology

Consultation responses were received online via the Welsh Government Smart Survey and via email. The responses received via email were uploaded into the Smart Survey to ensure that a full data set with consistent formatting was available for analysis.

All data from the consultation was collated and an initial quantitative analysis was completed. This highlighted the number of both 'complete' and 'incomplete' responses, the response rate per question and, for the applicable questions, the yes/no percentage. The initial quantitative analysis of each question provided an early opportunity to highlight areas that respondents indicated would need to be considered further.

All comments that were provided by respondents throughout the 23-question consultation were collated, along with the respondent ID and whether the respondent answered yes or no or did not answer the question. They were then grouped by question and chapter. The chapters within the analysis and summary report were derived from the sections within the consultation document. The above steps provided the opportunity to analyse responses in a variety of ways.

The next step undertaken was the qualitative analysis of the respondent's comments to each question. In total the consultation received 32 complete responses and 8 that were incomplete; from the 40 responses 441 comments were raised through the consultation. Using an inductive approach to the analysis, all comments were reviewed and considered, resulting in 7 themes being identified and defined (see Annex A).

All comments were reviewed and where applicable coded with a theme, some comments had multiple themes attached to them. In total 305 comments were coded with at least one theme, equating to 69% of all comments. Secondly, respondents answered 'no' to questions a total of 142 times during the consultation and provided 137 comments with this response, of those comments 79% were coded with a theme.

Once all comments were reviewed and where applicable coded with a theme(s) the data set was analysed and presented using Power BI. Using the Power BI software provided the opportunity to present a report that was interactive and easily accessible. This offered the ability to highlight themes and sub-themes arising by question, chapter, respondent and whether the respondent answered yes or no (where applicable). It also provided the opportunity to drill down into each theme and sub-theme to view the comments provided by respondents that were coded to that theme/sub-theme.

Note on data accuracy

Whilst the email responses were being uploaded into the Smart Survey and during the initial quantitative analysis, a discrepancy in the consultation documents was recognised. Question 10 within the online survey provided the option of a yes/no response whereas not all email submissions did. This discrepancy resulted in there only being 16 yes/no respondents from the complete and incomplete submissions, but 26 comments were received. Due to this discrepancy, it was decided that the yes/no data would be omitted from the consultation summary, however a thematic analysis of each response was completed and included.

4. Summary of Respondents

The Duty of Quality consultation generated 32 complete responses and 8 incomplete responses. Complete responses are those that were submitted as final, with the majority but not all the questions answered. Incomplete responses were not finalised prior to the consultation end date and in many cases no questions were answered.

The consultation did not require that every question be answered before final submission. On average from the 32 complete responses 26 responders answered each of the 23 questions within the consultation (an 82% completion rate). For the 8 incomplete responses an average of just under 2 responses were received per question (a 22% completion rate).

Throughout the report where questions have been answered within an incomplete submission, the numbers have been included in the yes/no percentages, and comments from these respondents have been recorded and considered in the thematic analysis.

Of the 32 completed submissions, 27 respondents identified an associated organisation, 1 identified as a service user/citizen. It has also been acknowledged that 7 respondents indicated they would like to remain anonymous.

The breakdown of respondents who submitted complete responses were:

- 9 NHS professional / organisational representative e.g., Health Boards or NHS Trusts
- 9 Professional associations e.g., Royal Colleges
- 4 charities e.g., Learning Disability Wales
- 2 independent providers
- 1 from citizens/service users;
- 8 incomplete responses did not list an answer.

A list of respondents along with their associated organisations has been included in Appendix B[1].

[1] 7 respondents requested anonymity.

5. Summary of Responses by Chapter

5.1 Chapter 1: Guidance, Governance and Oversight

Graphic 1.1: Chapter 1 questions, number of responses, yes/no breakdown and identified themes.

In this chapter of the consultation respondents were asked if the Duty of Quality guidance clearly outlined: a) what it was trying to achieve, b) who it applied to and c) whether the outlined governance and leadership structures were adequate and clear to support NHS bodies. It also asked if the responsibilities for the Duty of Quality within commissioned and hosted bodies were clearly

	Question	Number of Responses	Yes %	No %
Q1	Is the guidance clear on what we are trying to achieve with NHS bodies through the introduction of the duty of quality?	30	77%	23%
Q2	Is the guidance on to whom the duty of quality applies clear?	30	87%	13%
Q3	Is the guidance sufficiently clear on the governance structures needed?	28	86%	14%
Q4	Will this governance structure support NHS bodies to comply with the duty?	28	75%	25%
Q5	Does the guidance outline clearly the level of leadership required in organisations?	29	76%	24%
Q6	Is it clear where responsibility for the duty of quality lies in commissioned and hosted services?	32	72%	28%

Theme	Times Identified
Relationships with other Policies/Service Providers	26
Leadership, Culture & Accountability	24
Communication & Engagement	21
Implementation and Delivery	15
Further Clarity/ Information Required: Guidance and Terminology	14
Time, Staffing and Resources	8
Training & Development	4

highlighted.

Throughout each of the questions within this chapter, over 70% of respondents indicated that the guidance was clear in outlining what the Duty of Quality is trying to achieve, who it applies to and the governance and leadership structures that will be required. Although respondents highlighted 'yes,' the guidance is clear in these areas, many still outlined suggestions for further consideration or clarity. As highlighted in the graphic above, 3 themes arose more regularly than the others throughout the chapter, and this was irrespective of whether respondents answered yes or no to the question.

Question 1: Is the guidance clear on what we are trying to achieve with NHS bodies through the introduction of the Duty of Quality?

23 respondents stated that the guidance made it clear what the introduction of the Duty of Quality was trying to achieve. However, multiple themes arose throughout Question 1, one of them being communication and engagement. Respondents felt that information should be accessible and easy for service users to understand. This point was reiterated by a respondent who suggested there

should be an ‘Easy Read Statutory Guidance document to support the general public’s understanding of the Duty,’ this was raised numerous times throughout the consultation.

Respondents also highlighted that there may need to be more detail provided around the implementation and delivery of the Duty, with participants stating that, ‘work needs to be carried out to translate this for day-to-day operational processes/systems’ and another highlighted that they did not feel there was ‘sufficient implementation guidance to show how this will facilitate a whole system approach to improving patient experience’.

The most common theme for Question 1 was around relationships with other policies and service providers. Respondents felt the relationships and implications with policies such as The Wellbeing and Future Generations Act and A Healthier Wales would need to be further considered, whilst another stated that ‘output from the Quality Reporting Framework [work stream] will be essential in mapping the requirements of [the] Duty of Quality into the new Annual Quality Report.’ Respondents also enquired about the implications of the Duty on other service providers, with one asking, ‘how does [the] quality framework for health services integrate with others [for example] social care and [the] wider health system?’ Building on this, further acknowledgement of the independent sector and the responsibilities of independent hospitals working with the NHS was also requested.

Question 2: Is the guidance on to whom the duty of quality applies clear?

The theme around relationships with other policies and service providers was also prominent within Question 2, with almost half of all comments for this question highlighting that there should be further consideration of this in the guidance. Multiple respondents highlighted that further detail would need to be provided around Primary Care providers. For example, one respondent asked for clarification around GP surgeries that are run independently versus those run by a Health Board, this was also raised later in the chapter.

Others felt there would need to be further clarification for organisations working in partnership with the NHS and one respondent stated that ‘whilst the Duty may not directly apply to contracted primary care services, it will apply to the local Health Board which contracts them and will therefore provide the framework against which the local Health Board will measure the quality of their services’.

Finally, a number of respondents questioned why the Duty of Quality will not apply to primary care services or contractors.

Question 3: Is the guidance sufficiently clear on the governance structures needed?

and Question 4: Will this governance structure support NHS bodies to comply with the duty?

Whilst many respondents agreed that the guidance was clear on the governance structures required and whether they would support NHS bodies to comply with the Duty of Quality, the leadership, culture and accountability theme was raised consistently in comments for both questions.

A number of respondents to Question 4 asked for further detail on how NHS bodies will be scrutinised and held accountable to meet the Duty of Quality. One respondent highlighted that there would need to be alignment between the Duty of Quality and professional accountabilities.

The challenge to ensure that quality is recognised and owned by staff at all levels of an organisation was raised by one respondent, and they also felt that 'the delegation route [will] need to be clear … to ensure that the Duty does not become the sole responsibility of the Executive Lead and Independent Member.'

Highlighted under the implementation and delivery theme, some respondents felt the governance structure outlined may not 'transcribe into operational impact ... [and] it will depend on how the Duty is prioritised by the individual organisation.' This was supported by another comment which highlighted that it may be difficult to 'ascertain whether governance structures are adequate until [they are] seen in action'. Building on this, others suggested that the effectiveness of the governance structures should be continually monitored.

A suggestion that was raised by respondents was for the guidance documents to provide a visual or diagram example of governance structures.

Question 5: Does the guidance outline clearly the level of leadership required in organisations?

The theme that arose the most from all respondents was communication and engagement. Some felt that communication and engagement with staff is key to making them aware and embedding the Duty. Others stated that representation from the public should be included in the leadership structures to 'amplify the citizens voice.' This point was reiterated by another respondent who referenced NICE guidance on shared decision-making and the definition of the 'patient director' which would promote a strong voice to advocate for patients.

The leadership, culture and accountability and implementation and delivery themes also arose within responses to Question 5. Some felt that the guidance on leadership should include multi-professional and operational leadership, whilst another respondent felt more emphasis could be considered on the need for all staff in the NHS to play a role, which has previously been raised in the chapter.

Some respondents felt that the guidance needed more detail and raised concerns that in its current form it could lead to different interpretations from those that hold leadership duties, and subsequently lead to inconsistencies in implementation. However, one respondent felt that organisations should have the flexibility to apply the guidance locally as a statutory body. Finally, one respondent commented that although the guidance clearly outlined the level of leadership, it needed to include more information to support those in post.

Question 6: Is it clear where responsibility for the Duty of Quality lies in commissioned and hosted services?

The final question of the chapter concentrated on commissioned and hosted services. It resulted in the largest disparity of agreement between respondents within the chapter, however over 70% of respondents did agree that the guidance was clear where responsibilities lie within these settings. The theme that arose the most within this question was relationships with other policies and/or service providers, however a range of other themes were present within the comments.

A number of respondents felt that the responsibilities within service providers such as, social care, Digital Health and Care Wales (DHCW) and Welsh Health Specialised Services Committee (WHSSC) would need to be more clearly outlined or clarified. Other respondents felt that this area of the guidance could be further detailed and structured to make it clearer. One respondent suggested that 'a visual summary or glossary of commissioned and hosted services and who is responsible for them' would be useful and would support public understanding.

Respondents also queried how commissioned and hosted services would be held accountable for the services that they provide. One respondent asked, 'how the management of external providers will be held to account for the quality of their services.' Another asked how the NHS body commissioning the work of an independent provider would ensure the quality processes in the independent sector is robust?'

Chapter 1 Government Response

The Welsh government welcome the consultation responses and the clearly positive and challenging conversations being had across health care in Wales. Of principle importance within the Duty of Quality is the improvement of health services and outcomes for the population of Wales. An important element in achieving these aims is public understanding of the Duty. The consultation responses clearly requested an 'Easy Read' version of the statutory guidance which will be commissioned by the Welsh Government to support this.

We recognise the calls for more detail in several sections of the guidance, including how the new Duty interacts with other legislation and sectors, and the roles and responsibilities within NHS bodies. As outlined in the guidance, it is not intended to be a prescriptive document, nor is it intended to be a quality manual or 'how to' guide. It is, ultimately, for NHS bodies to satisfy themselves that they are complying with the new Duty to secure improvement in the quality of health services that is imposed on them within the 2006 Act, though it is envisaged that this guidance will provide a helpful framework to assist such bodies accordingly. It will be important that NHS bodies develop and own leadership responsibilities and structures in implementing the new Duty. Supporting resources, such as training material, awareness videos and posters, have been developed to support the NHS in establishing and implementing new arrangements to comply with the Duty.

The consultation highlighted several requests for more clarity on how the Duty applies within hosting and commissioning arrangements. To support this understanding, wording on how the Duty applies to primary care has been reviewed and strengthened to clarify that the Duty will apply via contracting with the health boards (as is the case with the Health and Care Standard 2015).

The paragraph on the independent sector (referred to as non-NHS) has had the wording clarified with some addition on the expected route of application. In view of the variety in commissioning and hosting arrangements, this guidance could not provide clarity on all scenarios but is designed to give guiding principles to be considered in setting up and reviewing arrangements.

We also echo comments on the importance of collective ownership, and we would look to the NHS bodies to ensure all staff own the Duty of Quality. We have ensured the guidance is clear on the importance of shared responsibility. We also welcome the conversation on communication and engagement with staff and the public and would encourage structures

within NHS bodies that promote the voice of people in their care. As previously mentioned, how this happens is within the remit of the NHS bodies, as this guidance is not designed to detail internal structures.

The chapter on monitoring and assurance has been reviewed with some simplification to reflect the developing role of the NHS Executive and their role in oversight of the NHS. We acknowledge the request for a diagram on governance structures but given the wide range of organisation types within the NHS in Wales (as well as consideration of hosting arrangements) there is no single diagram that could be used as a guide. NHS bodies and their boards will need to be assured that their internal structures provide for adequate oversight of compliance with the Duty as well as clear means of reporting.

	Question	Number of Responses	Yes %	No %
Q7	Are the expectations of quality clear within the definition and six domains of quality?	30	67%	33%

Theme	Times Identified
Further Clarity/ Information Required: Guidance and Terminology	12
Implementation and Delivery	7
Communication & Engagement	5
Relationships with other Policies/Service Providers	2
Leadership, Culture & Accountability	1
Time, Staffing and Resources	1

5.2 Chapter 2: Defining Quality

This chapter was comprised of one question, which asked respondents whether the expectations of quality are clear within the definitions of the six domains of quality.

Question 7: Are the expectations of quality clear within the definition and six domains of

A third of respondents (33%) did not feel that the expectations of quality within the definition and six domains were clear. Respondents indicated that further detail and information may be required within this section of the guidance, and others highlighted that certain terminology within this section may need to be revisited, such as the use of 'safe,' 'efficient,' 'timely' and 'service specification.'

One respondent made a comparison between the Health and Care Standards (2015) and the definition/six domains of quality and highlighted that the new proposal was very brief, and more

Graphic 2.1: Chapter 2 question, number of responses, yes/no breakdown and identified themes.

detail may be required; this was a statement supported by others. It was outlined by multiple

respondents that without the additional detail and underpinning information it will be difficult to monitor and measure if the Duty of Quality is being met. One respondent queried if there should be a minimum standard to support the measuring of the Duty of Quality.

Respondents also commented on the implementation and delivery of the definition and six domains of quality. Respondents felt that the guidance needed to be clearer and more robust on how the domains will be implemented and operationalised.

Chapter 2 Government Response

We recognise the calls for more detail in several places of the guidance. As outlined in the guidance, it is not intended to be a prescriptive document, nor is it intended to be a quality manual or 'how to' guide. It is for NHS bodies to satisfy themselves that they are complying with the new Duty to secure improvement in the quality of health services that is imposed on them in the 2006 Act, though it is envisaged that this guidance will provide a helpful framework to assist such bodies accordingly.

This is particularly relevant in the definitions of the new Health and Care Quality Standards which NHS bodies are required to "take into account" in discharging the new Duty of Quality. The new standards have been developed in response to a longstanding call to review and refresh the existing Health and Care Standards of 2015. The existing standards were considered to be overly detailed, difficult and timely to update, and secondary and acute care focused and insufficiently embedded from a whole-system approach. They did not keep abreast of developments in the vast array of services provided by NHS bodies and were therefore not updated in a timely fashion... The new Health and Care Quality Standards provide high-level intent as to what good quality looks like. It allows greater flexibility to ensure the high-level principles can be applied across the broad range of services provided. The detail of service standards will need to be reviewed and updated regularly based on best practice and as such, this document which contains both statutory guidance and the new standards is not the place to house operationalisation at this level. Promoting ownership of the principles within the Quality Standards and considering the application of them by the various services and specialties encourages their ownership of the Quality Standards.

The consultation did highlight certain wording within the definitions that was unintentionally exclusive and/or limiting. and where appropriate this has been amended.

5.3 Chapter 3: Quality Enablers

This section of the consultation asked respondents if they felt the guidance was clear on how the five quality enablers will support the six quality domains. It followed on by asking respondents if they felt any other quality enablers should be considered, and what supporting tools and materials will assist NHS bodies in fulfilling their Duty of Quality.

	Question	Number of Responses	Yes %	No %
Q8	We have outlined five quality enablers that we believe are necessary to support the implementation of the six domains of quality. Is this explanation clear in the guidance?	29	79%	21%
Q9	Is there other potential 'enablers' that we should consider including in the guidance?	31	58%	42%
Q10	What supporting tools and materials will assist NHS bodies to fulfil their duty of quality under the Act?	26		

Graphic 3.1: Chapter questions, number of responses, yes/no breakdown and identified themes.

Question 8: We have outlined five quality enablers that we believe are necessary to support the implementation of the six domains of quality. Is this explanation clear in the guidance?

The themes that arose from responses to this question were similar to Question 7. Respondents requested more clarity and information in some of the quality enabler definitions, such as:

i. Visionary and compassionate leadership within the Leadership enabler.
ii. More detail about how NHS organisations share learning – what is the mechanism for this outside of the individual organisations and how could this be operationalised and include wider health providers within the Whole-systems Perspective enabler; and
iii. Expanding the Learning, Improvement and Research enabler to clearly capture the requirement for effective, well controlled change management. (In response to Question 9).

There were also comments made about the definition of the 'Measurement' quality enabler, however this has since been updated to 'Information.'

One respondent suggested that providing examples of how the quality enablers will support the implementation of the six domains would be a useful tool.

The implementation and delivery of the quality enablers was also raised by a number of respondents, and it was felt that there needed to be more detail on how the enablers will enable quality and positive change within the NHS. One respondent highlighted that embedding the concepts will take years and suggested that 'NHS bodies should be encouraged to set long-term quality [strategies] to demonstrate when they expect to fully realise the [Duty].'

Question 9: Is there other potential 'enablers' that we should consider including in the guidance?

58% of participants felt that there were additional quality enablers that should be included within the guidance. From their responses, three thematic areas arose from respondents' suggestions for additional quality enablers to be included in the guidance. These were time, staffing and resources; leadership, culture, and accountability; and communication and engagement. Some examples of respondents' suggestions have been listed below:

i. Digital infrastructure and data sharing across organisations.
ii. Cultural development, safety, and improvement infrastructure.
iii. Workforce planning and sustainability.
iv. Reflection, using experience to inform problem solving and learning; and
v. Patient and stakeholder involvement, co-production and decision making.

In addition to these suggestions, responses outlined in the Question 8 summary could be considered.

Finally, respondents suggested that the enablers should be regularly reviewed and one asked if they could be amended over time as the needs and reviews of the Duty of Quality indicated.

Question 10: What supporting tools and materials will assist NHS bodies to fulfil their duty of quality under the Act?

The three themes that regularly emerged from this question were interlinked within the responses. Respondents felt that training and development would be key to ensuring that NHS bodies fulfil their Duty of Quality. Complimenting this, communication and engagement with staff will be key to embedding awareness and knowledge and finally, the availability of sufficient resources and skills will be needed to ensure the successful implementation of the Duty.

Some suggestions regarding training were highlighted by respondents, including that it should be mandatory through ESR, it should be available for all staff, and there should be more detailed training available for staff with operational responsibility for compliance with the Duty. This linked with the communication and engagement theme, as some highlighted that the training materials will need to be accessible and provide a baseline level of knowledge and understanding. It was also felt the resources such as presentations, posters and videos will need to be collated and shared with staff as part of a communications strategy.

Several respondents highlighted that additional resources will be required to implement the Duty successfully, whilst others asked what additional resources will be made available. One respondent suggested local assessments to indicate the infrastructure required to 'collate, monitor and make information about the quality of … services, readily available to the population.' A similar point was raised by another respondent who highlighted that the workforce would need to be considered as a tool, and they would need the correct skills to 'appropriately manage the data, knowledge and research that [is] undertaken to measure and monitor quality.' It was also suggested that Quality Improvement (QI) teams would need to support services whilst the Duty is being embedded.

Chapter 3 Government Response

As with the previous chapter, the standards within this guidance have been deliberately developed to allow for flexibility in application and update in light of the broad and complex nature of services. The Health and Care Quality Standards are intended to be meaningful to the Welsh population. Welsh Government acknowledges that additional detail to supplement the high-level principles will be needed. Work is ongoing with Healthcare Inspectorate Wales (HIW) and other appropriate organisations to establish the setting of this

	Question	Number of Responses	Yes %	No %
Q11	The new Quality Standards 2023 are based on high-level aspirations through the six domains of quality and five quality enablers. Are the quality standards clear?	25	76%	24%
Q12	Is the guidance clear about how the Quality standards 2023 will support development of the quality management system and assessment of progress with the duty of quality?	26	69%	31%
Q13	Do you think the incorporation of the new model for Quality Standards 2023 and the withdrawal of the 2015 Health and Care Standards is the appropriate measure to take?	27	78%	22%
Q14	Do you think a transition phase would be advisable to NHS bodies in the adoption of the new Quality domains and enablers?	26	77%	23%
Q15	Is the guidance clear on how an NHS body would meet the six steps listed above?	28	71%	29%

Theme	Times Identified
Further Clarity/ Information Required: Guidance and Terminology	27
Implementation and Delivery	17
Communication & Engagement	14
Leadership, Culture & Accountability	13
Relationships with other Policies/Service Providers	4
Time, Staffing and Resources	3
Training & Development	2

detail and its impact on reporting and inspection.

Through consultation and wider engagement, there has been a consistent call to strengthen the intention on workforce within the standards. Welsh Government recognise the significant role that workforce plays in all aspects of quality and as such, an additional quality standard / enabler has been added which specifically details workforce quality standards. Other suggestions made as potential quality enablers were either captured in rewording or were considered to be sufficiently covered within existing text

We welcome the comments on training and supporting materials and through the implementation programme, training tailored to various roles and responsibilities have been developed and will be available to all staff in the NHS and primary care. In addition, communication material such as awareness videos and posters have been developed to support NHS bodies in communicating and complying with the Duty. All materials will be available via established learning and communication platforms. Additional resources are planned by the NHS in accordance with feedback and requests that have been received.

5.4 Chapter 4: Quality Standards

This section of the consultation requested participants views on the clarity and introduction of the new Health and Care Quality Standards (2023).

Graphic 4.1: Chapter 4 questions, number of responses, yes/no breakdown and identified themes.

Question 11: The new Quality Standards 2023 are based on high-level aspirations through the six domains of quality and five quality enablers. Are the quality standards clear?

Question 12: Is the guidance clear about how the Quality standards 2023 will support development of the quality management system and assessment of progress with the duty of quality?

Question 13: Do you think the incorporation of the new model for Quality Standards 2023 and the withdrawal of the 2015 Health and Care Standards is the appropriate measure to take?

The first three questions of this chapter have been grouped together due to the same thematic areas consistently emerging from the comments. Statements provided by respondents to these questions drew similarities with those provided for questions 7 and 8. Respondents highlighted that the lack of detail in the new Health and Care Quality Standards (2023) could lead to varying interpretations and inconsistencies in implementation, which could subsequently lead to challenges in measuring and reporting quality. As highlighted in Chapter 7, comparisons were once again made between the level of detail in the Health and Care Standards (2015) and the new Health and Care Quality Standards. Some felt that more definition of what 'good' entails would be helpful, and others highlighted that the inclusion of examples would aid understanding.

Similarly to questions 7 and 8, respondents also highlighted that there was a need for more consideration and detail around the implementation and delivery of the new Health and Care Quality Standards and supporting concepts. Others highlighted that there would need to be further clarity provided around the transition from the Health and Care Standards (2015) to the Health and Care Quality Standards (2023).

Question 14: Do you think a transition phase would be advisable to NHS bodies in the adoption of the new Quality domains and enablers?

A number of respondents stated that a transition phase would not be advisable in the adoption of the new quality domains and enablers, and they commented that it could be counter-productive or confusing for staff. Whilst another queried whether specific domains or enablers would be staggered in their introduction and, if so, how would this be decided. One respondent also requested further detail on the time frames of a proposed transition period and how long this will last.

From all respondents, comments from multiple themes arose in response to this question. It was highlighted that the transition phase will need clear boundaries and the scope of what is in the transition would need to be agreed. Following this, information will need to be shared widely and be understood by all staff involved. It was also suggested that during the transition period further consultation could take place to highlight any issues or problems that need to be addressed. Building on this point, others felt that the transition phase could offer the opportunity to develop data to support quality and improvement and highlight good practice.

One respondent highlighted that during the transition period, how other service providers 'adapt to the new legislation, especially [those] working in joint health and social care locations will need to be considered.

Question 15: Is the guidance clear on how an NHS body would meet the six steps listed above?

This question asked respondents if they felt the guidance was clear on how NHS bodies would meet the following six steps: securing board support; assess readiness; secure wider organisational buy-in and co-creating a vision; develop improvement skills and infrastructure; align and coordinate activity; and sustain an organisation-wide approach.

Requests for further clarity and information arose within this question, as respondents felt the current level of detail could lead to organisations interpreting the steps differently. Respondents highlighted that using examples could support understanding, and more specifically an example of how to operate an interlinked Quality Management System would be helpful. Respondents also indicated that there needed to be further consideration of patient involvement and collaborative working between organisations. They felt sharing good practice was key and one respondent felt that 'it would be useful to ensure that Health Boards across Wales are sharing learning on implementation' and developing a culture of 'continuous learning.'

Finally, comments around time, staffing and resources emerged several times within this question. Some respondents felt that there needed to be more consideration towards workforce planning and sustainability within the guidance. Another respondent referenced the guidance stating, 'this should be underpinned by a willingness and financial support to develop skills and infrastructure for implementation' and questioned whether the financial support is available in the current climate. They felt that if it is not, then there is a risk NHS bodies are being set up to inevitably fail to be able to meet the Duty.

Chapter 4 Government Response

As with the previous chapter we recognise the calls for more detail in several places of the guidance. As outlined in the guidance itself, it is not intended to be a prescriptive document, nor is it intended to be a quality manual or 'how to' guide. This is particularly relevant to the new Health and Care Quality Standards. The new standards have been developed in response to longstanding call to review and refresh the existing Health and Care Standard of 2015. The new Health and Care Quality Standards provide high-level intent as to what good quality looks like. It allows greater flexibility to ensure the high-level principles can be applied across the broad range of services provided. The approach also applies to the quality management systems that will be developed and strengthened by the NHS in collaboration with Welsh Government.

The Welsh Government recognises the mixed responses in relation to a potential transition period for implementing the new Duty. We acknowledge that developing and improving our quality culture is an ongoing process that takes time and constantly changes. The change in standards is by no means insignificant within this context.

However, having reviewed the consultation feedback and the intent of the Duty within the current healthcare context and the legal parameters applied by the legislation, we feel the case for a transition period has not been made. The Duty of Quality provides a much-needed focus on the performance and improvement of health services in Wales. The current provision of healthcare in the country is under extreme pressure and the Duty of Quality provides a mechanism to support the NHS at this time by setting out the ambition to achieve

	Question	Number of Responses	Yes %	No %
Q16	Is the guidance clear on what is meant by 'always on' reporting?	29	79%	21%
Q17	Are the intended reporting systems ('always on' and a narrative yearly report) sufficient for NHS bodies to assure their population and Welsh Ministers?	28	54%	46%

Theme	Times Identified
Communication & Engagement	14
Leadership, Culture & Accountability	9
Time, Staffing and Resources	8
Further Clarity/ Information Required: Guidance and Terminology	7
Implementation and Delivery	3
Relationships with other Policies/Service Providers	3
Training & Development	2

improved quality of health services and a framework to achieve the work required. The Welsh Government feel that either a delayed or staggered implementation would only mean the potential support from the Duty will not be in place for longer and any such approach would not guarantee improvement in implementation or readiness.

5.5 Chapter 5: Quality Reporting Requirement

This section asked respondents whether the guidance is clear in defining what is meant by 'always on' reporting and whether the proposed reporting systems are sufficient for NHS bodies to assure their population and Welsh Government.

Question 16: Is the guidance clear on what is meant by 'always on' reporting?

The communication and engagement theme arises throughout this chapter, numerous respondents raised a query, concern, or suggestion about the 'always on' guidance and process.

It was queried how accessible and understandable the reporting will be for the public, and whether they would have the chance to provide their feedback. Some felt that there needed to be more detail around the 'always on' requirements, and one respondent asked if the term 'always on' was the simplest language for the public to understand and felt it could be left to subjective interpretation.

Respondents also underlined that time, staffing and resources would need to be considered to

Graphic 5.1: Chapter 5 questions, number of responses, yes/no breakdown and identified themes.

ensure the 'always on' reporting is meaningful and effective and not 'swamping people in data' as one respondent stated. It was also suggested that local assessments will need to be undertaken prior to implementation to evaluate the readiness and infrastructure available to organisations. Another respondent felt that there would need to be 'development across the whole clinical governance framework including access to data and information to support learning and improvement.'

Question 17: Are the intended reporting systems ('always on' and a narrative yearly report) sufficient for NHS bodies to assure their population and Welsh Ministers?

This question highlighted a clear contrast in responses, with 46% feeling that the intended reporting systems were insufficient for NHS bodies to assure their population and Welsh ministers.

As previously highlighted within the responses to question 16, comments reiterated that it was key for information to be easily accessible and understandable for all. One respondent requested more detail on how and where the public will be able to access reports. Others highlighted the term 'patient stories' within the guidance. They felt that there would need to be a level of co-production with patients/service users, and they would need to be centrally involved in the reporting processes with the opportunity to provide feedback. It was suggested that this should be formalised in the guidance.

The leadership, culture and accountability theme also arose from comments within this question. It was underlined by one respondent that the 'annual reporting should not be seen as a conclusion, but the starting point for further discussion.' It was also suggested that 'improvement in outcomes at a local level [should be] linked to national/local quality improvement or transformation programmes' and this point was reiterated by another respondent who suggested the reporting requirements could be supported by a national oversight of quality, provided by the National Quality Management system, managed as part of the NHS Executive.

Similarly, to responses to question 16, the staffing, time and resource's theme also emerged. Respondents highlighted that for the reporting requirements to be successful it will be key to develop skills, systems, and knowledge prior to implementation. To reiterate this, it was stated that sufficient resources and support will need to be in place and staff would need the capabilities and capacity to analyse and understand the information to produce the reports.

Chapter 5 Government Response

There has been clear feedback from NHS bodies regarding their experience with the former Annual Quality Statement. Welsh Government acknowledges the views expressed that quality reporting should not be limited to an end-of-year process. It is acknowledged that significant information about services is already produced and reported in the public domain. Welsh Government agrees with feedback received that information should be accessible, reliable, meaningful and updated in a timely manner in order that quality is driven by appropriate information. The intention is to make use of a limited number of reliable quality-related indicators and measures in the first instance and to build on this in line with improvement methodology. Appropriate quality-related information should be shared within organisations as well as with the population in Wales and other key stakeholders. To that end, we very much welcome calls for greater involvement of the public in the quality reporting process. Welsh Government's intention is that 'always on' reporting will evolve over time. A quality reporting framework is in development to supplement the statutory guidance. The agile nature of how 'always on' reporting will develop means that the statutory guidance is not felt to be the appropriate place to house the quality reporting framework.

We also recognise the comments of resources required to develop and maintain these processes but would emphasise that, particularly in relation to reporting, no new quality measures are stipulated by the Duty and wherever possible, existing processes and measure should be used to support reporting. This is deliberately intended to reduce the resource requirement. Quality (and this new duty) is something the NHS will need to invest in, but we expect that in many cases this investment will provide cost savings over time as services become more efficient. Higher quality services also reduce the need to spend money on the consequences of poor quality such as management of avoidable harm and extended lengths of stay. The guidance refers to the Quality and Safety Framework (2021) and National Clinical Framework (2021); data is integral to both of these Frameworks.

5.6 Chapter 6: Decision Making, Monitoring and Assurance

This section of the consultation asked respondents if the guidance was clear on the collective responsibilities of the Board and how monitoring the Duty of Quality will be embedded into existing Welsh Government and Healthcare Inspectorate Wales (HIW) procedures.

	Question	Number of Responses	Yes %	No %
Q18	Is the guidance clear on the collective responsibility of the Board to ensure: • quality-driven decision-making • system-wide application of the duty of quality • focus on learning and sustainable quality improvement • ensure better quality of services and improved outcomes for people • with appropriate monitoring in place to ensure quality improvements are maintained	29	72%	28%
Q19	Is the guidance clear on how monitoring of the duty of quality will be embedded into existing Welsh Government procedures and those of Healthcare Inspectorate Wales?	27	81%	19%

Theme	Times Identified
Leadership, Culture & Accountability	8
Implementation and Delivery	6
Relationships with other Policies/Service Providers	5
Communication & Engagement	2
Further Clarity/ Information Required: Guidance and Terminology	2
Time, Staffing and Resources	1
Training & Development	1

Graphic 6.1: Chapter 6 questions, number of responses, yes/no breakdown and identified themes.

Question 18: Is the guidance clear on the collective responsibility of the Board to ensure:

• quality-driven decision-making • system-wide application of the duty of quality • focus on learning and sustainable quality improvement • ensure better quality of services and improved outcomes for people • with appropriate monitoring in place to ensure quality improvements are maintained

As highlighted in the graphic above, the leadership, culture and accountability theme emerged the most regularly within this chapter. More specifically, in question 18 respondents requested more detail on the accountability of organisations when the Duty of Quality is repeatedly compromised. One respondent felt that there would need to be adequate monitoring and repercussions for failure. Another enquired who would be responsible for deciding if an organisation was complying with the Duty.

The comments outlined within this paragraph could also relate to question 17. There were concerns raised by respondents in reference to the 'peer review' and 'self-assessment' statements within the guidance. Whilst it was recognised that this may be helpful, one respondent felt that there may be some bias within this approach and another felt self-assessment is not 'sufficient to ensure quality, consistency or learning.' It was also queried if service users will be able to provide feedback to this process.

Respondents also felt that there needed to be more detail on how this section of the guidance will be achieved and implemented. One respondent asked 'whether HIW will be clear regarding expectations from the independent sector.'

Question 19: Is the guidance clear on how monitoring of the duty of quality will be embedded into existing Welsh Government procedures and those of Healthcare Inspectorate Wales?

Similar themes emerged from this question to those raised in question 18. Respondents requested more detail around the implementation and delivery of this section of the guidance. Respondents also enquired what existing mechanisms are in place within Welsh Government and Healthcare Inspectorate Wales that will enable the monitoring of the Duty being embedded. One respondent asked how Welsh Government will provide feedback on the content of the annual and 'always on' reporting, to facilitate continuous improvement.

Finally, a number of respondents asked about the role of the NHS Executive, and others asked how the Duty will interface with the National Performance Framework and Integrated Medium-Term Plan (IMTP) processes.

Chapter 6 Government Response

The Duty of Quality, alongside the Duty of Candour and the new Citizen Voice Body (Llais), has been designed to positively develop the culture of quality and safety within health care in Wales. All elements of the Act seek to promote greater openness and learning, promoting a culture where it is the norm to challenge poor practice and promote innovation in a safe environment. It is therefore not felt that punitive measures for failure to comply are helpful in promoting this culture. The guidance and legislation outline clear

requirements for reporting and oversight within in the context of a learning NHS. The developing NHS Executive alongside Minsters and HIW will have role in monitoring performance against the Duty, including feedback to NHS bodies, but within the context of promoting improvement and sharing learning.

5.7 Chapter 7: Integrated Impact Assessments

This section asked for respondent's views on how the proposals outlined within the consultation may impact on people with protected characteristics (as defined under the Equality Act 2010), health disparities or vulnerable groups.

	Question	Number of Responses	Yes %	No %
Q20	What are your views on how the proposals in this consultation might impact? • on people with protected characteristics as defined under the Equality Act 201010; • on health disparities; or • on vulnerable groups in our society. Please provide your comments here:	26		

Graphic 7.1: Chapter 7 questions, number of responses, yes/no breakdown and identified themes.

Question 20: What are your views on how the proposals in this consultation might impact?

• on people with protected characteristics as defined under the Equality Act 201010; • on health disparities; or • on vulnerable groups in our society.

Several respondents felt that the proposals in the consultation have the potential to positively impact the groups outlined. Engagement with groups with protected characteristics during the consultation process was acknowledged by respondents. However, more detail on which groups and the input and feedback they provided was requested. Once again, communication and engagement emerged from respondents' comments and more specifically the need for information to be accessible, with the individual's communication needs being considered and accommodated. Some respondents felt that more public/service user engagement is required for successful implementation, and one respondent felt that interactive feedback would be helpful to inform continuous improvement.

Chapter 7 & 8 Government Response

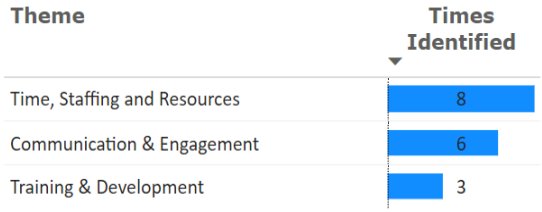
We welcome the comments and conversation on how the Duty will impact on people with protected characteristics and echo the comments on how the Duty supports better equity with the Welsh language. Throughout the development of the guidance, input was sought from a variety of stakeholders, predominantly through the formal governance and reporting routes that were established within Welsh Government.

We encourage NHS bodies across Wales to continue engaging with their populations to better understand the needs of people when they use services and what they would like to know about the quality of services.

5.8 Chapter 8: Integrated Impact Assessments (Welsh Language)

This section of the consultation asked respondents for their views on the effects the Duty of Quality would have on the Welsh language.

	Question	Number of Responses	Yes %	No %
Q21	We would like to know your views on the effects that the duty of quality proposals would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favorably than English. For example, what effects do you think there would be? How could positive effects be increased, or negative effects be mitigated? Please provide your comments here:	24		
Q22	Please also explain how you believe the proposed duty of quality could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favorably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favorably than the English language.	18		



Graphic 8.1: Chapter 8 questions, number of responses, yes/no breakdown and identified themes.

Question 21: We would like to know your views on the effects that the duty of quality proposals would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favorably than English. For example, what effects, what effects do you think there would be? How could positive effects be increased, or negative effects be mitigated? Please provide your comments here:

Question 22: Please also explain how you believe the proposed duty of quality could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.

It was felt that the Duty of Quality could have a positive impact on the use of Welsh language, and there was a consensus amongst respondents that offering communication in Welsh as well as English would be beneficial to service users. One respondent highlighted that 'in terms of the domains; 'Equitable' should drive improvements in opportunities for people to use [the] Welsh [language].'

However, it was highlighted by a number of respondents that implementing this in practice will be dependent on time, staff, and resources. One respondent felt that it may not be fully achievable within the current infrastructure. This point was reiterated by another respondent who stated that 'true person-centred care will need sufficient Welsh language skills' and currently this will require staff to be upskilled and more resources being made available. NHS bodies will be familiar with their responsibilities in line with the 'Five-Year Plan' set out in 'More Than Just Words' (2022).

5.9 Chapter 9: Additional Comments

The final chapter of the consultation provided respondents with the opportunity to highlight any further issues or comments that they had not been able to so far.

	Question	Number of Responses	Yes %	No %
Q23	We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:	20		

Theme	Times Identified
Communication & Engagement	4
Implementation and Delivery	4
Relationships with other Policies/Service Providers	4
Further Clarity/ Information Required: Guidance and Terminology	2
Leadership, Culture & Accountability	2

Graphic 9.1: Chapter 9 questions, number of responses, yes/no breakdown and identified themes.

<u>Question 23: We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them.</u>

Many of the points raised by respondents to this question have been addressed throughout the report, such as: engagement with service providers, further detail on implementation, and relationships with other service providers.

In relation to the latter point, respondents felt that there needed to be more consideration of the independent and social care sectors, one respondent underlined that 'quality in healthcare belongs to all organisations.

Respondents also highlighted that for the Duty of Quality to be successful it would be important for Welsh Government and the organisations implementing the Duty to be in continuous conversation to ensure an aligned approach regarding learning and development. They felt this would be, 'key to closing the gap between aspiration and implementation.' In relation to this point, another respondent

felt there needed to be more detail around how good practice and learning will be shared across Wales, this would also highlight where the Duty of Quality is being embedded well.

Chapter 9 Government Response

Following comments requesting more clarity on how the Duty interacts across services and the independent sector, wording has been clarified in the guidance. The Welsh Government fundamentally agrees with the comments on continuous conversation between Welsh Government and the NHS but also with the public. Over the coming months and years, we will continue to develop mechanisms that promote shared learning.

6. Conclusion and Next Steps

Welsh Government is grateful to the individuals and organisations who responded to the consultation process.

It is noted however, that a limited number of responses were received and that the responses were largely from NHS bodies, professional and third sector organisations with small numbers of responses from citizens.

Nonetheless, important feedback and perspectives were shared during consultation, and these have been adopted within reviewed guidance where appropriate.

Amendments have been made to the wording of the Health and Care Quality Standards, based on consultation feedback. An additional quality enabler of Workforce has been added. Clarity is given to the section on Health and Care Quality Standards to reinforce the importance of the six domains of quality and six quality enablers as an entirety.

It is recognised that responses in some areas sought clarity as to how the guidance can be achieved and what it means in practice. The guidance made clear that it was not a manual on how to do quality in healthcare. However, it demonstrates that the NHS bodies require and welcome ongoing support to strengthen their quality management systems and practical application of the duty of quality. The vast array of health services and specialties will need to consider how the duty of quality with the Health and Care Quality Standards influences their context.

It is further recognised that quality reporting is a particularly significant requirement, specifically the new concept of ‘always on’ quality reporting. It is anticipated that NHS bodies will mature their approach given time.

Indeed, the system-wide culture shift set out by the duty of quality will develop in time. Improving quality of health services takes vision, planning, investment, thorough implementation, and careful monitoring.

Welsh Government recognises the significant input and support NHS bodies and other partners have contributed to the duty of quality thus far. A programme of work to provide the practical support requested by NHS bodies is ongoing.

Appendices:

Appendix A: Theme Definitions

Theme	Definition
Communication & Engagement	It was highlighted that for the guidance to implemented successfully there would need to be continued engagement and communication with staff and service users. Providing the opportunity for voices to be heard, and information should be easily accessible and clear to understand for all.
Relationships with other Policies/Service Providers	The respondent has highlighted that there needs to be further information or clarity about how the Duty of Quality guidance will affect or be affected by other policies or service providers.
Implementation and Delivery	More information has been requested about how the Duty will be implemented and embedded in practice, or concerns are raised around the implementation and delivery methods proposed.
Leadership, Culture & Accountability	Further clarity has been requested around the roles and responsibilities, accountability and how the Duty of Quality will promote a culture of improvement and learning.
Time, Staffing and Resources	The respondent has highlighted that the implementation of the Duty will require consideration of additional resources, infrastructure and/or staff.
Training & Development	It was felt that for the guidance to be implemented in practice, colleagues would need further training and support to build their knowledge, confidence, and skills.

Further Clarity/ Information Required: Guidance and Terminology	Further detail, clarity or examples were requested to support a section of the guidance, or the respondent highlighted that terminology may need to be reconsidered.

Appendix B: List of Respondents

Respondent ID	Name of Respondent	Respondent Type
206374861	Anonymous	Anonymous
206990195	Jemaimah Morgan, Betsi Cadwaladr University Health Board	NHS professional/organisation representative
207022427	Anonymous	Anonymous
208039478	Not specified	Citizen/service user
208237978	Anonymous	Anonymous
208393233	Anonymous	Anonymous
208628586	Anonymous	Anonymous
208726413	Alexandra Scott, Cardiff & Vale University Health Board	NHS professional/organisation representative
208628764	Anonymous	Anonymous
209455304	Hywel Dda University Health Board	NHS professional/organisation representative
209456554	Ms Nicola Prygodzicz, Chief Executive, Aneurin Bevan University Health Board	NHS professional/organisation representative
209458400	Tanya Kaufmann, Royal College of Midwifes (RCM Wales)	Professional association/representative
209459251	Wendy Presgrave, Digital Health Care Wales (DHCW)	NHS professional/organisation representative
209459788	Nigel Downes, Interim Deputy Director of Nursing, Quality and Patient Experience, Velindre University NHS Trust	NHS professional/organisation representative
209461407	Christie Owen, British Dental Association Wales	Professional association/representative
209464795	Andy Long, NHS Wales Delivery Unit	NHS professional/organisation representative
209466965	Kelly Stuart, All Wales People First	Independent provider representative/association
209467150	Fair Treatment for the Women of Wales	Charity organisation/representative
209467965	Betsi Cadwaladr University Health Board Quality Directorate	NHS professional/organisation representative
209468471	Anonymous	Anonymous
209468435	Calum Higgins, Public Affairs and Policy Manager Wales, Chartered Society of Physiotherapy	Professional association/representative
209469546	Dr Grace Krause, Learning Disability Wales	Charity organisation/representative
209471233	Nick Unwin, Royal College of Nursing Wales	Professional association/representative

209481242	Prof John Boulton, National Director of NHS Quality Improvement and Patient Safety/Director Improvement Cymru, Public Health Wales	NHS professional/organisation representative
209483955	Jenna Hodges, Board of Community Health Councils in Wales (CHC Board)	Professional association/representative
209487129	Rebecca Jewell, Head of Strategy, Policy and Engagement, Health Inspectorate Wales	Professional association/representative
209488155	Heather Ferguson, Head of Policy and Projects, Age Cymru	Charity organisation/representative
209492968	Naila Noori (she/her), External Affairs Officer (Wales), Royal College of Speech and Language Therapists - Tess Saunders, Policy and Public Affairs Officer (Wales), Royal College of Podiatry - David Davies, Professional Practice Lead (Wales), Royal College of Occupational Therapists	Professional association/representative
209495219	Russell Goodway, Chief Executive, Community Pharmacy Wales	Independent provider representative/association
209495691	Alzheimer's Society Cymru	Charity organisation/representative
209496531	Valerie Billingham, Health and Care Lead, Older People's Commissioner for Wales	Professional association/representative
209497146	Daniel Edwards, Patient Safety and Engagement Officer, General Medical Council	Professional association/representative