Safe Care, Compassionate Care

A National Governance Framework to enable high quality care in NHS Wales

January 2013

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Our Vision

All Health systems are rightly focussing on the quality and safety of care they deliver. The NHS in Wales is no different. We want to build on all the progress we have made in recent years and ensure our system is:

- Providing the highest possible quality and excellent patient experience
- Improving health outcomes and helping reduce inequalities
- Getting high value from all our services.

Whilst complex and multi-faceted, our system will have one defining characteristic. The Welsh NHS 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 one of a Welsh NHS which is safe and compassionate.

This short document sets out what this means for everyone working in or for the NHS in Wales. It describes roles and responsibilities and what needs to be in place to seek and provide assurance about the quality and safety of health care services.

Our Assurance System – an overview

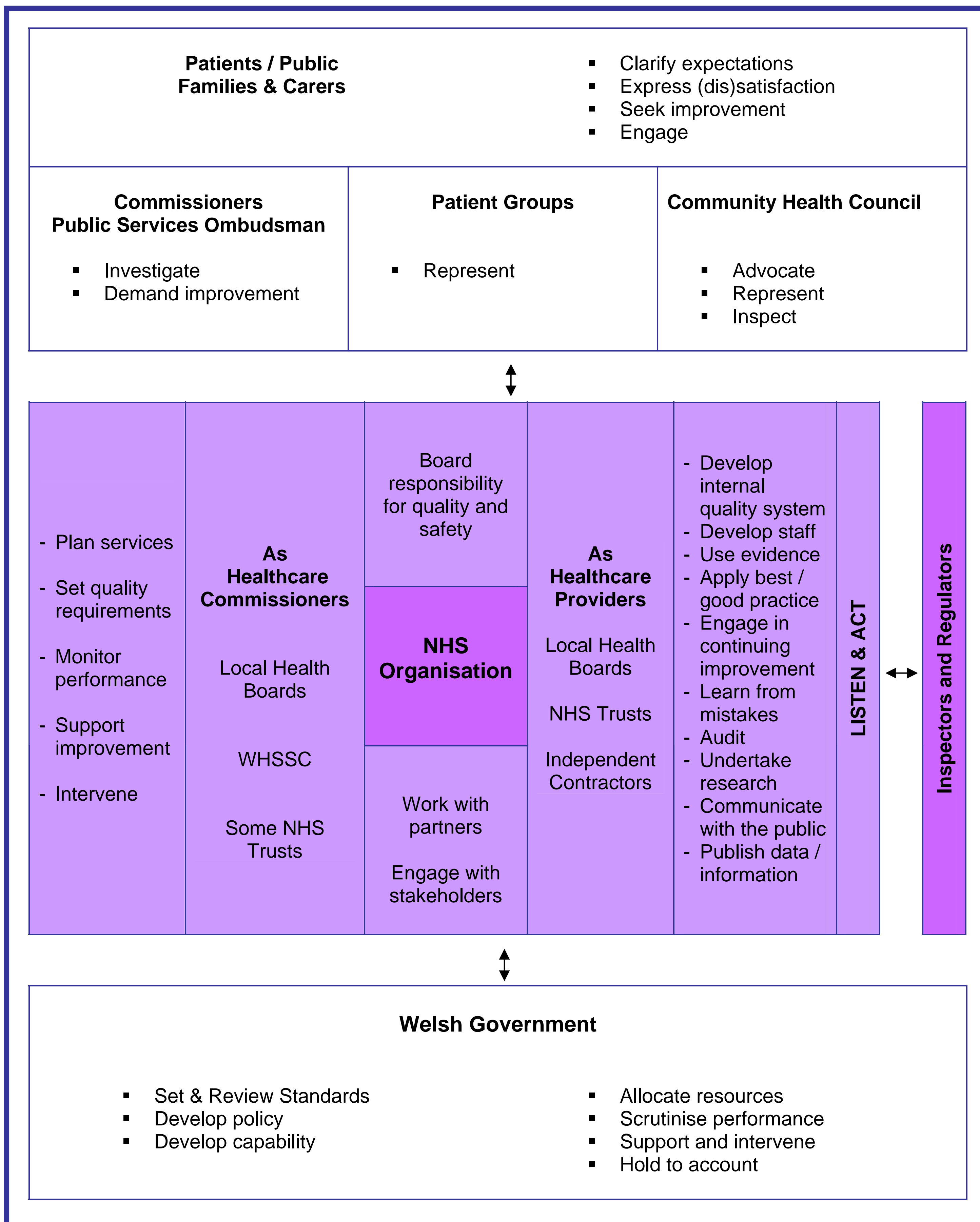
The consistent delivery of safe, high quality care relies on contributions from a wide range of organisations, individuals and stakeholders. This is summarised in figure 1.

Everyone who works in or for the NHS is there, first and foremost to serve the public. Therefore, everyone at every level has a part to play in driving up standards of safe, effective, patient-centred care. It is about always putting patients and patient safety central to decision making.

All organisations and every individual member of staff must be committed to providing the highest standards of care, ensuring every patient is treated with dignity and respect at all times. This means caring for patients in the most respectful and compassionate way. This must be intrinsic in all that we do, whatever the service and wherever it is provided.

Figure 1

THE QUALITY ASSURANCE SYSTEM



Services need to be driven by **patients and the public**. A range of mechanisms need to be in place to ensure their voices are heard. They must also have easy access to information about the availability and quality of services. Actively seeking the views of patients and citizens to measure their satisfaction with services and the experience of care received must be a priority for all organisations. This is essential to ensure services meet standards and to drive improvements where needed.

Community Health Councils have a key role in monitoring the quality of health services and ensuring the views of the people of Wales can be heard. They also support individuals through their advocacy role.

Patient Groups can also play a valuable role in representing the views of patients and what is important to them.

Other bodies such as **The Public Services Ombudsman, Children's Commissioner, Older People's Commissioner and Welsh Language Commissioner for Wales** can also take action and represent the patient, user or carers voice in identifying where improvements may be needed.

Every member of staff, including independent contractors has a personal responsibility and accountability for their actions commensurate with the role in which they are employed or contracted. Regulated health professionals also have a professional accountability for the decisions they make. All individuals must act in accordance with any codes of conduct and practise appropriate to their role. Medical staff must also participate in a revalidation programme to ensure that they remain up to date and fit to practise. All staff, whatever their role, have a duty to raise concerns if they have believe standards of patient care have been or are at risk of being compromised. They can also expect to be well supported and enabled to do their job to the highest standards at all times.

The Board of each NHS Organisation is accountable for ensuring the quality and safety of all services it provides and commissions. This includes promoting an open and supportive organisational culture where patients, staff and stakeholders can have their voice heard. All NHS organisations are required to have a Quality and Safety Committee to ensure sufficient focus and attention is given to such matters. This must be served by its independent members and report directly to the Board. This process needs to be underpinned by a robust quality assurance framework as described below.

NHS organisations operate within a much wider system and need to work closely with their **Partners**, especially social care, the third sector, the criminal justice system and others in ensuring that care is patient centred in order to meet individual need, safely and effectively.

Audit, Inspection and Regulation Bodies play a key role in assessing the quality of services to ensure standards are met and resources are being used effectively. This includes bodies such as Healthcare Inspectorate Wales (HIW), Wales Audit Office (WAO) and the Health & Safety Executive and in partnership with Care & Social Services Inspectorate Wales (CSSIW) for social care.

HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Government and healthcare providers that services are safe and good quality. If necessary, HIW will undertake special reviews and investigations where there appears to be systemic failures

in delivering healthcare services to ensure that rapid improvement and learning takes place.

An annual process of **Healthcare Summits**, co-ordinated by HIW, enable discussions between audit, inspection, regulation and improvement bodes in order to share intelligence on the quality and safety of healthcare services provided by NHS Wales. This facilitates closer working relationships and information sharing between the bodies, to inform future work programmes and targeted feedback to the NHS on areas for improvement and development.

At a national level the National Quality and Safety Forum is tasked with providing oversight and strategic direction on all aspects of quality and safety. It will determine areas that need national focus and attention. This may be as a result of concerns that emerge about care quality from external reports and national audits. It also has a role to facilitate shared learning across NHS Wales and track progress with the implementation of the actions set out in the Quality Delivery Plan. Membership is drawn from all NHS organisations, the third and independent sectors, Community Health Councils, Healthcare Inspectorate Wales and Welsh Government.

It has a number of groups that feed into it to help discharge that responsibility:

- **Quality assurance -** *ensuring our systems are robust and responsive to the recommendations from the Francis Inquiry into Mid Staffordshire NHS Foundation Trust when it reports in 2013*
- **Clinical audit and outcome review -** *raising the profile of audit and agreeing the national priorities for NHS Wales each year*
- **Patient experience -** *developing a national approach to measuring health service user satisfaction and experience and how we learn from it*
- **1000 Lives Plus programme -** *agreeing programme priorities and monitoring progress*
- **Putting Things Right -** *to promote shared learning and effectiveness of the new arrangements*
- **NICE implementation -** *to provide oversight on the introduction of the Quality Standards and other guidance*
- **Peer review -** *to advise Healthcare Inspectorate Wales on the introduction of a programme of peer review against the standards*

Welsh Government, through the **Minister for Health and Social Services** is responsible for setting policy and standards to promote high quality, safe services. It also sets out its expectations in respect of performance and the assurance it seeks from NHS organisations through its delivery and compliance frameworks. Performance is monitored internally through the Integrated Delivery Board, drawing on data and feedback from a number of sources. This informs routine delivery meetings and 6 monthly Joint Executive Team meetings with each NHS organisation, led by the Chief Executive, NHS Wales. This process includes escalation and appropriate intervention when there may be cause for concern or performance is unsatisfactory.

Our Assurance System - in detail

In recent years we have used the term *Clinical Governance* to describe the range of systems that need to be in place to provide assurance on the quality and safety of services. This is defined as: *the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.*[1]

However experience has shown us that it's not just systems, but also the culture, values and behaviours that organisations and staff exhibit which are equally important. It is this which has the greatest impact in ensuring all patients and service users get the very best standards of care. It is the responsibility of the Board to ensure an appropriate culture exists and is cultivated within the organisation, reflecting the core values of NHS Wales:

- **Putting quality and safety above all else:** providing high value evidence based care for our patients at all times
- **Integrating improvement into everyday working** and eliminating harm, variation and waste
- **Focusing on prevention, health improvement and inequality** as key to sustainable development, wellness and wellbeing for future generations of the people of Wales
- **Working in true partnerships** with partners and organisations and with our staff
- **Investing in our staff** through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively

The **Quality Delivery Plan** sets out a range of actions to help achieve this. This has a double goal – driving quality improvement and providing assurance. These two goals have much in common. Each requires a strong commitment to do the right thing and to do it well, but also to be able to demonstrate it. Both are essential to ensure good governance

Actions to drive **quality improvement** and ensure high standards of care include:

- Ensuring that staff and teams have access to training and development to enable them to fulfil their roles safely and effectively. This includes being skilled in quality improvement methodology, with opportunities to put this into practice. Continuously striving to improve what we do needs to be an integral part of everyone's job, including that of Board members. The 1000 Lives Plus programme is supporting the NHS in its efforts to continuously improve quality and safety.
- Listening to the patients voice by having ways to understand and measure their experience and satisfaction and acting on it.
- Listening to staff and students to understand their concerns and challenges they face in delivering care and identify excellence in practice which can be disseminated.

[1] Welsh Office, Quality Care and Clinical Excellence, 1999

- Participating in national clinical audit and clinical outcome reviews so that we can benchmark ourselves with others and see where we need to improve.
- Sharing good practice, participating in research and encouraging innovation and use of new technologies.
- Making good use of data and information to drive service improvement.

This is set within a system to provide robust **quality assurance**.

Seeking and Providing Assurance

There is no simple way for an organisation to gain assurance about the quality and safety of care across the range of its services. This includes those provided in primary care, by the third sector or any of the specialist services that it needs to commission. Information to provide assurance must be drawn from a number of sources, not just reliant on numbers but also on qualitative aspects of any feedback. The key is to be able to triangulate this information in order to form a clear view of how good a service is or if there may be some cause for concern.

This must be threaded through each organisation at every level so that it is possible to know that everyone is doing their best for their communities, patients and service users and that staff feel well supported to do a good job.

The local organisational assurance framework must also include ways to seek assurance not just about the services it provides directly, but also those it commissions from others. This is especially necessary within Local Health Boards to reflect their responsibility for providing integrated services.

Doing Well, Doing Better – Standards for Health Services in Wales

The Standards framework, made up of 26 specific standards set out the governance and accountability framework for the NHS in Wales. This is designed to enable services to assess if they are: "doing the right thing, in the right way, in the right place, at the right time and with the right staff". The standards are outlined in annex 1.

Clear, stretching standards are fundamental in our approach to driving continuous improvement. They also set out what citizens and patients have a reasonable right to expect from NHS services.

Organisations must test their practice and show they are meeting and continuously improving standards across all services. This should be 'bottom up' so that all teams and services know how well they are doing, identify where they need to improve and are supported to do so. HIW also use the Standards framework to monitor compliance in assessing service quality. All their findings are published. The introduction of a rolling programme of peer review from 2013/14 will further support this process.

As part of their annual assessment process all organisations have to complete the standards 'governance module' and submit to HIW, forming part of the organisations annual governance statement.

The standards need to be used alongside service and speciality specific standards, such as the Fundamentals of Care, the GP Quality and Outcomes Framework and NICE Quality Standards.

The Standards framework therefore forms the cornerstone of the overall quality assurance system, enabling Boards to provide demonstrable evidence of **meeting and improving standards:**

- Through honest self assessment, well tested through use of mechanisms such as internal audit and clinical audit
- Participation in peer review processes
- Encouraging and responding to external review from bodies such as Healthcare Inspectorate Wales
- Acting on feedback from bodies such as Community Health Councils.

Compassionate Care

All our work to ensure safety and to enable satisfactory clinical outcomes must go alongside a drive to consistently provide care which is compassionate and sensitive to personal need. So we not only need to be concerned about the quality of treatment but also the quality of care. We know our staff will work with great professionalism and commitment to achieve this, often in very demanding circumstances. To support them we will:

- foster a culture and workplace which promotes dignity and compassionate care
- ensure staff receive the training and development they need to fulfil their roles
- remove unnecessary bureaucracy to ensure staff spend as much possible time caring for their patients, building on the achievements of the *Transforming Care* Programme
- build on the Fundamentals of Care audit and look at where further improvements can be made
- ensure an overall focus on how well we meet patient expectation

Sadly there will be occasions when patients and their families are not satisfied with the care and treatment they have received. All organisations must have easily accessible and effective arrangements in place to listen to patients and their families and respond to their concerns. Openness and learning are at the heart of the ***Putting Things Right*** arrangements for dealing with concerns.

These arrangements also include the need for organisations to have processes in place for staff to report patient safety incidents locally for action and to the national reporting and learning system for learning, to ensure that national themes are identified to facilitate the development of national solutions to improve patient safety. Serious patient safety incidents must also be reported to the Welsh Government, so that they can be assured that the incident has been thoroughly investigated and action taken.

All organisations must therefore have robust arrangements in place to investigate and resolve concerns in an open, timely and meaningful way, with a focus on learning and improvement.

Being open and transparent about quality and performance

Managing risk effectively and being able to seek assurance that services are patient-centred, evidenced-based, safe and good quality requires reliable and robust information, which must be thoroughly understood at all levels in the organisation. Boards and staff need the best possible data to make the best possible decisions. A lack of information can

lead to a tolerance of unknown risks and sub-standard care. Robust risk management is an essential element of good governance. This information also needs to be widely accessible in line with the commitment set out in Together for Health for absolute transparency on performance. The importance of this is also made clear in the Quality Delivery Plan. From 2012/13 the publication of an **Annual Quality Statement** by all NHS organisations and the need to proactively track quality indicators through the introduction of **'Quality Triggers'** as an early warning system will be an important addition to the governance framework for NHS Wales.

So this means:

- Routinely using **Quality Triggers** at all levels in the organisation to monitor quality and act as an early warning system to identify services that may give cause for concern – developing a system based predominantly on foresight rather than hindsight. This needs to include a mix of 'hard' data based on quality indicators and 'softer' intelligence based on feedback from patients, users and staff, gathered in a variety of ways such as patient safety Walkrounds. Key trigger questions provide a structure to triangulate information from a variety of sources which cover all dimensions of quality:

    - Are we providing safe care?
    - Are we meeting required standards of effective care?
    - Are we improving user experience?
    - Are we providing efficient services within resources?
    - Are we engaging the workforce?
    - Are we providing accessible and equitable services?
    - Are we improving population health?

  Using quality triggers effectively will enable all organisations to demonstrate that they are truly listening and learning through strong and visible leadership of quality and safety. This needs to be set within the systems and processes that the organisation has in place for monitoring quality standards and safety such as clinical audit and incident reporting etc.

- Ensuring Board reports integrate all elements of performance so it can be clearly demonstrated if standards, experience and outcomes are improving and high value is being achieved within available resources. This is essential to show that no financial decisions or workforce considerations are made without considering the impact on service quality and safety.

- Publishing an **Annual Quality Statement**. This is first and foremost for the public. It provides an opportunity for Boards to routinely assess and inform their public and other stakeholders in an open and transparent way about:

    - how well they are doing across all their services, including primary and community care and those provided by other organisations, including the third sector, on their behalf
    - good practice that they wish to promote and share
    - areas that need to improve
    - progress made over the past year
    - priorities and commitments going forward.

The Board is accountable for the organisation’s statement and must assure itself that the information it publishes is accurate, accessible and representative across the breadth of its services.

Taking swift action when performance gives cause for concern

Using the mechanisms described above should enable organisations to pick up any areas where standards are falling and take rapid improvement action. Depending on the nature of the concern, organisations may determine that they need to seek an independent advice or review of a service. Where concerns may seriously impact on quality and safety of care and there is little evidence of improvement Welsh Government may intervene in accordance with its escalation framework. Alternatively regulators such as HIW may decide to intervene through undertaking unannounced or planned reviews.

In discharging their assurance role, Boards and individual Board members need to ensure that they have the required skills to fulfil their responsibilities. Effective Board Development should therefore be considered an essential ingredient within the organisation’s assurance framework and journey to being a truly Quality-Driven organisation.

January 2013

Annex 1

Doing Well, Doing Better: Standards for Health Services in Wales

The Standards framework covers all aspects of health care services. This is underpinned by comprehensive guidance for each standard setting out expectations on compliance

1. Governance and Accountability Framework
2. Equality, Diversity and Human Rights
3. Health Promotion, Protection and Improvement
4. Civil Contingency and Emergency Planning Arrangements
5. Citizen Engagement and Feedback
6. Participating in Quality Improvement Activities (including clinical audit)
7. Safe and Clinically Effective Care
8. Care Planning and Provision
9. Patient Information and Consent
10. Dignity and Respect
11. Safeguarding Children and Safeguarding Vulnerable Adults
12. Environment
13. Infection Prevention and Control and Decontamination
14. Nutrition
15. Medicines Management
16. Medical Devices, Equipment and Diagnostic Systems
17. Blood Management
18. Communicating Effectively
19. Information Management and Communications Technology
20. Records Management
21. Research, Development and Innovation
22. Managing Risk and Health and Safety
23. Dealing with Concerns and Managing Incidents
24. Workforce Planning
25. Workforce Recruitment and Employment Practices
26. Workforce Training and Organisational Development.