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Delivering Safe Care, Compassionate Care

Learning for Wales from The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

July 2013

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Ministerial foreword

I am immensely proud of our NHS. Although I knew it before, since becoming Minister for Health and Social Services earlier this year, I have seen first hand the selfless dedication and commitment shown by healthcare staff. Throughout the length and breadth of Wales they provide the very best care for their patients, even when working in challenging and pressurised circumstances.

Patients also tell me, as they report consistently through independent surveys, of the excellent care they have received. Of course, I know that doesn't happen everywhere, all of the time. I, like other Assembly Members, hear from those who wish to share concerns about aspects of the care they have received. Most do so because they are seeking improvements to benefit future patients.

Patients are experts in their own lives. They bring that expertise with them every time they use the health service. Understanding the contribution people can make to producing their own health, and creating the conditions in which that can be maximised, is a 21st century challenge. By making sure patients, their families and carers, have a strong voice we can promote joint decision-making about their care and treatment, in a partnership with staff who care for them. And in that way, too, we foster relationships based on trust and reciprocity, in which concerns can be freely raised, and answers readily provided.

Our staff need to feel cared for too. Staff who feel supported, who work in effective teams will undoubtedly feel motivated and satisfied that they are making a real difference in providing safe, effective and compassionate care for patients. Our staff survey shows that there is still much to do in ensuring that our health organisations listen to what staff have to say, capture the contribution they wish to make to improving services and demonstrate that action follows from such a dialogue. This is particularly important to ensure we realise the benefits of our integrated system.

When we reflect on the events that contributed to the many failures described by Robert Francis QC in his report of the Mid Staffordshire NHS Foundation Trust, I want us to ensure we continue to build strong defences into our system to strengthen still further the culture we already have and to ensure that the NHS in Wales is safe and compassionate in everything it does.

Mark Drakeford AM

Commitment from NHS Wales Chief Executive/Director General, Health & Social Services, Welsh Government

This document sets out our response to the Robert Francis Report into the terrible events in the Mid Staffordshire NHS Foundation Trust. It demonstrates our commitment to deliver safe and compassionate care to all who use our services.

We have much to be proud of in NHS Wales and, in particular, our staff who work with great professionalism to enable the delivery of high quality care and excellent patient experience. However we know good care is not also provided and at times we let our patients down. A need for change is recognised. This change will require us to draw on our values and take action in a number of areas. Action to support innovation and continuous improvement. Action to establish and meet key standards. Action to learn from and respond to any shortcomings and failings. And action to empower our staff and patients. This is not, however a traditional action plan. Such a plan might distract us from our overarching challenge – to ensure we have a culture which focuses, at all times, on the needs and rights of patients.

This will require strong leadership and effective partnerships across all parts of our Health and Social Services system. I am confident the Welsh NHS will rise to this challenge.

David Sissling

1. Key Messages – summary of our actions

Our underpinning purpose is a Welsh NHS which delivers safe and compassionate care focussed on the needs of the individual and the population we serve.

We will continue to build on the many things already in place to ensure high quality, safe care whenever and wherever it is provided. This is summarised below:

Achieving shared values and expectations
We will ensure patients are at the centre of all that we do as equal partners. We have to create the conditions in which everyone is able to know what they can expect from their NHS, and what is expected from them. In that way all those who use NHS services can be properly informed and involved in decisions about their care.

Doing the right things well
We will have an integrated set of standards with clear expectations of what needs to be achieved to ensure good care. This means providing care which is dignified, safe, effective and compassionate and meets individual need. How we measure achievement against standards needs to be carefully balanced to ensure we do not risk stifling innovation and continuous quality improvement. We need to be clear about what good looks like and taking action when it is not. We will work with Healthcare Inspectorate Wales and other bodies to strengthen inspection and regulatory regimes and information sharing by all.

Being a listening organisation – knowing how well we are doing
Our NHS bodies must be listening organisations. This means listening to patients; listening to staff and listening to the 'system' and then acting on what is heard and seen. Gathering feedback and learning from patient experience and that of its staff will be at the heart of the Board agenda. This must be considered alongside a range of reliable, timely and robust information on performance. There may be times when this reveals concerns about the quality of care. This must lead to swift action and improvement, ensuring that we remain committed to the best possible care at all times.

We must ensure we measure what matters to those who receive services and those who provide them. We must move away from a simple focus on activity to measuring the difference activity produces. Our delivery framework will ensure a greater focus on the outcomes that make a difference. Alongside this we will accelerate the transparent and meaningful publication of measures and information on the quality of NHS services.

Being open and honest in all that we do
Within NHS Wales there is an absolute expectation to be open and honest when things go wrong. We will build on the progress already made following the introduction of the *Putting Things Right* arrangements in April 2011.

We expect NHS organisations to have mechanisms in place for staff to raise any concerns they may have and be supported to do so. Whistle blowing must be the last resort. A new policy on Whistle blowing as well as updated advice on the use of confidentiality clauses and compromise agreements will be issued before the end of July 2013.

***Care, compassion and commitment*.**
Our NHS workforce must be supported to ensure they can provide dignified, safe, compassionate care at all times. The recent staff survey shows that the overwhelming majority of staff feel their role makes a difference to patients. They must have the skills and the support to help them do their jobs well and keep improving what they do. This also means having ways to determine the right staffing levels to meet patients' needs. The implementation of acuity tools in acute medical and surgical settings for nurse staffing will be rolled out next year. A programme of work will be in place to extend this to other settings. Our healthcare support workers make an important contribution. We will ensure that they too receive the right training to fulfil their roles confidently and competently.

We will work with the other UK health departments to take forward any plans to strengthen professional regulation amongst the healthcare professions.

Leading by example
The delivery of good healthcare requires high quality management and leadership at all levels in the NHS. Healthcare leaders – clinical and non-clinical - play an important role and must be supported and developed to maximise their individual and collective potential. We will develop our clinical leaders through local and national opportunities offered by Academi Wales, the national centre for leadership excellence. We will also develop a framework to underpin the improvement of managerial standards and continuing professional development for this staff group.

Delivering safe care, compassionate care today and tomorrow.
Healthcare does not stand still. Our systems need to evolve in tandem to ensure we support continuous quality improvement as well as the ways we seek assurance about the quality and safety of care.

What next?
We will continue to build on the improvements we see and strive for and will report on progress. From 2014 we will publish an all-Wales Annual Quality Statement, building on those of each NHS organisation.

Many of the actions we plan to take could be pursued through changes to strengthen and streamline existing legislation. We will seek views on the possible future introduction of an NHS Wales Quality Bill.

2. Introduction

NHS Wales staff are hugely committed to providing the highest standards in caring for patients. They want to and do provide good care in the vast majority of cases and they must be supported to do so. We know from latest surveys and audits that most patients report high levels of satisfaction with their healthcare experience, but we also acknowledge there will be occasions when we need to do better.

We have been shocked and saddened by the appalling standards of care at the Mid Staffordshire NHS Foundation Trust. We have reflected on the patient stories so vividly described as well as the systemic failures that Robert Francis QC lists in his report. These events challenged every aspect of a system which should have been there to protect patients and ensure the highest standards of safe and compassionate care. His findings reinforce that we must never be complacent and assume that such failures were merely a feature of Stafford Hospital. We must be vigilant at all times and be clear that poor care, whatever the circumstances, cannot and will not be tolerated.

Sadly, we know there will be times when avoidable harm does happen. We see this with healthcare associated infections and accept there is still more we need to do to prevent unnecessary suffering and in some cases, potentially avoidable deaths. Our systems need to support staff to achieve this and realise our aim of zero avoidable harm. In an environment as multi- faceted as healthcare, with ever increasing demand and complexity we must remove any barriers and make it easier for staff to do their very best for their patients.

There is already much in place to build upon; so we can be confident that we can make a positive difference. It is important that all of us - from Government, Regulator, Inspectors, Professional Bodies, NHS Health Boards and Trusts and critically staff who are dealing directly, day in day out, with the citizens of Wales - have taken the opportunity to view their actions 'through the lens of Francis' and keep asking:

- Is the individual person and their carer at the centre of all that we do?
- Are we asking '*what matters to you'* rather than '*what is the matter with you*?' – ensuring we are concerned about the quality of the care and not just the quality of the treatment.
- Are patients and patient safety central to our decision making?
- Are we actively listening to what the public, patients and staff are telling us?
- Are we involving the public, patients and staff in designing and improving our services?

This has guided the actions we set out in this document. We will be clear about our expectations, the standards we expect and what good looks like, with clear thresholds and tolerances. It builds on the many things that we already have in place in NHS Wales to drive continuous improvements in the delivery of safe, compassionate care.

Robert Francis captured the learning from his report against 5 Key themes, underpinned by a fundamental improvement culture and the adoption of common values:

- Fundamental standards;
- Openness, transparency and candour;
- Compassionate, caring and committed staff;
- Strong, patient centred healthcare leadership;
- Accurate, useful and relevant information;

We have centred our learning largely on these themes. We also need to ensure we learn from other failures in care, this includes that from the police investigation into concerns about neglect in nursing homes 'Operation Jasmine' and improving the care of those with learning disabilities following the shocking events identified at Winterbourne View Hospital.

Some aspects of the Francis recommendations cover areas which are non-devolved, particularly issues relating to professional regulation. We will continue to work with the UK Government and other devolved administrations in taking forward any changes.

In what follows we set out the outcomes we want to achieve and some immediate actions to help deliver those. We will judge success more on how we are progressing towards the outcomes versus reporting against individual actions and targets as these may necessarily need to change to adapt. The winner must be quality: we want to move from hindsight: rationalising what has happened and why, to foresight: anticipation and reaction to make sure services work correctly, every time – as intended.

We have advantages in Wales: our integrated model of Health and Social Services; our relatively small size gives us flexibility; Community Health Councils; and two key inspectorates already in place. We will build on these foundations as we set out below.

3. Our starting point

Our expectation for quality is very clear. *Achieving Excellence – the Quality* Delivery Plan for NHS Wales set out a range of actions to ensure continuous improvement (*fig 1*) and much has already been achieved. *Safe Care, Compassionate Care*, the national governance framework to enable high quality care in NHS Wales sets out roles and responsibilities at all levels. This has one defining characteristic:

We will put the patient, the family, the citizen, the community at the centre of all our work. We will listen to those who use our services, we will engage with them as we plan improvements, we will address their concerns and we will respond to their personal as well as clinical needs. Our vision is of a Welsh NHS which is safe and compassionate.

Our governance framework also makes very clear the accountability at all levels in our system for ensuring high quality care. This applies to everyone working for the NHS whether they are cleaners, therapists, managers, GPs, nurses, consultants, support workers, chief executives or Board members. It also means working in partnership with other bodies and not least our public and patients *(fig 2)*.

Our aspirations in social care mirror this. The Social Services and Well-being (Wales) Bill sets out a new landscape for care and support in Wales. At the heart of this is the concept of an outcomes based approach to service delivery. The Well-Being Statement, which we published in April 2013, describes the important well-being outcomes that users and carers can expect and how we will measure whether these outcomes are being achieved.

Following publication of the Francis report we have reinforced these expectations, made it clear that everyone has a personal responsibility and accountability to ensure care quality. We have stressed the words of Francis himself that "*no one should wait for the Government to tell them what to do."* Every single act of kindness, by every single individual, has the potential to make a real positive difference to the patient experience.

We have already made a number of commitments:

To increase our efforts to eliminate healthcare associated infections. This builds on our aspiration of zero avoidable harm.

To review the Fundamentals of Care Standards so everyone – patients, carers and staff are clear about expectations.

To introduce acuity workforce tools in nursing to guide the staffing levels required to meet the needs of patients, beginning with acute hospital wards.

To review arrangements in place for inspection and regulation.

A commitment to greater transparency, including the publication of hospital mortality data.

How we will achieve these are set out in more detail throughout this document.

4. Achieving shared values and expectations

Key outcomes: patients and service users are at the centre of all that we do as equal partners.

What Wales can expect: as individuals we will be clear about what we can expect from the NHS, as well as the responsibilities we each have to protect and improve our own health.

Robert Francis expects *"every single person serving patients to contribute to a safer, committed and compassionate and caring service."* We wholeheartedly agree with this; it accords with our vision for an NHS Wales that is safe and compassionate. We are therefore starting from his and our overarching aim of ***putting the patients first.***

The events described in Stafford Hospital primarily concerned the care of older people. In Wales we will apply the principles to all groups: they will apply equally to children as to adults and irrespective of the care setting, especially as we move to increasingly providing more care within communities, rather than within the walls of a hospital. This will be especially important as our locality networks begin taking the next steps in shaping local services, with resources to make decisions about how care is developed. So too will be the greater integration between health and social care, creating a single system of care planning and delivery of services.

Central to all this is the voice of the patient. **We will see through the changes already agreed to strengthen the independent role of Community Health Councils in Wales.** Providing a stronger central Board function will enable patient's voices locally to be heard more clearly.

"Treat me as a person, not an illness"

Last year we consulted on proposals for a patient's compact – we called it *The People's NHS*. Research we commissioned to seek views on what such a compact needs to contain was published in June 2013. Many ideas for improvement were suggested including: an improvement in communication and dialogue with the public; a reduction in waste and improvements in cost-efficiency within the NHS; and more emphasis on the education of the public on health promotion and healthy living. **We will build on this conversation, redrawing our 'contract' with those who use NHS services** so they know they can expect to:

- be cared for safely and compassionately, with dignity and respect
- have timely access to services
- be fully involved and informed in decisions about their care
- have easy access to their personal health information, which is kept securely and confidentially at all times
- be told openly and honestly when things may have gone wrong and they have been harmed by their care
- have their say about their care and health services and about any concerns they may have

Effective communication, meeting individual need must underpin this. This means satisfying the needs of those who wish to be communicated with through the medium of Welsh and meeting the needs of people with other communication challenges, including sensory loss.

In return, as individuals we need to take personal responsibility for our own health, taking steps to prevent ill health, as best as we are able.

We will make this clear through the standards we set.

By all playing their part and working together in this way, within the spirit of true partnership between communities and health services, we can all continue to have confidence and trust in our NHS.

5. Doing the right things well

Key outcomes: There will be a common understanding across Wales of what good looks like. Our Inspectorates and Regulators will be more effective through collaboration and clarity of roles.

What Wales can expect: an integrated set of standards with clear expectations to ensure safe and compassionate care.

Standards and expectations

Robert Francis sets out the need for a clear set of fundamental standards, together with those which drive continuous improvement in quality over the longer term. Such standards must be easily understood by patients, the public and healthcare staff themselves. This means being clear about what good looks like and taking action when it is not. This may need action at a range of levels from ‘nipping it in the bud’ at the point of care, to intervention where systemic and serious breaches may have occurred.

There is no shortage of standards to choose from. This is part of the problem. We wish to simplify this, to be much clearer and explicit about our expectations and about what matters most to people when accessing and experiencing healthcare. This means having a set of standards that set the bar on the quality, experience and safety of care as well as the clinical outcomes we aspire to. Such a set of standards are essential for the NHS to be held to account for what it does.

Doing Well, Doing Better – Standards for Health Services in Wales, sets out the expectations for the NHS in ensuring high quality services and good governance. Our standards also encompass the need to promote and protect health. This framework also underpins the work of Healthcare Inspectorate Wales (HIW) in inspecting and regulating health services to assure the public that no service is falling below the standards we expect, or if they do swift action can be taken.

Alongside this, the *Fundamentals of Care Standards* apply across health and social care, with an annual national audit against them in acute settings. The 2012 summary report was published last month. The fundamental standards of care are now 10 years old, so it is timely to take the opportunity to update them and embed these fundamental requirements within a refreshed *Doing Well, Doing Better* framework and through the legislation that underpins this[1].

[1] Health and Social Care (Community Health and Standards) Act 2003

We will update the Fundamentals of Care and embed them within the overall standards framework: *Doing Well, Doing Better.*

They will be centred on individuals and their needs. They will set out clearly the expectations of every member of staff and organisation in serving the needs of their patients or service users and their carers.

The work of National Institute for Health and Care Excellence (NICE) will support this, using their guidance to help determine how achievement against these standards will be assessed and how we define what good looks like.

The revised set of fundamental standards will also align with the outcomes and expectations set out in the Social Services Well-Being Statement.

In setting standards and how we measure achievement against them it is important to recognise healthcare is ever changing and advancing. It is important we do not develop a regime which risks stifling innovation and continuous quality improvement. Self assessment and a commitment to self improvement must be the cornerstone of any such process. **A comprehensive programme of peer review will support this, building on the progress already made.**

Assurance and Compliance

We will work with Healthcare Inspectorate Wales and other bodies to help strengthen inspection and regulatory regimes and information sharing across them. Where needed we will bring forward changes to legislation to enable this to happen.

HIW's role is to provide the citizens of Wales with independent and objective assurance of the quality, safety and effectiveness of healthcare services making recommendations to healthcare organisations and services to promote improvements. HIW was restructured in 2009/10 to include a knowledge management function. It has led to a number of improvements and key mechanisms have been put in place:

- Annual healthcare summits with other key regulators and review bodies
- Monthly internal summits
- Organisational records which document individual serious incidents and regulatory issues amongst other things.

HIW will build on this, using the resources at its disposal to provide timely, professional and effective intervention.

HIW will review its current key work streams e.g. Dignity & Essential Care (DECI) and Mental Health Act inspections to ensure the key themes and issues arising from Francis are captured. This will include all settings, including primary and community care. Steering groups are being established, with patients, service users and experts being invited to join.

HIW will ensure it maintains an overview of the risks and issues for each health body in Wales (within the NHS and independent sector) and have sufficient flexibility into its work programme to allow it to be responsive to issues of concern. HIW will shortly publish its work programme for the remainder of 2013/14, with a three year forward work programme for the period up to April 2018 to follow in October 2013.

Taking action when there is significant cause for concern

HIW has delegated powers to place 'special measures' upon on NHS organisations, but these can only be taken with Ministerial agreement. Greater clarity is needed in relation to what constitutes 'special measures', the escalation arrangements to determine when such measures should be taken, as well as the need to ensure HIW's independence. This needs to be transparent and clearly set out for all to see.

The situation within the independent sector is clearer as non-compliance can lead to civil or criminal sanctions, however enforcement procedures need to be strengthened and similarly published so that they are open and transparent.

The sharing of information between inspection and regulatory bodies

HIW, CSSIW, Estyn and the Wales Audit Office work closely under a Heads of Inspectorates Group and jointly fund work to focus on improved information sharing and collaborative working. In addition there is a well-established Concordat group of all health related review, audit and inspection bodies, including the General Medical Council, Nursing and Midwifery Council, Medical Royal Colleges, Care Quality Commission, Health and Safety Executive and HMI Probation. Various Memoranda of Understanding and information sharing protocols are in place.

There are currently overlaps in the roles and responsibilities of a number of bodies. This has the potential for there to be grey areas when action is needed. So, greater clarity is needed in relation to which bodies' statutory powers take precedent and when. The Francis report highlighted this as a particular issue between the health and social care regulator and the Health and Safety Executive in England. In Wales, work will be progressed to develop clear protocols across the various bodies so that that accountabilities and joint working arrangements are clearly defined.

HIW will lead work to agree a plan, through the Concordat and Heads of Inspectorates Group, to develop an external assurance framework for NHS Wales by autumn 2013.

The Government commitment to review Audit, Inspection and Review Bodies in Wales is now underway. The findings will inform any changes. The proposed white paper this autumn on the future regulation of social services in Wales also provides an opportunity to determine a common set of principles for inspection across health and social care settings. The introduction of the Social Services and Well-Being (Wales) Bill significantly alters the landscape for regulation and inspection. Over the past decade or more the Care

Standards Act 2000 (CSA 2000) has helped facilitate the modernisation of regulation and inspection in Wales. HIW as well as CSSIW draws many of its powers from this Act, but this now needs to be replaced, not least because it has been largely superseded in England by other legislation.

6. Being a listening organisation - knowing how well we are doing

Key outcomes: year on year increases in reported patient and staff satisfaction

What Wales can expect: Accessible, timely and meaningful information on NHS performance, with evidence of learning and improvements as a result of patient and staff feedback

In order to know where to improve the Boards of Health Boards and Trusts, services and teams at all levels need to have access to accurate, meaningful and timely information. More importantly, this information needs to be easily accessible to the populations they serve. Our Health Boards and Trusts are committed to becoming ***Listening Organisations.*** This needs to include not only being concerned about the services they provide directly but extend to services that they commission from others to provide services to their local population on their behalf. This includes services provided by independent contactors, other NHS organisations, including those in England, in care homes and the third sector

To truly deliver person-centred care means:

- Listening to patients;
- Listening to staff;
- Listening to the 'system';

and acting on what you hear and see.

Listening to Patients

In May 2013 we published our Framework for Assuring Service User Experience. This sets out a consistent approach and the expectation on NHS organisations to put patient or user experience at the heart of their agenda. They must be explicit about what types of feedback they will expect to receive against the three domains set out in the framework:

1. First and lasting impressions, including dignity and respect.
2. Receiving care in a safe, supportive, healing environment.
3. Understanding of and involvement in care.

This will include gathering feedback from wherever care is provided including primary and community care and those provided by other sectors or NHS organisations on their behalf. Clearly listening and seeking views must be followed up by action and clear evidence of how this drives improvements in care.

1000 Lives Plus is supporting this work and developing a range of tools and guidance. Its 'The Listening Organisation' paper sets out the approach that all organisations have committed to adopt.

Listening to Staff

A listening organisation listens to and values the views of its staff, including individuals contracted independently in primary and community care settings. This helps to identify and remove barriers to delivering patient centred care. The 2013 staff survey provides all Health Boards and Trusts with a timely opportunity to learn. We expect all organisations to build on this work and develop ways in which all individuals have the opportunity to routinely have their voice heard. All organisations need to have mechanisms in place to regularly assess staff views through use of tools such as 'cultural barometers'.

This must also include listening to the voices of our students and trainees as well as the many volunteers who all play an important role in helping to ensure a positive patient experience. Organisations and services must use their feedback to constantly improve what they do.

Listening to the system

Seeking assurance that services are patient centred, evidence-based, safe and good quality requires reliable and robust information which must be thoroughly understood at all levels. The Boards of our organisations, clinical divisions, localities, practices and teams need the best possible data to make the best possible decisions and manage risk.

The National Clinical Audit and Outcome Review Programme for Wales is now in its second year and this is providing an important framework for organisations and services to assess how they are meeting standards and benchmark against the highest performing.

Being intolerant of unacceptable care

Everyone, at every level has a part to play to ensure patients receive safe, effective and compassionate care. We need to ensure we have good defences in our system to be able to identify swiftly if the quality of care in any setting may give cause for concern. This is set out in detail in *Safe Care, Compassionate Care,* our national governance framework. Systems in place to identify problems include serious patient safety incidents, audit findings, complaints and concerns. This, together with other routine data and feedback from patients and staff, needs to be drawn together to form an overall view on standards and quality of care.

Boards must ensure they have clear lines of accountability in place so that any concerns are escalated and there is appropriate intervention to safeguard patients and support staff to deliver immediate improvements.

Similarly, as Welsh Government we need to ensure that we have robust and responsive mechanisms in place to track NHS performance and quality triggers. **We are strengthening our internal systems and our interfaces with the NHS to ensure we have the right information to inform our**

decisions and actions, as well as working with regulators and inspectorates to further develop our shared approach to intervention.

By September 2013 all NHS organisations will publish an **Annual Quality Statement.** This provides Health Boards and Trusts an opportunity to inform their local public and stakeholders in an open, honest and transparent way about how what they are doing to improve quality, where they need to do better, identifying priorities and commitments going forward. Statements will include data on patient safety indicators such as Never Events and patient safety alert compliance.

The National Quality and Safety Forum will undertake a peer review of Quality Statements in the autumn to promote shared learning and improvements for future years. This will be informed by the feedback from the Wales Audit Office Structured Assessment of each NHS organisation.

"Compare with the best, not the rest"

The Delivery Framework for 2013-14 sets out the national priorities and aims to ensure a more integrated view of NHS delivery with a greater focus on prevention, integration and outcomes across pathways of care. This includes a wide range of quality measures and incorporates the principle of using quality triggers to ensure early action and potential intervention on any areas which may begin to give cause for concern.

We will build on this approach. We are determined to measure what matters and what drives good care outcomes and experience and not be focussed on meeting 'targets', which may not be clinically owned. We have learnt through the 1000 Lives Plus programme that to achieve sustainable improvements teams need to focus on the right measures to ensure reliable care for every patient, every time. We need to build on this clinically driven approach, in partnership with patients and service users, to determine the suite of measures we need in place to track progress at a national level.

An engagement exercise will take place over the next six months to seek the views of clinicians and the public in designing a suite of measures that matter to those who receive services and those who provide them. This will inform our future NHS Delivery Framework from April 2014.

As part of the commitment to transparency on performance all NHS organisations published their acute hospital level risk adjusted mortality figures earlier this year. This will now become routinely available. This also showed how complex understanding such data can be and how it must be used as an 'alarm' and not an absolute if the figures are higher than expected. We want to build on this approach and have established a **Mortality and Transparency Taskforce.** This will facilitate and accelerate the transparent, consistent and meaningful publication of measures and information on the quality of NHS services across the range of care settings. This will include

developing a range of mortality indicators, including but not limited to deaths in hospitals.

Learning from mortality case note reviews

Since 2010 NHS Wales has introduced a process to review the case notes of patients who have died in hospitals to review the care they received. A number of different approaches were introduced and much learning has been achieved. We can now build on this to develop a consistent approach.

The Chief Medical Officer has therefore mandated all acute hospitals in Wales to set up a consistent standardised system for reviewing all in-hospital deaths to detect potential harm.

Health Boards and Trusts are working together on this and a core set of questions that should be used for first level clinical review of all cases is being tested across Wales. A more detailed set of review criteria to be used on selected cases has also been developed with the support of Cardiff University and is being tested by clinical staff at a local level across Wales. Our aim is to have a consistent process, with reporting and learning on findings shared in a transparent way, in place by the end of the year. This is essential to identify areas where local improvements need to made, but also to identify and share good practice. As we move to more care being provided in the community this approach will be developed further

Death certification

Through the UK Department of Health, new arrangements will be introduced in 2014 for the certification of all deaths, including those in primary care. This takes forward outstanding actions from the Shipman Inquiry. It will include the introduction of Independent Medical Examiners to confirm the cause of death. This new approach will ensure: greater consistency in how the causes of death are recorded; lessons are learnt when the death may have been untimely; and opportunity to take action and learn from any themes that may emerge locally and nationally. **These arrangements will be implemented in Wales.**

7. Being open and honest in all that we do

Key outcomes: Any concerns about NHS care will be dealt with openly with clear evidence of learning and improvements.

What Wales can expect: No patient, carer or member of staff will be fearful of raising any concerns they have about any aspect of care or services

In this section we focus on the absolute expectation to be open and honest when things have gone wrong. In April 2011 we introduced new arrangements for dealing with concerns about NHS care and treatment. The principles of our *Putting Things Right* arrangements align very closely with what Robert Francis recommends. We want both patients and staff to feel able and supported to raise a concern or report a patient safety incident. To know they will be taken seriously; involved and supported through the process to review or investigate

that concern; receive feedback on the action taken, and learning and improvements that will be made.

Amongst staff, there is encouraging evidence of openness. Results from the recent staff survey show 78% staff said their employer encouraged them to report errors, near misses or incidents, only 6% disagreed. We know there is still more to do. We want to eliminate any fear patients and staff may feel in bringing forward a concern.

The Francis report calls for a Statutory Duty of Candour. The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 already places a number of duties on responsible bodies. This includes a duty to be open when harm may have occurred *"where a concern is notified by a member of the staff of the responsible body, the responsible body must, where its initial investigation determines that there has been moderate or severe harm or death, advise the patient to whom the concern relates, or his or her representative, of the notification of the concern and involve the patient, or his or her representative, in the investigation of the concern…"*

We will make this more explicit in light of both the Francis report and the Robert Powell Investigation and if necessary amend the legislation.

Staff at all levels, including Board members need to be able raise concerns openly and without fear of reprisal. This must be set in the context of giving feedback as part of our daily working. Raising concerns and doing what we can individually to improve matters in systems is a key part of what we should encourage. We are supporting work hosted by the Older People's Commissioner on Raising Concerns in the workplace to help develop a culture where this is the norm.

NHS organisations must have mechanisms for staff to raise concerns and to be supported in doing so. Many are developing new, innovative and confidential ways for staff to raise any concerns they may have without fear of reprisal. Whistle blowing must be the very last resort.

NHS Employers are developing a new version of the All Wales Whistle blowing policy to ensure that it encompasses best practice and issues that have arisen from the Francis Inquiry. The will be agreed by the Welsh Partnership Forum this month. As changes in legislation are currently being taken through the parliamentary process the policy will be subject to further review.

We have previously issued advice to the NHS on the use of confidentiality clauses and compromise agreements. Updated advice will be issued this month.

8. Care, compassion and commitment

Key outcomes: An NHS workforce who remains committed to providing dignified, safe and compassionate care at all times.

What Wales can expect: All healthcare staff will have the skills and support to help them do their jobs well and keep improving what they do.

No policy or piece of paper can mandate care, compassion and commitment. That is down to every single individual and the personal responsibility they take to do their very best to provide the highest quality care to patients – whether directly or indirectly. The recent staff survey again shows positive messages:

- 86% said they are happy to go the extra mile when required
- 82% feel that their role makes a difference to patients and service users

Similar results were seen in the National Survey for Wales from a patient perspective. Of those surveyed 78% people had seen a GP about their own health in the previous 12 months. Of these, 92% were satisfied with the care they received at their GP surgery. Similarly 42% of people surveyed had attended a hospital appointment in the last 12 months. Of these 90% were satisfied with the care they received. These are encouraging findings but must not make us complacent as we know there are some patients where the quality of care they receive or their overall experience falls below the standards we expect.

We also know that many of our staff work in very challenging and pressurised conditions. They too need to be cared for and supported to do their jobs well. Evidence shows us that happy, motivated staff and good team working results in better patient outcomes and experience. It is for every organisation and service to make this the local reality and foster an open and supportive culture.

Working Together, Working Differently our workforce and organisational framework, sets out a wide range of actions to support and develop our staff and describes the behaviours required and the values we aspire to as an NHS.

Many organisations have already made changes to their recruitment and selection processes to ensure that staff are recruited on the basis of their values and not just their technical skills and experience. This needs to extend to our workforce of the future.

Within nursing and midwifery, since 2009, prospective students have been required to provide a character reference alongside their academic reference. This ensures a focus on communication and attitudes to care and compassion as part of the overall recruitment process. This reference is scrutinised during selection interview and is linked to the clinical assessment students undergo throughout the 3 years of their degree programmes.

We will promote research into how organisations can foster compassionate care. It is important to understand the factors that enable organisations to consistently deliver compassionate care. The National Institute for Health Research, supported by NISCHR in Wales has called for researchers to develop proposals to strengthen organisational capacity to deliver compassionate care in the NHS. This is focused on particular areas highlighted in the Francis report where local organisations are asked to take action to strengthen patient voice, improve frontline care and change culture through leadership.

Key to patient safety and good care is the need to determine the right staffing levels to meet patient's needs. As our in-patient population now consists predominantly of older people, who often have complex needs including chronic conditions and dementia, the workforce establishments need to change to remain appropriate to the care needs of patients. This is particularly true of front line nursing staff.

The Chief Nursing Officer is leading work to introduce a suite of acuity workforce tools for organisations to locally determine the nurse staffing levels needed at any given time. This must be a dynamic process to meet with demand and level of need. This will be implemented firstly with adult acute – medical and surgical inpatient environments. Subject to successful testing this will be rolled out further from April 2014.

A programme of work will be taken forward to extend this approach to other settings including community and mental health services during 2014.

In the interim all NHS organisations are working to a set of core principles to determine nurse staffing needs in these acute areas. Where staffing levels are below this best practice guide, plans are being put in place by all organisations to address the gap. All organisations have robust governance arrangements to ensure staffing levels remain safe at all times.

The work of the ***Free to Care, Free to Lead*** group under the leadership of the Chief Nursing Officer will continue to tackle issues identified by staff and patients. The most recent output from this group is a continence and toileting care bundle for frontline staff, launched in June 2013. This includes assessment tools, guidance on referral for specialist care, audit and patient experience questions. Further work this year focuses on strengthening arrangements that promote professionalism in health professionals, e.g. clinical leadership development, clinical supervision arrangements and the quality of annual appraisal and individual performance development planning. There is continued work on reducing bureaucracy by streamlining the range of documentation the nursing workforce, with work to develop an electronic approach to recording a core nursing data set; phase 1 of this work will be completed by the end of 2013.

We all have a right to be treated with dignity and respect. Following the Older People's Commissioner review ***Dignified Care?;*** Both Welsh Government and the NHS have made significant progress in taking forward its

recommendations. Dignity in care remains a tier 1 delivery requirement for NHS Wales.

There has been a particular focus on caring for people with dementia. All organisations are working to plans to improve care for those with dementia in acute care settings. Changes to care environments as well as the way people with dementia are cared for are now being implemented across all organisations. For example many areas have introduced the Butterfly scheme which helps staff identify those patients that need specific care; or are using the 'This is me' tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests; this is supported by the Alzheimer's Society.

For vulnerable adults accessing health and social care services Wales we established an independent advocacy service in August 2010 [http://www.advocacyserviceswales.co.uk/]. Ensuring all people are supported to have the right care at the right time and having someone who will speak up for them when they cannot do it for themselves is essential.

Treating people as individuals needs constant attention and needs to be embedded in all that we do day in day out.

We want a **system of professional regulation** that supports the highest possible level of professional standards throughout the healthcare workforce in Wales to deliver patient centred services. The Francis report makes a number of recommendations in this area, including for the bodies who oversee these functions. Any changes will be taken forward on a UK basis. The regulation of healthcare professionals is a non-devolved matter with changes or extensions to regulation agreed by all four UK Health Ministers.

Healthcare Support Workers make an important contribution to caring for patients in all settings, including care homes. They spend a great deal of time with individual patients, supporting them often at their most vulnerable. They are an essential part of the service and we need to ensure they are recognised for the key role they play. They need to be properly supported and trained to fulfil their roles. In Wales we have a clear definition of the role set out within a code of conduct. This is supported by an Employer Code of Practice and national guidance on delegation which sets out the responsibilities of registered health staff and those of support workers who undertake delegated and supervised activity.

The Workforce and Education Development Service is reviewing the training requirements for this group of staff. Ensuring all support staff receive the right level of training so that they are confident and competent to fulfil their roles is essential. This will be completed by end of December 2013.

Where support staff have been found to fall below standards expected they can be barred from working. This is managed by the Disclosure and Barring Authority

We will continue the roll out of medical revalidation for all doctors in Wales which is a new process designed to ensure that licensed doctors are up-to-date and fit to practise. The process ensures that every doctor is engaged in regular appraisal, based on key areas of evidence including patient feedback, and that any development needs are supported. Similarly following the Nursing and Midwifery Council's planned decision on the future for the revalidation of nursing and midwifery, due this autumn, any changes will need to be implemented in a planned and collaborative way, focussing on the needs of patients.

Staff at all levels need the skills and tools to do their jobs well and keep making improvements. The **Improving Quality Together (IQT)** framework provides staff with the skills to make quality improvements in their workplace and with their teams. By March 2014 all organisations have committed to training 25% of their local workforce, including primary care, in quality methods. This promotes a common language and approach to quality improvement from the frontline to the Board, delivered locally to ensure it fits local needs and priorities.

We also need to ensure our workforce of the future are skilled in quality improvement so, working with our universities across Wales, IQT is becoming embedded within the curricula of our healthcare students across the professions. IQT will also extend to Welsh Government staff who work within the Department of Health and Social Services to ensure a common approach to improvement across all levels of our system.

This approach builds on the learning from the 1000 Lives Plus programme, the Transforming Care programme and others where providing frontline staff and teams with these skills enables them to drive local improvements to deliver evidence-based, person centred care.

The 1000 Lives Plus programme will continue to support organisations in achieving national and local priorities to improve patient safety and high quality care. A key element of the work will be the Flow and Unscheduled Care programme to help better manage the current demands and ensure the right care, in the right place at the right time for all patients.

9. Leading by example

Key outcomes: Leaders at every level in the NHS put patients and patient safety central to all that they do.

What Wales can expect: Our healthcare leaders are supported and developed to maximise their individual and collective potential.

The delivery of safe and effective health care requires high quality management and leadership at all levels within our NHS organisations. We are fortunate to have a leadership workforce motivated to go above and beyond, to do their best for patients as well as their staff. We must foster a

culture will enables those in clinical and non-clinical leadership roles to be able to make the positive contribution they desire.

Leaders need to live the values and behaviours that we expect to ensure a culture where all staff know it is normal:

- To be caring and compassionate;
- To put patients and their families first;
- To be held to account personally and up to date in all that we each do;
- To make it easier for patients to have integrated care;
- To be open and honest with colleagues;
- To recognise that staff make mistakes and help them to do it right;

and it is not normal to:

- Harm people, to ignore concerns or hide things when things go wrong;
- To assume 'I know best.'

This is our norm.

The Deputy Chief Medical Officer is leading work to develop our clinical leaders in NHS Wales.

A national leadership and engagement conference was held recently to launch this work. It will include building a Clinical Leadership Community for NHS Wales, aligned with work locally within organisations to develop their own local improvement faculties. This needs us to look at our existing clinical advisory arrangements. Our aim is that clinicians across all professions are at the heart of the NHS system alongside patients.

Academi Wales was recently established as a consequence of a key Programme for Government commitment to establish a national centre for leadership excellence in Wales. It works across the public sector and supports the development of senior managers within the NHS as well as the development of the next generation of leaders.

Academi Wales, NHS Leadership and Development Team is currently developing and delivering a number of leadership programmes specifically aimed at clinicians. In March 2012 a Medical Leadership programme designed to support North Wales Senior Clinical Leaders with the implementation of major service reconfiguration was launched. A further national Medical Leadership Programme to include Wales Deanery clinical leadership training fellows is planned for Autumn 2013. These initiatives provide knowledge and skills to secure credible and influential clinical leaders for the future.

NHS Leadership and Development Team has recently supported the Mental Health Strategy Clinical Leaders Group, to provide leadership support to assist in the delivery of efficient and effective outcomes in relation to the group role at national and local level. Interventions include group development using

diagnostics, training needs analysis supported by access to online learning resources and a series of events to support their personal and professional development.

NHS Leadership and Development Team also support wider clinical groups including the Welsh Therapies Advisory Committee, the Academy of Royal Colleges and the All Wales Pharmacist Leadership Development Programme. This support provides leadership development to assist in the planning and delivery of efficient and effective services at both a national and local level.

Academi Wales will consider the recommendations of the Francis report in relation to its work programme for the NHS and where relevant the interface with other sectors.

The Francis inquiry makes a number of recommendations regarding strengthening management and leadership across the NHS and in particular raises the question as to whether NHS managers should be regulated in the same way as other professions.

We do not have national standards in relation to management and leadership development and there is no consistent professional framework in place governing the work of NHS managers in Wales. Defining the NHS management community is not straightforward given the different levels at which people operate, the overlap in roles with clinical professional responsibilities and the different specialties that exist within the wider managerial community e.g. Finance and Human Resources.

We are establishing a working group to scope the development of a framework to underpin the improvement of managerial standards across NHS Wales. This will be led by Chief Executive of Public Health Wales and Chair of the Welsh Division of the Institute of Healthcare Management (IHM).

The group will work alongside developments at the UK level by the IHM in re-launching the IHM Accredited Manager Programme and the Vocational Scheme for managers in general practice. The IHM is currently exploring the potential to develop a route to Chartered Status for NHS managers. The group will draw membership from the NHS, *Academi Wales*, the NHS Confederation, the IHM and other stakeholders as required.

In developing a framework the group will consider:

- Clarity of definition about the population of NHS managers.
- The development and adoption of a code of conduct for NHS managers.
- The interface with other regulatory and professional bodies for some NHS managers.
- The development and adoption of standards of practice at different managerial levels within the NHS in Wales.
- The delivery of support to managers to develop appropriate skills and competencies e.g. educational providers, mentoring and coaching.

- Defining requirements for Continuing Professional Development (CPD) for managers.
- Development of a framework for accreditation including approaches to assessment, accreditation of prior learning, CPD and revalidation.
- The maintenance of a register of practice.
- Arrangements for supporting and dealing with managers who fail to meet standards.

10. Delivering safe care, compassionate care today and tomorrow

Healthcare does not stand still so the ways and means in which we ensure the quality, safety and experience of the delivery of care needs to be dynamic. We know we need to reconfigure our services to ensure the sustainable provision of safe and effective care. This means redesigning our hospital and specialist services to ensure we deliver safe, compassionate care as well as the best clinical outcomes. As we have described in our Local Health Care Plan, more and more care will be delivered in our communities rather than in our hospitals. The roles of our primary care teams will be evolving to meet local service needs. As well as this we must keep pace with increasing developments in technology. This will impact on how people access services and how they manage their own care.

The Chief Executive of Cardiff & Vale UHB is leading work to see how technology can be used to bring clinician and patient interactions and communication closer, without the need to travel to actually be in the same room as each other. ***Healthier Connections*** will look at how we can truly drive patient centred care through the use of new technologies technology, including things such as Skype. A recent conversation with a mixture of doctors, academics, technology providers and people who look after loved ones or who have long term conditions themselves explored this.

Our systems need to evolve, as do our inspection and regulatory regimes, to ensure we have robust mechanisms in place to support continuous quality improvement, together with the ways in which we seek assurance about the quality of care.

11. What next?

The lessons from Francis permeate all that we do so the actions set out here should not been seen in isolation, but viewed alongside the many improvements we see and strive for everyday at all levels in the system.

All NHS organisations and stakeholders are also setting out their individual responses, specific to their own circumstances, and over and above what is included here.

We will undertake an annual 'stock take' and report on progress through the publication of an All-Wales Annual Quality Statement from 2014, building on those published by every NHS organisation.

Many of the actions described will need changes to strengthen and streamline existing legislation. We will do this through the future **introduction of an NHS Wales Quality Bill.**

Alongside this the work of the Commission on Public Service Governance and Delivery provides an opportunity for those who are involved in delivering services, those who are politically accountable for them and users of them to examine how public services are governed. The Commission's findings will inform our future direction.

12. Having your say

We have set out a number of proposals in this document. We are very keen to hear what you think about what we are proposing. We would like to know if you think there is anything else we should be considering. You may also want to give us some suggestions to help take forward some of these proposals or contribute in some way. Please do let us know.

You can do this by emailing us at improvingpatientsafety@wales.gsi.gov.uk or by writing to us at:

Healthcare Quality Division
Department of Health & Social Services
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

Fig 1

Achieving Excellence -The Quality Delivery Plan for the NHS in Wales 2012 -2016 (Summary of Actions)

ACTION	
1	The National Quality and Safety Forum will provide oversight and strategic direction in determining areas needing a national focus and attention.
2	1000 Lives Plus will continue to be the core NHS improvement programme, ensuring a common and consistent language and approach to improvement.
3	Welsh Government will establish a Good Practice and Innovation Panel in summer 2012.
4	Health Boards and Trusts will agree a plan to train 25 per cent of their directly employed and contractor workforce in quality improvement methodology (at basic, expert or leadership level) by the end of March 2014, supported by 1000 Lives Plus.
5	During 2012 Welsh Government will develop a national approach to measuring health service user experience.
6	In 2012/13 Welsh Government will publish an annual rolling programme of clinical audit and outcome reviews.
7	NISCHR will publish a delivery framework by 1 September 2012 to monitor Health Boards and Trusts progress against its national objectives. NISCHR will also support a number of schemes to promote and facilitate opportunities for innovative ideas to be utilised in the NHS for patient benefit.
8	During 2012 Health Boards and Trusts will work together to put effective processes in place to ensure the prompt uptake of evidence-based new technologies that maximise benefit and value.
9	During 2012, HIW will support and facilitate the introduction of peer review against the standards in specific services, beginning with cancer care and end of life care.
10	The Welsh Government will work with the NHS to develop Quality Triggers and a standard template for the Annual Quality Statement by October 2012 in readiness for organisations to report for the first time at the end of 2012/13.
11	Welsh Government will work with the NHS to develop an initial Outcome Indicator Framework, supported by service specific performance measures by summer 2012.

*(NISCHR) National Institute for Social Care and Health Research

fig 2

THE QUALITY ASSURANCE SYSTEM