Llywodraeth Cymru
Welsh Government

Quality and Safety Framework:

Learning and Improving

Welsh Government 2021

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Foreword

In 2016, the OECD commented that quality is at the heart of the NHS in Wales, a point reiterated by the publication of A Healthier Wales, with quality and safety being highlighted as a priority above all else. As a citizen in Wales, I recognise the key importance of being able to access a safe, effective service that provides an excellent user experience.

Despite the progress that has been made in terms of establishing the NHS as a quality-led system, there is further work to do. Senedd members last year passed the Health and Social Care (Quality and Engagement) Act 2020 to introduce a strengthened Duty of Quality and Duty of Candour for the NHS in Wales, as well as create a Citizen Voice Body to strengthen the voice of our population. This legislation, together with the need to learn from recent system failings in the NHS, and to recover from the COVID-19 pandemic are the principle drivers in developing this Quality and Safety Framework.

The Framework states that organisations at every level should function as a quality management system to ensure that care meets the six domains of quality; care that is safe, effective, patient-centred, timely, efficient and equitable.

It sets out the need for a robust quality assurance framework that brings all the information surrounding quality together so it is utilised to implement effective change and improvement in care.

The COVID-19 pandemic has been the biggest challenge the NHS has faced since its creation by Aneurin Bevan, and our workforce has responded in the most incredible ways. However, despite these efforts, this new disease has caused avoidable harm, and will continue to do so unless quality and safety are placed at the heart of our approach to recovery. It is very much a priority for me that we innovate and transform as part of this recovery, and the six domains of quality provide a framework within which we can do this.

A Quality and Safety Programme overseen by a new National Quality and Safety Board will be developed to drive the high level actions described in this Framework. This Board will enable strong clinical leadership with a multi-disciplinary approach to help drive the NHS organisations in Wales along their journeys to being truly quality led.

Now, perhaps more than ever in the history of the NHS, we need to ensure a relentless focus on quality and safety, as a priority above all else. It needs to be the central focus of any decision made with regards to the care of the population as well as the design of services. I am pleased to endorse this framework and will be investing in a Quality and Safety Programme with the aim of ensuring that we have a quality-driven NHS.

Eluned Morgan, Minister for Health and Social Services

Document purpose

An overarching goal of the NHS is to improve outcomes for people, whoever they are and wherever they live, by providing people with access to high-quality health and care, delivered through a sustainable culture of learning and improvement.

Although well recognised, health and care quality can be difficult to define. This framework provides an overview of what quality looks like, highlights the key principles that underpin it and the arrangements that needs to be in place to be assured of high quality services at all times. There will need to be a strong focus on quality and safety as we emerge from the Covid-19 pandemic, trying to understand the true harm that has occurred over the past eighteen months and, moving forward, to ensure we meet the needs of our population.

Many areas of the NHS are recognised for providing exceptional high quality services. This framework provides guidance and direction for all NHS organisations with a focus on having a strong quality management system in place at all levels, in turn reducing variation in quality. This is key in meeting the aspirations set out in A Healthier Wales for a quality-driven NHS in Wales, and in readiness for meeting the expectations of the new and strengthened duty of quality.

Everyone has a role in improving quality and the framework shows what needs to be in place to ensure how everyone's voice can be heard. This document replaces the now expired Welsh Government Quality Delivery Plan, and describes a way forward, learning from recent system failures in Wales, as well as the coronavirus pandemic and its associated potential for harm. It also serves to provide a stepping stone to the new duties of quality and candour expected in 2023.

1. Context and background

1.1 Strategic background

A Healthier Wales (AHW) sets out a long-term vision that everyone in Wales should have longer, healthier and happier lives. It proposes a whole-system approach to health and social care which is equitable, and where services are designed around individuals and groups based on their unique needs and what matters to them, as well as quality and safety outcomes. The first NHS Wales core value described in A Healthier Wales is "Putting quality and safety above all else – providing high-value evidence-based care for our patients at all times."

Healthcare organisations in Wales are focused on meeting the quadruple aim of excellence in population health and wellbeing, personal experiences of care, best value from resources and an engaged and committed workforce. Our philosophy of value-based, prudent, health and care underpins this and will continue to be a distinctive feature of the Welsh system. The recent Health and Social Care (Quality and Engagement) (Wales) Act 2020 which places both an enhanced duty of quality and an organisational duty of candour will strengthen the approach to high quality, safe care.

To achieve the aspiration of having a quality-led health service, all organisations need to operate within an effective quality management system. This Quality and Safety Framework describes the interlinked key elements that must always be working together to ensure continuous improvement in quality: planning; improvement; and control; and to provide overall assurance that the system is working effectively to deliver the outcomes that we need for the people of Wales.

In line with the direction set in A Healthier Wales, work continues to bring the quality agendas within health and social care together. However, this framework focuses largely on NHS organisations in Wales, fully recognising that partnership working is key to success.

The recently-published National Clinical Framework provides a clinical interpretation of A Healthier Wales and describes a learning health and care system, centred on clinical pathways that focus on the patient, grounded in a life-course approach. In recent years, major health condition delivery plans set out policy expectations for high priority clinical services. These plans came to an end in December 2020 and as described in the National Clinical Framework, will gradually be replaced by Quality Statements. These successor arrangements will help to set out what stakeholders think are important quality attributes of high priority clinical areas, such as cancer, heart disease and stroke services; as well as services such as critical care and end of life care.

1.2 Recovery from COVID-19 Pandemic

Over the last year, the NHS has faced its biggest challenge since its inception, with the unprecedented COVID-19 pandemic. The staff and leadership of NHS organisations have responded to this challenge in an extraordinary way by developing new ways of working to support our population. During the pandemic we saw wonderful examples of high-quality care, including the retraining and redeployment of staff to the highest risk areas, effective team working and communication and, above all, arrangements centred on the new and changing needs of people.

As we emerge from the pandemic, NHS organisations are considering how to adapt services and learn from the innovative practice and outstanding clinical leadership that we have seen. Quality and safety are going to be of paramount importance in this recovery process and it is essential there is this quality and safety focus at every level. Patients waiting for treatment will be exposed to widely varying levels of symptoms and risk, so the limited clinical resource now available must be targeted at those likely to gain the most benefit. A co-productive approach to clinical care and decision making will be essential to gain and maintain public understanding and confidence.

Welsh Government has recently published Looking forward to help health and social care emerge from the pandemic, describing the challenge as building the integrated health and social care service that we want going forward and to deal with the long-term impacts of COVID-19. The opportunity is to change for the better, recognising that COVID-19 is still with us.

A key aspect to this recovery is ensuring that care is as safe as possible, and that harm is minimised. The five harms we describe in health and care in Wales, are:

1. Direct harm from COVID-19 itself
2. Indirect harm from COVID-19 due an overwhelmed health and social care system and reduction in healthcare activity as a result
3. Harm from population based health protection measures i.e. educational harm
4. Economic harm both directly and indirectly as a result of COVID-19 i.e. unemployment as a result of lockdown
5. Harm as a result of exacerbation or introduction of new inequalities in society

There is no doubt that people and their loved ones will have come to harm as a result of the pandemic, and when it comes to harm from healthcare, areas such as nosocomial transmission and delayed healthcare due to reduction in normal services, together with people trying to not over-burden the NHS, will have already, or may in the months ahead, result in harm for some individuals.

Understanding the true level of harm that has occurred, or which may still occur without mitigating actions, is a significant yet hugely important task as we recover from this pandemic. Sadly, there will be situations where harm, and possibly death have occurred, and we need to make sure that in such cases the care provided is reviewed thoroughly, to understand if harm was at all preventable and also that we learn and ensure that our policies (particularly infection control and prevention) evolve as a result.

Action 1: NHS organisations to ensure harm (both direct and indirect) associated with the COVID-19 pandemic is minimised. Organisations should implement a risk and benefit focussed approach to recovery of other services, and measure, monitor and learn from any harm.

The co-production of services going forward is also a vital aspect of recovery. As “Looking forward” describes, we need to build on the innovative ways of delivering services particularly using technology. This will be key to be able to keep in touch with individuals awaiting treatment and ensuring that robust arrangements are in place so those at greatest risk are prioritised. It will be important to take stock and ensure that any interventions are of high value and improve outcomes for people.

1.3 Quality in Wales and the Quality and Engagement Act (2020)

We have previously published several policy documents on quality within the NHS in Wales. The previous Quality Delivery Plan (2012) set out actions to drive continuous service improvement and transparency, including the introduction of Annual Quality Statements. In 2013, ‘*Delivering Safe Care, Compassionate Care’* provided a national governance framework. This framework builds on and now replaces these previous documents.

The OECD Review of Health Care Quality published in 2016 commented that quality is at the heart of the healthcare system in Wales however it did make recommendations to strengthen what has already been built. These include a

stronger relationship between health boards and Welsh Government, more visible accountability within health boards, with the technical, managerial and leadership capacity to drive up standards.

In June 2020 new legislation gained royal assent: the Health and Social Care (Quality and Engagement) (Wales) Act. The Act introduces a new duty of quality placed on NHS bodies and Welsh Ministers (in relation to their health-related functions). This enhanced legal duty sets out that all decisions that are made are done so as to secure improvement in the quality of the services provided within the Welsh NHS, and to deliver improved outcomes for the people of Wales. This legislation emphasises the need for organisations to go beyond simply maintaining their services, and to strive for continuous improvement and excellence with as much focus on health improvement and protection as sickness management.

Reframing the duty of quality in this way, moving beyond the current duty, will shift the focus of decision-making and represent a further step on the journey towards ever higher standards of person-centred health services in Wales.

To reinforce the emphasis we wish to place on person-centred services and the importance of patient experience as a determinant of a quality service, the Act specifically lists patient experience as a core component of the new duty of quality.

The Welsh Government's Health and Care Standards must also be taken into account by organisations in their discharging of the duty of quality. This framework of standards is designed to support the NHS and partner organisations in providing quality services across all healthcare settings. These standards describe what the people of Wales can expect when they access health services.

The standards were last updated in 2015 and to ensure alignment with the new legal duty of quality, these standards will now be reviewed and updated.

Action 2: Welsh Government to work with key stakeholders to review and update Health and Care standards reflecting the strengthened duty of quality.

The duty of quality mandates the requirement for NHS organisations to commit to and deliver improvements in the quality of health services. NHS organisations will be required to publish an annual report setting out the steps they have taken to secure these improvements, and include an assessment of the extent to which any improvements in outcomes that have been achieved. This new report will replace the current Annual Quality Statement.

In turn, and for the first time, Welsh Ministers will be required to present their own annual report to the Welsh Parliament, Senedd Cymru about the actions they have taken to secure improvements that will lead to higher quality care for the Welsh population. A programme of work is underway to prepare for the implementation of the new duty.

As well as a duty of quality, the 2020 Act also introduces a new organisational duty of candour. The duty will apply to NHS organisations, primary care providers in respect of their NHS services, and independent health care providers. The duty will

apply when a person who has received healthcare has suffered an adverse outcome and the provision of health care was or may have been a factor. In this context an adverse outcome will mean if the individual has experienced, or could experience, any unexpected or unintended harm that is more than minimal.

There is a clear link between candour and quality of services. There is evidence that increased openness, transparency and candour are associated with the delivery of higher quality health and social care. Organisations with open and transparent cultures are more likely to spend time learning from incidents, and they are more likely to have processes and systems in place to support staff and service users if things go wrong. This is of vital importance in a health and care setting where patients often have ongoing relationships with their health and care providers. In general, patients and service users want to be told honestly what happened and be reassured that everything is being done to learn from what went wrong.

Placing a duty of candour on NHS organisations, including providers of primary care, will improve service user experience, communication and engagement between the NHS and its service users. It will build on the work that has already been undertaken through the Putting Things Right arrangements for dealing with concerns, complaints and incidents.

Action 3: Welsh Government to work with key stakeholders on implementation of the duties of quality and candour to enable NHS organisations to be ready when the duties come into force.

The 2020 Act, when commenced, will also establish a new Citizen Voice Body (CVB) for Health and Social Care. The CVB's general objective is to represent the interests of the public in matters related to health and social services. The CVB will also have the ability to make representations about such matters to NHS organisations and local authorities, and there are duties of co-operation placed on NHS organisations, local authorities and the CVB under the Act. We envisage the new CVB developing a close working relationship with the NHS and local authorities. It will be a tremendously useful source of feedback from service users and the wider public. Our aspiration is for NHS leaders to see the CVB as a source of information and advice about what people think of health services at both national and local level. As a Body exercising functions across health and social services it also helps to deliver on the recommendations of the Parliamentary Review of Health and Social Care for the integration of health and social care services alongside more integrated citizen engagement.

This framework recognises that enabling people to access services using the Welsh language is an intrinsic part of the quality of care, and helps to ensure the safety, dignity and experience of Welsh speakers. Actions described within this framework will be developed in line with this principle and the More than just words framework.

2. A quality system

2.1 What does good quality look like?

There are various ways to describe quality in healthcare. In 1999, the then Institute of Medicine described six characteristics of quality:

- Safe - avoid harm
- Effective - evidence based and appropriate
- Person-centred - respectful and responsive to individual needs and wishes
- Timely – at the right time
- Efficient - avoid waste
- Equitable – an equal chance of the same outcome regardless of geography, socioeconomic status etc.

These characteristics of quality align with our prudent health and care principles:

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production (person centred)
- Care for those with the greatest health need first, making most effective use of all skills and resources (timely, efficient, effective)
- Do only what is needed - do no less, do no harm (safe, efficient)
- Reduce inappropriate variation using evidence-based practices consistently and transparently (equitable, effective, efficient)

Prudent health and care is being taken forward through the concept of Value-Based Health Care, to ensure care is not only high quality but also the most effective it can be for each individual.

2.2 Safety

2.2.1 Patient Safety

One domain of quality that particularly resonates with the public and staff is patient safety. Several health systems focus almost exclusively on this. The NHS in Wales has a long-standing commitment to safety, since the 1000 lives programme that ran between 2008 and 2010. That commitment remains evident in many of our processes and practices, including mortality reviews, national incident reporting and many ongoing programmes including for example those on acute kidney injury, neuro-axial connectors and medication safety.

Patient safety can be examined in two general ways. Safety I describes the traditional approach which considers safety as the absence of unsafe acts. In healthcare, a Safety I approach has led to a focus on the minority of events in care in which something has gone wrong. In Wales, we want to move towards a Safety II approach, where safety is viewed as what happens when things go right. A Safety II approach will encourage more consideration and learning from what has gone well, in addition to what has gone wrong, providing a more holistic view of safety. Every day, despite complex environments, staffing pressures and ever-changing evidence and new treatments, the staff of the NHS adapt to provide great care. It is important

to understand how they are able to overcome these issues, to celebrate that achievement and spread that learning.

Another aspect to patient safety is that of harm to patients, not due to healthcare intervention but due to the lack of treatment - harm by omission. As described previously, many routine services paused during the pandemic in order to prioritise the provision of acute care to people with COVID-19. However the population may suffer harm if these services are not re-started. Essential Services, described as life-limiting or life-impacting services, were maintained during the pandemic. The essential services quality assurance framework issued by Welsh Government focuses on the need for local accountability, governance, guidance and evidence-based assurance.

The reporting and investigation of incidents play an important role in terms of changing culture, transparency and shared learning from when harm occurs. The current Welsh incident reporting framework is being reviewed to ensure it helps develop those areas, creates a focus on immediate make safes, drives improvement and aligns with duty of candour. Investigations must be targeted for most impact, and be effective in identifying system issues. Incidents in the healthcare system can occur anywhere in Wales and there needs to be a strong focus on sharing learning that takes place across Wales, striving to make care as safe as possible. The new framework must enable learning from Safety I and Safety II type events.

Action 4: Welsh Government to work with key stakeholders to develop a new National Incident Reporting framework focussing on maximising and sharing learning from incidents.

In Wales, mortality reviews have been mandated for hospital deaths since 2013 and have been crucial in confirming important areas for continuous improvement, including sepsis and recognition of the unwell patient. A medical examiner service is now being implemented across Wales with commitments to improving patient safety and end of life care. Medical examiners independently scrutinise all deaths that are not investigated by the coroner. Their scrutiny includes asking the person's loved ones about any concerns. Where the medical examiner service detect potential issues in patient care, they will highlight these to NHS organisations to review. This will build on what has already been developed with mortality reviews in Wales and highlight areas for learning.

Action 5: National work to be undertaken to develop a learning from deaths framework, building on the continued national roll out of the Medical Examiner Service and processes already in place for reviewing mortality.

2.2.2 System Safety

It is also important that we learn from specific patient safety and care issues that may emerge. In 2020, First Do No Harm, the report from the Independent Medicines and Medical Devices Safety Review, looked at the use of pelvic mesh as well as the use of sodium valproate and the harm caused to women and children as a result of these interventions. This report was specifically looking at the use of these interventions in England, but has valuable learning for the NHS in Wales. It has

highlighted that the healthcare system as a whole did not respond quickly enough to listen to concerns raised by patients and act more rapidly.

Maternity and neonatal services are an example of systems that need a strategic approach when it comes to safety, and to maximise learning on an all-Wales basis from where harm has occurred and where the need for improvements have been identified. We want to build on the all-Wales learning that has already taken place following the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives review of maternity services in the former Cwm Taf University Health Board and other similar reviews in the UK to ensure consistent and constant improvements are made and sustained.

Action 6: National work to be undertaken to lead an all-Wales improvement approach to maximise the opportunity for learning from independent reviews of maternity and neonatal services.

The implementation of the new duties of quality and candour and the Citizens' Voice Body will significantly strengthen our system defences against such difficult experiences being repeated, particularly in terms of how critical it is that we listen to patients, their families and staff when things go wrong.

Safety in healthcare needs to go beyond individual patient safety and consider the safety of our systems. As services evolve beyond organisational boundaries to create systems of healthcare, we need to ensure that these whole systems are safe. The Safety I / Safety II concept needs to be applied to systems as a whole with reflection on what we can learn from systems that are safe and apply that learning to all our systems. We also need to consider areas such as ensuring the medical devices used are safe and that where there are concerns, these are escalated to the Medicines and Healthcare products Regulatory Agency (MHRA). We need to invest in electronic systems that ensure consistency of practice. We also need to monitor use of these systems and measure outcomes from clinical interventions including device implantation. These electronic systems include those such as electronic prescribing.

Action 7: Welsh Government to work with NHS organisations to implement vital electronic systems to support safe care, such as Electronic Prescribing and Medication Administration, Scan for Safety and the Medical Devices Information System.

3. The Quality Cycle

3.1 The Quality Cycle – A quality management system

People need public services to be organised around their needs and experiences. The culture in these services needs to be open, trusting and supportive, and planning, improvement and measurement processes need to be connected and focused on quality and learning. The elements that make up a cycle of improvement must form the backbone of an organisation, driven from the top. It is essential that

organisations create the conditions for this, through a clear vision and strong leadership.

The board must drive an effective quality management system across the organisation. When services such as maternity or frail elderly care have failed there has usually been a wider organisational weakness, in Wales as elsewhere.

Across the world, there is concern that boards can prioritise finance and performance over quality. These are easier to monitor and use in accountability discussions, but can be delivered at the expense of quality.

The boards of organisations can be at different stages of maturity in their governance approach to improvement. Organisations with high levels of maturity for quality tend to prioritise quality improvement with a long-term focus, to use data for improvement, not just for assurance or control, and engage staff and patients in quality improvement with an open culture of continuous improvement and true clinical leadership.

Quality Improvement is a common concept discussed in healthcare but it needs to be part of a bigger process - a Quality Management System.

Fig 1

This quality cycle needs to be intact and connected at local, regional and national levels to enable and drive the greatest improvement. Everyone must understand their role in this quality system. Staff as well as the public and patients must be able to contribute to each part of the cycle, through co-design and co-production, to ensure actions are relevant and meaningful to those who must benefit.

Central to the quality management system is continuous learning. It is not enough to simply repeat the cycle, each time we must capitalise on what was learnt from the previous round, gaining intelligence from all sources and improving the process.

3.2 Quality Planning

The NHS in Wales is a planned healthcare system. Organisations must plan to improve the health of the population they serve. This responsibility starts with the most crucial part, prevention, to keep people healthy and at home, whenever possible, and ultimately to improve health outcomes for the population as a whole. Good quality, timely information is needed to identify where improvement is required at every level within our systems; this includes the views of staff and patients. The duty of quality also sets out this expectation and the organisational annual reports will need to confirm how improvements in quality are being realised.

Prior to the COVID-19 pandemic, health boards were required annually to submit to Welsh Government for Ministerial approval, their Integrated Medium Term Plan (IMTP) for the following three years. During the pandemic, NHS planning changed with a more immediate focus on reducing harm and the response to COVID-19. IMTPs were temporarily replaced with a quarterly planning process. The Welsh NHS remains a planned care system but this still needs to be a dynamic process. As longer-term planning, including the return to IMTP processes, resumes, NHS organisations should build on the learning from the experience of the pandemic, to improve planning, and ensure that quality remains fundamental throughout all that they do.

NHS organisations continue to use the Wellbeing of Future Generations Act and the five ways of working as the context in which they plan. This will ensure that how organisations work, who they involve and what decisions are made will impact positively both now and in the future. Quality must always be a central to these decisions.

Wales is a bi-lingual country and it is vital our health services reflect that and develop with that principle in mind. People using the health service and staff within the service should be able to communicate in Welsh if they choose.

Action 8: **NHS organisations demonstrate through their plans that patient care and experience is central to their approach and delivery and that their governance arrangements support this requirement.**

3.3 Quality Improvement

There is world-wide evidence on how to support improvement, and NHS organisations must ensure their staff have the right skills, support and permission to make improvements in their everyday work, and to speak up when there are areas for improvement outside of their role or expertise. It is not enough to teach the workforce improvement theory, the workforce needs the capacity to carry out improvement and build it into every day work. Equally, frontline improvements must be balanced with a number of planned strategic improvements linked to the organisations' priorities if there is to be truly transformational, organisation-wide change.

The Health Foundation has outlined the need for an organisational approach to quality improvement. Without board-level leadership, system improvement will fail. It is critical to create the conditions for quality improvement at all levels within an organisation.

However organisations may not yet be fully equipped to improve. Planning, measurement and improvement teams must be strongly connected. There are areas where effective change is delivered and we need to focus on how to scale up effective change across Wales and ensure people are receiving equitable care.

In response to A Healthier Wales, Improvement Cymru, our national improvement support service, is changing to support the quality cycle across organisations, using a consistent approach to the spread of improvement and learning. Within A Healthier Wales six key areas for improvement were identified: medicines management; surgery and surgical pathways; frail elderly care; acute illness; equitable health and social care; and end of life care. Whilst responding to the COVID-19 pandemic has impacted on these plans, the areas remain relevant and a focus for Improvement Cymru as we move into recovery.

Improvement skills and behaviours needs to be built into the work of everyone working in healthcare, so the culture becomes one of continual personal and positive challenge as to how can we do better. The satisfying personal experience of leading improvement builds confidence and starts to create the leaders of the future.

Action 9: Healthcare organisations to ensure they have the capacity and capability for continuous improvement and learning.

3.4 Quality Control

Quality control occurs at the frontline of our services. People providing services need to agree, maintain and monitor the desired quality of the services they provide, and be able to detect and react when there is variation from that desired quality. Organisations need to create the processes and culture for staff to manage and standardise their daily work. This must be enabled by a systems view of the organisation and clear and consistent measures and communication throughout the organisation.

3.5 Quality assurance

Quality assurance is essential for organisational boards to understand the quality of services being provided, including those commissioned from others, how it compares with others and that, if identified, improvement work is making a difference. A systematic approach to quality planning, quality improvement and quality control can provide this. As well as the numbers, quality assurance needs to accommodate ‘qualitative intelligence’, such as the lived experiences of staff, patients and carers, as these often highlight problems before the measurement does. The existing Framework for Assuring Service User Experience sets out a range of methods to be used.

There are therefore many factors that contribute to quality assurance, including patient / user feedback, concerns and compliments, learning from deaths, incidents including serious incident reporting, clinical audit, and quality indicators and benchmarking. We need a quality assurance system that brings together intelligence on all aspects of the quality management cycle to present a coherent picture of the quality of care that organisations provide.

While regulators and inspectors also play a key role in quality assurance, they are not there in place of needing a strong organisational assurance framework

Action 10: National work to be undertaken in conjunction with key stakeholders to develop a Quality Assurance Framework to help capture all the elements of a quality management system. This will include a refreshed Framework for Assuring Service User Experience, and help prepare the way for the duties of quality and candour.

3.6 Information throughout the quality cycle

Intelligence is fundamental to improvement and assurance, and information should be consistent and widely available. Timely data is key to both understanding what is happening in organisations at any point in time but also to look at outcomes, identify areas for improvement as well as for benchmarking. Organisations need to be transparent when it comes to data and share this across Wales, striving to make care equitable. The National Data Resource, currently being developed, will facilitate this.

Value in healthcare is realised when we achieve the best possible healthcare outcomes for our population with the resources that we have. These outcomes should be comparable with the best in the world, and Prudent Healthcare has already provided a strong foundation for healthcare improvement in Wales. Realising value in healthcare requires better reporting and collection of outcome data to try to understand which interventions provide the most value to people and where there is unwarranted variation. It is vital that we provide care that is equitable and uses an evidence-based approach with implementation of NICE guidelines to help ensure high-value care.

Changes in health are important milestones in the lives of patients and we should use Patient Reported Outcome Measures (PROMs) to measure them. This can help us assess and meet patient needs, and to understand their experience of care, and to improve services.

The Once for Wales Concerns Management System (OfWCMS) is a new approach to how NHS organisations in Wales consistently report, record, learn and monitor improvements following incidents, complaints, claims and other adverse events that occur in healthcare. By bringing all this vital data together there is an opportunity for a platform that allows shared learning and will help to improve patient safety as well as patient experience. Though in early stages there is potential that data captured from OfWCMS can be used by health organisations as part of their routine management information on quality, identifying areas where improvement work is needed and helping with cultural change.

We need to harness the information that is available to us across all aspects of quality management systems to measure the quality and outcomes of care. This can be used locally and nationally, and can inform a framework for measurement and benchmarking. Quality measures need to be on at least an equal footing with performance and finance measures.

Action 11: Work to be undertaken nationally and locally to develop a measurement framework to inform a quality management system, underpinned by improved information about the quality of care.

3.7 Having an effective organisational quality management system

The Institute for Healthcare Improvement (IHI) has described a framework for effective quality governance. They found little evidence of education for independent members on effective quality management and, where it did exist, it was often focused on patient safety (just one of the six domains of healthcare quality) and also hospitals, as opposed to community and population health. Although this research was based on the American healthcare system, it is likely that similar issues would be found in the NHS.

NHS organisations should review their current quality management systems, and consider where they are, and where they need to develop, to ensure they maximise the effectiveness of their quality management system.

Action 12: NHS organisations to review and consider what needs to be in place in order to develop a fully-functioning quality management system, including ensuring the Board have the appropriate skills and knowledge to provide effective leadership of the system.

Action 13: National work to be undertaken to develop a toolkit that organisations can use to gain assurance of an effective Quality Management System.

4. Values, culture and leadership

In order to have a quality-led system, NHS Wales needs to ensure it has the right values underpinning it, with a just culture and compassionate leadership. It needs to demonstrate active listening to truly understand the views of its staff, the patients using the services and their families, and incorporate that active listening into the quality cycle. Board members need to have a presence, both in the community and within hospitals. They need to be prepared to disrupt and encourage open feedback from citizens and members of staff as to how care can be improved.

Leaders need to be relentlessly focused on a sense of common purpose, values and quality, continually improving and showing compassion to all. Compassionate leadership - “compassionate leadership for compassionate health services” - can

include attending (paying attention to staff); understanding (finding a shared understanding of the situation); empathising; and helping (taking intelligent action to help).

Compassionate leadership has been vital during the pandemic. Healthcare workers have faced unprecedented pressures both in terms of the risk and fear of getting COVID-19 from the workplace but also the desire to provide the best possible care to patients in difficult circumstances. Strong leadership has never been more important and now needs to continue with everyone contributing.

An open culture of learning and improvement is essential. We need to celebrate what goes well and acknowledge the truly amazing care and services provided by all staff within healthcare in Wales.

However, when something fails or goes wrong staff must feel safe, supported and able to speak up, having confidence that they will be listened to. If concerns are raised about the quality of care, they need to be listened to, acknowledged and acted upon. The staff of the NHS need to know that concerns are taken seriously, indeed they are welcomed. When an organisation is open and honest, staff feel able to raise concerns and to implement improvement actions. No health service is perfect and this must be acknowledged in order to feel confident in a continually improving service. The introduction of the duty of candour will support this as an approach.

When errors do occur, they need to be investigated to understand how the system failed, with rapid action taken to prevent the risk being repeated. This approach needs to not apportion blame. Even if the key action was an individual error, there will have been multiple steps that contributed and must be understood. Adequate support needs to be provided both to the patient and their loved ones but also to the members of staff involved, to know that they remain valued and supported throughout any investigation. A punitive environment is a powerful barrier to fair and authentic reflection. A just and learning culture balances fairness, justice and learning with responsibility and accountability.

Patients also need to be encouraged to speak up when things go wrong and know that their concerns and experiences are listened to and not dismissed. This is crucial in a truly learning system.

The whole workforce needs to be engaged fully in the need to improve. Personal wellbeing is a fundamental requirement for this to take place. If members of staff are suffering from burnout or feeling disengaged from the organisation, service improvement will inevitably drop off, but if wellbeing is prioritised, patient care will be safer and of higher quality and continual service improvement will occur.

Implementing the action points contained within the HEIW workforce strategy, A Healthier Wales: Our Workforce Strategy for Health and Social Care will help organisations address staff shortages by improving staff retention as well as recruitment. The Strategy aims to enrich wellbeing and working experience for those who currently provide health and social care, including volunteers and carers, and to promote health and social care as the sector of choice for the future workforce. The overarching aim for 2030 is to provide the right number of motivated, dynamic and

appropriately skilled people to help meet the health care needs of the population they serve in a sustainable, cost-effective way.

Ultimately, quality is everyone's business and needs a multi-disciplinary approach at both a local and national level. This concept needs to be embedded within the culture of our workforce, understanding and improving the quality of care we provide.

Action 14: Health organisations to engage their workforce with the quality agenda and empower all to get involved to help make the NHS in Wales a quality-led system.

5. Accountability

In order for the NHS to develop along its quality journey, strong accountability is required for all aspects of the quality management system as well as through the quality assurance framework, with as much focus on quality as there is for performance and finance. The accountability structures will strengthen with the NHS Executive function, ensuring there is always a strong focus on quality.

We need to assure that any data obtained, be it through clinical audit, peer review or errors in healthcare, is used to drive change for the better. The NHS needs to be held accountable to assure that change is happening and that data will lead to meaningful and improved outcomes for our population.

6. Going forward

Quality needs to be everyone's business with strong leadership throughout NHS in Wales. The broad actions set out in this framework are the start of the next phase of the quality journey, and the implementation work for the duties of quality and candour will build on these actions and help to ensure that we have the effective quality management system at all levels in Wales. Organisations now need to be considering how to implement and improve a quality management system, especially in light of the pandemic, and accelerate our journey.

To facilitate this, existing national quality governance structures need to be reviewed to ensure there is strong governance of quality and safety and to drive the NHS along its journey.

Action 15: A Quality and Safety programme will be established to drive forward the national actions set out in this Framework. This programme will be overseen by a new Quality and Safety Board facilitated by an NHS Executive function. This board will work to drive the quality and safety agenda and be led in partnership with the NHS. It will have a multi-disciplinary approach with participation from different professional groups.

The COVID-19 pandemic has demonstrated what an amazing health service we have in Wales, with a workforce we are extremely proud of. The challenges are far from over. A nationwide approach to quality management with an enhanced

commitment under a new duty of quality will move the NHS in Wales along its journey to become a truly quality-driven system, providing the best care for the people of Wales.

Summary of Actions

Action 1: NHS organisations to ensure harm (both direct and indirect) associated with the COVID-19 pandemic is minimised. Organisations should implement a risk and benefit focussed approach to recovery of other services, and measure, monitor and learn from any harm.

Action 2: Welsh Government to work with key stakeholders to review and update Health and Care standards reflecting the strengthened duty of quality.

Action 3: Welsh Government to work with key stakeholders on implementation of the duties of quality and candour to enable NHS organisations to be ready when the duties come into force.

Action 4: Welsh Government to work with key stakeholders to develop a new National Incident Reporting framework focussing on maximising and sharing learning from incidents.

Action 5: National work to be undertaken to develop a learning from deaths framework, building on the continued national roll out of the Medical Examiner Service and processes already in place for reviewing mortality.

Action 6: National work to be undertaken to lead an all-Wales improvement approach to maximise the opportunity for learning from independent reviews of maternity and neonatal services.

Action 7: Welsh Government to work with NHS organisations to implement vital electronic systems to support safe care, such as Electronic Prescribing and Medication Administration, Scan for Safety and the Medical Devices Information System.

Action 8: NHS organisations demonstrate through their plans that patient care and experience is central to their approach and delivery and that their governance arrangements support this requirement.

Action 9: Healthcare organisations to ensure they have the capacity and capability for continuous improvement and learning.

Action 10: National work to be undertaken in conjunction with key stakeholders to develop a Quality Assurance Framework to help capture all the elements of a quality management system. This will include a refreshed Framework for Assuring Service User Experience, and help prepare the way for the duties of quality and candour.

Action 11: Work to be undertaken nationally and locally to develop a measurement framework to inform a quality management system, underpinned by improved information about the quality of care.

Action 12: NHS organisations to review and consider what needs to be in place in order to develop a fully-functioning quality management system, including ensuring

the Board have the appropriate skills and knowledge to provide effective leadership of the system.

Action 13: National work to be undertaken to develop a toolkit that organisations can use to gain assurance of an effective Quality Management System.

Action 14: Health organisations to engage their workforce with the quality agenda and empower all to get involved to help make the NHS in Wales a quality-led system.

Action 15: A Quality and Safety programme will be established to drive forward the national actions set out in this Framework. This programme will be overseen by a new Quality and Safety Board facilitated by an NHS Executive function. This board will work to drive the quality and safety agenda and be led in partnership with the NHS. It will have a multi-disciplinary approach with participation from different professional groups.